UK National Screening Committee

NHS Screening Programmes

Diabetic Eye

Quality Assurance Visit Report

Central Mersey

Diabetic Eye Screening Programme

QA Visit Observations and Recommendations from Visit on 17 July 2014

UK NSC

Change Control

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1.0	30.08.14	Final report approved for distribution	Madeleine Johnson

Contents

Executive Summary

The findings in this report relate to the quality assurance (QA) visit (peer review) of the Central Mersey Diabetic Eye Screening Programme held on 17th July 2014.

Purpose and approach to Quality Assurance

The aim of quality assurance in the NHS Diabetic Eye Screening Programme (NHSDESP) is to maintain minimum standards and promote the continuous improvement in all aspects of screening and assessment prior to specific treatment in order to ensure that people with diabetes have access to a high quality service wherever they live.

Quality Assurance visits are carried out by peer reviewers who have been trained in the role and are supported by members of the regional quality assurance team.

The evidence for this report is derived from the following sources:

- Routine monitoring data collected by the NHS Diabetic Eye Screening Programme;
- Evidence submitted by the provider(s) and signed off at the programme board level and/or by the commissioner;
- Information collected during pre-review visits: administration review and clinical observations
- Information shared with the QA Team during interviews

Description of Local Screening Programme

The Central Mersey Diabetic Eye Screening Programme (DESP/the programme) has an eligible population of approximately 38,000 patients. It is commissioned by NHS England Merseyside, and by NHS England Cheshire, Warrington & Wirral Area Teams, with the lead commissioner being Merseyside.

The programme is provided by Bridgewater Community Health Care NHS Trust (BCHT), by Medical Imaging UK Ltd (MI) and by 27 optometrist practices. Service provision is split between these providers as follows.

- BHCT provide clinical leadership and all administration to the programme, including all failsafe functions, all call and recall for the DESP, and a portion of screening appointment management.

- MI provides overall programme management and all grading services for the programme through use of directly employed staff. MI also provides a portion of screening services with the use of staff technicians for clinics held within 10 NHS fixed sites.

- Slit lamp bio-microscopy services are sub-contracted by MI to one local optometrist who provides the service to patients. The Clinical Advisor (optometrist) provides cover for the service during periods of annual leave.

In addition, 27 local optometrist practices provide digital photography screening services for the programme. A mix of opticians and technicians are used to carry out these services.

For assessment and treatment, patients are primarily referred to either Warrington and Halton Hospitals NHS Foundation Trust (WHFT) or St Helens & Knowsley NHS Trust (SHKHT). A smaller proportion of patients are referred to Aintree Hospitals NHS Foundation Trust (AHFT), or other hospitals at the patient's request.

The DESP has two named Clinical Leads (CL) who are both contracted by BCHT for the purposes of programme leadership and referral outcome grading. An additional post of

Clinical Advisor (CA) is performed by the Lead Optometrist of the DESP and is contracted directly with the Merseyside AT to provide these services.

The DESP has a part time Programme Manager (PM) and full time Team Leader (TL), both employed by MI. Programme administration and failsafe is led by a full time Failsafe Manager (FM), employed by BCHT.

The DESP now uses Digital Healthcare Optimise Software common pathway version 4.0, upgraded from version 3.6 in March 2014. Prior to March 2013 the DESP used Orion software.

Evidence was collected prior to the visit while the programme used version 3.6 of software, but version 4.0 of software and new pathway configurations were in place at the time of the QA visit. Comments are made throughout the report to demonstrate where this may have affected observations. In these cases it will be recommended that the programme and commissioners conduct a further internal QA review to assure themselves of the quality of the area in question.

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Key Findings

A number of significant challenges were identified during the visit, including the following:

- Risk to programme data resulting from limited server capacity, lack of service contract for IT support, and no confirmed data back-up process or disaster recovery plan;
- Clinical Lead role is not well-defined within the programme. As a result there is minimal clinical oversight provided in terms of internal quality assurance, grading oversight, guidance for grading, and outcome decisions within the digital surveillance pathway, and a lack of clearly defined clinical governance across the entire DESP;
- No contractual relationship exists between the programme providers resulting in unclear clinical governance, reduced ability for joined up working, and lack of consistent processes and training maintained for screening staff at both providers;
- Limited resilience within the slit lamp biomicroscopy service where only one assessor contracted to provide service for entire programme;
- Lack of confidence in completeness of single collated list due to inconsistent participation from GP practices during reconciliation process;
- Lack of thorough and regular audits (laser book, SI/SSI audit) to ensure patients are not being missed by the service.

The programme demonstrates that they meet 10 of the 19 National Quality Standards:

2. To invite all eligible persons with known diabetes to attend for the DR screening test
3. To maximise the number of invited persons receiving the test
4. To ensure photographs are of adequate quality
5. To ensure grading is accurate
14. To ensure that screening and grading of retinal images are provided by a trained and competent workforce
15. To ensure optimum workload for all graders in order to maintain expertise
16. To optimise programme efficiency and ensure ability to assure quality of service
17. To ensure that the screening interval is annual
18. To ensure the public and health care professionals are informed of the screening programme at regular intervals
19. To ensure the service participates in quality assurance

The programme is able to demonstrate partial achievement 1 of the 19 National Quality Standards:

9. To follow up screen-positive patients (those with referable retinopathy) (failsafe)

The programme is unable to meet or provide appropriate evidence for 8 of the 19 National Quality Standards:

1. To ensure database is accurate.
6. To ensure GP and patient are informed of all test results
7. Ensure timely referral of patients with R3 screening results
8. To ensure timely consultation for all screen-positive patients
10. To ensure timely biomicroscopy assessment of patients recorded as ungradeable.
11. To ensure timely treatment of those listed by ophthalmologist
12. To minimise overall delay between screening event and first laser treatment
13. To ensure regular collection of data indicating levels of new blindness due to diabetic retinopathy

Good Practice

The visiting team identified a number of areas of good practice, these include:

- Screening appointments available 7 days a week;
- Support provided to patients who demonstrate anxiety about screening appointment (e.g., offering pre-appointment visit for patient to view screening clinic and ask questions in advance).
- Good grader participation in online test & training sets;
- All three clinics observed were viewed as easily accessible to patients with wheelchairs or with sight impairment and all were located close to public transportation routes. The atmosphere in each was observed to be both professional and friendly with staff noted as very welcoming;
- Screening staff were seen to be approachable and were able to have a good rapport with patients during the screening visit.

There are several challenges facing the programme and a number of high level recommendations are made which are reflected in the key recommendations as below.

Key Recommendations

1. Increase capacity of DESP server to remove immediate risk to programme data (Immediate);

2. Agree service contract for provision of IT services to screening programme in order to ensure appropriate IT support to programme.

3. Review role of Clinical Lead(s) against requirements of programme as outlined in the National Diabetic Eye Screening Programme (NDESP) service specification, and the document: 'Roles and responsibilities of clinical leads of diabetic eye screening programmes, version 1.0, May 2013.' Ensure proper clinical accountability, governance, and internal quality oversight across all sections and providers of the programme. Ensure that revised arrangements are adequately described within job plan(s).

4. Review ROG grading responsibilities, and availability of expert clinical guidance and support to ROG graders within the digital surveillance pathway. Provider and commissioners should assure themselves that appropriate clinical oversight is in place within this grading queue.

5. Conduct workforce capacity review and develop business continuity plan for provision of SLB assessments to ensure all essential tasks can be maintained during times of planned or unexpected absence and that resilience can be maintained within the system.

6. An urgent review of the laser book audit to identify those patients who attended for laser treatment without being known to or properly managed through the DESP. Follow up of those who were treated without coming through the DESP should be undertaken to learn circumstances and the root cause where appropriate.

7. Investigate reasons behind low performance within objective eight (timeliness of first appointment after referral from screening programme). Identify actions where possible to address underlying gaps in information return, scheduling or capacity issues within hospital eye service.

8. Undertake reconciliation of full single collated list, including all GP practices;

9. For cross-border patients, review current practice and document a clearly written SOP to cover policies and procedures, including a robust failsafe plan to ensure no patients are lost between programmes.

10. Commissioning and contract arrangements for all parts of the screening pathway should be reviewed and amended across all service providers as necessary. These must incorporate requirements of the National Diabetic Eye Screening Programme service specification, including requirements for the New Common Pathway and governance arrangements across whole of programme.

It should be noted that recommendations and statements made throughout this report will overlap several of the 'screening themes' and this report should be read and digested as a complete document rather than individual sections.

<u>Next steps</u>

NHS England Merseyside Area Team will be responsible for monitoring progress against the action plan and ensuring that all recommendations are implemented. The regional QA team will support this process and the on-going monitoring of progress.

Purpose of the Quality Assurance Visit

Objectives
The aim of quality assurance (QA) in the NHS Diabetic Eye Screening Programme (NHS DESP) is to maintain minimum standards and promote continuous improvement in diabetic eye screening. This is to ensure that people with diabetes have access to a consistent, high quality service wherever they reside.

Quality assurance visits are essential in order to minimise harm and maximise benefits. Participation in the formal process of quality assurance is mandatory for each screening programme. Each screening programme is expected to have clear arrangements for internal quality assurance within the programme; and to have a systematic approach to the management of quality. There should be regular review of quality and performance against the service specification and national standards for the NHS DESP. Quality assurance arrangements for the screening programme should be integrated into local clinical governance arrangements.

QA visits are an integral part of diabetic eye screening quality assurance. As part of the QA visit process, the performance of the screening programme is monitored in a variety of ways. This includes a review of statistics, attendance by QA staff at Programme Board meetings and pre-visits to specific parts of the screening programme. Together with the QA visit itself, these activities offer a valuable insight into the programme. QA visits to a screening programme provide the only forum for a review of the whole multidisciplinary screening pathway and an assessment of the effectiveness of team working within the screening service and associated referral sites. QA visits are carried out by a team of trained peer reviewers, representing each of the key disciplines involved in the delivery of the screening programme.

The NHS Diabetic Eye Screening Programme Quality Assurance visit is designed to meet the following objectives:

- To examine overall service performance affecting the quality of the screening programme
- To verify achievement of national minimum standards and identify any variance from these standards.
- To support professionals working in the programme to maintain and improve on those standards
- To gain knowledge and expertise of best practice and disseminate this to all screening programmes
- To provide evidence based recommendations that will help the programme to address any areas of concern, and strive for continuous quality improvement

Recommendations
Recommendations are made where the programme is unable to meet a quality standard or requirement in the service specification, or where there is a lack of evidence to show that the requirement is being met. Each peer reviewer has provided a report and made recommendations where necessary based upon data submitted in advance of the QA visit, any pre-visits carried out, and their observations on the day.

All the QA recommendations made in the body of the report are presented in a table at the end, and have been prioritised as immediate, high, medium or low priority. In making this assessment of priority, the QA Team has exercised a judgement based upon the input from the expert QA advisors and wider experience across the NHS DESP.

Immediate – (7 days)	A recommendation has been prioritised as 'immediate patient concern' if unaddressed it could lead to significant risk of harm to people seen by the service.
High – (3 months)	A recommendation has been prioritised as 'high' where due to an absence of data or evidence the quality of the Unit cannot be assessed because the QA process cannot be conducted satisfactorily. We acknowledge that there are occasions when a recommendation may be allocated a high risk grading even though the probability that an adverse event will occur is small. This is because even though the occurrence may be rare, the event would have a significant impact on the patient.
Medium – (6 months)	A recommendation has been prioritised 'medium' when a process or practice does not meet the expected standard or the recommended practice of the NHS DESP but does not lead to direct clinical risk to individual people. Many of the NHS DESP standards are designed to ensure the acceptability of the screening programme, the maintenance of the value of screening by adhering to professionally-agreed performance standards and quality measures to reduce the anxiety of users.
Low – (12 months)	A recommendation has been coded 'low' when it carries no risk to the people seen by the service but which, if implemented could enhance the performance of the Unit and/or the experience of the people screened.

Evidence
The contents of this report and the data used have been taken from the following sources:

- Routine monitoring data collected by the NHS Diabetic Eye Screening Programme.
- Information from the pre-visit questionnaire completed by the staff from the programme and signed off at programme board level.
- Information shared with the QA Team during QA visit interviews.

The effectiveness of the QA Team Visit is dependent upon the openness of the service to share all necessary information in a frank and complete manner.

This report identifies what has been reported to peer reviewers during the visit and what has been observed by peer reviewers during the visit. These observations are then triangulated against the views of other members of the peer review team, and evidence provided by the programme.

Action Planning and Follow-up
This QA visit report will be sent to the Chief Executive(s) and a wide variety of stakeholders. The Chief Executive(s) of the screening provider(s) should ensure that the report is considered at executive board meetings and an appropriate clinical governance forum. The Screening & Immunisation Lead in the local NHS England Area Team will work with the provider(s) to develop an action plan that will address the recommendations made. The NHS Diabetic Eye Screening Programme Quality Assurance Team will check on progress against this action plan at regular intervals, and will continue to provide expert assistance to the programme in addressing recommendations.

The Quality Assurance Visit

The peer reviewers and QA Review Team would like to thank the Central Mersey Diabetic Eye Screening Programme, the Merseyside Area Team, the Cheshire, Warrington & Wirral Area Team, Medical Imaging Ltd UK, Bridgewater NHS Community Trust, and all participating optometrists for their hard work in collecting/collating information for the review process, and for their open and honest approach throughout the process.

External Quality Assurance Team

Gillian Vafidis	Consultant Ophthalmologist, North West London Hospitals NHS Trust QA visit roles: External Quality Assurance Lead and Clinical Lead/Ophthalmology Peer Reviewer
Liz Rochelle	Screening and Immunisation Manager, Shropshire & Staffordshire Area Team QA visit role: Public Heath/Commissioning Peer Reviewer
Simon White	Programme Manager, South Tees Diabetic Eye Screening Programme QA visit role: Programme Manager and Administration Peer Reviewer
Malcolm Gray	Quality Assurance Lead, Staffordshire Diabetic Eye Screening Programme QA visit role: Screener/Grader Peer Reviewer
Sue Pott	Programme Lead, North Tees Diabetic Eye Screening Programme QA visit role: Screener/Grader Peer Reviewer

UK NSC/NHS Diabetic Eye Screening Programme (part of PHE)

Kristin Bash	Senior Quality Assurance Manager
Hannah Bruntnell	Regional Quality Assurance Manager

Observers

N/A

Programme Structure

The findings in this report relate to the quality assurance (QA) review (peer review) of the Central Mersey Diabetic Eye Screening Programme held on 17th July 2014.

The Central Mersey Diabetic Eye Screening Programme (DESP/the programme) has an eligible population of approximately 38,000 patients. It is commissioned by NHS England Merseyside, and by NHS England Cheshire, Warrington & Wirral Area Teams, with the lead commissioner being Merseyside.

The programme is provided by Bridgewater Community Health Care NHS Trust (BCHT), by Medical Imaging UK Ltd (MI) and by 27 private optometrist practices. Service provision is split between these providers as follows.

- BHCT provide clinical leadership and all administration to the programme, including all failsafe functions, all call and recall for the DESP, and a portion of screening appointment management.

- MI provides overall programme management and all grading services for the programme through use of directly employed staff. MI also provides a portion of screening services with the use of staff technicians for clinics held within 10 NHS fixed sites.

- Slit lamp bio-microscopy (SLB) services are sub-contracted by MI to local optometrists who provide the service to patients

In addition, 27 local optometrist practices provide digital screening services for the programme. A mix of opticians and technicians are used to carry out these services.

For assessment and treatment, patients are primarily referred to either Warrington and Halton Hospitals NHS Foundation Trust (WHFT) or St Helens & Knowsley NHS Trust (SHKHT). A smaller proportion of patients are referred to Aintree Hospitals NHS Foundation Trust (AHFT).

At the request of the patient, the DESP will also refer to Royal Liverpool University Hospital NHS Foundation Trust (RLFT) and Countess of Chester NHS Foundation Trust (CCFT).

The DESP has two named Clinical Leads (CL) who are both employed by WHFT and contracted by BCHT for the purposes of programme leadership and referral outcome grading.

An additional post of Clinical Advisor (CA) is performed by the Lead Optometrist of the DESP. This role was found to incorporate much of the Clinical Lead role as defined in national guidance. The CA provides training and policy updates for the optometrist screeners but does not have line management responsibility or clinical accountability for any area of the programme.

The DESP has a part time Programme Manager and full time Team Leader (TL), both employed by MI. The PM is responsible for the strategic and operational management of the DESP. The TL is accountable for daily management of MI technicians, training of screening/grading staff, and collates audit data, providing general support role for the PM.

The PM is line managed by the Operations Director for MI and line-manages the Team Leader and technicians employed by MI.

Programme administration is managed separately, and staff is employed by BCHT. This team is led by a full time failsafe manager with support from a part time administration/failsafe coordinator. There is no line-management overlap or formal contractual arrangement in place to define coordination or governance arrangements between the Programme Management and screening/grading functions of the programme (MI), and the administration of the programme (BCHT).

The DESP now uses Digital Healthcare Optimise Software common pathway version 4.0, upgraded from version 3.6 in March 2014. Prior to March 2013 the DESP used Orion software.

1. Identification of Cohort

This theme aims to ensure that all eligible people are identified to be offered screening.

Performance against standards:

Objective 1	Criteria	Minimum standard	Achievable standard	Performance
1. To ensure database is accurate	1. Single collated list of all people with diabetes and systematic call recall from a single management system	1. To be present		Present
	2. Comparison of DES database programme size with QMAS (Quality Management and Analysis System) diabetic population. (Note: QMAS discontinued in 2014, now is CQRS (Calculating Quality Reporting Service)	2. 6 monthly comparison	2. Quarterly comparison	Not completed since PCT dissolved in 2013
	3. Proportion of GP practices participating	3. 100%		100%
	4. Regular database cleansing using national standard operating procedure (SOP)	4. 6 monthly	4. Monthly	Database cleansing not complete

Compliance:

The programme is not compliant with National Quality Standard Objective 1.

Observations:

Population served

The Central Mersey DESP provides screening services for 121 GP practices that comprise the St Helens CCG (37 GP practices), Knowsley CCG (37 GP practices), the Halton CCG (18 GP practices) and the Warrington CCG (29 practices). These CCGs cover a population of approximately 650,000 people. The number of patients on the single collated list is approximately 38,000 patients (source: March 2013 – March 2014 performance report).

Public Health England Health Profiles were provided as evidence for review and illustrated a range in deprivation ranging from 15% to 60% across the four CCGs covered by the DESP. The population of Warrington CCG demonstrated the lowest percentage of deprivation (15%) and the lowest number of patients with diabetes (5.9%). Knowsley CCG showed the highest deprivation within the patch (60%) but shows lower recorded numbers of patients with diabetes than both St Helens (6.7%) and Halton (7%).

There are three institutions within the DESP boundary: Risley short stay prison, Scott Clinic medium secure psychiatric unit and Thorn Cross open Young Offenders Institution. No screening is carried out for patients within Risley short stay prison. For Scott Clinic and Arbury Court, patients are chaperoned to either optometrist sites or one of the fixed screening venues.

A programme boundary issue was identified during interviews. There are a number of patients residing on the border with Wigan who who choose to be screened by the Wigan DESP. It was reported that a single GP practice on the border has approximately 50% of patients screened by Central Mersey DESP and the remaining 50% by Wigan DESP.

To manage this cohort, the programme notifies Wigan DESP of patients believed to be screened by Wigan, and Wigan DESP then sends confirmation of this screening. However, no formal documentation was observed and it is unclear how the reconciliation and complete failsafe of these patient lists takes place. The review team recommends an SOP be written to cover policies for cross-border patients, including a robust failsafe plan to ensure no patients are lost between programmes.

Single Collated List (SCL) Reconciliation

The Central Mersey DESP manually validates their SCL and has an SOP in place for this process. This process involves sending each GP practice a list of their patients who are registered with the DESP on a 6 monthly basis. The GP practice then returns the list with amendments to the DESP who update their SCL.

During the interview process and in evidence provided by the DESP, it was highlighted that less than 30% of GP practices participated in the last validation exercise (December 2013). It was also suggested during interview that some GP practices may never have taken part in the validation process. While the programme reported that they have large numbers of new referrals each month, evidence was not available to provide detail of the numbers involved. Commissioners did not report being aware of this issue.

It is recommended that an escalation policy be put in place to track and highlight which GPs are not participating in data validation exercises so that the Area Team can escalate appropriately via Clinical Commissioning Groups.

Deceased patients are notified to DESP admin team via a weekly report by the Halton & St Helens from the Health Agency and periodically on an ad-hoc basis from GP practices. These are updated in the DESP software as received, and then re-validated 6 monthly against Exeter. The visiting team thought that a single review of patients added to the deceased list would be sufficient.

Exclusions

Exclusions are managed by the administration team as part of the failsafe process and with the use of national guidance.

Patient opt-outs are documented through a signed form from the GP, with a maximum term of three years. However, it was noted that patients who opted out prior to the national introduction of recall at 3 yearly intervals may not be recalled as per guidance. It is recommended that the administration team review all patients excluded for opt-out and implement a 3 year maximum opt out for these patients as per national guidance.

It was unclear to the visiting team whether appropriate supporting documentation was held for patients excluded as medically unfit.

The DESP are informed of patients who have no perception of light (NPL) by both the hospital eye service (HES) and GPs. The GPs are asked to provide copies of HES letters to substantiate patients are NPL.

The DESP was not aware of national guidance that patients with resolved diabetes should continue with screening. Because of this, patients moved off register as being no longer diabetic have not been validated by their GP to ensure they are appropriately marked as ineligible for screening (i.e., that they were incorrectly reported as having diabetes and wrongly referred to screening).

During interview it was noted that the programme was in the process of reviewing all excluded and ineligible patients to ensure they are appropriately excluded/marked as ineligible. The visiting team recommends that this review be completed to ensure compliance with current national guidance.

Health inequalities

The most recent Health Equity Audit (HEA) specific to the programme was carried out in 2011 but was not provided as evidence for this visit. Commissioners have implemented a CQUIN to incentivise completion of a new HEA.

The programme is not currently adopting any additional measures to address inequities to access to screening.

Evidence:

Administration Review 20th May 2014
Pre Visit Questionnaire
Interviews
SOP documents submitted as evidence

Recommendations – Identification of cohort:

High

1.1 Undertake reconciliation of full single collated list, including all participating GP practices.

1.2 For cross-border patients, review current practice and document a clearly written SOP to cover policies and procedures, including a robust failsafe plan to ensure no patients are lost between programmes.

Medium

1.3 Review all exclusions (medically unfit and opt-outs) and ineligible patients (no longer diabetic and NPL) to ensure compliance with current national guidelines, appropriate documentation of status, and that all patients are in the correct category within software.

1.4 Develop quarterly summary report to show which GP practices have returned electronic lists for reconciliation. Summary report should be provided to Programme Board on a quarterly basis for review and escalation as needed to ensure all GPs participate in SCL reconciliation process.

Low

1.5 Use suitable public health information tools (e.g., NHS Equality & Delivery System or a Health Equity Audit (HEA)), to address screening inequalities, to consider the needs of diverse populations, and those populations that rarely access screening services or don't access screening services at all. An action plan to be developed and implemented in coordination with relevant local authority and CCG stakeholders, based on recommendations from the use of these tools.

2. Informing cohort

This theme is concerned with informing all eligible people about the screening test and subsequent pathway in a timely and accessible manner.

Performance against standards:

Objective 2	Criteria	Minimum standard	Achievable standard	Performance
2. To invite all eligible persons with known diabetes to attend for the DE screening test	1. Percentage of the eligible population invited to screening 2. All newly diagnosed patients must be offered first screening within three months of the programme being notified of their diagnosis	1. To be set following analysis of current information – minimum standard to be set at lower quartile value 2. Policy endorsed by Programme Board and recorded in Programme Board minutes	1. To be set following analysis of current information – achievable standard to be set at upper quartile value 2. Policy endorsed by Programme Board and recorded in Programme Board minutes	101% invited per March 2013 to March 2014 programme performance report (PPR) 2. 100% new patients invited within 3 months, per self-reporting. (9.9% per Mar 2013 – Mar 2014 PPR (possible data quality issues)). DESP should verify data and check if standard is met.

Compliance:

The programme is compliant with National Quality Standard Objective 2.

Observations:

Screening pathway

New patients are referred into the screening programme on an ad-hoc basis from GP practices. Six monthly validations of the DESP register are done as described within the Identifying Cohort section.

At the time newly referred patients are entered into screening software, the system is automated to generate an open invitation to the patient. The programme reports that they are confident this method ensures all patients are invited to screening within three months of referral.

Contrary to this, the programme performance report (March 2013 to March 2014) submitted as evidence demonstrates that just under 10% of new patients were invited to screening appointments within three months of notification to the service.

Because of the recent software upgrade to version 4, it is recommended the DESP validates this data and reviews the policy for appointing new patients to ensure patients newly referred into the programme are offered screening within 3 months.

In order to confirm compliance with objective 2.2, the programme should review whether a three month timeliness standard for newly referred patients has been agreed by the Programme Board.

The Central Mersey DESP maintains a 12 month recall schedule, with invitations sent at 11 month intervals. The programme invites patients to screening through an open booking system across 37 screening sites (see Programme Structure, page 5). This invitation letter is sent together with a list of screening sites and contact information, and the national standard leaflet. Patients may make appointments by phoning an optometrist practice directly, or by phoning the central DESP administration office.

Translation services are provided by Bridgewater when required; patients are given contact information and are responsible for arranging their own services.

DESP administration staff reported that additional support is given to patients who appear nervous about attending their screening appointment. These patients are invited to visit the screening site in advance of their appointment so they are familiar with the surroundings prior to screening. The QA team viewed this to be good practice.

Patient correspondence

During the administration review it was reported that the national standard leaflet is provided with all screening invitation letters. The programme uses the national standard result letter templates but does not use national invitation letters.

It is recommended that the invitation letters are reviewed to ensure all key information highlighted in the national template is reflected locally. These should then be verified by local patient groups or approved through Trust corporate policy as required.

Samples of the Medical Imaging website were reviewed by the visiting team and were felt to be a very useful source of patient information. It is recommended that the invitation letters incorporate a link to this site.

Screening appointment

Consent from patients is considered to be implied at the time the patient phones to arrange their appointment. However, the current invitation letter does not include language to inform patients for this purpose and patients are not asked to consent during the appointment booking process. It is advised that the programme use the national standard invitation letter as outlined in national guidance.

During clinical observations it was observed that not all patients received information about contraindications. It is recommended that a review of the warnings given to patients takes place to ensure consistent information is given to patients across all screening sites.

Patients do not receive a result at the point of screening. The screener advises the patient how and when their result will be generated. The level of patient education was observed as variable across screening sites. As with review of warnings given, a consistent approach to patient education should be encouraged across all screening sites.

Correspondence – result reporting

Results letters are regularly sent to GP and patient, and are generated and sent for every completed screening event.

No evidence was seen that result letters are sent to a patient's diabetologist where this information has been collected. It is recommended that the programme develop a policy to keep all clinicians informed of the patient's screening outcomes.

The programme counts all printed letters to minimise the risk of multiple patient letters being posted in one envelope and an SOP is in place to define this process. The admin team also hand check each result letter for any anomalies prior to posting.

The software identifies letters that have failed to print. However the programme does not use the software failsafe tool called Datastorm to check for errors in the software pathway or for letters that have failed to generate. This was considered to be a risk by the visiting team and it is recommended that this tool is used as part of routine failsafe measures. (For recommendation regarding use of Datastorm, please see Minimising Harm recommendations, page 29.)

The programme reports good verbal communication with practice nurses and a GP representative attends the programme board meetings. However, other than the standard outcome letters and summary of DNAs during validation, no additional reports are provided regularly for GPs.

Evidence:
Administration Review 20th May 2014
Clinic observations 20th May & 16th June 2014
Pre Visit Questionnaire
Interviews
SOP documents submitted as evidence
Pre-visit questionnaire
Screening venue leaflets
Invitation letters
Result letters

Recommendations - Informing cohort:

Medium

2.1 Write and implement SOP for sharing screening results with diabetologists for all patients when information is available to do so.

2.2 Write and implement SOP to cover information given to patients during screening appointment. SOP to cover importance of providing information about contraindications prior to taking consent for screening appointment (and prior to mydriasis), and a clear process for informing all patients at time of appointment about what to do and where to call or go in the case of serious adverse reaction. Consider providing written information to hand to the patient at appointment.

2.3 Review quality of reported data for first screening offer made to newly referred patients (objective 2.2). Identify if there are gaps in policy and make necessary adjustments to ensure all newly referred patients are offered a screening appointment within three months.

Low

2.4 Implement use of national standard invitation letter, with any additions made with sign off from Clinical Leads and Programme Board.

3. Uptake

This theme is concerned with maximising uptake in those who want screening, ensuring that screening is timely, acceptable and does not promote health inequalities. This theme addresses potential barriers to screening, such as multiple appointments or difficult access to locations.

Performance against standards:

Objective 3	Criteria	Minimum standard	Achievable standard	Performance
3. To maximise the number of invited persons receiving the test	The proportion of those invited to screening by digital photography who have a digital screening outcome.	=/>70%	=/>80%	82.7% uptake per March 2013 – March 2014 performance report >80% consistently on KPI DE1 Q1-Q4 2013-14 DESP meets achievable standard.

Compliance:

The programme is compliant with National Quality Standard Objective 3.

Observations:

The programme operates a 12 month screening interval, sending an open invite at an 11 month interval. Uptake rates are above the achievable standard of 80%, however rates have decreased from 91% to 80% between Q1 and Q4 of 2013-14 financial year (source: Key Performance Indicators (KPI), DE1).

Variances in supplied data were observed during review of pre visit evidence provided by the DESP. This raised concerns about data quality following past and recent software upgrades. The QA review team felt that validation was necessary to verify accuracy and consistency of data.

Programme uptake is not discussed in detail at Programme Board meetings, and reporting on uptake is currently limited to the overall KPI DE1 measure. However it was reported to the visiting team that the DESP plan to create a dashboard to monitor uptake by GP practice, and that this will be shared with commissioners on a quarterly basis.

Screening is delivered via a mixed model of optometrist sites (27) and NHS sites (10). Evening and weekend appointments are available at several optometrist practices, including a few who provide appointments 7 days per week. This was seen as good practice by the visiting team.

All sites observed during the clinical observation visits were accessible for wheelchair users and patients who are sight impaired. All sites had access to public transport and adequate parking.

The Medical Imaging (MI) website has a venue locator so that patients can enter their postcode to find a local MI NHS screening venue. The website then links with on line maps to provide directions and advice on public transport to the venue.

There is no structured management of patients who do not respond to invites or fail to attend screening appointments. Neither is there evidence that these rates are shared with the GP practices, or that they are analysed by the programme to identify trends or significant variations in access. This is not discussed at Programme Board meetings and reports of this nature are not routinely requested by commissioners. (Please see recommendation on page 14.)

During the administration review it was reported that all patients booked for slit lamp examination receive a phone call reminder from the administration team prior to their appointment, to improve uptake. It was reported that this is not for routine screening appointments due to the limited capacity of the administration team.

The DESP has established 3 additional screening sites to provide better patient access and reduce waiting lists for popular screening and slit lamp review appointments.
(For additional recommendations on engaging with service users, please see User Experience section, p. 38)

Evidence:
Administration Review 20th May 2014
Clinic observations 20th May & 16th June 2014
Pre-visit questionnaire
Interviews
KPI Submissions
Performance report

Recommendations - Uptake:

Low

3.1 Analyse and share “did not respond” (DNR) and “did not attend” (DNA) rates with GP practices to provide feedback and promote engagement between GP and patient and encourage higher uptake of screening services.

4. The Screening Test

This theme is concerned with the accuracy of the screening test. It includes the process from image capture to reporting the screening result.

Performance against standards:

Objectives 4 & 5	Criteria	Minimum standard	Achievable standard	Performance
4. To ensure photographs are of adequate quality	Percentage of patients where a gradable digital image cannot be obtained	Less than 7% total ungradeable	Programmes should have between 2.5-6.3% total ungradeable.	4.9% unassessable outcomes (source: March 2013 – March 2014 performance report) DESP meets achievable standard.
5. To ensure grading is accurate	1. Every grader registered on the software as a grader to participate in the online test and training scheme. 2. Evidence of clinical lead or nominated senior grader feeding outcomes of the online test and training set back to grading staff on a regular basis.	1. 80% of grading staff are compliant.	1. 100% of grading staff are compliant.	1. 100% of graders participate in test and training sets. DESP meets achievable standard. 2. Evidence of Clinical Advisor and Team Leader feeding back results of test & training sets to graders. DESP meets standard.

Compliance:

The programme is compliant with National Quality Standard Objectives 4 and 5.

Observations:

Screening Clinic Observations

Four screening clinic sites were reviewed as part of this EQA visit:

- Millbrow Clinic, Millbrow, Widnes
- Specsavers Optometrists, Warrington
- R. Millican Optometrists, Prescott
- Crompton & Gilmore Optometrists, Newton-le-Willows

The following summary of screening process is compiled from a combination of clinic observations, and written evidence provided by the DESP.

Clinic environment

Clinics observed were viewed as easily accessible to patients with wheelchairs or with sight impairment and all were located close to public transportation routes. The atmosphere in each was observed to be both professional and friendly with staff noted as very welcoming. The environments were all noted to be clean and tidy. Clinic venue assessments are carried out for all fixed sites on annual basis to ensure venues remain fit for purpose.

The number of appointments per screening sites varies. NHS sites have between 26 and 29 appointments per day. One screener provides all aspects of the screening appointment.

Screening staff were seen to be professional and approachable. Those observed established a good rapport with patients during the screening visit.
In all except one location reviewed, screeners encouraged patients to ask questions when possible anxiety was observed in the patient, and they provided suitable answers.

No issues regarding privacy of written patient information was observed in any of the 4 clinics. However, the peer reviewer noted that conversations could be heard outside one screening room and inadequate signage was in place to advise private consultations were taking place at the same site.

The process for ID verification was noted to be consistent between clinics. All screeners observed asked the patient to provide name, address and date of birth as a minimum. This verification was done prior to beginning the appointment and repeated prior to photography.

Visual acuity testing and mydriasis

Protocols for testing visual acuity (VA) and Mydriasis are available to screeners and were viewed as fit for purpose. There are two versions of each protocol, one developed by MI and the other by the Clinical Advisor (CA). Those developed by the CA are referred to as the main point of reference for screeners.

Clinics observed used a mixture of Snellen, Logmar or computerised projection charts. Overall the process used was viewed to be appropriate. Alternative charts (Sherridan Gardner or E charts) were available in all clinics observed.

All clinics use tropicamide 1% and phenylephrine hydrochloride 2.5% as required. The approach to installing drops was observed as variable but acceptable. However, the quantity of Tropicamide 1% installed should be reviewed to ensure consistency across sites.

Hand washing and/or gel use hygiene methods were observed in all three clinics but not all screeners washed their hands before and after each procedure.

In the majority of clinics, questions were not asked about possible contraindications (e.g., past allergic reactions) or previous eye problems before applying the drops. Equally not all patients were provided with information about possible adverse reactions before drops were installed. Written adverse reaction information was not provided consistently across all sites during clinics observed. Also, it is not clear from the evidence observed, if consent to screening is requested during all appointments prior to installation of drops.

Drivers were advised by either written or verbal means not to drive after drops. No consistent approach to providing this information was observed. (Please see recommendation within Informing Cohort, page 17.)

It is recommended that a review of these aspects is undertaken to ensure all sites are equitable in their approach to preparing patients for the screening test.

Imaging

Cameras were noted to be over 5 years old in most screening sites. Although this does not mean they are too old to use, they should be audited regularly to ensure image quality is adequate. The team observed that cameras have not been regularly inspected or serviced, and as such recommend regular checks are put in place.

No equipment replacement plans were evidenced, although this was not specifically requested by the review team. It is recommended that this is reviewed by provider and commissioners to ensure resilience within programme.

Screeners occasionally check camera settings but only adjust flash settings. No evidence to suggest settings are assessed regularly or SOP was observed. All digital cameras and camera backs need to be checked against the national recommendations on the approved and current list as it is not clear if all meet with the required national specifications.

Grading

Grading takes place at the Millbrow Health Clinic only. There is a single grading room which accommodates 5 grading stations. MI employs 7 graders including the team leader. Graders currently work on a rota basis to share the grading facilities and occasionally work at weekends to clear backlogs. This is commendable but does not allow for future growth of grading capacity. It was noted that the grading room was very warm and uncomfortable to be in on the day of the clinical observation which was not at full capacity.

There are 6 grading monitors in use, 5 of which displayed a resolution of 1680x1050. This resolution does not meet the minimum standard of 1600x1200 (4:3 monitor), or 1920x1080 (wide screen monitor). This has been included on the DESP risk register.

Other than the limitations described above, grading procedure was reviewed to be adequate during clinical observation. In the grading session observed, grading was viewed to occur at a measured pace with approximately 4 minutes spent on each image set.

All graders attend Heartlands training course at the start of their employment and later the advanced grading course. Two competency drop-in assessments take place annually for each grader.

Grading protocol

Two versions of grading protocol were provided as evidence by the DESP. One developed by MI and the other by the Clinical Advisor. Those developed by the CA are referred to as the main point of reference for graders.

Grading follows national protocol, including features-based grading and the new version 4 pathway version of disease grading form. R0/R1 arbitration is performed within Central Mersey DESP.

IT and software

All but 4 of the screening venues (including the 4 observed) have live VPN connection between the clinic and grading /administration centre at Millbrow., so all images are stored directly on the server. If this live connection fails, the optometrist uses their own computer to capture images.

It is recommended that the practice of capturing images on local computers is avoided where possible in order to prevent mix up of images between patients during later image

transfer. However, it was observed that SOPs have been put in place to tighten up on the process of image transfer in the event of network failure. The DESP should monitor adherence to this SOP in order to reduce the risk of error.

Laptops are used at 4 of the NHS screening sites and are synchronised at the end of each clinic day.

Evidence:

Clinic observations 20th May & 16th June 2014
Pre-visit questionnaire
Interviews
SOP documents submitted as evidence

Recommendations – The screening test:

Medium

4.1 Review different versions of screening and grading SOPs currently in use by DESP. Create one single document for each (VA capture, mydriasis, and grading protocol) with Clinical Lead sign off, and implement across all screening providers to ensure consistent SOPs are in use across entire programme.

4.2 Review monitors and resolution capacity to ensure all equipment is in line with national standards

4.3 Produce workforce capacity plan to address issue of future programme growth and need for additional grading staff, equipment and facility.

Low

4.4 Write and implement an equipment replacement plan to ensure digital cameras continue to be fit for purpose; plan to include IT equipment used within the DESP, across all screening, grading and administration providers.

5. Minimising Harm

This theme is concerned with minimising the harms of screening in those who are screened as well as those who are not.

Performance against standards:

Objectives 6, 7, 8, 9 & 10	Criteria	Minimum standard	Achievable standard	Performance
6. To ensure GP and patient are informed of all test results	Time between screening encounter and issuing of result letters to GP and patient.	70% <3 weeks 99% <6 weeks	95% <3 weeks	93% < 3 weeks 93% < 6 weeks (March 2013 – March 2014) Consistently over 96% KPIs Q1 to Q4 2013-14 Conflicting evidence; not clear if meeting standard.
7. Ensure timely referral of patients with R3 screening results	Time between screening encounter and issue of referral request	95% referred within 2 calendar weeks	98% referred within 2 calendar weeks	Inadequate evidence observed to support achievement of minimum standard.
8.To ensure timely consultation for all screen-positive patients	Time between notification of positive test and consultation: 1.Urgent (*R3M0 R3M1)* 2.Routine (R2M0, R2M1, R1M1)	1.a. 60% <2 weeks 1.b. 95% <4 weeks 2.a. 70% <13 weeks 2.b. 95% < 18 weeks	1. 95% <2 weeks 2. 95% <13 weeks	Reported in Jan to March 2014 timeline tracker: 1. 36% < 2 weeks 36% < 4 weeks 2. 44% < 13 weeks 44% < 18 weeks Does not meet minimum standard. (Possible data quality issues.)
9. To follow up screen-positive patients (those with referable retinopathy) (failsafe)	Timeline tracking undertaken to agreed national template	6 monthly feedback reports to the Programme Board of the results of timeline tracking.	Quarterly feedback report to the Programme Board of results of timeline tracking.	Timeline tracking completed – provided with questionnaire. Summary outcome not reported to PB. Partially meeting standard.

10. To ensure timely biomicroscopy assessment of patients recorded as ungradeable	Maximum time between digital screening encounter and attendance for assessment by slit lamp biomicroscopy to be no more than 14 weeks	Quarterly review of the results of timeline tracking, reported to the Programme Board.	Monthly review of results of timeline tracking, reported to Programme Board.	Verbal report that SLB waiting time is within timescales, but no SLB tracker evidence provided. Quarterly review of timeliness of SLB appointments not provided to PB. Not meeting minimum standard.

Compliance:

The programme is partially compliant with National Quality Standard Objectives 9.
The programme is not compliant (or evidence not sufficient to support compliance) with National Quality Standard Objectives 6, 7, 8 and10.

Observations:

Performance against national objectives regarding minimising harm
Taken together, objectives 6 through 10 reflect the timeliness with which results are obtained after a screening event, as well as how fast assessment and treatment services are provided in hospital eye service, following a screen positive result.

Central Mersey DESP consistently reports meeting standard against Key Performance Indicator (KPI) DE2 (>96% each quarter in 2013-14), indicating that results are sent out in a timely manner and the programme does not experience backlogs within the grading process.

In conflict with this, data within the Programme Performance Report (March 2013 – March 2014) was slightly below minimum standard. Data quality may be an issue within this report and it's recommended that the programme and commissioners review data to ensure compliance with national standard objective 6.

Performance against objective 7 cannot be verified due to lack of data against this measure. Because of this, it is recommended that the provider and commissioners review more robust and current data (including completed STTT data) to assure themselves of performance against this measure.

For objective 8.1 (urgent referrals) data reported within the pre-visit questionnaire was taken from the programme's STTT. Data provided demonstrates that the programme is not meeting the minimum standard for this measure. In addition, KPI measurement DE3 also reflects the time between urgent referrals and first attended appointment within hospital eye service (HES) and the programme has performed below the target of 80% for the last two quarters measured (Q3 and Q4 2013-14).

For objective 8.2 (routine referrals), data was also provided by the programme from their STTT. Data showed 44% of routine referrals met the 13 week timeframe, and the same 44% achieved the 18 week timeframe, neither of which is sufficient to meet minimum standard.

Because information links are viewed to be good between DESP and the treatment centres, it is believed that the performance levels in objective eight represent a scheduling and/or capacity issue within the hospital eye services. It is recommended that this be investigated and possible solutions identified with cooperation between service providers, treatment centres and commissioners.

For objective 9, a timeline tracker was reviewed by the QA team during the administration visit and viewed to be fit for purpose. However, the results of this timeline are not summarised and reported to the Programme Board on a six monthly basis, and therefore the objective is only partially met.

For objective 10, data is collected by the programme against this measure and it was reported verbally that there is no delay for patients referred to the SLB pathway. However no details on this data shared with the visiting team or provided as evidence. It was also not seen in evidence that data for objective 10 have been regularly shared with the Programme Board on a quarterly basis. Therefore the minimum standard for this objective is not met.

Failsafe

Failsafe tasks are the responsibility of the full time Administration Manager within BCHT. Tasks are split between this role and the Administration/Failsafe Coordinator in a split capacity, providing resilience to the team. It was reported that failsafe duties within the DESP are manageable except during times of leave or unexpected absence when the administration team is unable to provide all essential tasks.

The list of failsafe tasks was observed during the administration visit and found to be comprehensive and generally well-managed, with one exception. The datastorm tool is not utilised by the administration team. The datastorm is an internal QA tool provided by the software company that provides an alert to possible errors within software that would not be otherwise apparent. It is strongly recommended that the DESP liaise with the software supplier and begin to use this datastorm tool as a regular feature of failsafe within the programme.

It was reported that any breaches found during failsafe reviews would be discussed at operational meetings, but it was not clear how an incident would be managed if identified.

While there are several SOP documents that cover aspects of the administration tasks, no SOP covers failsafe as a single process, regarding the purpose and outcomes required across both the screening/grading and administration teams. As such, it was recommended by the visiting team that the programme should write and implement a single SOP to cover the full scope of failsafe policy and processes.

A laser book audit and 6/60 audit were not submitted as evidence for this review and should be undertaken by the programme as soon as possible. A clear SOP for each type of audit and how to follow up positive findings should be written and implemented in line with national guidance. (For recommendations regarding audits, please see Outcome section below, pp. 29-30)

The failsafe trigger in the software had previously been used by the DESP since the migration from Orion to Digital Healthcare in March 2013. This means that patients who are in hospital eye service for longer than one year without updated screening grades input into their record will be automatically returned to active status within the screening software.

However following the upgrade to DHC version 4 software, this failsafe tool has changed and now provides an alert to the DESP when a patient has not had HES appointment within 12 months (i.e., there is no automated return of the patient into the screening pathway). It is

recommended that the process for management of this new failsafe alert system is reviewed and a robust SOP is written and implemented regarding its management. This policy should be written to ensure the safety of those patients who may not have been seen in HES within a timely fashion.

Clinical Leadership

The Central Mersey DESP has been operating with the support of two Clinical Leads (CLs) who are each contracted to provide 0.09 whole time equivalent (wte). This time is used for providing Referral Outcome Grading (ROG) for the routine digital pathway only. If any additional time is required, the CLs use personal time as needed. It was noted by the visiting team that due to the limited time available to the CLs, the full scope of CL roles and responsibilities are not being performed.

Tasks not performed or directly overseen by a Clinical Lead include: DESP grading quality reviews and other internal quality assurance checks, individual grader feedback, participation in MDT meetings, and general clinical governance and oversight for the programme.

Several of the roles of the Clinical Lead are being performed by the Clinical Advisor who is an optometrist working within the programme who provides grading feedback to all graders, and screening guidance to the optometrists. However, because there is no formally accountable Clinical Lead with sessions dedicated to the DESP, there is no single point of clinical oversight within the programme. This was identified as a risk to the programme by the review team.

Please see section below, Workforce & IT (p.34 - 38) for additional information and recommendations regarding the role and responsibilities of both the clinical lead and ophthalmology lead posts.

Grading Quality

MDT meetings are held in alternate months. These meetings include all grading staff, the Clinical Advisor and SLB assessor. Historically these meetings focused on TAT results, but more recently have included discussions around changes in software, unusual or interesting grading examples and the identification of urgent R3 grades.

There was evidence to demonstrate some feedback is given to individual graders regarding their own performance from daily grading in the form of data regarding grader performance (e.g., arbitration levels, retinopathy and ungradeable levels, agreement with primary retinopathy grade, etc.). Interview evidence suggests that some of this feedback is provided by the Clinical Advisor and in some cases by the Screening/Grading Team Leader. This type of feedback is important as a means to enable learning and improvement.

No oversight or involvement from the Clinical Lead was noted.

It is recommended that the commissioners and programme review policy for individual grading performance feedback for all graders working within the programme. Commissioners and the Clinical Leads should enhance this policy as needed to ensure robust clinical oversight and a thorough feedback loop to support and improve grading performance across both providers.

On-line test and training sets (T&Ts) are done by all grading staff, including the Clinical Advisor. The Clinical Leads do not participate in T&Ts, which is recommended practice.

Digital surveillance (DS) clinics

Evidence taken from multiple interviews and the pre-visit questionnaire suggest that there is currently a limited DS pathway in place. No evidence was provided to show a clear policy regarding which patients are seen in this pathway, and it was unclear to reviewers how the pathway is being managed.

Pregnant patients were being seen in digital surveillance clinics at the time of the QA review.

Senior grading staff within MI is responsible for the ROG level grading within the DS clinics. (Please see Workforce and IT, page 37-8 for more information on DS clinic management, and page 39 for recommendations.)

Pregnant patients

A protocol for managing pregnant patients was evidenced as part of this review. Details regarding the timeliness and failsafe process for monitoring this cohort were included, but overall the SOP was not viewed as fit for purpose. This was largely due to the policy not reflecting the new common pathway and the requirement for pregnant patients to be managed within the digital surveillance pathway.

It is noted that the upgrade to version 4.0 software took place one month prior to the QA visit, and that the SOP was therefore only recently made out of date.

However, the visiting team recommended that an SOP for management of pregnant patients be developed to be in line with the new common pathway, which requires pregnant patients to be seen in the digital surveillance clinic. This is to ensure that local protocol is in line with national guidance, and to provide all existing and new staff with a single point of reference regarding management of pregnant patients.

This policy should be written and/or signed off by the Clinical Lead, approved by the Programme Board and adopted by all providers within the Central Mersey DESP service.

Slit Lamp Biomicroscopy (SLB)

SLB appointments are provided by one optometrist across 6 locations, with coverage provided by the Clinical Advisor (CA) during times of absence. It was reported that both SLB assessors are accredited according to national protocols, and that the acting Clinical Lead provides all required annual refresher sessions.

Evidence was provided to show that the main SLB assessor performs the 100 minimum screening events per rolling 12 calendar months. However, the CA was not included on the grading volume report provided, and the visiting team could not confirm that he met the minimum standard. It is recommended that this volume is reviewed and results reported to Programme Board, in order to ensure that the CA meets national SLB assessor accreditation standards.

It was reported in interview that there are known capacity issues within the SLB pathway. There is no resilience or business continuity plan built into the SLB screening pathway and this was noted as a risk by the visiting team.

It was verbally reported that patients with first time SLB appointments were seen within the required 14 week timescales. However, no data were show to evidence this statement. While there is no minimum percentage set within the national standard, it is recommended that commissioners and the programme review the performance data in this area, and review capacity and scheduling arrangements for SLB referrals to ensure timely appointments are available.

It is recommended that the DESP reports outcomes from Objective 10 to the Programme Board for monitoring, and ensures that enough SLB appointments are available to meet the demand of the service.

Evidence:
Administration Review 20th May 2014
Clinic observations 20th May and 16th June 2014
Pre-visit questionnaire
Responses from Clinical Lead/Ophthalmology, Programme Management/Administration, and Screening/Grading interviews.
SOP documents as provided

Recommendations – Minimising harm:

High

5.1 Investigate reasons behind low performance within objective eight (timeliness of first appointment after referral from screening programme). Identify mitigating actions to address underlying information return, scheduling or capacity issues within hospital eye service.

Medium

5.2 Review current SOP for identification and management of internal grading QA issues to ensure appropriate clinical oversight and consistency in grading feedback and performance management. Ensure SOP includes recommended involvement and oversight responsibilities of Clinical Lead.

5.3 Write SOP for management of pregnant patients in line with national guidance and implement across all screening providers.

5.4 Review process for management of the new failsafe alert system in version 4.0 of software. Write and implement a robust SOP regarding its management, to ensure the safety of those patients who may not have been seen in HES within a timely fashion.

5.5 Review information flow between each HES treatment centre and DESP admin team, to ensure compliance with NDESP failsafe guidance.

5.6 Report timeliness of appointments within SLB pathway to Programme Board as required within national standard objective 10.

5.7 Review rolling 12 month volume of SLB assessments made by each assessor to ensure minimum of 100 per rolling 12 months is achieved by all.

6. Intervention and Treatment

This theme is concerned with interventions following the screening test, and is linked to the minimising harm theme.

Performance against standards:

Objectives 11 & 12	Criteria	Minimum standard	Achievable standard	Performance
11. To ensure timely treatment of those listed by ophthalmologist	Time between listing and first laser treatment, following screening, if listed at first visit: *1.* Urgent (*R3M0, R3M1)* 2. Routine (R2M1, R1M1)	1. 90% <2 weeks 2. 70% <10 weeks	1. 95% <2 weeks 2. 95% <10 weeks	No evidence observed to support achievement of minimum standard.
12. To minimise overall delay between screening event and first laser treatment	Time between screening encounter and first laser treatment, if listed at first visit to hospital eye service following screening, does not exceed: 1. Urgent (referred as R3*M0/R3M1)* 2. Routine (referred as R2M1, R1M1)	*1. 70% <6 weeks* 2.a. 70% <15 weeks *2.b. 95% <18 weeks*	1. 95% <6 weeks 2. 95% <15 weeks	No evidence observed to support achievement of minimum standard.

Compliance:

The programme is not compliant with both National Quality Standard Objectives 11 and 12. .

Observations:

Primary treatment centres for the Central Mersey DESP are Warrington and Halton Hospitals NHS Foundation Trust (WHFT) and St Helens and Knowsley NHS Trust (SHKHT). Less frequently patients will be referred to Aintree Hospitals NHS Foundation Trust (AHFT). Treatment centres referrals are made based on a patient's resident post code, or by request of the patient for a specific treatment centre.

The programme benefits from strong links to the hospital eye service (HES) within WHFT and SHKHT. The Administration Manager and Admin/Failsafe Coordinator together provide failsafe checks and clinical data chasing for patients within both treatment centres.

However, because it is unclear how much data is captured within the timeline tracker, it was not possible for the visiting team to assess how complete the information transfer is between the HES and the programme.

Outcomes from HES appointments are sent by each treatment centre on a feedback form, and results are entered into DESP software by the administration team. Although this is a completely manual process, the process of collecting clinic data was reported to work well, due in large part to the close relationships the DESP administration team has built up with the corresponding HES admin teams. This was viewed as good practice by the visiting team.

It was reported in interview that SHKHT hold general clinics and patients referred from the DESP are distributed across all clinics. However there are plans to start a weekly Diabetic Retinopathy (DR) clinic for new patients, although it is expected that follow-up patients will still be distributed across all clinics. There were no capacity issues at St. Helen's identified within interview, however no interviewee was aware of a fast track approach to urgent referrals for R3 patients.

For WHFT, there are dedicated DR clinics run by four medical retina specialists (two consultants and two associate specialists (DESP CLs)). There is also potential to open new dedicated DR clinics as needed. No capacity issues were identified within Warrington within interview, however no interviewee was aware of a fast track approach to urgent referrals for R3 patients.

It was reported that digital screening images are available within WHFT and SHKHT, but are not consistently accessed by all clinicians.

Patients with non-DR pathology are referred to HES for those conditions, but are also maintained within the DESP to ensure continuity of annual screening, which is in line with the new common pathway.

Upon discharge from the HES for reasons of DNA, information is sent to the DESP administration team via a paper form. It was described to the visiting team efforts made by the administration staff to encourage patients to attend for HES appointments, including discussions with GP practices and with patients themselves. This was viewed as good practice by the visiting team.

Evidence:
Administration Review 20th May 2014
Clinic observations 20th May and 14th June 2014
Pre-visit questionnaire
Responses from Clinical Lead/Ophthalmology, Programme Management/Administration and Screening/Grading interviews
SOP documents as provided

Recommendations – Intervention and treatment:

Medium

6.1 Review urgent R3 pathways at all treatment centres to ensure timely appointment and fast track to laser when required.

6.2 Confirm that patients referred from DESP for DR are seen within dedicated clinics by retinal specialist clinicians; design and implement policy for such dedicated clinics if not already in use across all treatment centres.

7. Outcome

This theme is concerned with outcomes following the screening process and is the corollary of the minimising harm theme.

Performance against standards:

Objective 13	Criteria	Minimum standard	Achievable standard	Performance
13. To ensure regular collection of data indicating levels of new blindness due to diabetic retinopathy	Audit of severely sight impaired/sight impaired certifications predominantly due to diabetic retinopathy Audit of incident visual acuity of 6/60 or worse in the better seeing eye.[Log MAR equivalent +1.0], which is predominantly due to diabetic retinopathy	An annual report submitted to the Programme Board; to include the results of the audit of all incident cases of certifications of SSI/SI and VA data using national template.	An annual report submitted to the Programme Board; to include the results of the audit and case reviews of all incident cases of certifications of SSI/SI and VA data using national template.	SI/SSI and 6/60 audit not evidenced. Standard not met.

Compliance:

The programme is not compliant with National Quality Standard Objective 13.

Observations:

The visiting team found no evidence to assure itself that patients were not being missed by the screening service. This was identified as an area of high risk within the programme.

SI/SSI and 6/60 audits were not presented as evidence and interview responses suggest that these have not been completed. Similarly, a laser book audit was not submitted to the visiting team.

The intended purpose of these audits is to identify any patient who has presented with sight threatening retinopathy (STDR) without being identified through the DESP. It is noted that special care is required in the case where a patient who is currently registered with a participating GP practice presents to HES and receives treatment for diabetic retinopathy without being previously known to the DESP. These cases represent a potential failure of the DESP to prevent sight loss and should be considered as a potential incident or serious incident.

An SOP was provided that reviewed generally how to identify patients presenting with proliferative retinopathy without being known to the DESP, and this was viewed as a good starting point. However, as a complete and useable document the visiting team found this SOP was not fit for purpose. Details of what information to review, how often it should be done, how to document and report the findings were not included.

It is therefore recommended that the DESP review the expected purpose and outcome data for the SI/SSI, 6/60 and laser book audits. A clear SOP for the completion of these audits should be written and adopted by the programme.

Evidence:
Administration Review 20th May 2014
Clinic observations 20th May and 16th June 2014
Pre-visit questionnaire
Responses from Clinical Lead/Ophthalmology and Programme Management/Administration interviews
SOP documents as provided

Recommendations - Outcome:

High

7.1 An urgent review of the laser book audit to identify those patients who attended for laser treatment without being known to or properly managed through the DESP. Follow up of those who were treated without coming through the DESP should be undertaken to learn circumstances and the root cause where appropriate.

Medium

7.2 Undertake an audit of SI/SSI patients and present findings to Programme Board.

7.3 Write and implement a robust SOP for regular audit of laser book, including policy for how to follow up with patients identified to have had laser but not known to the programme.

7.4 Write and implement detailed SOP to define regularly scheduled 6/60 and SI/SSI reviews and case reviews in order to maintain adherence to national standard objective 13.

8. Workforce & IT

This theme is concerned with training and competence of staff and accreditation of screening services. This theme is concerned with ensuring appropriate IT systems are in place to support the screening pathway and audit.

Performance against standards:

Objectives 14 & 15	Criteria	Minimum standard	Achievable standard	Performance
14. To ensure that screening and grading of retinal images are provided by a trained and competent workforce	Screening and grading staff to be appropriately qualified in accordance with national standards	100% of staff classified as graders (group a) to achieve qualification in accordance with national standards 100% of staff taking images (group b) to achieve qualification in accordance with national standards	100% of all staff groups (groups a-f) to achieve qualification in accordance with national standards	All active screening/grading staff has City & Guilds qualifications in line with national standard. Not clear from evidence whether administration staff members are registered for C&G. Achievable standard is met.
15. To ensure optimum workload for all graders in order to maintain expertise	Graders who do not hold additional job roles as either an optometrist or an ophthalmologist must grade a minimum of 1,000 patient image sets per annum.	95% of staff recorded on grading system meets minimum requirements.	100% of staff recorded on grading system meets minimum requirements.	100% graders meet minimum volume requirements for 2012-13 Achievable standard met.

Compliance:

The programme is compliant with National Quality Standard Objectives 14 and 15.

Observations:

The workforce for Central Mersey DESP is divided between the two providers, Bridgewater Community Healthcare Trust (BCHT) and Medical Imaging Ltd. UK (MI).

The administration (call/recall) and failsafe staff for the programme are employed by BCHT, and are led by the Administration Manager (AM) (1.0 wte). The AM line-manages one Administration/Failsafe Coordinator (0.6 wte), and three screening programme administrators (total of 2.4 wte).

The two acting Clinical Leads are each contracted by BHCT for 0.09 wte to provide referral outcome grading for the programme. In addition to their screening role, both CLs have full time (10 sessions/week) employment with Warrington and Halton Hospitals NHS Foundation Trust (WHFT), within the ophthalmology department.

MI provides the Programme Manager (PM) role (0.8 wte), along with that of Team Leader (1.0 wte) and 6 screener/grader staff members (total of 5.0 wte).

MI also provides all grading and some screening functions to the programme, including slit lamp biomicroscopy (SLB) assessments, which MI sub-contracts out to a single private optometrist provider. It was noted in interview that while the Clinical Advisor (CA) provides cover for the SLB pathway, there is no contract in place to cover this service provision.

In addition, screening services are provided by 27 private optometrists through 26 separate contracts held directly with the Merseyside Area Team commissioners. One of these optometrists provides the role of Clinical Advisor within the DESP.

Despite the separate management, budgetary and contractual links between these areas of the programme, staff were reported to work as a team throughout the visit process.

Administrative Functions

The Administration Manager (AM) has management responsibility for the call/recall and failsafe functions of the programme, all failsafe functions and appointment setting for screening that takes place in NHS screening clinic locations.

Together, the AM and the Administration/Failsafe Coordinator (A/FC) share the responsibility of and tasks related to failsafe. It was noted that failsafe was not included in the job description for the A/FC, but that plans were in place to document the responsibilities and include this in the job description to accurately reflect the role.

Three Administration Clerks report to the AM (total of 2.4 wte). This team is responsible for all administration and some failsafe tasks. It was reported that the AM and team were able to manage the admin and failsafe functions, except during extended planned or unexpected staff absence when they were not able to perform all essential tasks.

The DESP administration office is located in the same building where the Programme Manager and Team Leader are located. It was reported to the visiting team that ad-hoc communication between the two teams happened regularly, although there were monthly operational meetings where the two teams could discuss issues and cross-over responsibilities.

Evidence was provided to show all administration staff has completed the appropriate City and Guilds qualification in line with the achievable standard for national objective 14.

Screening and grading – Medical Imaging Ltd. UK and private optometrist practices

Six screening/grading staff members work for the Central Mersey DESP, a total of 5.0 whole time equivalents.

The PM (0.8 wte) has managerial oversight of the entire programme, and direct line management responsibility for the Team Lead (TL) (1.0 wte) and all screening/grading staff employed by AHFT (5.0 wte).

The TL works with the Clinical Advisor to provide education, internal grading QA reviews and feedback to the screening and grading staff on grading performance and updates on national guidance and requirements. The TL carries out both screening and grading functions including arbitration level grading and ROG level grading for the Digital Surveillance pathway.

One optometrist holds the role of Clinical Advisor, and provides screening and grading services to the programme, including ROG level grading in the Digital Surveillance (DS) pathway. The CA also provides training and guidance to the optometrist screeners, as well as to the DESP grading staff. Inter-grader agreement reports, missed grades, TAT results and interesting cases are reviewed with grading staff, both within MDT meetings and on a one-to-one basis.

All screeners and graders have completed their City & Guilds qualifications.

Slit Lamp Biomicroscopy (SLB) Provision

SLB assessments are made by one optometrist who is sub-contracted by BCHT to provide these services.

As reported in the pre-visit questionnaire, this optometrist regularly complete the online test and training sets, and has been accredited in line with national requirements. Plans are in place for yearly accreditation with oversight from the Lead Ophthalmologist. However documentation to demonstrate this was not requested or reviewed as evidence for the visit, and should be confirmed internally and by commissioners.

The Central Mersey DESP produced clear records to record the yearly minimum SLB assessment requirements (100 per 12 months).

It was noted as a risk to the programme that the only provision of SLB assessments are made by a single qualified assessor. As such, there is no resilience built into the SLB pathway, and in cases of extended absence there is risk of delayed SLB appointments. The visiting team recommends that commissioners and providers review SLB service provision and restructure in order to provide business continuity and resilience within this part of the screening pathway.

Clinical Leadership role

As has been noted, 0.18 wte is provided for provision of Clinical Lead (CL) responsibilities for the Central Mersey DESP. The roles and responsibilities of a CL (as documented in national guidance) are not included in the job plan or job description of either ophthalmologist who is considered to hold this position.

The CLs are not directly involved in the monitoring or feedback of grading quality within the programme, although each reported in interview that they were aware of grading feedback being provided and interest in becoming more involved. However, as they each work 10 sessions on top of the DESP responsibilities, any additional work they undertake for the programme is completed in personal time. This was deemed inappropriate by the visiting team.

The CLs are not involved in any grading services other than the routine digital ROG level grading. This means there is no clinical supervision or oversight of ROG level grading

within the digital surveillance (DS) pathway. Therefore, it is unclear what clinical supervision or support is available to graders when undertaking ROG grading within digital surveillance.

The visiting team acknowledges that the DS pathway is new to the programme, as it started in March 2014; therefore its impact on the service is not yet known. However, because the DS pathway reviews patients known to have referable eye disease, there is higher risk of developing advanced eye disease within this cohort, and outcome decisions made within this queue (regarding whether to keep patients in digital surveillance or refer to hospital) are essential to maintaining safety in the system.

It is therefore recommended that provision of the DS grading is reviewed and altered as necessary to ensure there is appropriate clinical oversight and support for the technician graders undertaking these grading and outcome decisions.

IT and software

Historically Central Mersey DESP used screening software provided by Orion, and migrated to Digital Healthcare Optimize in March 2013. This migration process necessitated several weeks of downtime, during which the programme did not screen patients. The CLs reported in interview that this was a difficult time for the programme and that adjustment to the new software had been a challenge.

The programme was using Digital Healthcare's Optimise version 3.6 at the time initial reports were produced that comprised the evidence pack.

The programme upgraded to DHC version 4.0 software in March 2014, and was using this version at the time of the administration review and the clinical observations. The CLs reported that this transition was a challenge to the programme.

Some functionality issues and data quality issues have been raised by the programme since the time of the upgrade. It is recommended that these be monitored and resolved in line with supplier guidelines and with the use of national programme support as appropriate. The issues with software were taken into account by QA reviewers. In cases where information was viewed as not robust (potentially as a result of the software functionality), further review has been recommended within this report.

All NHS screening clinics have direct links to the network at BCHT, and optometrist screening sites link in through a VPN connection. These links provide direct, real-time two-way sharing of information between the screening clinics and administration team and no issues were noted within the visit.

IT support is not currently fit for purpose and this was picked up as a risk to the programme by the visiting team. IT support is provided by St Helens & Knowsley NHS Foundation Trust's (HKFT) IT team, but there is no dedicated service contract in place. It was reported in evidence that IT concerns are not dealt with in a timely manner, and that it is thought to result from the lack of a contract with the supplier.

Another risk to the programme is data security. It was unclear to reviewers if daily back-ups were being made of programme data. No disaster recovery process had been performed to ensure restoration of data would be possible in the case of catastrophic failure.

However the most serious and immediate risk identified was the lack of capacity on the server used to house all programme data. At the time of the visit it was noted that only 5% capacity remained on the server. The visiting team was told of plans to replace the server, and that these were underway at the time of the visit. Due to the serious risk this poses to

the programme however, it is an urgent recommendation that commissioners and the programme resolve this issue quickly.

Evidence:
Administration Review 20th May 2014
Clinic observations 20th May and 16th June 2014
Pre-visit questionnaire
Responses from Programme Management/Administration, Screening/Grading, and Clinical Lead/Ophthalmology interviews
SOP documents as provided

Recommendations – Workforce & IT:

Immediate

8.1 Increase capacity of DESP server to remove immediate risk to programme data;

High

8.2 Procure service contract for provision of IT services to screening programme in order to ensure appropriate IT support to programme.

8.3 Review role of Clinical Lead(s) against requirements of programme as outlined in the National Diabetic Eye Screening Programme (NDESP) service specification, and the document: 'Roles and responsibilities of clinical leads of diabetic eye screening programmes, version 1.0, May 2013.' Ensure proper clinical accountability, governance, and internal quality oversight across all sections and providers of the programme. Ensure that revised arrangements are adequately described within job plans.

8.4 Review ROG grading responsibilities, and availability of expert clinical guidance and support to ROG graders within the digital surveillance pathway. Provider and commissioners should assure themselves that appropriate clinical oversight is in place within this grading queue.

8.5 Conduct workforce capacity review and develop business continuity plan for provision of SLB assessments to ensure all essential tasks can be maintained during times of planned or unexpected absence and that resilience can be maintained within the system.

Medium

8.6 Write and implement plan for regular data back-ups, formulate a disaster recovery plan for IT and test for viability in case of disaster

9. Commissioning and Governance

This theme is concerned with ensuring that each screening programme is appropriately managed, commissioned and works across professional boundaries

Performance against standards:

Objective 16, 17, 18 & 19	Criteria	Minimum standard	Performance
16. To optimise programme efficiency and ensure ability to assure quality of service	Minimum programme size.	Greater than 12,000 people diagnosed with diabetes on	Programme size > 30,000 patients Objective is met.
17. To ensure that the screening interval is annual.	Programme operates an annual screening interval	Policy endorsed by Programme Board stating annual screening interval and recorded in Programme Board minutes.	DESP operates a 12 month screening interval and invites patients every 11 months. Objective is met.
18. To ensure the public and health care professionals are informed of performance of the screening programme at regular intervals	1. Production of annual report 2. Production of KPI data	1. Submission of annual report, for preceding financial year, via the Electronic Annual Reporting System (EARS), by 31st October. 2. Quarterly submission of KPI data to the NSC as required.	1. DESP submitted 2011-12 annual report in time for deadline in 2013. 2. Central Mersey DESP regularly submits all three KPI measures before quarterly submission deadlines. Objective is met.
19. To ensure the service participates in quality assurance	External quality assurance	Participation in peer-review visit programme.	EQA visit in 2009 and participating in QA review April 2014. Objective is met.

Compliance:

The programme is compliant with National Quality Standard Objectives 16, 17, 18 and 19.

Observations:

The DESP has an eligible population of just over 38,000 which is above the national minimum standard of 12,000. The programme report having a policy of 12 month recall although no formal documentation was provided as evidence (e.g., notes from Programme Board approval of policy).

Contracting arrangements

NHS England Merseyside is the lead commissioner for the programme however they also commission services on behalf of NHS England Cheshire, Warrington and Wirral. Services are commissioned on behalf of populations of 4 CCGs: St. Helens, Knowsley, Halton, and Warrington.

Medical Imaging Ltd. UK is contracted to provide DESP clinical leadership, programme management, screening in the 10 NHS sites and all the grading, excluding ROG grading within the routine digital pathway. Bridgewater NHS Trust is commissioned to deliver the administration, failsafe, call and recall function, IT support, and ROG grading within the routine digital pathway through a contract with Warrington NHS Trust.

There are 27 private optometrists contracted (through 26 contracts) to provide screening services. These optometrists currently have individual contracts with the commissioners that have been rolled over from previous arrangements, with the new NDESP service spec added in.

Contracting arrangements are complex and in interview, commissioners acknowledged this model of commissioning leads to difficulties in identifying clear roles and responsibilities, and escalation processes in regards to risk and incidents. It is recommended that commissioners review contracting arrangements in order to harmonize and simplify contracting arrangements for the programme.

The Merseyside Area Team's screening and immunisation team reported they will be performing a gap analysis on the NDESP Service Specification. The contracting team has produced a spread sheet to identify any gaps and in turn an action plan to enable delivery against the service specification.

Commissioners reported that a CQUIN related to addressing health inequalities was included in the contracts for both providers, but reported that they weren't sure providers were aware of this.

While different services are provided by separate entities, there is no Memorandum of Understanding (MOU) or Service Level Agreement (SLA) between these service providers regarding programme governance, roles and responsibilities. The visiting team noted this as a risk to the programme, particularly around the role of accountable Clinical Lead.

Programme Board and Governance

An oversight model has been put in place whereby the Merseyside Area Team hold Programme Board (PB) meetings which also include the two other DESP programmes covered by the team (Central Mersey DESP and Liverpool DESP).

The joint PB meetings will be held every six months and are intended to enable sharing of good practice, and to stimulate challenge between providers. It will also enable the Area Team to make use of the limited administrative support.

The visiting team noted that there was potential risk due to the infrequency of meeting dates for the Programme Board in that meeting every six months may not be adequate to monitor performance of three separate DESPs. There is a risk that this may be too infrequent to approve key actions, performance plans, and any required recovery plans or serious incident reports.

It is also noted that the national service specification requires quarterly Programme Board meetings. Less frequent meetings are noted as potentially acceptable, provided local operational meetings are held more frequently and are attended by commissioners.

It is planned that Central Mersey DESP providers will continue to hold local quarterly operational group meetings and will report any key outcomes to the Programme Board as appropriate. A member of the Area Team attends these meetings. Any service specification issues not addressed through these groups or through the Programme Board will be brought to the attention of the wider quarterly contract management meetings held by the Area Team.

The visiting team recommends a review of Programme Board and operational meetings in twelve months' time to assess their combined effectiveness and efficiency.

Board representation was viewed by the visiting team to be fit for purpose. The Area Team plan to add representation of a service user from Diabetes UK, and this was seen as appropriate by the visiting team.

The Programme Board is accountable to a newly established Commissioning and Performance Committee. Reports from the Screening and Immunisation Lead will be made to this group and also to the Health Protection Forums, which will give local Directors of Public Health regular assurance of programme performance.

<u>Incident Management</u>
It was reported in interview that the national interim guidance on managing screening incidents is adhered to within the programme. There is currently no documented local SOP regarding the identification and management of DESP incidents or the maintenance and reporting against internal risk registers.

An open culture to incident reporting was noted by the visiting team. However, commissioners acknowledged system and communication issues that have contributed to incidents.

Regarding management of incidents, any potential incident within the optometrist providers would be escalated to the Screening and Immunisation Team for management. A potential incident occurring within services provided by Medical Imaging would be managed by MI, and Bridgewater would manage incidents occurring within their part of the service.

MI holds a risk register which is shared at the operational group, but commissioners were unaware if the Bridgewater Trust risk register is shared.

The inconsistent policy in incident management highlights a key risk within the governance arrangements for the DESP. All sections of the screening pathway are inter-connected and often an incident may occur across multiple pathways and have multiple root causes originating throughout the service. Seamless cooperation in the case of an incident is essential to address issues quickly and mitigate further occurrence and risk to patients.

For this reason, it is advised that the DESP writes a single local incident SOP (for approval and sign-off by the Programme Board) to cover all sections of the screening pathway and

define clearly the responsibilities of each provider, regardless of the area of screening provision where the potential incident is initially identified.

Evidence:
Administration Review 20th May 2014
Pre-visit questionnaire
Interview responses from Programme Manager, Clinical Lead, Public Health & Commissioning
SOP documents as provided

Recommendations – Commissioning and governance:

High

9.1 Commissioning and contract arrangements for all parts of the screening pathway should be reviewed and amended across both service providers as necessary. These must incorporate requirements of the National Diabetic Eye Screening Programme service specification, including requirements for the New Common Pathway and governance arrangements across whole of programme.

Medium

9.2 Fully documented accountability, governance and escalation arrangements should be put in place and defined within executed contracts. These arrangements need to support the formal oversight and reporting of DESP performance, quality, reporting and management of incidents, and working relationships across the whole screening pathway.

Low

9.3. Undertake a formal review of the current Programme Board arrangements with regard to frequency, ability to approve and influence change, and links with local provider led operational groups. To be made one year after current Programme Board arrangements were initiated.

10. User Experience

Observations:

The most recent Health Equity Audit and/or other equality/equity analysis for Central Mersey DESP was completed in 2011. A Commissioning for Quality and Innovation (CQUIN) goal has been established to encourage new analysis of health equity needs within the programme. (Please see recommendation on page 14).

Patient feedback forms are available at the NHS screening sites for patients to record any compliments, complaints or suggestions. Patients can either return these by post, or hand to the screener or screening office directly.

It was reported to reviewers that in the case when verbal comments are received (either positive or negative), patients are encouraged to submit in writing to allow the DESP to capture the views of patients and provide a response when appropriate.

No patient satisfaction survey has been completed by the DESP in the past two years. However, the programme reports plans to undertake a patient satisfaction survey in 2014 within NHS sites and optometrist practices.

Patients who have complaints are instructed to phone in to the DESP administration office in the first instance. From there further complaints are either handled by MI or BCHT as appropriate. No complaints log was in evidence for this visit and it's unclear if one is maintained by the programme.

It was reported that a patient representative from Diabetes UK is to be included as a member of the Programme Board. However, it was not clear at the time of the visit whether or not this had been established.

Evidence:
Administration Review 4th April2014
Clinic observations 9th April 2014
Pre-visit questionnaire

Recommendations – User experience:

Low

10.1 Complete planned patient satisfaction survey to determine views of service users. Identify potential changes or improvements to be made to programme that could increase uptake and acceptability of service for users.

10.2 Appropriate patient representation should be appointed for membership on the Programme Board.

Annex 1 – Table of Recommendations

(Please note recommendations are not consolidated in a particular order)

Recommendation	Priority
8.1 Increase capacity of DESP server to remove immediate risk to programme data;	Immediate
1.1 Undertake reconciliation of full single collated list, including all participating GP practices.	High
1.2 For cross-border patients, review current practice and document a clearly written SOP to cover policies and procedures, including a robust failsafe plan to ensure no patients are lost between programmes.	High
5.1 Investigate reasons behind low performance within objective eight (timeliness of first appointment after referral from screening programme). Identify mitigating actions to address underlying information return, scheduling or capacity issues within hospital eye service.	High
7.1 An urgent review of the laser book audit to identify those patients who attended for laser treatment without being known to or properly managed through the DESP. Follow up of those who were treated without coming through the DESP should be undertaken to learn circumstances and the root cause where appropriate.	High
8.2 Procure service contract for provision of IT services to screening programme in order to ensure appropriate IT support to programme.	High
8.3 Review role of Clinical Lead(s) against requirements of programme as outlined in the National Diabetic Eye Screening Programme (NDESP) service specification, and the document: 'Roles and responsibilities of clinical leads of diabetic eye screening programmes, version 1.0, May 2013.' Ensure proper clinical accountability, governance, and internal quality oversight across all sections and providers of the programme. Ensure that revised arrangements are adequately described within job plans.	High
8.4 Review ROG grading responsibilities, and availability of expert clinical guidance and support to ROG graders within the digital surveillance pathway. Provider and commissioners should assure themselves that appropriate clinical oversight is in place within this grading queue.	High
8.5 Conduct workforce capacity review and develop business continuity plan for provision of SLB assessments to ensure all essential tasks can be maintained during times of planned or unexpected absence and that resilience can be maintained within the system.	High
9.1 Commissioning and contract arrangements for all parts of the screening pathway should be reviewed and amended across both	High

service providers as necessary. These must incorporate requirements of the National Diabetic Eye Screening Programme service specification, including requirements for the New Common Pathway and governance arrangements across whole of programme.	
1.3 Review all exclusions (medically unfit and opt-outs) and ineligible patients (no longer diabetic and NPL) to ensure compliance with current national guidelines, appropriate documentation of status, and that all patients are in the correct category within software.	Medium
1.4 Develop quarterly summary report to show which GP practices have returned electronic lists for reconciliation. Summary report should be provided to Programme Board on a quarterly basis for review and escalation as needed to ensure all GPs participate in SCL reconciliation process.	Medium
2.1 Write and implement SOP for sharing screening results with diabetologists for all patients when information is available to do so.	Medium
2.2 Write and implement SOP to cover information given to patients during screening appointment. SOP to cover importance of providing information about contraindications prior to taking consent for screening appointment (and prior to mydriasis), and a clear process for informing all patients at time of appointment about what to do and where to call or go in the case of serious adverse reaction. Consider providing written information to hand to the patient at appointment.	Medium
2.3 Review quality of reported data for first screening offer made to newly referred patients (objective 2.2). Identify if there are gaps in policy and make necessary adjustments to ensure all newly referred patients are offered a screening appointment within three months.	Medium
4.1 Review different versions of screening and grading SOPs currently in use by DESP. Create one single document for each (VA capture, mydriasis, and grading protocol) with Clinical Lead sign off, and implement across all screening providers to ensure consistent SOPs are in use across entire programme.	Medium
4.2 Review monitors and resolution capacity to ensure all equipment is in line with national standards	Medium
4.3 Produce workforce capacity plan to address issue of future programme growth and need for additional grading staff, equipment and facility.	Medium
5.2 Review current SOP for identification and management of internal grading QA issues to ensure appropriate clinical oversight and consistency in grading feedback and performance management. Ensure SOP includes recommended involvement and oversight responsibilities of Clinical Lead.	Medium
5.3 Write SOP for management of pregnant patients in line with national guidance and implement across all screening providers.	Medium

5.4 Review process for management of the new failsafe alert system in version 4.0 of software. Write and implement a robust SOP regarding its management, to ensure the safety of those patients who may not have been seen in HES within a timely fashion.	Medium
5.5 Review information flow between each HES treatment centre and DESP admin team, to ensure compliance with NDESP failsafe guidance.	Medium
5.6 Report timeliness of appointments within SLB pathway to Programme Board as required within national standard objective 10.	Medium
5.7 Review rolling 12 month volume of SLB assessments made by each assessor to ensure minimum of 100 per rolling 12 months is achieved by all.	Medium
6.1 Review urgent R3 pathways at all treatment centres to ensure timely appointment and fast track to laser when required.	Medium
6.2 Confirm that patients referred from DESP for DR are seen within dedicated clinics by retinal specialist clinicians; design and implement policy for such dedicated clinics if not already in use across all treatment centres.	Medium
7.2 Undertake an audit of SI/SSI patients and present findings to Programme Board.	Medium
7.3 Write and implement a robust SOP for regular audit of laser book, including policy for how to follow up with patients identified to have had laser but not known to the programme.	Medium
7.4 Write and implement detailed SOP to define regularly scheduled 6/60 and SI/SSI reviews and case reviews in order to maintain adherence to national standard objective 13.	Medium
8.6 Write and implement plan for regular data back-ups, formulate a disaster recovery plan for IT and test for viability in case of disaster	Medium
9.2 Fully documented accountability, governance and escalation arrangements should be put in place and defined within executed contracts. These arrangements need to support the formal oversight and reporting of DESP performance, quality, reporting and management of incidents, and working relationships across the whole screening pathway.	Medium
1.5 Use suitable public health information tools (e.g., NHS Equality & Delivery System or a Health Equity Audit (HEA)), to address screening inequalities, to consider the needs of diverse populations, and those populations that rarely access screening services or don't access screening services at all. An action plan to be developed and implemented in coordination with relevant local authority and CCG stakeholders, based on recommendations from the use of these tools.	Low
2.4 Implement use of national standard invitation letter, with any	Low

additions made with sign off from Clinical Leads and Programme Board.	
3.1 Analyse and share “did not respond” (DNR) and “did not attend” (DNA) rates with GP practices to provide feedback and promote engagement between GP and patient and encourage higher uptake of screening services.	Low
4.4 Write and implement an equipment replacement plan to ensure digital cameras continue to be fit for purpose; plan to include IT equipment used within the DESP, across all screening, grading and administration providers.	Low
9.3. Undertake a formal review of the current Programme Board arrangements with regard to frequency, ability to approve and influence change, and links with local provider led operational groups. To be made one year after current Programme Board arrangements were initiated.	Low
10.1 Complete planned patient satisfaction survey to determine views of service users. Identify potential changes or improvements to be made to programme that could increase uptake and acceptability of service for users.	Low
10.2 Appropriate patient representation should be appointed for membership on the Programme Board.	Low