Public Health England

NHS

Screening Quality Assurance visit report

NHS Diabetic Eye Screening Programme North and East Devon

26 April 2017

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 four 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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Published: May 2018
PHE publications gateway number: 2018056

PHE supports the UN Sustainable Development Goals

Executive summary

The NHS Diabetic Eye Screening (DES) 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 (QA) visit of the North and East Devon diabetic eye screening service held on 26 April 2017.

Purpose and approach to quality assurance (QA)

Quality assurance aims to maintain national standards and promote continuous improvement in diabetic eye screening. 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 of data collected by the NHS screening programmes
- evidence submitted by the provider(s), commissioner and external organisations
- information collected during pre-review visits to service management and screening/grading observational visits
- information shared with the SQAS south as part of the visit process

Description of local screening service

The North and East Devon Diabetic Eye Screening Programme (NEDDESP) provides retinal screening for a registered diabetic population of 32,730 on the screening database as of January 2017.

The service is provided by Royal Devon and Exeter NHS Foundation Trust and is commissioned by NHS England South (South West). The most deprived areas in the programme are the urban areas. The areas in the most deprived 10% parts of England include Ilfracombe Central, Barnstaple Central Town, Newtown and Priory, constituting approximately 6,600 people [1].

The NEDDESP provides all elements of the eye-screening pathway (including programme management, call/recall, image capture and grading) up to the point of referral for any screen positive patients.

The service uses screener/grader technicians to provide screening across 64 sites, including one fixed site and 63 mobile sites, operating at acute hospitals, community hospitals, health centres and GP practices. They also serve one prison and remand centre.

Screen positive patients requiring ophthalmic assessment or treatment are referred to two centres at the West of England Eye Unit (Royal Devon and Exeter NHS Foundation Trust) and North Devon District Hospital (Northern Devon Healthcare NHS Trust).

Findings

Immediate concerns

The QA visit team identified no immediate concerns.

High priority

The QA visit team identified 6 high priority issues as summarised below:

- low levels of reporting screening safety incidents
- identification and implementation of actions following evaluation of audit outcomes
- transfer and use of additional clinical information within the screening programme
- engagement with GP practices relating to identification of cohort
- revision of image capture standard operating procedure
- clinical lead time for service improvement

Shared learning

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

- use of Commissioning for Quality and Innovation (CQUIN) by commissioners to support providers in undertaking health equity audit
- screener/grader technicians trained as slit-lamp biomicroscopy (SLB) examiners for un-assessable images
- uptake initiatives such as targeting patients who fail to attend or respond, working age patients and hard to reach populations
- developing simplified letters for patients with learning difficulties
- patient representation at programme board
- failsafe team contacts patients to encourage attendance for urgent hospital eye service appointments
- screening sessions to support adolescent diabetes and endocrinology clinics
- collaborative work with diabetes specialist nurses, linking diabetes care pathway with the screening service

Table of consolidated recommendations

Governance and leadership

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
1.	Ensure that the Trust's governance arrangements provide a framework for regular support and reporting of risks, performance and quality of the screening programme	Service specification [2] [3]	6 months	Standard	Clear accountability and governance arrangements between the screening programme and the Trust board at executive level Regular quality reports provided by the screening programme to the Trust within the clinical governance arrangement
2.	Develop a policy for the systematic review of controlled documents, including dissemination, change control and ratification	Service specification [2] [3]	6 months	Standard	Policy presented to programme board

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
3.	Investigate outliers identified in annual screening intervals audit to determine reasons for delays in repeat screening	Service specification [2] [3] National quality standards [4] [5]	6 months	Standard	Screening interval review completed and measured in line with the new national quality standard
4.	Ensure that screening incidents are reported in accordance with the 'Managing safety incidents in NHS screening programmes' guidance	Service specification [2] [3] National guidance [6]	3 months	High	Revised trust incident policy to be presented at programme board
5.	Conduct risk assessment of screening pathway including availability of access to screening venues for service provision	Service specification [2] [3] National guidance [7]	6 months	Standard	Risk reported via internal governance arrangement such as risk register Action plan to mitigate risks to be presented at programme board
6.	Conduct regular laser treatment register ('laser book') audits at all treatment centres to determine any gaps in the identification of the screening cohort	National guidance [8]	6 months	Standard	Laser treatment register audit completed Summary report of outcomes and investigation submitted to programme board

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
7.	Identify and implement actions following evaluation of all audit outcomes	Service specification [2] [3] National guidance [6]	3 months	High	National screening incident policy should be followed when potential screening incidents have been identified Clinical lead to oversee reporting of audit outcomes. Outcomes and investigations to be presented at programme board

Infrastructure

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
8.	Review the clinical lead job plan and allocate adequate protected time to provide strategic and clinical governance leadership for the programme	National guidance [9]	3 months	High	Revised clinical leadership time and programme activities, provided to programme board
9.	Revise multi-disciplinary team meeting agenda in accordance with national guidance	National guidance [8]	6 months	Standard	Revised agenda to be presented at programme board
10.	Conduct a risk assessment and action plan to ensure adequate working environment for grading staff	National guidance [8]	6 months	Standard	Risk assessment to be presented at programme board and internal Trust's governance arrangement

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
11.	Complete disaster recovery strategy and conduct test of database backup retrieval	Service specification [2] [3]	6 months	Standard	Report of database backup retrieval testing to be presented at programme board
12.	Conduct risk assessment to identify and mitigate risks associated with synchronisation of laptops to screening database	Service specification [2] [3]	6 months	Standard	Risk reported via internal governance arrangement such as risk register Action plan to mitigate risks to be presented at programme board

Identification of cohort

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
13.	Seek advice from the Caldicott Guardian or senior information governance officer for the transfer and use of additional clinical information within the screening programme	National guidance [10]	3 months	High	Written confirmation from Caldicott Guardian or senior information risk officer Report outcome at programme board

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
14.	Conduct database cleansing on a minimum quarterly basis using the national diabetic eye screening GP2DRS solution if possible	National quality standards [4] Service specification [2] [3]	6 months	High	Introduction of GP2DRS solution, if deemed possible Summary of GP list validations to be presented at each programme board
15.	Develop an escalation standard operating procedure for non-responding GP practices to ensure list validation for all GP practices is conducted quarterly until the national diabetic eye screening GP2DRS solution is fully implemented	Service specification [2] [3]	6 months	Standard	Process agreed between Diabetic Eye Screening Programme, commissioners, clinical commissioning groups and local medical committee Standard operating procedure developed and signed-off
16.	Address discrepancies in list size between general practitioner (GP) practices and the diabetic eye screening programme (DESP) following comparison with calculating quality reporting service (CQRS) data and single collated list (SCL)	Service specification [2] [3] National guidance [11]	3 months	Standard	Results/outcomes of the single collated list (SCL) comparison reported to programme board and resulting findings actioned

Invitation, access and uptake

No.	Recommendation	Reference	Timescale	Priority *	Evidence required

The screening test – accuracy and quality

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
17.	Conduct audit of patients categorised as 'Other' within the digital surveillance pathway	Service specification [2] [3]	6 months	Standard	Summary outcomes of audit and action plan presented to programme board
18.	Ensure that all staff undertaking slit-lamp biomicroscopy (SLB) participate in regular quality assurance of the accuracy of SLB surveillance, overseen by the clinical lead	Service specification National guidance [12]	9 months	Standard	Quality assurance (QA) processes/policy for accuracy of SLB surveillance Undertake QA of SLB surveillance Summary findings of QA of SLB to be submitted to the programme board
19.	Revise image capture standard operating procedure to ensure classification of image quality is in line with national standard	National guidance [13]	3 months	High	Standard operating procedure revised and signed-off by clinical lead

Referral

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
20.	Ensure patients receive slit-lamp biomicroscopy (SLB) assessments within national quality standards timescales	National quality standards [4] [5]	6 months	Standard	Breaches reported at programme board for review and action/ management agreed

Intervention and outcome

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
21.	Develop formal agreement with treatment centers, such as a Memorandum of Understanding (MOU), with support from commissioners, to clarify responsibilities as outlined in the national guidance	National guidance [14]	6 months	Standard	Formal agreement established with treatment centres and signed at executive level

I = Immediate
H= High
S = Standard

Next steps

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

SQAS will work with commissioners to monitor activity/progress in response to the recommendations made for a period of 12 months, following the issuing of the final report. After this point, SQAS will send a letter to the provider and the commissioners summarising the progress made and will outline any further action(s) needed.