Full Report : COVID-19 pandemic -related Harms in Uveitis.

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Telemedicine into uveitis practice was rapidly introduced during the COVID-19 Pandemic and large cohorts of patients were rapidly triaged to telephone clinics to enable social distancing measures This study enquired whether the pandemic-enforced reduction in face-to-face appointments resulted in harm to uveitis patients.

Objectives:

- Report the number of uveitis patients in the UK who came to harm during COVID 19 pandemic
- Identifying the COVID-19 pandemic- related cause of harm e.g. patient factors, social factors, service delivery factors.
- Characterize the severity of systemic and ocular harm.

Methods:

Specialist centers involved in the care of uveitis patients were invited to take part in this study. Five U.K specialist uveitis centres collected anonymized data over a 7-month period from January 2021-July 2021. This included the January 'lockdown'. Data was collected using Redcap tool.

Table 1 Causes of Harm

Cause	Definition	Exclusion
1.Service delivery	No follow-up /face to face appointment changed to telephone or cancelled / treatment delayed/ blood monitoring cancelled due to COVID	Service-delivery variation unrelated to COVID-19 . E.g. rescheduled appointment due to staff on leave.
2. Patient factors	Patient declines to come to hospital. Patient self-stops treatment due to concerns regarding COVID.	Patient declines care unrelated to COVID-19.
3. Social Factor	Patient unable to attend clinic due to COVID 19 factors eg Unable to access transport due to the pandemic or the driver in household member is shielding.	Factors unrelated to COVID.

We used the RCOPhth framework for categorizing the level of harm [1] as follows: catastrophic, major, moderate and minor . We excluded expected complications of planned treatment, disease progression which would have occurred despite adequate care, and development of a new disease.

Results:

14 cases of harm were reported in uveitis patients. Harm was identified in 11/14 cases during face-to-face encounters compared to 3/14 during telephone consultations. 4 uveitis patients experienced major harm, 6 moderate harm, 4 minor harm. Causes of harm were related to service delivery n=7,

patient factors n=2, social factors n=1, and in 2 cases, a combination of service delivery and patient factors, patient and social factor (n=1), service delivery and social factors(n=1).

Delayed care was identified in 10 patients (average 4 months; range 2 weeks- 12 months) In 3 patients who experienced major harm there was at least a 4-month delay in review.
In the free text comments section , mental health issues and in particular, anxiety related to COVID were highlighted by the reporting clinician. One clinician was concerned the wrong patients were being triaged to telephone clinics.

Figure 1 showing anatomic classification of Uveitis patients who experienced harm.

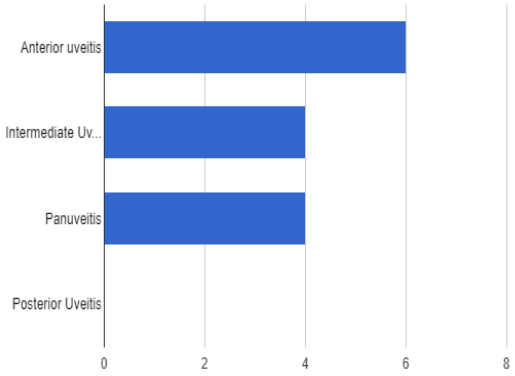

Table 2

Certainty of Harm related to COVID	Cause of Harm.	Category of Ocular Harm.
10 Definite 4 Possible	7 Service Delivery factors alone 2 Patient factors alone 1 social factor alone 1 patient and social factor 2 Service delivery and patient 1 service delivery and social factor	4 Major 6 Moderate 4 Minor

Clinicians' comments about remote consultations
Table 3

Telephone consultation not safe in complex uveitis patients
Unable to contact patient over the phone
Low mood during COVID 19
Patient's anxiety made worse by COVID

Conclusions:

This study provides a valuable insight into the causes of harm to uveitis patients during the COVID-19 pandemic. From analyzing all submissions when deciding on the setting for a review for patients on long term treatment during a pandemic or similar event, clinical factors including the need to change

treatment, history of steroid response, patient vulnerability and time from last face to face review must be considered.

Findings from this study indicate the importance of safety- netting when managing uveitis patients in the COVID 19 pandemic. From comments made by clinicians it is important that the assessing clinician considers screening for psychosocial distress during virtual or telephone clinics to better support this group of patients. Our results indicate that complex and vulnerable patients should be triaged to be reviewed face to face wherever possible in the setting of a pandemic or when a service is proposing to incorporate remote consultations as part of service delivery.

Reference 1. Categories of Harm derived from the provisional Royal College of Ophthalmology Guidance on categorizing Harm in 2020. This has since been updated. Current guidance available from: https://www.rcophth.ac.uk/wp-content/uploads/2022/01/Measuring-levels-of-harm-in-an-ophthlamic-setting-.pdf