



A checklist for implementing a DRS service

Although the National Screening Committee (NSC) and others provide information and support for DRS programmes, there are a number of key areas, which, if left unaddressed, may lead to significant weaknesses within a primary care trust's DRS programme.

For PCTs that have already set up a DRS programme, this checklist offers them the opportunity to ensure that their current system provides them the best service possible.



Establishment of a Diabetes Register

All diabetes registers must include details of all those with a coded diagnosis of diabetes appearing on a GP practice register and under the care of a hospital-based diabetes service.

PCTs should establish which organisations should be included and what geographical area should be covered by the screening service. Problems arise when an attempt is made to pin down specific numbers of people eligible for screening. For example, the number of people moving out of or into the area or being newly diagnosed with diabetes must be taken into consideration.

The commissioning process

Inclusion is essential. Those responsible for commissioning a DRS programme must ensure that all key stakeholders are involved in the planning process.

It is important that a service lead is appointed at an early stage with responsibility for developing the service through consultation with the stakeholders.

Hardware and software

The NSC provides guidance on camera specifications. The list of manufacturers and models is limited by strict guidance on factors including image field (ideally 45°) and effective pixel resolution.

As well as the three remaining software suppliers contracted with the NHS Purchasing and Supply Agency (PaSA), a whole range of other software has already been employed. The NSC's guidance on what functionality should be included in DRS management software; grading, archiving / backup, call / recall, clinic tracking, referral / treatment tracking, audit/QA and reporting does not cover all the processes involved in a screening service.

Formal identification of those with diabetes, data extraction from GP practice or secondary care systems and provision of data for preventative measures must be considered.

Good relationships with local IT personnel are extremely important when considering network links (in particular issues of network security and firewall protection), storage space on dedicated servers including adequate backup measures, the service and maintenance of computer hardware.

Screening

Accommodation, the number of screening clinic(s) and who will carry out the screening must be resolved. For PCTs that are struggling with issues of resource and time, the inclusion of screening services by community optometry should be considered.

Waiting room facilities, a VA testing room/area and a screening room of appropriate dimensions, with adequate security and blackout provision will also be required.

When selecting rooms, the issue of patient confidentiality must be a fundamental consideration.

Accessibility for wheelchair users (relatively common amongst the diabetic population), and good public transport must also be a consideration.

Retinal screeners come from a number of professional backgrounds. The NSC has stated a need for trained and accredited screeners. The new City and Guilds National Certificate in Diabetic Retinopathy Screening developed in conjunction with the NSC will ensure that in future all screeners will be trained and accredited in an appropriate fashion.

Service administration is vital for any successful service; the importance of this role should not be underrated with huge volumes of invitation, reminder and appointment confirmation letters as well as telephone calls required.

Ensure timely call and recall, effective result reporting to patients, GPs and other healthcare professionals.

It is important to be aware that the patient pathway is not straightforward and there are many instances where exceptional circumstances will apply. For example when dealing with people with physical or learning disabilities, mental health problems and those unable to speak or read English.

Grading

From a clinical point of view, disease graders clearly have the greatest responsibility. As with screeners, training and accreditation is paramount and the National Certificate makes provision for this.

As well as a systematic grading process, provision of internal quality assurance (QA) must be included and should be undertaken by the higher-level graders. Guidance states the need for at least double reading of all positive results as well as for 10% of negative results as a QA measure.

All grading including QA should be attributable to an individual and the production of 'intergrader' comparison reports is essential for ongoing training and CPD.

Management of positive results

Clearly there will be a need for onward referral and management of those patients identified by the screening programme as having diabetic retinopathy requiring further investigation and possibly treatment.

It has been argued that a DRS programme should be tied to one treatment service (ophthalmology department). This clearly works against patient choice, and in some cases may compromise existing arrangements for referring patients to more than one hospital. An agreement should be reached at an early stage where patients will be referred and if appropriate more than one destination should be considered.

Prevention

Many programmes forget that a DRS Programme has a dual role and that as well as detection, prevention should be regarded as a major factor to be addressed. In some cases, programmes are already identifying cases of people with low levels of retinopathy but where other risk factors for progression, such as high blood pressure and blood sugar levels are present. Once identified, these risks can be highlighted to both the patient and those responsible for their diabetes care and it may be possible to intervene and prevent progression of DR.

It is clear that a multitude of considerations must be made in the process of developing an effective high quality DRS programme. However, by following this basic checklist, drawing on the experience of others who have been there before and using the guidance available from the NSC, this daunting task is achievable.

Managed Service Provision

Where commissioners are struggling with demanding timescales, politics or availability of experienced personnel to drive the introduction and management of a DRS programme, an option to establish a managed service should be considered. 1st Retinal Screen, along with a small number of other companies, offers a fully managed service in this area and arrangements can be established via a clinical tender process. Several PCTs have already taken this approach.

For further information on Diabetic Retinopathy Screening contact:

**1st Retinal Screen, Saxon House, Moston Road, Sandbach, Cheshire,
CW11 3AD Tel: 01270 765124 Fax: 01270 765078**

sales@1stRetinalScreen.com www.1stRetinalScreen.com