



Resumption of Paediatric Ophthalmology Services During COVID-19

This guidance has been developed by The Royal College of Ophthalmologists in response to the pandemic and may be subject to change.

Introduction

The COVID-19 pandemic has resulted in widespread curtailment of clinical services. The NHS is intent on recovering services with a resumption of clinical activity set within the constraints of social distancing and minimising the risk of exposure of patients to the COVID-19 virus which continues to circulate within the community and within hospitals. At the time of writing, the national picture is of COVID-19 infections once again rising and the possibility of increased restrictions remains. There is a need to adapt services to meet the sometimes-conflicting demands of keeping waiting lists and risk due to delays down whilst maintaining a safe environment. This document provides a guide to assist hospital departments to manage their paediatric ophthalmology service during the pandemic.

All decisions on the timing, modality of appointment (medical vs non-medical, setting e.g. community vs hospital, face to face vs video or virtual), discharge, advice and guidance to be managed in the community depend on issues of:

- risk of harm and complexity
- suitability of the patient and the disease for the action proposed.

To undertake changes to the service it is important to have an agreed written system or framework for what sort of conditions or patients might be suitable for earlier or later review and for different types of assessment, or might not need to be seen at all. This can help bring consistency to all decision makers. This should be agreed with the multidisciplinary paediatric ophthalmic team including the consultants and ideally is shared with local optometrists, paediatricians, and GPs. Even better, if it can be consistent across the local region with all the local eye units using the same or similar criteria. Supplementing this with short protocols and guidelines on managing common eye conditions allows for a consistent approach in primary and secondary care and across the team.

Improved patient information materials and support resources e.g. leaflets or videos on self-management and natural history of conditions such as nasolacrimal duct obstruction and chalazion, and some teaching and training or information for local GPs and optometrists helps to keep low risk disease from requiring hospital intervention.

Waiting list review

It is important for hospitals to review patients on the waiting list for follow-up regularly as well as new referrals, and significant senior clinician input helps to take a more definitive and robust decision. Prioritisation and risk tools, as above, help a wider group of clinicians understand the consultants' approach. Many paediatric eye consultants report they have found by doing this, there are many patients "on the books" who can be safely discharged and many more whose checks can be made less frequent. It is very important to ensure that, if patients have their appointment deferred or discharged, they and their primary care clinicians (GP, and orthoptist / optometrist as appropriate) receive communications on the plan, reassurance that clinicians have reviewed their records to ensure the decision is safe and information on their condition and what to do if there is a serious concern or deterioration in their eye condition.

Telephone or video consultation

In some cases, new and follow-up patients may be suitable for teleconsultation or video consultation. This may be able to provide enough care to avoid a face to face visit, but there are many other uses: triage, reassurance and counselling, confirming whether to go ahead with an operation in light of the COVID situation or following a virtual clinic to explain test results or discuss the ensuing management plan.

Examples of where this may work well as standalone consultation include:

- patients on the waiting list for a minor eye conditions such as chalazion or congenital nasolacrimal duct obstruction
- cases of external eye and adnexal diseases and A&E conditions.

A degree of examination is possible using a video screen and visual acuity apps do exist to supplement this, but they are not fully validated against standard visual acuity tests. The record of these clinical interactions should adhere to standard hospital record keeping according to local policy and this and the letters should make it clear that this was not a face to face appointment and any potential limitations arising from this.

Involvement with trust IT departments to enable the setting up of relevant equipment, staff training to use the equipment and troubleshooting for any technical problems is required. In addition, they may need to facilitate setting-up of video or teleconsultation rooms or access to systems from clinicians working from home. Patients and families need specific support for video consultations to access the system.

Feedback from early adopters of this technology has been positive with parents / guardians preferring the convenience of not having to come into hospital and quicker consultation times. Careful patient selection is required and the limitations of the system, particularly the inability to assess visual acuity, needs to be made clear to those parents / guardians who undertake this type of appointment.

Virtual reviews

Patients with conditions that may be monitored using clinical data (e.g. symptoms, medication compliance, IOP, vision, visual fields) and imaging such as optical coherence tomography, corneal topography, or other imaging modalities may be amenable to virtual review. Examples could include paediatric keratoconus, older children with lower risk glaucoma related conditions or being screened for glaucoma, some retinal or optic nerve conditions. This can utilise non-medical clinicians (nurses, orthoptists, optometrists) or healthcare support workers and technicians to collect clinical information using proformas which may then provide the consultant or senior clinician relevant information to review alongside images. The setting of clinical standards for collection of data, time to review the data, recording of decisions and relaying such decisions to parents and other relevant parties should be agreed and within a reasonable and clinically safe timeframe. This needs to be allowed for in job plans.

New clinical models of care

Many patients are already on clinical pathways which are delivered by non-medical or allied healthcare professionals such as nurses, orthoptists, and optometrists. The expansion of these services has been stimulated by the pressures on the traditional medically delivered pathways. The current COVID crisis has further highlighted the need to continue to develop and expand these extended role and advanced practice pathways. In developing these, delivery of training and assessment of competencies requires the supervision of ophthalmologists but can also be performed by cascade training using experienced non-medical advanced practitioners. This may be negatively impacted by restrictions in place within the outpatient setting. However, many aspects of training may still be delivered through “virtual teaching sessions” or dedicated teaching clinics. Remember that the NHS Attend Anywhere video platform allows more than one clinician to consult with a patient which can provide training opportunities. This care should also be supported by flow charts, protocols, and guidelines to support consistent decisions.

Clinic re-organisation

Structural lay out of clinics will vary in different hospitals and, with social distancing measures in place such as the “2-metre” rule or “1-metre+” rule, a significant reduction in clinic activity will be inevitable. Appropriate selection and triaging of patients who require face to face reviews as opposed to any alternative form of review is an important step. Overcoming these social distancing restrictions may require clinics to be run in different ways.

Possible mechanisms include:

1. **Mixed clinic models** with face-to-face consultations admixed with remote consultations via telephone or video-consults. Clinic templates will require some working through depending on number of doctors in clinic, size of waiting area, and balance of new and follow-up patients to ensure timing of appointments do not cause a clash or delay in seeing patients, for example, scheduling video or telephone

consultations could be at the start of a clinic. The advantage of this would be to keep waiting times for both face to face and remote consultations separate. Mixing remote consultations within the workflow of face-to-face clinics can be more challenging. Whilst some patients / parents in a virtual waiting room may not be too frustrated at any delay in their remote consultation, those waiting for a face-to-face consultation may be less tolerant of delays and it is difficult to keep a watch on the overall clinic flow or delays. Some overcome this by some clinicians performing the video and phone consultations and the others the face to face during the session. Use of paging systems to enable patients to leave the department until they are ready to be reviewed can help reduce crowding in waiting areas.

2. **The patient at the centre:** Allocating a clinic room for a patient and parent / guardian. The reduction in waiting room capacity due to social distancing may be partly alleviated by allocating each patient and their parent / guardian directly into a clinic room, organising and undertaking all tests within that room. This would require the orthoptists, optometrists, and doctor to each visit the patient in the clinic room in turn to carry out their respective parts of the assessment. The advantage of this is to minimise the circulation of the patient in the waiting areas. To manage this successfully requires careful co-ordination within the clinic to minimise delays between, for example, the orthoptist and doctor. The disadvantage is that this puts a room out of action if there are any delays, for example waiting for the pupils to dilate. The clinicians will not have a set clinic room to work in but would “float” between clinic rooms, entering when the patient is ready to see them. They do also need easy access to the records and if these are electronic this can be an issue with multiple logging in and out of the system on a desk top computer for each clinician entering the room.
3. **Rescheduling clinics for evenings or weekends.** Capacity issues with paediatric ophthalmology have pre-existed COVID-19 and many centres already undertake 3 session days or weekend work. Re-negotiating job plans and contracts for orthoptists, optometrists and other support staff is essential for these additional capacity sessions to run. Evening and weekend clinics have the potential advantage of reducing impact on school and work schedules for patients and their families, but still have variable take up, particularly for evening clinics, for obvious reasons. However, video or telephone consultation clinics outside of the usual hours may be popular for some working families.
4. **Grouped or themed clinics** where patients with the same condition, requiring the same tests or investigations as part of their routine care could be set up to maximise the efficient use of resources and enable a more predictable flow of patients. This can be supported by agreed standardised “diagnostic bundles” of tests for specific conditions with the bundle agreed before the day of attendance for greatest efficiency. In “diagnostic hub” type arrangements, some units (if they can be flexible with the layout or are able to set up new space designed specifically for this practice), set this up as parallel one way flows in which the patient moves linearly from one test station to the next, with each station far enough to socially distance but near enough to move on rapidly. At the end of the last test, the patient sees the

clinician or, in a virtual model, then leaves. This is being very actively pursued by some units for adult glaucoma and medical retina conditions.

5. **Shared Care Arrangements.** Reducing the number of hospital visits can be facilitated by increasing shared-care arrangements with community orthoptic and optometric services. Review of patients within the hospital eye service may identify patients who are amenable to review and follow up in community orthoptic facilities. During the height of the COVID-19 lockdown, community clinics were shut down. Since then there has been an opening up of community clinics. In many cases patients would find it easier to be seen in a more local setting. Clear lines of communication and information exchange are required to ensure that patients can return to the hospital-based setting if their condition requires. In addition, review of patients on the follow up waiting lists may identify patients that are stable enough to be actively discharged for monitoring at their local optometrists, for example older children with stable cataract who have completed amblyopia treatment and not on any active treatment for associated conditions such as glaucoma, but require yearly monitoring review. Once again clear information given both to parents and optometrists is essential.
6. **Supporting primary care management.** It may be possible to prevent unnecessary attendances by empowering primary care GPs and optometrists to understand more about which patients do and do not need referral or who they might provide more care for in the community. This is best done by communications and working with primary care colleagues, providing them with more information or informal training on suitable conditions, how they are managed or self-managed, and understanding natural history. For example, some patients with blepharitis and dry eye, congenital nasolacrimal duct obstruction or chalazion may be able to be managed by their primary care practitioner. In addition, establishing a formal Advice and Guidance scheme, potentially supported by remote prescribing, can allow primary care clinicians to manage much more in the community jointly with the paediatric ophthalmologist. Be aware, however, of the limitations of the GOS system, which primary care optometrists operate under. This does not allow them to recall patients to reassess ophthalmic conditions unless they are also justified in delivering a sight test i.e. refraction and provision of spectacles. To allow them to see patients again for ophthalmic conditions, this needs to be within a commissioned service. It is worth exploring the national CUES COVID Urgent Eyecare Scheme with commissioners and the local optical committee which does provide a commissioned framework for optometrists to manage urgent adult and paediatric ophthalmology.

School Vision Screening

Whilst COVID-19 was at its height in early spring and summer, the schools vision screening programme, like many other screening programmes, was halted. The screening of children in schools is anticipated to recommence and may have done so in some areas. However, there remains a challenge regarding “catch up screening” for the cohort of children who missed screening from March to August.

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The implementation of school vision screening has been supported by the British and Irish Orthoptic Society (BIOS) and The Royal College of Ophthalmologists and is commissioned by Local Authorities as per the Healthy Child Programme.

At the time of writing, the status of the Child Vision Screening Programme remains uncertain, but the College of Ophthalmologists is seeking clarification.

Surgery

Prioritisation of surgery can be based on the guidance published by The Royal College of Ophthalmologists (<https://www.rcophth.ac.uk/wp-content/uploads/2020/05/Prioritisation-of-ophthalmic-procedures-COVID19-1.pdf>). Note that the same information is contained in brief format within the wider NHS England publication on all specialty surgery.

Local regulations around pre-operative swabbing and isolation should be adhered to. Organisations may designate green pathways for elective patients where patients known to be COVID-19 negative undergo surgery, whilst urgent (level 1) cases may be routed through different (amber) theatres. Theatre turnaround may be slow due to requirement to minimise exposure to staff from aerosol generating procedures such as extubating airways, allowing sufficient air exchange and cleaning. Operating lists will run less efficiently than before, and it is therefore imperative to review cases on the waiting list balancing clinical need and length of time on the waiting list.

Patients who have been waiting for surgery, particularly those requiring strabismus surgery, may not have had up to date measurements or refraction. Therefore, arrangements for reviewing these patients prior to surgery will need to be made. Pre-operative discussion of risks and benefits of surgery need to include the potential risk of the patient or family of inadvertent COVID-19 exposure despite every effort to minimise this risk.

All COVID-19 guidance is subject to change. Please visit the [RCOphth COVID-19 web page](#) for regular updates.