Programme Specific Operating Model for Quality Assurance of Diabetic Eye Screening Programmes

Public Health England leads the NHS Screening Programmes
Programme Specific Operating Model for Quality Assurance of Diabetic Eye Screening Programmes

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Public Health England (PHE) exists to protect and improve the nation’s health and wellbeing, and reduce health inequalities. We do this through world-class science, knowledge and intelligence, advocacy, partnerships and the delivery of specialist public health services. We are an executive agency of the Department of Health, and are a distinct delivery organisation with operational autonomy to advise and support government, local authorities and the NHS in a professionally independent manner.

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About PHE screening

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

www.gov.uk/topic/population-screening-programmes
Twitter: @PHE_Screening  Blog: phescreening.blog.gov.uk
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# Programme Specific Operating Model for Quality Assurance of Diabetic Eye Screening Programmes

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1. Introduction

1.1 This document sets out the programme specific operating model (PSOM) for quality assurance (QA) of the NHS diabetic eye screening programmes and should be read in conjunction with the ‘Operating Model for PHE Screening Quality Assurance Service: 2015/16 to 2017/18’ and the relevant screening quality assurance service (SQAS) generic standard operating procedures documents.

Background

1.2 The QA of NHS screening programmes consists of 2 elements:

- an assurance process - measuring the quality of screening services against a set of agreed standards
- quality improvement activities - to support screening programmes to increase the quality of their services

1.3 SQAS undertake a number of activities to assure and improve the quality of screening services. These include but are not limited to:

- peer review (QA) visits carried out every 3 to 5 years
- production of data reports (monthly/quarterly/annually)
- incident advice and support for investigations
- expert advice and support through regular attendance at screening programme board meetings
- network and educational meetings
- targeted support to providers

1.4 This PSOM has been developed by a working group led by the national portfolio leads for diabetic eye screening and consisting of members from the SQAS teams and external stakeholders. It sets out how SQAS will work with, support and quality assure local diabetic eye screening services.

1.5 All associated processes and documentation have been approved by the SQAS Quality Assurance Executive Group and the Screening Division Strategy Management Group.

Programme description

1.6 Diabetic eye screening QA begins with the identification of eligible people and includes digital photography and surveillance. It also includes assessment of the time taken to receive intervention and treatment within hospital eye services.
Purpose and scope

1.7 The purpose of this operating model is to outline the agreed QA process for diabetic eye screening programmes which should be adhered to by all SQAS staff and any professional and clinical advisors (PCAs) supporting the SQAS team. This will ensure consistency of approach across all screening providers.

The quality assurance process

1.8 The quality assurance process for the SQAS is provided in Appendix A and details:

- the relevant section of the screening pathway to be addressed
- specific activities to be conducted by SQAS staff and PCAs
- the evidence used to inform the QA process
- data and information sources that will be used for quality assurance
- the required frequency at which the QA activities should be carried out
- mapping of the QA activity to standards, key performance indicators (KPIs) or service specifications that detail the requirement
2. Quality assurance activities

Service engagement

2.1 A senior quality assurance advisor (SQAA) / quality assurance advisor (QAA) or deputy will attend programme steering or oversight boards to:

- identify new issues
- monitor progress against recommendations
- monitor other known issues
- support service improvement

Systematic and routine collection and analysis of data

2.2 SQAS will collect and/or review statistics and data on a monthly, quarterly or annual basis. This is described further in chapter 3.

2.3 Services will be benchmarked using national data sets.

2.4 SQAS and PCAs (where appropriate) will perform an annual review of data and intelligence at a regional or sub regional level. This data set will also be used to complete the prioritisation matrix for SQAS activities.

2.5 Further information and intelligence may be collected via forms, submission of an annual questionnaire or attendance at programme steering/oversight boards. This will be supplemented by intelligence gained by SQAS staff in the course of their routine activities and interactions with services and national screening programmes.

Visits and reviews

QA visits

2.6 The frequency of QA visits starting in April 2017 will be based on findings from the prioritisation exercise. In most cases it will lie between 3 and 5 years. The maximum interval for a full visit for all services will be 5 years. This approach of targeting QA resources and visits to services which require support will be kept under review.

2.7 Visit schedules and other QA activities will be decided by assessment against an agreed set of criteria each year. This new approach is designed to align SQAS resource according to services’ needs. SQAS will evaluate this approach and
consider the impact on the average visit interval, findings at QA visits and SQAS capacity.

2.8 SQAS may undertake a focussed visit or assessment of any individual discipline or group of disciplines of the screening programme that require more detailed investigation or intervention outside the routine QA visit process. The level of intervention and most appropriate approach will be informed by the prioritisation assessment. A set of principles will be devised linked to a set of QA interventions, to support consistency of this approach. A review of the number, rationale and outcome of non-routine visit interventions will be undertaken as part of the evaluation of QA visit activities.

2.9 SQAS will share learning internally and with other relevant local services and commissioners where risks in service delivery are identified that are applicable to more than one service. This is to ensure that information can reach the front line in a rapid manner.

2.10 The QA visit process will include all providers delivering the full or part of the screening pathway. This includes private providers commissioned to deliver NHS screening programmes.

2.11 The QA visit and review of screening services will cover:

- programme management and governance
- the screening pathway
- referral to relevant diagnostic or treatment services

2.12 QA of public health system leadership and commissioning has been developed and will be rolled out across all programmes from July 2017.

2.13 The visit and review process will be informed by:

- identified datasets by programme
- core evidence submitted and the completed context grid (where applicable)
- ad hoc data identified as required
- delivery against national service specification
- delivery against national guidance
- specified job descriptions
- specified protocols
- administration pre-visit
- pre-visits to a selection of screening locations
- observation of practice
- walkthrough of the patient journey where applicable
QA visit reports

2.14 All reports will be addressed to the provider and commissioner(s). The provider may be an NHS trust or private sector organisation.

2.15 The programme manager is the point of contact for liaising with the provider with respect to the factual accuracy check of the QA reports. They will be responsible for circulating the report to other service leads.

2.16 Recommendations for subcontracted services will be included in the reports for the lead provider.

Executive summary publication on GOV.UK

2.17 The chief executive of each organisation involved and the NHS England Director of Commissioning Operations (DCO) or their representative will be asked for their consent to publish the executive summary on GOV.UK. If SQAS do not receive a response, it will be assumed that consent is granted.

2.18 Executive summaries will be published online in accordance with national guidance.

Reviews

2.19 Any QA interventions due to ad hoc events such as incidents, identification of poor performance, and so on, may be managed with recommendations or an action plan, similar to those for a QA visit.

Follow-up against recommendations

2.20 Recommendations designed to improve the quality of the service will be made at QA visits.

2.21 The wording of the recommendations will give the context to enable all reviewers, provider management and commissioners to understand the rationale for the recommendation.

2.22 The recommendations will have an associated timescale.
2.23 The provider is responsible for developing an action plan in collaboration with the commissioners to address the recommendations made within the available timeframe.

2.24 The commissioners require assurance that timely action is being taken to address the issues raised. Progress against the action plan should be an agenda item at the Programme Steering or Oversight Board meetings.

2.25 SQAS makes recommendations and states what evidence is required to close the recommendation. The Screening and Immunisation Lead (SIL) is responsible for ensuring that action is taken. It is the responsibility of the provider to send the evidence to the SIL and SQAS to review. SQAS will advise the provider and SIL if the evidence submitted provides assurance that the recommendation has been met.

2.26 SQAS will work with commissioners to monitor activity and progress in response to recommendations. This is for a period of 12 months following the issuing of the final report. This will allow adequate time for at least one response to all recommendations. A letter will then be sent to the provider chief executive and commissioners summarising the progress made and asking for their direct intervention to address any remaining issues.

2.27 Escalation to chief executives and commissioners will occur earlier if serious concerns are identified.

Support with screening safety incidents and serious incidents

2.28 The activity of the SQAS is outlined in PHE’s guidance ‘Managing safety incidents in NHS screening programmes (October 2015)’ and is detailed in PHE Screening Division’s ‘Managing safety incidents in NHS screening programmes standard operating procedure (March 2016)’.

2.29 The national and regional portfolio leads will work together to develop greater consistency in the handling of suspected or confirmed safety incidents and serious incidents.

2.30 SQAS regional teams are to track and record their advice from the reporting of each incident through to closure. SQAS records of active incidents will be reviewed regularly by each regional portfolio lead.

2.31 The national portfolio leads will contribute to producing quarterly detailed thematic reports. They will agree lessons to be shared and national actions with the
programme managers. Lessons to be shared will be done in a timely manner appropriate to the incident.

Networking and support

2.32 There are a wide variety of approaches to professional networking support across SQAS. These have received good feedback, showing evidence of value to both SQAS and service representatives.

2.33 Professional meetings are an important forum for SQAS to share information relating to new standards, guidance and programme developments with the relevant professionals. They provide an opportunity to share data, discuss support needs, and enable feedback on products and plans. They help identify quality issues or potential risks which could inform future QA activity.

2.34 The forums are also important to the professionals working within local screening services. They can share issues, identify possible solutions, develop networks that foster resilience and share out tasks such as development of protocols.

2.35 The meetings can also be educational events with input from external speakers or the sharing of local audit information. SQAS will work in conjunction with the national screening programme where applicable to develop joint agenda for these meetings.

2.36 The frequency of these meetings will vary by professional group. There will be a minimum of 1 per year per region. These will cover staff groups depending on prioritisation and current issues.
3. Data and intelligence for quality assurance

3.1 This chapter describes the specific data requirements for the diabetic eye screening programme. General information on the data requirements of the Programme Specific Operating Models can be found in the ‘Programme Specific Operating Model Data & Intelligence Overview’.

Data Sources

3.2 There are 3 suppliers approved for providing software to local diabetic eye screening services: EMIS, Health Intelligence and Health Information Systems (UK) Ltd (HISL). Each local screening service has a local database with a nationally specified minimum dataset. This is used for the call and recall of eligible people with diabetes, the grading of images and reporting.

3.3 The diabetic eye screening programme register is sourced from GP practices and there is a mixture of manual referrals, GP list validation and automatic extracts to obtain the eligible population.

3.4 Local services are required to provide data to the PHE national programme team through the production of a performance report on a quarterly and annual basis. The performance report in each software package adheres to a national specification and calculation document.

Data analysis

3.5 The diabetic eye SQAS will comply with the national SQAS methodologies.

3.6 SQAS undertakes validation on the data received by SQAS staff through production of SQAS standard operating procedures and/or automated validation processes.

3.7 Data analysis is undertaken by national screening programme data analysts and the national data and information team in the case of KPIs.

3.8 The programme performance report is used by the national screening programmes data team to calculate the pathway standards and KPIs on a quarterly and annual basis. Local services are then able to validate and agree the figures.
Data reporting

3.9 Reporting and analysis will be done once, nationally where possible. Dissemination of data to local services will be done by the local SQAS team.

3.10 The current list of outline reports is given in the table below.

3.11 A regional summary of the quarterly data is available to the screening quality assurance service (SQAS) regions. The annual data is published nationally on GOV.UK both service and clinical commissioning group (CCG) level. Uptake of screening data is included in the Public Health Outcomes Framework tool.

Key performance indicators

3.12 KPIs for diabetic eye screening are a subset of screening standards and are identified as part of the section 7a service specification. They focus on areas where important improvements in quality can be made. Once a KPI consistently reaches the achievable level, the KPI is either withdrawn as a KPI and remains as a standard, allowing entry of another KPI or the KPI thresholds are reviewed to promote continuous improvement.

3.13 KPIs are collated and reported quarterly. If numbers are small, aggregate data is reported annually. The information on surveillance patients and the aggregated figures for each KPI are sent by the PHE national team to the local screening services for sign off in line with the published submission guidance. KPIs are published on GOV.UK.

Screening pathway reporting

3.14 The current list of outline reports is given in the table below.

<table>
<thead>
<tr>
<th>Report title</th>
<th>Geography</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pathway standards</td>
<td>Local service</td>
<td>Quarterly</td>
</tr>
<tr>
<td></td>
<td>National</td>
<td></td>
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<tr>
<td>Key performance indicators</td>
<td>Local service</td>
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<td>Pathway standards</td>
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<td></td>
<td>CCG</td>
<td></td>
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<tr>
<td></td>
<td>National</td>
<td></td>
</tr>
</tbody>
</table>

Data sharing

3.15 Routine data sharing activities between PHE Screening and Chief Knowledge Officer directorates are covered by a data sharing agreement, ODR_2014_220b.
3.16 Routine data sharing between PHE Screening and NHS England for all 11 screening programmes is underpinned by the Memorandum of Understanding (MoU) signed by both organisations. This MoU extends to any onward sharing to any third party, for example, PHE Centre Directors, providers of screening services, local authority, clinical commissioning groups (CCGs), voluntary organisations and other health professionals using screening data to improve and monitor services. This is for the purpose of improving quality of screening services. The set of data items covered by the MoU is shared prior to publication and for management purposes only. Data flows, schedules and the list of data items shared are managed by the national data and information team.

3.17 Non-routine data requests from commissioners and service providers should be discussed with regional SQAS who will consider requests in line with data release principles including, but not limited to, the following questions:

- has the data already been shared via the MoU or available in the public domain?
- is the data likely to support population health improvement?
- is the data likely to improve the quality of screening services?
- what is the level of anonymisation required (open government licence to potentially identifiable and identifiable information)?
- what are the resources and costs required to extract, collate, quality assure and release the data set?

3.18 Regional SQAS will, if necessary, involve programme managers and the national data and information team in the initial discussion of non-routine data requests and seek advice from research committees where appropriate. All requests for personal confidential information will be discussed with the PHE Office for Data Release.

3.19 All data requests and releases will be centrally logged and tracked.
4. The QA visit

Objectives

4.1 The objectives of the QA visit are to:

- examine the performance of the local screening service
- verify achievement of national standards, identify variance from these standards and support professionals working in the local screening service to maintain and improve standards
- gain knowledge and expertise of areas for shared learning and disseminate this to all screening services
- share experiences and understanding of current problems or concerns in NHS diabetic eye screening services and contribute to national development

Requirements

Frequency of visits

4.2 The frequency of QA visits starting in April 2017 will be based on findings from the prioritisation exercise and in most cases will lie between 3 and 5 years. The maximum interval for a full visit for all services will be 5 years. This approach of targeting QA resources and visits to services which require support will be kept under review.

4.3 Visit schedules and other QA activities will be decided each year by an assessment against an agreed set of criteria. This new approach is designed to align SQAS resource according to services’ need. SQAS will evaluate this approach and consider impact on the average visit interval, findings at QA visits and SQAS capacity.

4.4 PHE, NHS England and provider organisations will be informed of the proposed schedule of visits.

Membership of visiting team

4.5 The visiting team will be selected by the SQAS.

4.6 The visiting team will be led by the visit chair.

4.7 Members of the team may include the following PCAs:
• public health and commissioning
• clinical lead (which may be a diabetologist or ophthalmologist). If the clinical lead is not an ophthalmologist, an ophthalmologist PCA may also be required
• programme manager
• screening/grading
• optometrist where the local programme is optometry based

4.8 Members of SQAS:

• senior quality assurance advisor
  and/or
• quality assurance advisor / quality assurance facilitator (QAF)

4.9 Visiting team members will be asked to declare conflicts of interest before the visit. If this raises concerns about the use of a PCA for a visit, SQAS will take advice within PHE.

4.10 A maximum of 2 observers may also be present at a QA visit, for training and education purposes. The observers will only act in an observational capacity: they will not be involved with providing feedback nor will they have any input into the interviews or decision making processes.

Role of the QA visit chair and QA advisor in QA visits

4.11 The visit chair will normally lead all QA visits with the support of a SQAA or QAA.

4.12 For diabetic eye screening, the visit chair will either be the regional head of quality assurance (RHQA) or head of quality assurance (HQA) who holds the diabetic eye screening portfolio or a PCA who has undergone additional training in order to undertake this role. Where the visit chair is a PCA, this will be their sole role during the visit. They will not be acting in the capacity of a PCA, except in exceptional circumstances agreed in advance.

4.13 The visit chair is responsible for:

• chairing and directing the conduct of the QA visit
• providing considered, consistent feedback on the visit findings
• managing sensitively and appropriately any serious issues or concerns raised prior to or on the day of the QA visit
• facilitating the exchange of knowledge and ideas and encouraging productive networking in order to foster developments in quality

4.14 The SQAA/QAA supporting the visit chair is responsible for:
ensuring that the local screening services are fully aware of what is required in preparation for the visit
acting as a point of contact for any queries regarding organising and coordinating the visit
assembling and managing the visiting QA review team who will be accountable to the visit chair during each visit (up to and including production of the final report)
ensuring that all PCAs selected have undergone appropriate training
ensuring collection of evidence to support the visit and that any required observational pre-visits have been completed
ensuring that adequate preparatory work is undertaken
supporting the visit chair to assemble feedback during the visit
ensuring that an accurate, considered report of the visit is issued within an agreed timescale and disseminated to provider chief executives and NHS England / SILs
ensuring that all agreed recommendations are followed up and monitored or escalated where necessary, within an agreed timescale
arranging any preliminary meetings between the SQAS and the local screening service as necessary

Skills and experience of visiting QA team

4.15 Members of the visiting QA team will need to demonstrate the following generic skills and training:

- PCAs / QA training course
- report writing
- interview techniques
- public health aspects of screening
- have an understanding of incident identification and management
- analytical skills
- ideally will have observed a QA visit

4.16 Specialist skills required of the individual PCAs are documented in the diabetic eye screening PCA person specification / job description.

Locations to be visited

4.17 The QA visit will assess the entire local screening service. It may not be possible to visit all screening sites on the same day if a service has sites located away from the main provider unit. The SQAA/QAA will therefore liaise with the local
screening service to arrange visits to the other sites before the day of the main QA visit.

Local screening service personnel attendance

4.18 The personnel from the local screening service who should attend during the visit, depending on service configuration, are:

- screening service clinical lead
- programme manager
- screening staff
- grading staff
- administration staff, including failsafe officer(s)
- public health leads
- commissioning leads
- lead ophthalmologists from hospital eye services (HES)

Sources of evidence considered as part of QA visits

4.19 The QA report will be built up from a number of sources of evidence. These will be:

- response of the local screening service to the pre-visit questionnaires, where applicable
- supporting evidence and documents submitted to the SQAS for review
- interviews undertaken during the QA visit
- observational visits, where applicable
- case reviews, where applicable
- analysis of annual report data and routine data for the preceding 12 month period
- analysis of audit reports

Preparation for a QA visit

4.20 The SQAS will liaise with the local screening service and commissioners to make arrangements for the visit at least 6 months prior to the visit date. A mutually convenient date within a set timeframe will be agreed and a named contact within the local service for visit preparation should be identified. This named contact will be responsible for ensuring that members of the local screening service team are invited and able to attend the visit. The date will not be changed once it is agreed, except in exceptional circumstances, and only with the agreement of both parties.
4.21 The chief executive of the host trust, stake holding trusts, commissioners, providers of any associated services and treatment providers will be informed by the SQAS that a visit is taking place. They will be invited to attend or send a suitable representative to the summary of the visit feedback session and subsequent discussions as appropriate. For timescales in the QA visit process see Appendix B.

Preliminary meeting between Screening QA Service and the local screening service

4.22 A preliminary meeting between the SQAS and providers or commissioners may take place where applicable. This will vary by programme, for example, SQAS might request to attend the first scheduled local screening programme board meeting or operational group meeting after notification of the visit is made.

4.23 If a local screening programme board or other appropriate meeting has not been set between notification and the day of the visit, the SQAS might ask for one to be organised approximately 3 months before to the visit date.

4.24 A member of the SQAS will attend this meeting to inform the local screening service about arrangements for the visit. This will include arrangements for any observational visits, an outline of the agenda and answering any questions that the local screening service and its stakeholders may have. This will also give the local screening service an opportunity to comment on current progress.

Information to be provided by local screening service

4.25 Local screening services will be asked to provide the following information in preparation for a QA visit:

- action plans from previous QA recommendations (where not already available to SQAS)
- action plans from pre-visit questionnaire or desk top review (where applicable)
- completed pre-visit questionnaire (where applicable)
- supporting documents and protocols as outlined in the pre-visit questionnaire or documentation
- performance reports as requested
- information on any incidents that have occurred in the last 12 to 24 months
- information on venue organisation – where the visit will be held and what rooms have been booked for interviews and feedback sessions
- other relevant information requested by the SQAS
- update on adherence to national standards
4.26 This information should be provided to the SQAS at least 10 weeks prior to the visit date. There will be no flexibility on extending deadlines for evidence submission unless it enables a reduction in burden for the SQAS. Such cases will be agreed by the visit chair and SQAA/QAA responsible for the visit.

4.27 Evidence provided which is out of date, for example policies or guidelines, will not be assessed but will be used to inform decisions relating to local screening service governance.

4.28 Any request for clarification of evidence or for further evidence from providers should be coordinated by the SQAA/QAA responsible for the visit.

4.29 Any evidence transfer must conform to information governance rules. It must not contain patient identifiable or sensitive information and should be transferred to the SQAS following SQAS information governance protocols.

Observation of clinical practice and premises

4.30 The screener/grader PCA and/or designated reviewer (SQAA/QAA) will arrange a mutually convenient time to visit agreed screening and grading locations to observe premises and clinical practice as an ‘observation of clinical practice’ visit. This will take place before the QA visit, and the SQAA/QAA will liaise with the local screening service regarding when and where this visit will take place.

Observation of administration practices

4.31 The Programme Manager PCA or designated administration reviewer (SQAA/QAA) will arrange to visit the local screening service in advance of the visit to examine policies and evidence as an ‘observation of local screening service administration’ visit. This will take place before the QA visit and the SQAA/QAA will liaise with the local screening service regarding when and where this visit will take place.

Review of evidence to inform the visit

4.32 The lead SQAA/QAA will complete the context grid (summary document) where applicable and review the evidence with the visit chair to determine key lines of enquiry (KLOE). At this stage the visit chair and SQAA/QAA will decide which PCAs are required for the visit with support from the RHQA / HQA if necessary.

Standing down of PCAs
4.33 PCAs will be notified at least 6 weeks before the visit date if they are not required to attend the visit. PCAs may be asked to carry out a variety of tasks, including scrutiny of specific elements of evidence, development of KLOEs and telephone interviews.

4.34 The minimum visit team will consist of the visit chair and SQAA/QAA who will meet with the programme manager, clinical lead and lead commissioner. A full QA visit will take place where necessary. The lead SQAA/QAA will inform PCAs of any required actions.

Information for the QA visit team

4.35 The SQAS will provide an information pack, usually in electronic format, for the visiting QA team which will include:

- contact details of visiting PCAs
- list of local screening service personnel
- agenda for the visit day (including details of venue and rooms booked)
- overview of the local screening service
- copy of last QA visit report (where applicable)
- all documents submitted by the local screening service
- outcome of the observation of clinical practice and premises (where applicable)
- outcome of the observation of administration practice (where applicable)
- data relating to performance of the local screening service
- results of annual prioritisation exercise

4.36 The information pack will be sent to the PCAs at least 2 weeks before the date of the visit.

Format of a QA visit

4.37 In some instances, a pre-visit may take place or a case notes, slide and imaging review may be undertaken.

Components of the QA visit

Briefing for visit chair, PCAs and SQAA/QAAs

4.38 The visiting team will either meet before the day of the QA visit or just before the visit commences. The aims of the briefing meeting are to:

- introduce all members of the QA visit team
enable the SQAS to provide PCAs with an accurate overview of the core elements of the local screening service prior to the QA visit
initiate discussions and enable any potential areas of concern to be highlighted prior to the QA visit
enable triangulation of initial findings from pre-visit evidence review such as KLOEs generated by the PCAs and SQAS
ensure that all members of the visiting QA team are aware of their roles and responsibilities for the QA visit

Introductions between the visiting team and the local screening service staff

4.39 Members of the visiting QA team and SQAS representatives will introduce themselves to the local screening service on the day of the visit.

A short presentation from the clinical lead about the local screening service’s achievements

4.40 The clinical lead or designated representative will be asked to give a short 10-15 minute presentation giving a brief overview or description of the service, including:

- changes since the last visit
- activity
- achievements
- any challenges or particular issues

Individual interviews between each PCA and the local screening service representative for that profession

4.41 Each PCA member of the visiting QA team will ideally meet their professional counterpart(s) in the local screening service. This will be a structured interview to assess adherence to national minimum standards, professional performance and the relationship between the different components of the local screening service.

4.42 The PCA should summarise the discussion, feedback main issues and check for mutual understanding at the end of the interview.

Discussion by the visiting QA team of findings and preparation of feedback session

4.43 The visiting QA team will meet to discuss outcomes of individual interviews and amalgamate their findings. They will focus on areas of risk, recommendations and shared learning. Findings will be summarised and this may take the form of a presentation.
Feedback session

4.44 The feedback on the day will be given in 2 sessions.

4.45 The visit chair and SQAA/QAA will meet with the provider chief executives and NHS England DCO team representative, for example, SIL, to give a verbal summary of risks, high level findings and recommendations. This session may also be used to raise concerns regarding performance of an individual, or concerns for patient safety where it would not be appropriate to report these findings to a wide audience.

4.46 This session will usually, but not always, take place prior to the main feedback session and it is anticipated that this will last no longer than 15 minutes.

4.47 The main feedback session will consist of a short presentation by the visit chair of the main findings and recommendations to all local screening service staff and some stakeholders. All those interviewed should be invited to the main feedback session.

4.48 Senior management representatives of the provider trust, chief executives, CCG representatives (where applicable), NHS England DCO team representatives and other stakeholders identified by the local screening service will also be invited to attend this session. Directors of public health or their nominated representative can be invited to attend by the DCO team.

4.49 The feedback session will highlight:

- areas for shared learning
- risks
- recommendations
- intention to publish the report executive summary on an external facing website 8 weeks following the production of the final QA report

4.50 It is anticipated that this feedback session will take no longer than 30 minutes.

4.51 Where immediate concerns related to safety are raised, a letter from the RHQA or HQA outlining the main concerns and corresponding remedial actions will be sent to the chief executive of the provider organisation and the lead commissioner within 2 working days. The letter will be copied to the RHQA (where applicable) and to the National Lead, Screening QA Service. The national programme managers will be informed where applicable.
Feedback from local screening service provider on QA visit

4.52 Local screening services will be asked to complete a feedback questionnaire after the QA visit in order to evaluate the visit process and provide feedback for the SQAS as part of its ongoing review process.

Written report and follow-up

4.53 Each member of the visiting QA team will submit to the SQAA/QAA a summary of their findings. It is expected that these summaries will be available to the SQAA/QAA within one week of the visit (or earlier as agreed). It is the responsibility of the lead SQAA/QAA to produce a draft report for factual accuracy checking by the local screening service and commissioners within 20 working days of the visit. Day 1 is the first working day after the visit takes place.

4.54 The final report will be completed within 8 weeks of the visit.

4.55 The QA visit report will:

- be completed using the agreed report template and associated headings
- use plain, clear English in line with the PHE style guide
- include summary descriptions of local screening service organisation and leadership arrangements
- comment on the adequacy of resource, accommodation, and equipment to meet national standards
- identify areas of shared learning
- identify variance from national standards as a centre and within specialties
- identify strengths and weaknesses within the local screening service
- make structured recommendations to address issues identified

Circulation of the report

4.56 A copy of the report will be sent to:

- provider chief executive(s)
- NHS England DCO team representative, for example SIL and the Head of Public Health Commissioning (HOPHC)

4.57 The report will be sent via email and will be copied to the programme manager.

4.58 The chief executive and SIL will be asked to disseminate to relevant colleagues including those in the local health economy with a responsibility for screening
services and relevant colleagues in public health centres. Details of where the executive summary will be published will be included in the correspondence.

4.59 The executive summary of the QA report will be published on the GOV.UK website 8 weeks after the final report is issued (16 weeks after the visits) with consent from the local screening service provider and NHS England commissioners. The provider may choose to submit an action plan with progress at this time and if so, details of where the action plan can be found will be provided.

4.60 Where consent is not given by the provider, the provider’s name and the date of the visit will be published instead with an acknowledgement that a visit took place and consent to publish the executive summary was declined. A similar note will be placed on the website if NHS England commissioners declined publication.

4.61 Provider and commissioning organisations should note that the full report can be requested by a member of the public using a Freedom of Information request and may be released by PHE if requested.

Development of the action plan

4.62 SQAS will support the providers and commissioner through the action planning process. Each provider and NHS England DCO team will have a named SQAA/QAA.

4.63 The QA process should identify whether providers have met the nationally agreed programme standards and any statutory guidance or guidelines and should state the evidence used to assess how the judgement about quality was made.

4.64 The SQAS will write recommendations from which action plans can be developed. The evidence required to show that an action has been completed will be stated as part of the recommendations.

4.65 A criteria for closure will be included detailing exactly what action or documentation is required to show that an action has been satisfactorily implemented.

4.66 Timescales for the recommendations should be specific, with dates for completion clearly stipulated.

4.67 It is the responsibility of the NHS England DCO team’s SIL (the commissioner) to ensure that the recommendations made in the QA visit report are implemented. This will be done in conjunction with the provider.
4.68 An action plan should be developed by the local screening service within 4 weeks of receiving the final report, which is agreed with the SIL or HOPHC. It is good practice for this to be submitted to the next local screening programme board or equivalent governance structure within 3 months of the visit.

4.69 The SIL will ensure that progress against the action plan is maintained using relevant commissioner oversight mechanisms and levers, with SQAS kept informed via local programme / oversight boards and direct contact with the providers and commissioners.

4.70 SQAS will work with commissioners to monitor activity and progress in response to recommendations. This is for a period of 12 months following the issuing of the final report. This will allow adequate time for at least one response to all recommendations. A letter will then be sent to the provider chief executive and commissioners summarising the progress made and asking for their direct intervention to address any remaining issues.

**Escalation process**

4.71 Failure to undertake recommended actions will necessitate appropriate escalation by SQAS if progress is not being made. This will initially be through the local screening programme board or equivalent governance structure and NHS England DCO team.
5. Training and development

5.1 All staff taking part in QA activity should undertake training related to the role. The training requirements for professional and clinical advisors are set out in the relevant job descriptions / role outlines which are available from the SQAS team.

Continuous improvement

5.2 We are committed to improving our processes and measuring the impact of QA and as such we request feedback from local screening services and providers on all aspects of the QA process and visit. Any feedback received will be shared as appropriate in relevant forums, or individually where applicable, to improve the QA process.
Appendix A: The quality assurance process

Details of the process described below are in development and will be reviewed.

SQAS activity key:

- Black: provider function reviewed by SQAS
- Pink: public health system leadership and commissioning function (please refer to pre visit questionnaire for complete list of functions for peer review)
- Green: under development
- Blue Highlight: prioritise activity

<table>
<thead>
<tr>
<th>Pathway Element: Call &amp; Recall</th>
<th>SQAS Activities</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Cohort identified and recorded on DESP software</td>
<td>1. Notification processes from GP practices</td>
<td>1. At visits</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pathway Element: Identifying Cohort</th>
<th>SQAS Activities</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Validation of DESP patient list against GP lists</td>
<td>1. GP practices not responding to validation should be escalated to programme board. May trigger incidents</td>
<td>1. Quarterly</td>
</tr>
<tr>
<td>2. CQRS/Read codes</td>
<td>2. Quarterly reports to programme boards/Internal QA processes to be checked/verified at QA visits</td>
<td>2. Quarterly/programme boards</td>
</tr>
<tr>
<td>3. Prisons</td>
<td>3. At visits</td>
<td></td>
</tr>
<tr>
<td>4. Other non-GP registered populations</td>
<td>6. Patients not ceased/excluded inappropriately – check for high levels of exclusions, local processed. May trigger incidents</td>
<td>4. At visits</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5. At visits</td>
</tr>
</tbody>
</table>
### Programme Specific Operating Model for Quality Assurance of Diabetic Eye Screening Programmes

#### Pathway Element: Identifying Cohort

<table>
<thead>
<tr>
<th>SQAS Activities</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. Information governance</td>
<td></td>
</tr>
<tr>
<td>6. Ceasing</td>
<td></td>
</tr>
<tr>
<td>7. Death notifications</td>
<td></td>
</tr>
</tbody>
</table>

#### Pathway Element: Invitation, reminders & results

<table>
<thead>
<tr>
<th>SQAS Activities</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Letters to patients (invitations, DNA letter, results letters) using approved national templates</td>
<td></td>
</tr>
<tr>
<td>2. Coverage</td>
<td></td>
</tr>
<tr>
<td>3. Version of software being used</td>
<td></td>
</tr>
<tr>
<td>4. Results to patients and GP practices in timely manner</td>
<td></td>
</tr>
<tr>
<td>5. Disaster recovery</td>
<td></td>
</tr>
<tr>
<td>1. Check correct leaflets are used, easy read and alternative language versions in use</td>
<td></td>
</tr>
<tr>
<td>2. Monitor quarterly standard reports and KPI data provided to PHE; discussed at programme boards</td>
<td></td>
</tr>
<tr>
<td>3. Check up to date software in use</td>
<td></td>
</tr>
</tbody>
</table>

#### Pathway Element: Primary Screening

<table>
<thead>
<tr>
<th>SQAS Activities</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Staff progress to gaining initial qualifications</td>
<td></td>
</tr>
<tr>
<td>2. Checking of ID/consent of patient</td>
<td></td>
</tr>
<tr>
<td>3. Local QA of image quality</td>
<td></td>
</tr>
<tr>
<td>4. Security of images, reconciliation and downloading at base</td>
<td></td>
</tr>
<tr>
<td>5. Grading practice</td>
<td></td>
</tr>
<tr>
<td>6. Participation in Test and Training (TaT)</td>
<td></td>
</tr>
<tr>
<td>1. Reported at programme board and reviewed as part of QA visit process</td>
<td></td>
</tr>
<tr>
<td>2. Process reviewed at QA visit in selection of screening locations</td>
<td></td>
</tr>
<tr>
<td>3. Process for checking camera settings/identifying artefacts reviewed at QA visit. Equipment maintenance and replacement programme reviewed at QA visit.</td>
<td></td>
</tr>
<tr>
<td>4. Check at QA visit to ensure system is effective and meets governance/IT policy. Failsafe processes reviewed to ensure</td>
<td></td>
</tr>
</tbody>
</table>

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## Programme Specific Operating Model for Quality Assurance of Diabetic Eye Screening Programmes

### Pathway Element: Primary Screening

<table>
<thead>
<tr>
<th>SQAS Activities</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>7. Internal QA measures</td>
<td>8. Quarterly/Programme board</td>
</tr>
<tr>
<td>8. Timely referral to ophthalmology</td>
<td>9. At visits</td>
</tr>
<tr>
<td>9. Use of Screenings to Treatment Timeline Tracker</td>
<td>10. At visits</td>
</tr>
<tr>
<td>10. Failsafe into Hospital Eye Services</td>
<td>11. At visits</td>
</tr>
<tr>
<td>11. Surveillance</td>
<td>12. At visits</td>
</tr>
<tr>
<td>12. Slit lamp biomicroscopy (SLB) provision</td>
<td>13. Quarterly/Programme board</td>
</tr>
<tr>
<td>13. Waiting times for SLB</td>
<td>14. At visit</td>
</tr>
<tr>
<td>14. Return to routine screening for HES, surveillance &amp; SLB</td>
<td>15. At visit</td>
</tr>
<tr>
<td>15. Accommodation for administration</td>
<td>16. At visit</td>
</tr>
<tr>
<td>16. Accommodation for grading</td>
<td>17. At visit</td>
</tr>
<tr>
<td>17. Accommodation for grading</td>
<td></td>
</tr>
</tbody>
</table>

### Pathway Element: Screening Test Reporting

<table>
<thead>
<tr>
<th>SQAS Activities</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Identified Programme Manager</td>
<td>1. QA visit</td>
</tr>
<tr>
<td>2. Identified clinical lead with JD and dedicated time</td>
<td>2. QA visit</td>
</tr>
<tr>
<td>3. Identified lead ophthalmologist (if CL from different discipline)</td>
<td>3. QA visit</td>
</tr>
<tr>
<td>4. Sufficient screening staff</td>
<td>4. QA visit</td>
</tr>
<tr>
<td>5. Lines of accountability</td>
<td>5. QA visit</td>
</tr>
<tr>
<td>6. Organisational chart for the programme</td>
<td>6. QA visit</td>
</tr>
<tr>
<td>7. Risk assessment and management</td>
<td>7. QA visit</td>
</tr>
<tr>
<td>8. Business continuity and</td>
<td>8. QA visit and on going</td>
</tr>
<tr>
<td>9. Job descriptions reviewed</td>
<td>9. QA visit</td>
</tr>
<tr>
<td>WTE and numbers for each staff group</td>
<td>10. QA visit/Programme board</td>
</tr>
<tr>
<td>6. Reviewed as part of QA visit</td>
<td></td>
</tr>
<tr>
<td>7. Reviewed as part of QA visit</td>
<td>11. Adhoc and reviewed</td>
</tr>
<tr>
<td>8. Discussed at contract meetings as part of Service Spec delivery (QA not normally present). QA visit and on-</td>
<td></td>
</tr>
<tr>
<td>Pathway Element: Screening Test Reporting</td>
<td>SQAS Activities</td>
</tr>
<tr>
<td>-----------------------------------------</td>
<td>--------------------------------------</td>
</tr>
<tr>
<td>succession plans</td>
<td>going data</td>
</tr>
<tr>
<td>9. Clinical governance, escalation</td>
<td>9. Reviewed as part of QA visit and</td>
</tr>
<tr>
<td>10. Equipment replacement and</td>
<td>via incident management</td>
</tr>
<tr>
<td>11. Management of Serious</td>
<td>10. QA visit, programme boards</td>
</tr>
<tr>
<td>12. Complaints and compliments</td>
<td>11. Appropriate management and</td>
</tr>
<tr>
<td>received, results of patient</td>
<td>reporting of incidents</td>
</tr>
<tr>
<td>survey/user surveys, audit and</td>
<td>12. Assessed as part of QA visit</td>
</tr>
<tr>
<td>feedback mechanisms</td>
<td>(user experience).</td>
</tr>
<tr>
<td></td>
<td>Programme should be assessing</td>
</tr>
<tr>
<td></td>
<td>via regular patient user surveys</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Appendix B: Timescales in the QA visit process

**Key:**
- **Red text:** visit process milestones

<table>
<thead>
<tr>
<th>Time (weeks)</th>
<th>Process</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>annual</strong></td>
<td>Prioritisation of visits takes place following discussion with national screening programme and review of annual quality reports.</td>
</tr>
<tr>
<td>-26</td>
<td>Local screening service notified of visit date following negotiation with local screening service, provider and commissioner</td>
</tr>
<tr>
<td>-26</td>
<td>Identify PCA team</td>
</tr>
<tr>
<td>-26 to -21</td>
<td>Inform local screening service and stakeholders with:</td>
</tr>
<tr>
<td></td>
<td>- letter(s)</td>
</tr>
<tr>
<td></td>
<td>- QA guidance document</td>
</tr>
<tr>
<td></td>
<td>- evidence list</td>
</tr>
<tr>
<td></td>
<td>- pre-visit questionnaire</td>
</tr>
<tr>
<td>-26 to -16</td>
<td>Lead SQAA / QAA attends local programme board or bespoke meeting to deliver presentation and undertake familiarisation visit</td>
</tr>
<tr>
<td>-12</td>
<td>Reminder to local screening service of evidence submission deadline</td>
</tr>
<tr>
<td>-10</td>
<td>Local screening service submit pre-visit questionnaire and evidence</td>
</tr>
<tr>
<td>-9</td>
<td>SQAA / QAA prepares PCA information pack</td>
</tr>
<tr>
<td>-8</td>
<td>SQAA / QAA and QA visit chair review evidence to determine preliminary key lines of enquiry (KLOE)</td>
</tr>
<tr>
<td>-6</td>
<td>RHQA / HQA, SQAA / QAA and QA visit chair review PCAs required, for instance:</td>
</tr>
<tr>
<td></td>
<td>- PCAs may not be needed and therefore stood down</td>
</tr>
<tr>
<td></td>
<td>- PCAs may be asked to scrutinise specific elements of evidence</td>
</tr>
<tr>
<td></td>
<td>- PCAs may support refinement of KLOEs</td>
</tr>
<tr>
<td></td>
<td>- PCAs may conduct telephone interviews to clarify areas</td>
</tr>
<tr>
<td></td>
<td>- further evidence may be requested where not clear (1 week turnaround only)</td>
</tr>
<tr>
<td></td>
<td>- PCAs informed of requirements</td>
</tr>
<tr>
<td>-6</td>
<td>Information pack sent by SQAA / QAA to PCAs</td>
</tr>
<tr>
<td>Time (weeks)</td>
<td>Process</td>
</tr>
<tr>
<td>-------------</td>
<td>-------------------------------------------------------------------------</td>
</tr>
<tr>
<td>-2</td>
<td>Local screening service and stakeholders sent visit agenda. If:</td>
</tr>
<tr>
<td></td>
<td>• minimum visit – SQAA / QAA and QA visit chair meet with</td>
</tr>
<tr>
<td></td>
<td>programme manager, clinical lead and lead commissioner</td>
</tr>
<tr>
<td></td>
<td>• maximum visit – full QA visit</td>
</tr>
<tr>
<td>0</td>
<td>SQAA / QAA, QA visit chair and PCAs meet for evening pre-visit</td>
</tr>
<tr>
<td></td>
<td>meeting</td>
</tr>
<tr>
<td>0 VISIT DAY</td>
<td>Includes verbal feedback on main QA visit findings</td>
</tr>
<tr>
<td>+1</td>
<td>Visit team submit notes to SQAA / QAA</td>
</tr>
<tr>
<td>+1 to +3</td>
<td>SQAA / QAA writes draft report and submits to PCAs, RHQA / HQA</td>
</tr>
<tr>
<td></td>
<td>and QA visit chair for factual accuracy checking</td>
</tr>
<tr>
<td>+3 to +4</td>
<td>Telecon between SQAA / QAA and RHQA / HQA to review draft report</td>
</tr>
<tr>
<td></td>
<td>(if necessary)</td>
</tr>
<tr>
<td>+4</td>
<td>Draft report and consent to publish executive summary on website</td>
</tr>
<tr>
<td></td>
<td>issued to interviewees and local screening service within 20 working</td>
</tr>
<tr>
<td></td>
<td>days</td>
</tr>
<tr>
<td>+6</td>
<td>Local screening service to return feedback to SQAA / QAA on factual</td>
</tr>
<tr>
<td></td>
<td>accuracy</td>
</tr>
<tr>
<td>+6 to +7</td>
<td>SQAA / QAA completes response template with any comments in</td>
</tr>
<tr>
<td></td>
<td>response to factual accuracy from the local screening service and</td>
</tr>
<tr>
<td></td>
<td>interviewees</td>
</tr>
<tr>
<td>+7 to +8</td>
<td>Report sent to senior administrator for sense checking prior to issue</td>
</tr>
<tr>
<td>+8</td>
<td>SQAA / QAA issues final ‘pdf’ report to local screening service and</td>
</tr>
<tr>
<td></td>
<td>stakeholders</td>
</tr>
<tr>
<td>+8 to +9</td>
<td>SQAA / QAA updates national KPI report tracker</td>
</tr>
<tr>
<td></td>
<td>SQAA / QAA uploads final ‘pdf’ visit report to national shared drive</td>
</tr>
<tr>
<td>+12</td>
<td>Local screening service action plan to be submitted to Screening and</td>
</tr>
<tr>
<td></td>
<td>Immunisation Team and SQAS (region) (4weeks after visit report</td>
</tr>
<tr>
<td></td>
<td>received)</td>
</tr>
<tr>
<td>+16</td>
<td>Executive summary published</td>
</tr>
</tbody>
</table>