COVID-19 Inquiry: Module 3 questions

K: Any recommendations that the Academy would seek to make in order to improve healthcare and the conditions for medical professionals in the event of a future pandemic.

The Royal College of Ophthalmologists (RCOphth) believes there are four key recommendations that the Academy of Medical Royal Colleges (AoMRC) should include when outlining how the UK's health system and workforce can be better placed to face a future pandemic.

They are:

1. Better plan for the delivery of elective and outpatient services during the acute stage of a pandemic to continue appropriate levels of patient care.

2. More effectively coordinate the delivery of additional independent sector capacity in the acute and post-pandemic stage, meeting patient need while supporting comprehensive NHS services.

3. Accelerate integration between primary and secondary services to improve the availability and quality of care provided during a pandemic, including through provision of services in primary care and virtual settings.

4. Ensure there is full consultation between NHSE, DHSC, and medical colleges when taking decisions which impact the delivery of services and expand this approach across all UK nations.

Below we outline in more detail how these recommendations can be delivered, with examples from the experience of NHS ophthalmology services. Please contact policy@rcophth.ac.uk for any questions.

Better plan for the delivery of elective and outpatient services during the acute stage of a pandemic to continue appropriate levels of patient care

- NHS provider organisations and local eye care units must better plan how routine elective and outpatient ophthalmology services can be maintained during a pandemic, with consideration to appropriate infection prevention and control. There was a blanket shut-down of ophthalmology services during the initial phase of the pandemic, which is a key reason why there are now around 650,00 people waiting for a consultant-led ophthalmology appointment – almost 10% of the entire NHS backlog.

- In ophthalmology, primary care optometry and diagnostic centres not based in hospitals would be suitable for delivering routine care in the event of a future pandemic, ensuring patients continue to be treated while freeing up capacity in hospitals to provide acute care.

- An appropriate level of training provision should be maintained by providers during the acute stage of a pandemic to minimise the impact on the development of the trainee workforce. Prior to the pandemic, in 2019 94% of senior ophthalmology trainees (in their fifth year of training or higher) were on track to meet the curriculum competencies for cataract surgery. That dropped to 78% in 2021 and has still not recovered to the 2019 level. Better maintaining training provision in ophthalmology can be achieved through a combination of digital learning alongside continued practical procedures where routine services are

maintained, such as in primary care optometry or diagnostic centres not based in hospitals.

- Future planning should consider the availability of personal protective equipment (PPE) and specialty-specific guidance that instructs its use. During the COVID-19 pandemic, guidance on the use of PPE – particularly medical-grade face masks – unduly prevented many ophthalmologists from assessing and treating patients. By providing specialty-specific guidance on the use of PPE during a pandemic-type event, ophthalmology services can continue in way which is safe for patients and staff.

- NHS provider organisations should continue to share the burden of care across different settings within their localities, allowing patients to be treated as soon as possible in a setting with the most relevant sub-specialty expertise and capacity, facilitated by more cross-recognition of skills.

- Hospital management should be encouraged to seek solutions to maintaining elective services, supported by sufficient national guidance, when the acute stage of a pandemic passes. Beyond the initial phase of the pandemic, a lack of coordination regarding the maintenance of elective care fostered an overly risk-averse approach to the resumption of services which hampered the ability of units to treat patients and contributed to the extensive post-pandemic ophthalmology backlogs.

- Future planning should also take account of the availability of and pressures on the medical workforce during a pandemic-type event. Rising workloads and increasing difficulties in providing sufficient patient care is leading to doctors feeling less satisfied, as 26% of the ophthalmology workforce plan to leave ophthalmology within the next five years, hampering the ability of the NHS to tackle post-pandemic backlogs. The Long Term Workforce Plan provides long-term certainty but efforts must be made in the short term to increase workforce capacity to tackle current backlogs and secure workforce capacity ahead of any future pandemic-type event. While the plan proposes reforms to encourage those who have retired back into the workforce, more needs to be done to retain existing senior ophthalmologists and those who have already retired early to return to the workforce.

More effectively coordinate the delivery of additional independent sector capacity in the acute and post-pandemic stage, meeting patient need while supporting comprehensive NHS services

- There was a significant increase in independent sector (IS) provision of NHS cataract surgery during the pandemic, which has been maintained in the recovery phase. Approximately half of NHS cataract procedures are now delivered by IS providers, up from 34% pre-pandemic.

- While this has helped to bring down the cataract backlog, it has created challenges for the sustainability of comprehensive NHS services (in terms of available workforce and funding of NHS units). In RCOphth's 2022 census, 58% of NHS eye units said that IS providers were having a negative impact on patient care and ophthalmology services in their area. Training delivery also remains an issue – GMC's 2023 National Training Survey found that only 8% of trainees are easily able to access independent sector training opportunities when they need them.

- It is likely that in a future pandemic when hospital-based NHS ophthalmology services need to be reduced, IS provision can again help to deliver additional capacity. In this eventuality, as well as the continuing recovery phase, there must be a more coordinated approach across regions to commissioning IS providers according to local patient need, supporting rather than detracting from comprehensive NHS eye care services.

- When IS providers are commissioned to deliver NHS services, there must be contractual provisions that ensure training is delivered, and for ophthalmology services specifically these provisions should also ensure that post-operative complications and an appropriate proportion of complex procedures are delivered by IS providers.

Accelerate integration between primary and secondary services to improve the availability and quality of care provided during a pandemic, including through provision of services in primary care and virtual settings.

- Primary care optometry and secondary ophthalmology services worked much more closely during the pandemic, with more joint pathways as highlighted in the RCOphth/College of Optometrist joint vision for eye care services. This more integrated way of working was boosted by the use of virtual clinics and video appointments.

- With further technological innovation and investment, in a future pandemic more routine ophthalmology care can be maintained meaning better outcomes for patients and reducing post-pandemic backlogs. This can be enabled in England by the rollout of a national electronic eyecare referral system and the standardising of digital imaging standards. This will allow patients and clinicians more options in the diagnosis and management of eye conditions, which is particularly valuable when secondary care settings may be inaccessible due to a pandemic.

- We must build on foundational improvements outlined above to ensure near-future technological developments in areas such as artificial intelligence can be fully realised, expanding capacity, and improving patient outcomes.

Ensure there is full consultation between NHSE, DHSC, and medical colleges when taking decisions which impact the delivery of services and expand this approach across all UK nations.

- While there was strong engagement with RCOphth through meetings between College Presidents and the Chief Medical Officer for England Chris Whitty, and other senior NHS England officials, consultation on critical decisions was poor. In particular, the suspension of all routine elective care was taken with little to no consultation with RCOphth. Although we recognise that decisions had to be taken at pace with imperfect information, the consequences of this decision are still being felt today in terms of long backlogs and worse patient outcomes. Engagement was not as strong, and consultation equally poor, across the other three UK nations.

- It is imperative that in any future pandemic, medical royal colleges are properly consulted when decisions affecting the delivery of services are considered, such as the blanket shutdown of routine elective care. This critical decision, made without appropriate consultation with RCOphth, led to a range of challenges which may have been avoided if there had been appropriate opportunity to provide guidance on how services could have safely been maintained. Likewise, the decision to re-open routine eye care services was taken with little consultation with the RCOphth, resulting in central guidance lacking specialty-specific nuance. Hospital eye care units were frequently unable to restart surgery once given the green light to re-open because ophthalmology theatres continued to be prioritised for other specialties such as cancer or orthopaedics. An opportunity for advanced local planning for the continuation of ophthalmology services

could have sped up the restoration of eye care.

- High level-engagement that took place in England should also be implemented in Scotland, Wales, and Northern Ireland for future pandemic-type events, with regular meetings between chief medical officers and royal college presidents.

- Better communication regarding the role expected of medical colleges during a pandemic is also needed. For example, in relation to providing specialty-specific guidance on a range of issues including use of staff, infection prevention and control, and PPE. Physical space and staffing made available by the halt to routine care was often not utilised, infection prevention and control guidance was frequently irrelevant for ophthalmology services.

J: Any matters identified by the Academy or its member organisations that indicate what went well or was a success in how the healthcare systems responded to the pandemic.

1. The culture of innovation during the pandemic demonstrated the ability of NHS services to safely and rapidly develop their offerings to meet patient need and improve capacity.

    a. Whether through technological innovations such as virtual clinics in medical retina services, redeveloped ophthalmology services such as the COVID-19 Urgent Eyecare Services (CUES) and the prioritisation of ophthalmic outpatient appointments, or greater integration of primary and secondary eye care, when appropriately empowered and resourced by NHS management, UK ophthalmology services were able to quickly adapt to changing patient need.

    b. This cultural shift should be maintained and encouraged across the NHS, empowering clinicians to work in partnership with NHS managers to develop and implement service improvement offerings with appropriate resourcing from local stakeholders.

D: A summary of what the Academy considers to have been the impact of the increased use of technology within healthcare systems, in particular to communicate between healthcare professionals and patients, during the relevant period and whether this had a positive or negative impact on the care provided.

1. Technological innovations have improved capacity as well as reducing footfall at in-person clinics where physical infrastructure is often inappropriate but come with additional clinical risk if not implemented and managed correctly.

    a. Technology utilised to improve capacity in ophthalmology services, such as virtual clinics and remote consultations, have proved useful to increase ophthalmology capacity during the pandemic and as short-term solutions to match challenges in physical space and workforce shortages. Additional capacity allows ophthalmologists to see more patients during the acute stage of the pandemic and increase capacity to tackle the significant post-pandemic backlogs. These measures have also proven

popular with patients as alternative, convenient routes to be seen by a clinician as part of their routine or urgent care.

b. However, these alternatives can come with additional clinical risks if not implemented correctly and without adequate support from medical colleges and NHS management. In addition, an over-reliance on technological solutions such as virtual appointments can widen the inequalities gap as some patients may not find these appropriate while also not wanting to risk exposure during a pandemic-type event, leading to significant barriers to accessing care if there is no option for routine care in a physical setting. This can be alleviated if routine ophthalmology services can continue to be provided in healthcare settings such as primary care optometry or a diagnostic centre.

B: Details of any concerns the Academy was made aware of during the relevant period in relation to:

a. shortages of medicines or equipment used to provide care for Covid-19 patients during the relevant period;

b. the willingness of individuals to seek healthcare or treatment whether linked to concerns around contracting Covid-19 in healthcare settings or otherwise;

c. the increased use of NHS 111;

d. the impact of redeployment of medical staff into other areas of the healthcare system;

e. a lack of training and/or lack of adequate training for those required to provide care to patients who were seriously ill with Covid-19;

f. the use of DNACPR notices including any concerns that blanket issuing of DNACPR notices was encouraged or taking place in relation to groups of patients due to characteristics such as old age, disability or neurodivergence;

g. discharge of patients from hospital; and

h. palliative care of patients with Covid-19.

1. Some patients were reluctant to seek ophthalmology care during the COVID-19 pandemic.

    a. To help tackle this, RCOphth, AoMRC, and patient charities including Macular Society urged patients to continue to seek medical treatment. However, the blanket shut down of routine services with few physical alternatives – such as providing routine care in optometry services or diagnostic centres – still left barriers for some patients and may have exacerbated inequalities.

2. Staff were often not redeployed to help with the pandemic response after routine services were halted, meaning many clinicians were unable to undertake productive work.

    a. During the early stages of the pandemic, many ophthalmologists were not deployed to help with the response because of a lack of training to allow ophthalmologists to relearn the medical skills required to be effectively redeployed to provide frontline COVID care. This led to many ophthalmologists unable to provide routine care due to the blanket shut down while also unable to contribute to frontline services during the acute stages of the pandemic.

A: Whether the Academy considers that it was appropriately consulted by NHS/HSC or government bodies in relation to decision-making affecting its member organisations during the relevant period. Please set out any matters on which the Academy considers it ought to have been consulted or invited to provide its input but was not.

1. As outlined above, engagement between DHSC, NHSE and medical royal colleges was strong but consultation on significant decisions was poor, and similar engagement was lacking across Scotland, Wales, and Northern Ireland.

    a. Engagement with the College was good throughout the pandemic, supported in particular by regular meetings between medical college presidents and the Chief Medical Officer for England, Chris Whitty and other senior officials NHS England and the Department for Health and Social Care. This regular, high-level engagement between colleges and leading Government figures was not happening in Scotland, Wales, or Northern Ireland, however.

    b. Despite this strong engagement however, the blanket decision to suspend all routine elective care was taken with little consultation with the College. This has led to large ophthalmology outpatient backlogs across the UK, with 74% of eye units reporting they have become more concerned about the impact of said backlogs on patient care compared to a year ago. The blanket shutdown of routine care and subsequent backlogs may also contribute to loss of sight for patients unable to receive treatment either during the pandemic or while waiting for treatment post-pandemic. Similarly, a lack of sufficient consultation with RCOphth regarding the resumption of ophthalmology services meant there was little nuance in central guidance over how different specialties should reopen. This contributed to a nervousness by NHS managers over the speed and breadth of reopening ophthalmology services.

    c. Requirements of the College from Government were not always clearly communicated, particularly in relation to its role in providing specialty-specific guidance across areas such as PPE.

H: Details of the impact of the Covid-19 pandemic during the relevant period on the ability of the Academy to:

a. administer and assess examinations;

b. award qualifications; and

c. provide training to medical professionals

1. Exams were unable to be undertaken for several months at the outset of the pandemic, but the exams process was digitised before the end of 2020.

    a. RCOphth was unable to run any exams for several months at the outset of the pandemic, though the College was able to digitise its exams process and relaunch both oral and written examinations within several months

    b. RCOphth's exams department had to pause all examinations between the period of March - October 2020. During this time, the practical Refraction Certificate and Part 2 FRCOphth oral exams that

utilised real patients were redesigned to use simulators and videos instead of patients, with these exams relaunched in November 2020. Meanwhile, the College's written exams were redesigned to be delivered solely online and were relaunched as online exams in October 2020.

2. The shutdown of routine care led to a dearth of training opportunities for many specialties.

    a. The shutdown of routine care resulted in significantly fewer opportunities for trainee ophthalmologists to progress in their training programme at the beginning of the pandemic, with 31% of ophthalmology trainees currently not on course to undertake an indicative number of procedures for their stage of training according to the GMC National Training Survey 2022.

    b. To meet the lack of training opportunities in ophthalmology, the College issued decision aids from 2020 to 2022 listing curriculum derogations as appropriate to ensure training continued to progress throughout the pandemic. Decisions the College took were designed to support training progress and to reduce disruption.

    c. In addition, measures were taken to ensure training available during the pandemic was safe to trainees and participants, such as the RCOphth's mandatory 'Introduction to Phacoemulsification' course. RCOphth also continued to deliver its 'Training the Trainers' course during the pandemic virtually but found the virtual format to be less effective than the traditional face to face setting.

F: A summary of any concerns or issues reported to the Academy by its member organisations about:

a. the level and availability of Covid-19 testing for healthcare staff;

b. the nature and extent of staff-related risk assessments carried out;

c. levels of ventilation within healthcare settings;

d. the availability and allocation of PPE;

e. clinical guidance provided in relation to PPE;

f. the impact of limited PPE, or the non-availability of PPE, on the care that could be provided to patients;

g. the nature of the PPE available for use. This should include any issues relating to fitting of and training in the use of PPE and/or IPC procedures that were provided to medical professionals. Please describe any difficulties which arose due to the physical attributes of members according to their age, sex, ethnic background, disability or other reasons such as facial hair or wearing glasses.

- Please let us know if there were concerns that you raised through the Academy, rather directly than with DHSC, NHSE etc.

1. Guidance for the use of PPE and its application in specialty-specific settings was inappropriate or ineffective for a significant duration of the pandemic.

    a. National guidance on the use of PPE in ophthalmology settings was often inappropriate as it was blanket guidance with no regard for the nuances in particularly specialties, including ophthalmology. This was due to a lack of opportunity for RCOphth to provide specialty-specific guidance, for example national guidance prohibited clinicians from using masks when undertaking a slit-lamp

procedure despite being in very close proximity to a patient. Alongside this, the suitability of PPE frequently made it difficult for ophthalmology surgeons to undertake operations, often exacerbated by the inappropriateness of the PPE for certain body types.

b. If RCOphth, local NHS provider organisations or local eye units were empowered to utilise PPE in a way that worked safely and in way which facilitated more procedures, then more ophthalmology patients may have been treated. However, the approach taken during the acute stage of the pandemic was understandable given the national context of PPE shortages and a dearth information about COVID-19 transmissibility.

G: Whether the Academy's member organisations raised any concerns in relation to the development of shielding policies and the designation of individuals as Clinically Vulnerable ('CV') or Clinically Extremely Vulnerable ('CEV'), including:

a. the decision to designate individuals as CEV or CV;

b. the process by which certain medical conditions were identified as giving rise to clinical extreme vulnerability or clinical vulnerability;

c. the appropriateness of advising those designated as CEV to shield and not those designated as CV;

d. the potential impact on the willingness of those designated as CEV or CV to access healthcare services; and

e. the appropriateness of the length of time and/or periods of time during which the guidance in relation shielding remained in place.

- Please let us know if there were concerns that you raised through the Academy, rather directly than with DHSC, NHSE etc.

N/A

I: So far as not covered by any topic above, any inequalities issues (whether relating to any protected characteristic under the Equality Act 2010 or characteristic identified in s.75 Northern Ireland Act 1998, or otherwise) affecting medical professionals which the Academy was made aware of during the relevant period.

- Please let us know if there were concerns that you raised through the Academy, rather directly than with DHSC, NHSE etc.

N/A

E: Details of any concerns brought to the Academy's attention, by their member organisations or otherwise, in relation to Infection Prevention Control measures in healthcare settings during the relevant period, including

those relating to Aerosol Generating Procedures, from the perspective of health and safety in the workplace as well as patient safety.

- Please let us know if there were concerns that you raised through the Academy, rather directly than with DHSC, NHSE etc.

N/A

August 2023