Public Health England

NHS

Screening Quality Assurance visit report

NHS Diabetic Eye Screening Programme Brighton and Sussex

18 January 2017

Public Health England leads the NHS Screening Programmes

About Public Health England

Public Health England 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.

Public Health England, Wellington House, 133-155 Waterloo Road, London SE1 8UG
Tel: 020 7654 8000 www.gov.uk/phe
Twitter: @PHE_uk Facebook: www.facebook.com/PublicHealthEngland

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.

PHE Screening, Floor 2, Zone B, Skipton House, 80 London Road, London SE1 6LH
www.gov.uk/topic/population-screening-programmes
Twitter: @PHE_Screening Blog: phescreening.blog.gov.uk

Prepared by: Screening Quality Assurance Service (South East).
For queries relating to this document, including details of who took part in the visit, please contact: phe.southQA@nhs.net

PHE publications
Gateway number: 2017346

PHE supports the UN
Sustainable Development Goals

Executive summary

The NHS Diabetic Eye Screening (DES) Programme aims to reduce the risk of sight loss among people with diabetes by the prompt identification and effective treatment of sight-threatening diabetic retinopathy, at the appropriate stage of the disease process.

The findings in this report relate to the quality assurance (QA) visit of the Brighton and Sussex diabetic eye screening service held on 18 January 2017.

Purpose and approach to quality assurance (QA)

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

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

The evidence for this report comes from the following sources:

- routine monitoring data collected by the NHS screening programmes
- evidence submitted by the provider(s), commissioner and external organisations
- information collected during pre-review visits to service management and screening/grading observational visits
- information shared with the SQAS south as part of the visit process

Description of local screening service

The Brighton and Sussex Diabetic Eye Screening Programme (BSDESP) provides retinal screening for a registered diabetic population of 35,838 on the screening database as of July 2016.

The service is provided by Brighton and Sussex University Hospital NHS Trust and is commissioned by NHS England South (South East). The diabetes prevalence in the population is between 4.1% and 6.31% and Index of Multiple Deprivation (IMD) between 8.3 and 23.4, with areas within Brighton and Hove being the most deprived in the South East and has a population with significant health needs and inequalities [1].

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

The service uses screener/grader technicians to provide screening across seven fixed sites and two mobile cameras across eight sites operating at acute hospitals, community hospitals, health centres and GP practices.

Screen positive patients requiring ophthalmic assessment or treatment are referred to four referral centres at the Sussex Eye Hospital (Brighton and Sussex University Hospital NHS Trust), Pembury Hospital (Maidstone and Tunbridge Wells NHS Trust), East Surrey Hospital (Surrey and Sussex Healthcare NHS Trust) and Eastbourne District General Hospital (East Sussex Healthcare NHS Trust).

Findings

Immediate concerns

The QA visit team identified no immediate concerns.

High priority

The QA visit team identified seven high priority issues.

The recommendations within the report can be summarised as follows:

- accuracy of single collated list
- interface between the Trust and other treatment centres
- workforce and skills mix for resilience and capacity
- risk assessment of screening pathway
- protected clinical lead time for service improvement
- monitoring audit progress
- achievement of quality standards in timescales of assessment and treatment

Shared learning

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

- screener/grader technicians trained as slit-lamp biomicroscopy (SLB) examiners for ungradable images
- established contacts with clinical commissioning group (CCG) diabetes clinical lead and CCG commission support manager to strengthen links between the programme, CCG and GPs
- referral outcome grader actively follows up with patients who fail to attend any urgent referrals, encourages attendance and re-refers the patients where necessary

- screening clinic run alongside the diabetes centre at the Royal Sussex County Hospital, which allows screening to be requested by diabetes consultants and diabetic nurse specialists as required

Table of consolidated recommendations

Governance and leadership

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
1	Ensure that the Trust's governance arrangements provide a framework for regular reporting of risks, performance and quality of the screening programme	Service specification [2]	6 months	Standard	Clear accountability between the screening programme and the trust board Regular attendance to programme board by senior level representative Regular quality reports provided by the screening programme to the Trust within the clinical governance arrangement
2	Develop a formal relationship between the Trust and the other treatment centres which receive screen referred patients from the programme	Service specification [2]	6 months	Standard	Formal agreement established with each treatment centre and signed at executive level

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
3	Develop a policy for the systematic review of controlled documents, including dissemination, change control and ratification	Service specification [2]	6 months	Standard	Policy presented to programme board
4	Develop an action plan for the identification, production and sign off of standard operating procedures covering all aspects of the screening pathway, in particular failsafe	Service specification [2]	12 months	Standard	Action plan developed Index of standard operating procedures to be developed Standard operating procedures developed and ratified by the clinical lead
5	Ensure that the Trust's incident management policy references 'Managing safety incidents in NHS screening programmes' guidance	Service specification [2] and National guidance [3]	6 months	Standard	Revised policy to be presented at the programme board

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
6	Review and risk assess the screening pathway	Service specification [2] and National guidance [4]	3 months	High	Risk reported in internal governance arrangement such as risk register Action plan to mitigate risks to be presented at programme board
7	Develop a standard operating procedure for regular audit of risk reduction measures and reporting of incidents	Service specification [2]	6 months	Standard	Standard operating procedures developed and presented at programme board
8	Conduct an audit of sight impairment, predominately due to diabetic retinopathy, across all treatment centres	National quality standards [5] and National guidance [6]	6 months	Standard	Severely sight impaired/sight impaired case review completed Summary report of outcomes submitted to programme board
9	Conduct regular laser treatment register (‘laser book’) audits at all treatment centres to determine any gaps in the identification of the screening cohort	National guidance [6]	6 months	Standard	Laser treatment register audit completed Summary report of outcomes submitted to programme board

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
10	Monitor progress of regular audits at programme board in accordance with audit schedule	Service specification [2]	3 months	High	Schedule of audits developed based on service specification requirements Schedule of audits reviewed at each programme board
11	Conduct patient satisfaction survey on an annual basis and report the summary outcome to the programme board	Service specification [2]	12 months	Standard	Patient satisfaction survey completed Summary report and action plan presented to programme board

Infrastructure

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
12	Develop a job description for clinical lead, stating the overall responsibilities and accountability for the screening programme within the Trust's clinical governance framework	National guidance [7]	6 months	Standard	Clinical lead job description completed Job description presented to programme board

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
13	Review the clinical lead job plan and allocate adequate protected time to provide strategic and clinical governance leadership for the programme	National guidance [7]	3	High	Clinical lead job plan reviewed with protected time allocated for the role
14	Revise the additional administrative duties of all graders to ensure minimum number of patient image sets graded per year	National quality standards [5] and Service specification [2]	6 months	Standard	Workforce review completed All graders to achieve the minimum image set per annum
15	Complete a workforce capacity and skill mix review, to release key staff capacity ensuring programme resilience	Service specification [2]	3 months	High	Capacity and skill mix review completed Summary report of outcomes submitted to programme board Commissioners assured of programme resilience
16	Conduct regular reporting of failsafe activities in line with national guidance	National guidance [4]	6 months	Standard	Documented evidence of failsafe activity reporting
17	Revise the multi-disciplinary team meeting agenda to ensure compliance with national guidance	National guidance [6]	6 months	Standard	Revised agenda agreed by clinical lead

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
18	Develop an action plan to ensure adequate server capacity for the delivery of safe programme operation	Service specification [2]	6 months	Standard	Action plan to be presented and monitored at programme board

Identification of cohort

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
19	Develop a standard operating procedure for General Practitioner (GP) practices to generate patient lists for submission to the Diabetic Eye Screening Programme	National quality standards [5] and Service specification [2]	6 months	Standard	Standard operating procedure developed and signed-off by the clinical lead
20	Develop an escalation standard operating procedure for non-responding GP practices	Service specification [2]	6 months	Standard	Process agreed between Diabetic Eye Screening Programme, commissioners and clinical commissioning groups Standard operating procedure developed and signed-off by the clinical lead

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
21	Conduct database cleansing on a quarterly basis	National quality standards [5] and Service specification [2]	3 months	High	Summary of GP validation to be presented at programme board
22	Ensure that there is an effective process in place to accurately identify all patients eligible for screening	National quality standards [5] and Service specification [2]	3 months	High	Commissioner assured effective processes are in place
23	Conduct an audit of suspended patients	National guidance [8]	6 months	Standard	Audit completed Summary report and action plan presented to programme board

Invitation, access and uptake

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
24	Investigate the root cause for newly diagnosed patients not being offered first screening within three months and develop an action plan to improve performance for this standard	National quality standards [5] and Service specification [2]	6 months	Standard	Summary of findings and action plan presented at programme board

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
25	Complete the health equity audit or similar tool, to inform service improvements, maximise uptake and reduce local inequalities	Service specification [2]	12 months	Standard	Action plan developed to address recommendations within health equity audit Summary report of outcomes submitted to programme board
26	Conduct an audit of patients failing to attend or respond and take appropriate action to address issues on non-attendance	Service specification [2]	12 months	Standard	DNA/DNR audit completed Action plan developed to address issues of non-attendance Summary report of audit and action plan submitted to programme board

The screening test – accuracy and quality

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
27	Ensure that all staff undertaking slit-lamp biomicroscopy (SLB) participate in regular quality assurance of the accuracy of SLB surveillance, overseen by the clinical lead	Service specification [2]	9 months	Standard	Develop quality assurance (QA) processes for the accuracy of SLB surveillance Undertake QA of SLB surveillance Summary findings of QA of SLB to be submitted to the programme board
28	Develop a camera assessment policy outlining the procedure for assessing older cameras no longer available to buy	National guidance [9]	12 months	Standard	Policy developed and signed off by clinical lead Image quality review completed

Referral

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
29	Ensure patients receive slit-lamp biomicroscopy (SLB) assessments within national quality standards timescales	National quality standards [5]	3 months	High	Breaches reported at programme board for review and action/ management agreed
30	Develop a standard operating procedure for referring and tracking of patients to treatment centres	National quality standards [5] National guidance [10] and National guidance [4]	6 months	Standard	Standard operating procedure developed and signed-off by the clinical lead

Intervention and outcome

No.	Recommendation	Reference	Timescale	Priority *	Evidence required
31	Establish information technology network links to allow digital images from the screening encounters to be accessible at all treatment centres	The Royal College of Ophthalmologists guidance [11]	12 months	Standard	Action plan developed and monitored
32	Develop formal agreements with each treatment centre, with support from commissioners, to clarify responsibilities in relation to screening and improve data transfer	National guidance [8]	9 months	High	Formal agreement established with each treatment centre and signed at executive level

I = Immediate. H= High. S = Standard.

Next steps

The screening service provider is responsible for developing an action plan to ensure completion of recommendations contained within this report.

SQAS will work with commissioners to monitor activity/progress in response to the recommendations made for a period of 12 months following the issuing of the final report. To allow time for at least one response to all recommendations to be made.