Public Health England

NHS

Screening Quality Assurance Visit Report

NHS diabetic eye screening programme Aintree University Hospitals NHS Foundation Trust

18 January 2018

Public Health England leads the NHS screening programmes

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About PHE Screening

Screening identifies apparently healthy people who may be at increased risk of a disease or condition, enabling earlier treatment or better informed decisions. National population screening programmes are implemented in the NHS on the advice of the UK National Screening Committee (UK NSC), which makes independent, evidence-based recommendations to ministers in the 4 UK countries. The Screening Quality Assurance Service ensures programmes are safe and effective by checking that national standards are met. PHE leads the NHS Screening Programmes and hosts the UK NSC secretariat.

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Executive summary

The NHS diabetic eye screening programme aims to reduce the risk of sight loss among people with diabetes by the prompt identification and effective treatment of sight-threatening diabetic retinopathy, at the appropriate stage of the disease process.

The findings in this report relate to the quality assurance visit of the North Mersey diabetic eye screening service 18 January 2018.

Quality assurance purpose and approach

Quality assurance (QA) aims to maintain national standards and promote continuous improvement in diabetic eye screening (DES). This is to ensure all eligible people have access to a consistent, high quality service wherever they live.

QA visits are carried out by the PHE screening quality assurance service (SQAS).

The evidence for this report comes from the following sources:

- routine monitoring data collected by the NHS screening programmes
- data and reports from external organisations
- evidence submitted by the provider, commissioner and external organisations
- information collected during pre-review visits
  - familiarisation visit, 16 October 2017
  - administration review, 6 November 2017
  - clinical observation review, 27 November 2017
- information shared with SQAS (North) as part of the visit process

Local screening service

The North Mersey diabetic eye screening programme has an eligible population of 23,000. The service is commissioned by NHS England (North) Cheshire and Merseyside and is provided by Aintree University Hospitals NHS Foundation Trust (AUHT) and Southport and Ormskirk NHS Trust (SOHT).

The service has 3 clinical commissioning groups (CCGs) within its boundary: Southport and Formby, South Sefton and West Lancashire, and 2 local authorities: Sefton and West Lancashire. The population lives in urban and rural areas and is mainly white (97%). There are pockets of deprivation in Bootle, central Southport and Skelmersdale.

The service operates a fixed-booking community-based model with 5 fixed screening sites and 1 high-security hospital.

AUHT provides programme management, clinical leadership, failsafe/administration and screening and grading. SOHT provides screening and grading for patients living in the Southport area only and is commissioned separately by NHS England (North) Cheshire and Merseyside.

There are 2 referral centres and 3 treatment centres. Patients who are screened by SOHT are referred to SOHT hospital eye services (HES) at Southport and Formby District General Hospital or Ormskirk District General Hospital and those screened by AUHT are referred to Aintree Hospital HES. Patients screened by Aintree staff at the Ormskirk diabetes centre are referred to SOHT.

Findings

Immediate concerns

The QA visit team identified no immediate concerns.

High priority

The QA visit team identified 3 high priority findings:

- a screening backlog in Southport and Ormskirk NHS Trust
- lack of clarity and accountability in the commissioning arrangements with the 2 providers
- the need for a clear handover of clinical leadership due to retirement

Shared learning

The QA visit team identified several areas of good practice for sharing, including:

- comprehensive and effective failsafe arrangements for all elements of the screening pathway
- locally produced failsafe and administration guidance documents
- a bespoke information leaflet sent alongside the standard invitation letter
- a GP pack promoting the screening programme and providing locally produced posters
- robust ‘did not attend’ (DNA) management processes which support good uptake and low DNA rates
- locally produced screening guides
- support for staff regarding career progression

Other good practice is documented throughout the report.

Recommendations

The following recommendations are for the provider to carry out unless otherwise stated:

Governance and leadership

No.	Recommendation	Reference	Timescale	Priority	Evidence required
1	Commissioner to complete the governance structure review and ensure relevant terms of reference for the joint programme board	Service specification 2017 to 2018	6 months	Standard	Revised structure and terms of reference signed off at programme board
2	Commissioner to agree and implement a recovery plan with SOHT to clear the backlog of screening patients	Service specification 2017 to 2018 Pathway Standards DES-PS-1 DES-PS-2	3 months	High	Operational board minutes showing oversight of the recovery plan Audit overdue patients screened, graded and referred (if necessary) and present the audit at the operational programme board
3	Commissioner to agree with the provider a schedule of audits	Service specification 2017 to 2018	12 months	Standard	Audit schedule, results and action plans signed off at programme board

No.	Recommendation	Reference	Timescale	Priority	Evidence required
4	Commissioner to review the contracting arrangements between the 2 provider organisations to ensure clear accountability	Service specification 2017 to 2018	3 months	High	Commissioner to provide an update regarding the contracting arrangements at the operational programme board
5	The provider, screening and immunisation team and stakeholders to use the PHE Health Equity Tool or similar to identify population groups at risk of inequitable access to screening	Service specification 2017 to 2018 Guidance for NHS commissioners on equality and health inequality duties 2015	12 months	Standard	Report to be produced and presented at programme board

Infrastructure

No.	Recommendation	Reference	Timescale	Priority	Evidence required
6	The clinical lead job description should be reviewed to ensure it meets national guidance and that there are adequate PAs within the job plan to perform this role	www.gov.uk/government/uploads/system/uploads/attachment_data/file/403088/Roles_and_Responsibilities_CL_v1_0_final_2May13.pdf	12 months	Standard	Operational board minutes showing that results of the review have been presented
7	Produce a clinical lead succession plan documenting responsibility, handover and timescales	www.gov.uk/government/uploads/system/uploads/attachment_data/file/403088/Roles_and_Responsibilities_CL_v1_0_final_2May13.pdf	3 months	High	Minutes from operational board showing that plan has been presented
8	The clinical lead should have oversight of grader performance feedback	www.gov.uk/government/uploads/system/uploads/attachment_data/file/403088/Roles_and_Responsibilities_CL_v1_0_final_2May13.pdf	6 months	Standard	Minutes from operational board showing updated standard operating procedure has been presented

No.	Recommendation	Reference	Timescale	Priority	Evidence required
9	The multi-disciplinary team (MDT) meeting should be led by the clinical lead with an agreed structured agenda which encourages discussion on case reviews, learning and continuous development	www.gov.uk/government/uploads/system/uploads/attachment_data/file/403088/Roles_and_Responsibilities_CL_v1_0_final_2May13.pdf	6 months	Standard	MDT agenda and minutes
10	Review the service provision within Ashworth high security hospital to comply with national guidance including the camera and laptop software	Service specification 2017 to 2018	6 months	Standard	Minutes from the operational board showing that a review of the service provision and action plan if appropriate, has been presented

Invitation, access and uptake

No.	Recommendation	Reference	Timescale	Priority	Evidence required
11	Evaluate potential to provide evening or weekend clinics to ensure equity of access	Service specification 2017 to 2018	12 months	Standard	Minutes from operational board meeting showing that report has been considered

The screening test – accuracy and quality

No.	Recommendation	Reference	Timescale	Priority	Evidence required
12	Send results letters to diabetologists, obstetricians, paediatricians and any other relevant care givers as standard practice	Service specification 2017 to 2018	12 months	Standard	Minutes from operational board meeting where revised SOP has been presented

Referral

No.	Recommendation	Reference	Timescale	Priority	Evidence required
13	Develop links with antenatal services to ensure that all pregnant patients are known to the service	Pathway standard DES-PS-6	6 months	Standard	Direct links with antenatal services established. Minutes of operational board where new arrangements have been reported
14	Review the digital surveillance pathway to ensure compliance with national guidance and that all eligible patients and patients discharged from hospital eye services are included	Diabetic eye screening surveillance pathway http://www.gov.uk/government/uploads/system/uploads/attachment_data/file/403752/Surveillance_Pathways_V1_3_24Oct12_SSG__4_.pdf	6 months	Standard	Minutes from operational board meeting where review of the digital surveillance pathway has been presented

Intervention and outcome

No.	Recommendation	Reference	Timescale	Priority	Evidence required
15	Implement formal agreements with each linked HES unit which specify the activities, data flows, roles and responsibilities and governance arrangements	www.gov.uk/government/collections/diabetic-eye-screening-commission-and-provide	6 months	Standard	Minutes from operational board meeting where formal agreements have been reported

Next steps

The screening service provider is responsible for developing an action plan with the commissioners to complete the recommendations in this report.

SQAS will work with commissioners for 12 months to monitor activity and progress in response to the recommendations following the final report. SQAS will then send a letter to the provider and the commissioners summarising the progress and will outline any further action needed.