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Guidance

Diabetic eye screening: managing referrals to hospital eye services

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This publication is available at https://www.gov.uk/government/publications/diabetic-eye-screening-programme-failsafe-procedures/diabetic-eye-screening-managing-referrals-to-hospital-eye-services

1. Introduction and scope

Individuals may require referral for assessment or treatment (or both) within a hospital eye service (HES) if they are identified with sight-threatening diabetic retinopathy (STDR) in routine digital screening, digital surveillance or slit lamp biomicroscopy (SLB).

This publication provides guidance on the management of referrals from screening providers and associated failsafe systems. This document also clarifies the roles and responsibilities of the stakeholders involved in the screening to treatment pathway.

Local screening providers may have developed local failsafe mechanisms and processes to ensure failsafe of these individuals. Providers should work towards fully implementing this guidance by April 2019.

For the purpose of this guidance, hospital eye services include any provision of specialist ophthalmology services for the assessment and management of patients with diabetic retinopathy (DR).

2. Management of incidental findings (non-diabetic retinopathy)

The management of incidental findings (non-diabetic retinopathy) is not within the scope of the screening programme.

It is acknowledged that local screening services may have existing direct referral processes in place for incidental findings for non-diabetic retinopathy and this is acceptable. However, there should be a standard operating procedure that outlines these processes and the individual's GP should be informed of the referral.

It is not the role of the local screening service to failsafe referrals for non-diabetic retinopathy.

All patients referred for non-diabetic retinopathy eye conditions remain on the active patient register and are not suspended from screening.

While these patients are in the care of hospital eye services, their screening can be carried out in one of 2 ways:

1. Patients continue to be recalled for regular diabetic eye screening, and the non-DR referral made to HES will have no impact on their participation in screening.
2. Patients who are referred to HES for a condition other than DR can be screened within the HES for diabetic eye screening by a medical retinal specialist. This must include a RxMx grade (https://www.gov.uk/government/publications/diabetic-eye-screening-screening-exclusions-and-suspensions-and-managing-ungradable-images).

3. Referral process from local provider to HES

Patients are identified as requiring a referral to HES in accordance with the national grading criteria.

The referral is generated by the local screening provider to the appropriate HES on behalf of the individual's GP.

The individual and their GP or relevant healthcare professional should receive full information about the referral. If an individual asks for a referral outside the agreed local process, this should be managed in accordance with the patient choice and transfer of patients across programme boundaries guidance (https://www.gov.uk/government/publications/diabetic-eye-screening-patient-choice-and-transfer).

4. Failsafe of patients requiring a new referral to HES

The method of referral and its acknowledgement can vary between local providers and hospital eye services. Clinical responsibility for the patient is transferred to HES upon acknowledgement of receipt of the referral. This process must be auditable. Failures in this transfer of clinical responsibility should be escalated using local protocols.

On referral to HES, the screening provider should apply a ‘suspended’ status to the patient’s record. They should not be invited for routine screening or surveillance unless discharged from HES. The screening provider should review and audit all suspensions on an ongoing basis.

5. Reporting for pathway standards

The local provider requires sufficient information to report on the national pathway standards for patients newly referred to HES.

The provider and HES should agree the timeliness and method of communication of this data.

6. Failsafe of patients suspended under HES

Clinical responsibility for patients from receipt of referral, follow-up and discharge lies with the HES. This includes the examination of the retina for DR as part of ongoing care management for patients referred from diabetic eye screening (DES).

Confirmation of date last seen or planned appointment date in ophthalmology will form the basis of the failsafe process to make sure that suspension of the patient is still appropriate.

Patient status should be monitored at least once every 12 months.

Receipt of a retinopathy and maculopathy (RxMx) grade from HES is not required for failsafe purposes. However, local screening providers may wish to continue to collect this information for grading quality measures.

7. Failsafe of patients discharged from HES

It is important for the provider to reinstate screening following an individual’s discharge from HES. Patients may be discharged due to non-attendance, after the completion of treatment for their diabetic retinopathy or because they do not require management. Arrangements for the notification of a patient’s discharge from HES should be established in accordance with local agreements between the screening provider and HES.

All patients discharged after completion of interventional treatment or investigation should be invited to a digital surveillance clinic, with the exception of:

- patients identified within the HES as unsuitable for digital imaging, who should be invited for SLB surveillance

- patients with R3S stable disease who are unsuitable for digital imaging, who should receive continued management within HES rather than discharge
- patients whose referable DR has resolved and can be invited to routine digital screening or digital surveillance (DS)

For patients who have been discharged from HES due to non-attendance, there may be an opportunity to provide further advice about the importance of attending HES at their next DS clinic.

Patients should only be opted out or excluded from further invitations for screening or surveillance in accordance with the national guidance for exclusions and suspensions. Patients discharged back to screening after first attendance should be audited by the local screening provider.

Baseline digital retinal images should be captured within 3 months of discharge from HES for R3S patients and for non-attenders with referable disease. Local policy should determine whether baseline images for other DR grades are appropriate.

Baseline imaging can be completed by the local screening provider or HES.

8. Failsafe of patients with postponed or planned appointment in HES

Patients may have a postponed or planned appointment in the medical retina clinic in HES that is more than 12 months after the date they were last seen in ophthalmology. For these patients, the failsafe alerts must remain active until they are seen or discharged from the medical retina clinic in HES.

For patients without a planned appointment, assurance must be obtained from HES that they will remain under HES care for DR. This format should be agreed and determined locally in agreement with commissioners and HES. This assurance should be added to the individual's screening record. Without this assurance, the patient should be returned to DS as outlined below.

Following DES failsafe processes, if patients are identified who are not being seen in HES within a timely manner, the service may want to escalate this via their clinical lead to NHS England and Improvement (NHSEI) regional commissioners.

Patient status should be monitored at least once every 12 months.

9. Failsafe of patients with no feedback from HES

Patients who have not been seen in HES for more than 12 months, with no feedback or assurance of ongoing care management within HES, should be invited for DS. The number of patients returned to DS, for this reason, should be monitored and reported at programme board and escalated as appropriate.

The local screening providers and commissioners will need to decide how this will be managed and commissioned, as there could be additional screening episodes associated with these patients.

10. Use of virtual clinics or assessments, remote consultations and triage processes for DES to HES referrals

For the purposes of this guidance, a triage clinic or triage process is where screening images are reassessed by a HES clinician for the purposes of prioritisation within the HES.

A remote consultation is when a medical retina clinician discusses the results from the virtual clinic or assessment appointment with the referred individual via telephone or video conferencing facility.

A virtual clinic or assessment is the point where a clinical management decision about a DES referral is made in HES without the patient being present. The HES then communicates the results to the referred individual by an appropriate medical retina clinician.

10.1 Urgent referrals

Only a physical in-person consultation should be used for urgent referrals from DES to HES and this date should be reported to the DES for pathway monitoring.

Do not use any of the following as the date of consultation for urgent referrals from DES to HES:

- virtual clinic
- remote assessment consultation appointments
- triage clinic or process appointments

If dates of remote consultations or virtual clinic assessment are being returned to the DES, rather than dates of a physical in-person consultation, the service should:

- escalate and resolve using existing governance processes initially
- make NHSEI commissioners and PHE Screening Quality Assurance Service (SQAS) aware
- escalate to NHSEI commissioners for intervention if a resolution is not reached

10.2 Routine referrals

Individuals referred as routine from DES to HES can be monitored within HES using virtual clinics or assessments.

The clinical management decision must be made by an appropriate ophthalmology specialist in a virtual clinic or assessment after reviewing:

- the referred individual’s screening images
- additional imaging, for example optical coherence tomography (OCT)
- pertinent clinical information which has been collected following the referral

The date of the clinical management decision can then be used as the date of consultation for DES pathway standard reporting.

Individuals referred to the HES for maculopathy must receive an OCT scan before the clinical management decision is made. Recent OCT images from the DES can be used.

An appointment for additional retinal imaging is not acceptable as a consultation date for DES reporting purposes. The only exception is where the results are interpreted and discussed with the patient by a medical retina clinician at the appointment.

Remote consultations

When the HES uses remote consultations as above, the date of the virtual assessment where the decision was made can be used as the date of consultation for DES pathway standards reporting for routine referrals. This could be the same date as the remote consultation.

10.3 Triage clinics and processes for DES referrals

Triage clinic or triage process dates should not be used as the date of clinical management decision or date of consultation for DES pathway standards reporting of referrals.

HES should not routinely discharge patients back to DES without additional imaging. If this occurs it should be escalated to clinical lead, local NHSEI commissioners and SQAS.

10.4 Communication with referred individuals

If an individual requires a referral to HES following screening, they will receive a letter advising them of this referral. If a clinical management decision is made in a virtual clinic or assessment as part of this referral, the HES should inform the individual of the results. This can be by letter, in-person consultation or remote consultation.

10.5 Local governance of process

HES should be made aware of this guidance by the screening service. This governance of this process should be outlined in the memorandum of understanding or data sharing agreement between the DES and HES.

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