

# National Programme development

Sue Cohen, National Quality Assurance Director

Anne Stevenson, Programme Manager

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Steve Aldington, National Education Lead



# A new home



# Current Accountability

- Department of Health
  - Provision of funding and governance of national programmes
- National Screening Committee – Non Cancer Programmes
  - Advises Ministers across the four countries
  - Monitors effectiveness and quality of its screening programmes
  - Overarching Governance
  - Direct Accountability
- National Programme Centres
  - Antenatal
  - Newborn
  - Adult
    - DRS/AAA



**Dr Anne Mackie**  
**Director of Programmes**  
**UK National Screening Committee**

**Dr Mike Richards**  
**NHS Cancer Programmes**  
**Department of Health**

**Fetal, Maternal and Child Health  
Screening Programmes**

**Vascular Screening Programmes**

**Cancer Screening  
Programmes**

Infectious Diseases:  
HIV, Hepatitis B,  
Syphilis and Rubella  
Susceptibility

Sickle Cell &  
Thalassaemia

Fetal Anomaly:  
Down's Syndrome  
and Fetal Anomaly  
Ultrasound

Abdominal Aortic  
Aneurysm

Diabetic Retinopathy

Newborn Blood Spot

Newborn and Infant  
Physical  
Examinations

Newborn Hearing

Cervical

Breast

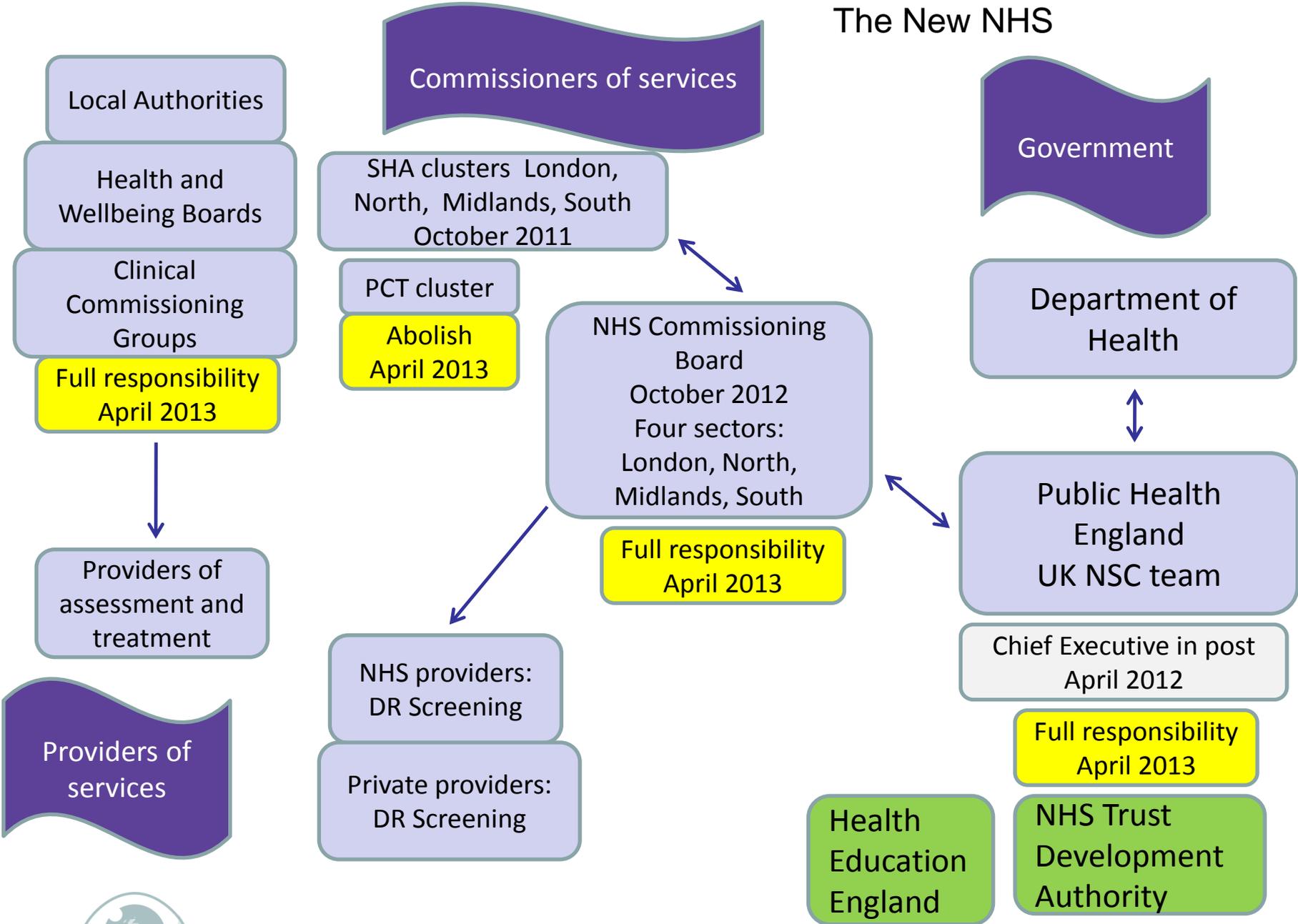
Bowel Cancer



# National reforms



# The New NHS

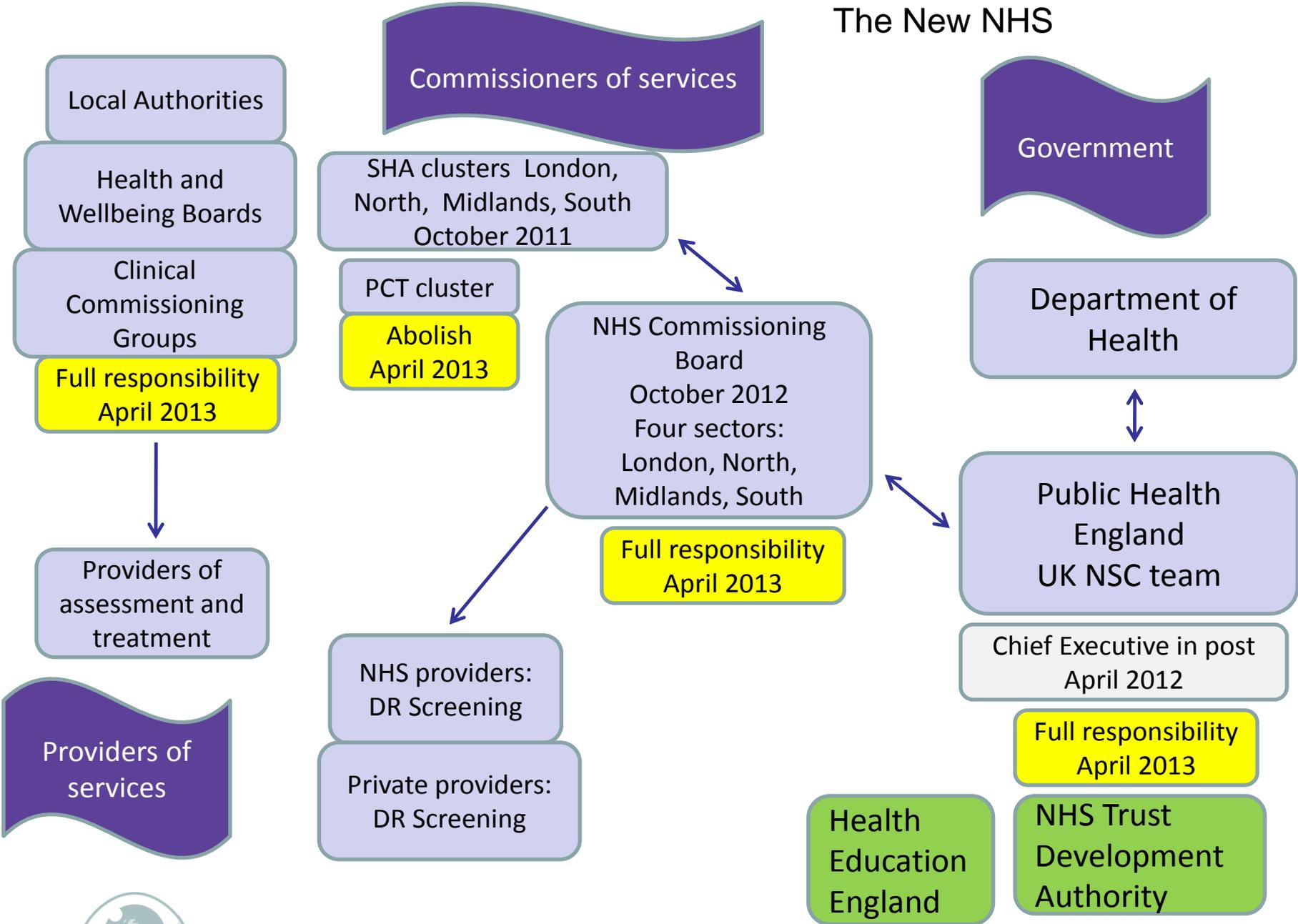


# National reforms

- National reform strategy around commissioning and provision of services
- PHE will hold responsibility for screening and provide strategic leadership, expert advice and EQA
- Mandate NHS CB (NHS England) to undertake commissioning entire screening pathway
- BUT – probably..... clinical commissioning groups to arrange provision of HES



# The New NHS



Providers of services



# National reforms

- Local programmes operate different pathways with significant variation across the country – often out of necessity to manage costs and minimise impact
- Clear what's in DRS/ HES – where does screening start and finish –delivery, responsibility and money issues.
- Implications
  - Asked by Dept of Health to develop single service specification – not possible
  - Can't inform policy due to variation in data
- In addition: managing transition and oversight.



# Service Specification and Pathway Implications

- Single service specification in development but that requires a clear single pathway – a work in progress but IS time limited!
- Programmes will be required to change some of their working practices but this should deliver a more consistent approach
- Approved through Programme Advisory Group and finally UK NSC
- Long term changes with emerging evidence and technologies
- Shorter term changes to inform and deliver national pathway



# Changes....

- Need to be clear what's reasonable and not ask for the impossible
- Implement change slowly
- Future pathway needs to take account of:
  - Working for all patients across country
  - Doesn't rely on workarounds because of lack of capacity
  - Pathway appropriately commissioned from relevant providers with contractual frameworks underpinning
  - Cost effective and sustainable for the future



# I.T

- Software improvement consultation ended June '11
- Thank you if you took part and gave us your views
- Recommended
  - Redesign and publish a new exemplar support contract that contains enhanced clauses relating to nationally determined change control, serious incident management and support processes
  - To promote the implementation of the new contract in all programmes and where possible to promote consolidation of contracts across localities where this is practical.
  - To develop an Output Based Specification for software as soon as practicable based on the output of the pathway review and then to mandate this OBS within all software systems



# IT

- Digital Healthcare merger with Orion
- Company are developing migration plans and will do this in consultation with programmes
- Clear understanding of risks with previous experience gained



# GP<sub>2</sub>DRS

- Enable collection of demographic data and (optionally) key clinical risk factor data on all patients registered with a GP and diagnosed as diabetic.
- Demographic data available once agreement with practices to activate data extraction is obtained.
- Clinical data will be available on implied patient consent basis.
- Phase 1 well underway with all providers of GP systems now engaged
- Phase 2 and 3a/3b underway with some early piloting of phase 2 by the end of this year.



# Workbook

- Ongoing!
- Plan B
- Put existing workbook on the website but broken into sections.
- We will revise sections as changes come into effect.
- When a change is made it will state the date from which it will take effect



# Where we are at: communications and information

Mike Harris  
National Communications Lead



# Programme identity

- New name should be recognisable to public and adopted by all programmes
- Aim to develop a renewed shared sense of identity within the national and local programmes

## **Name options:**

1. NHS Diabetic Retinopathy Screening Programme
2. NHS Diabetic Eye Disease Screening Programme
3. NHS Diabetic Eye Screening Programme
4. Other – we're open to ideas



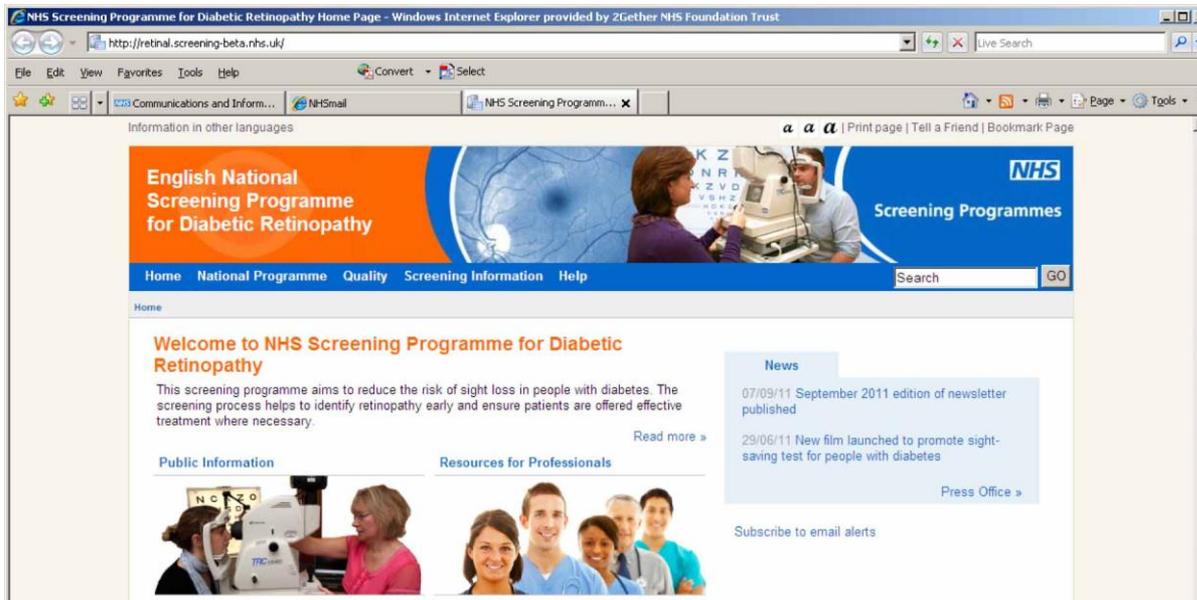
# Patient information materials

- National leaflets and letters are being reviewed and revised
- We aim to develop materials that are accurate, clear, concise and engaging
- Information should help to raise awareness, support informed decision making and be suitable for consistent use by programmes nationwide
- Development of new materials will be informed by patient and professional focus groups, survey of local programmes, engagement with stakeholders and your feedback



# New look website and timescales

- Revamped website will be more user friendly and include an extranet for programme use only



- Aim to launch new name, new patient information materials and new website in the new year



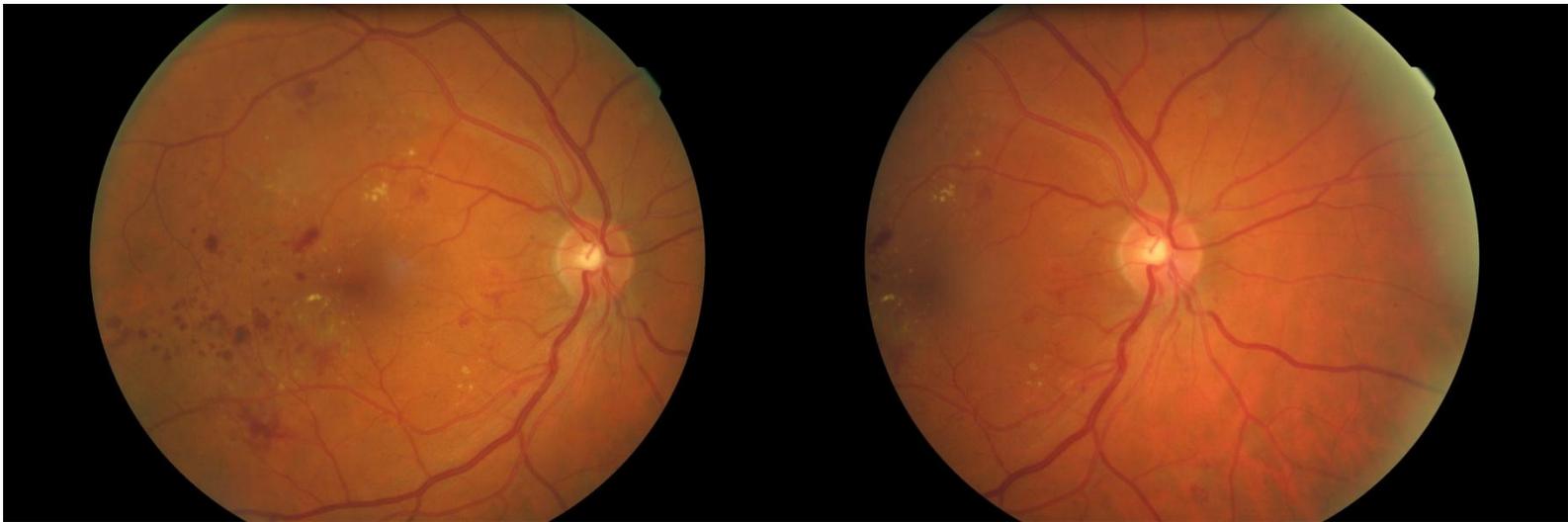
# Education, Training and Development

Steve Aldington  
National Education Lead



# Diabetic retinopathy

- Presence of STDR and any DR are highest risks for future visual loss
- Largely preventable or at least containable
- Often asymptomatic even to late stages but frequently symptoms are ignored – as feature of age



# A diverse workforce

Number of individual people (not WTE) working **directly** in DR screening in the UK:

- England: >2500 for total 51.1 million population
- Scotland: Approx 130 for total 5.1 million
- Wales: Approx 100 for total 3.0 million
- Northern Ireland: Approx 35\* for total 1.8 million

This diverse workforce (you) includes screeners, graders, optometrists, admin staff, HCAs, managers, Failsafe staff, training staff, Clinical Leads, some ophthalmologists....

– who are working together, trying to provide annual DR screening for all eligible people with diabetes



# The appropriate Legal Framework

- The NHS Constitution (England) 2010 states:
  - **Principle 3.** The NHS aspires to the highest standards of excellence and professionalism – ..... in the people it employs and the education, training and development they receive....
  - (*patients*) have **the right** to be treated with a professional standard of care, **by appropriately qualified and experienced staff**, in a properly approved or registered organisation that meets required levels of safety and quality
  - (*staff*) should aim to **take up training and development opportunities** provided **over and above** those legally required of your post



# What is 'A right'?

- **A right** is a **legal entitlement** protected by law. The Constitution sets out a number of rights, which include rights conferred explicitly by law and rights derived from legal obligations imposed on NHS bodies and other healthcare providers.



# How are we doing on C & G?

**937 (38%)** have completed

**1528** have yet to complete

Some programmes doing really well

**BUT 686 (69%)** have completed unit 7 & 8 exams

Others still have a way to go...



# Appropriately qualified & experienced staff

Improve accuracy of results

Deal with patients fairly and equitably

Reduce unnecessary referrals

Keep up-to-date on developments

Reduce patient anxiety

Work within limits of their authority

Use resources effectively

.....



# Current T, E & W activities

- Training sessions
  - Programme Managers
  - Peer Reviewers (for EQA visits)
  - C & G Assessors
  - C & G Internal Verifier standardisation
- College of Graders
  - Invitations to consistently high performing TAT participants
  - Work on peer-review grading for EQA
  - ‘Ground-truthing’ images for TAT
- C & G Fitness for Purpose review (pilot then roll-out)
  - Candidate, Assessor and PM/Clinical Lead questionnaires
  - Detailed / task group participation



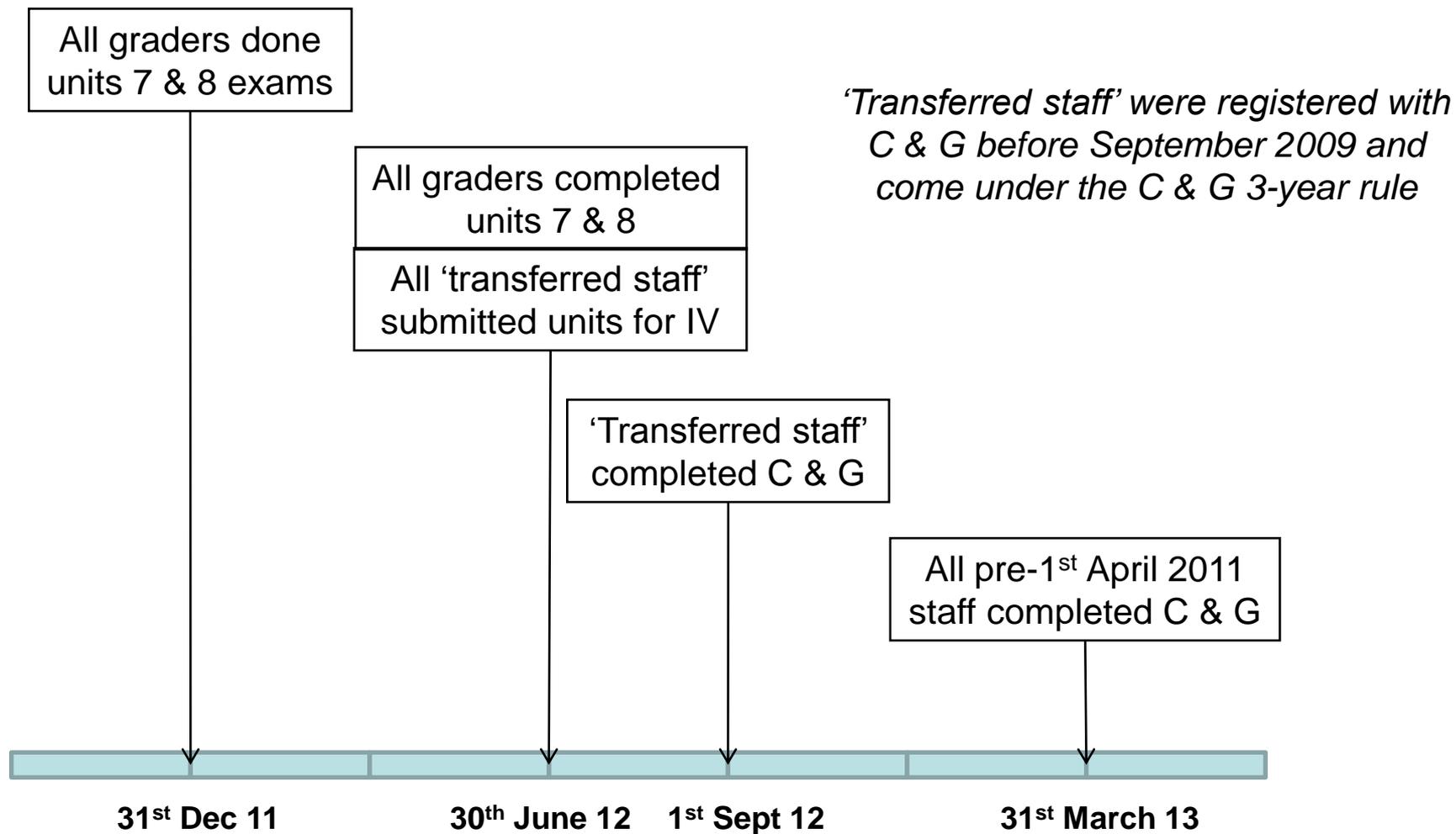
**More...**

# Current T, E & W activities cont..

- Test and Training
  - Lesion Annotation Tool
- Workforce Registers
  - Grader ID numbers (staff achieving Units 7 & 8 or exempted)
  - SLB practitioners
- Possible C & G exemptions for certain staff
  - Professional Standards Review Committee under TEWC
- Job Descriptions for Clinical Leads
- Additional qualifications
  - Warwick MSc in Health Sciences (Retinal Screening – Diabetes)
  - Introductory 3-module cross-programme (AAA, NHSP, DRS)
  - Failsafe module



# C & G Qualification deadlines

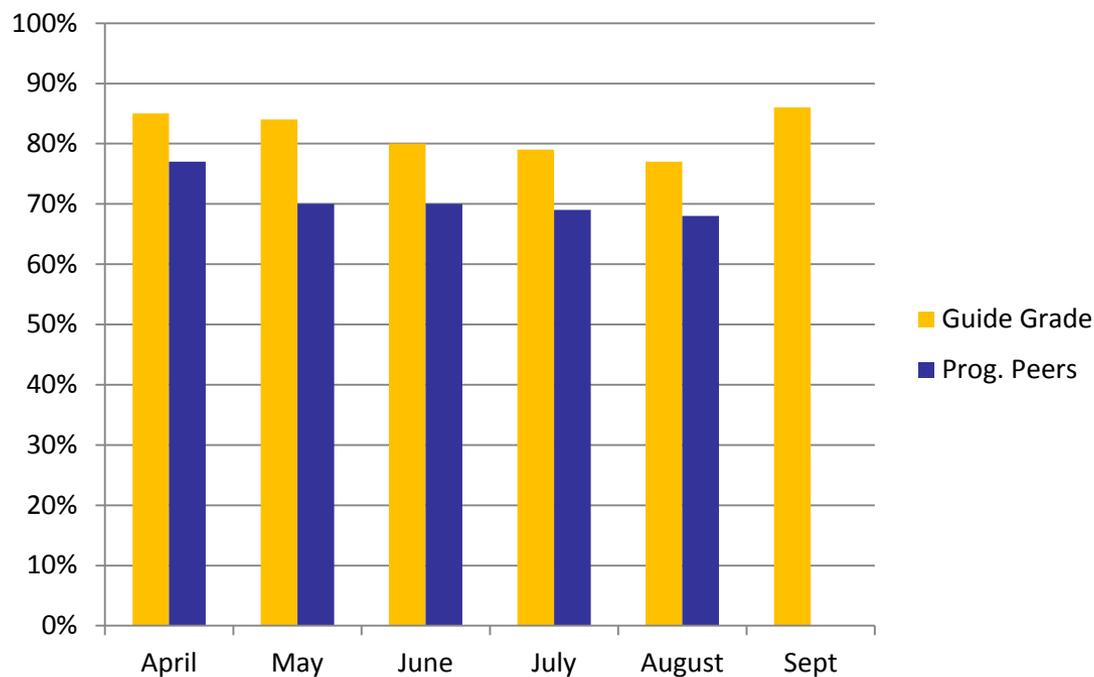


# Test and Training 2011-12

2,184 currently registered Full Disease Graders

243 registered Trainee FDG

FDG Completers - 735 870 941 848 918 713\*



# Test and Training 2011-12 cont..

Does access to images at month-end help?

Does national average results data help?

Does programme peer results data help?

Does recording of lesions help?

Will the Lesion Annotation Tool help?

What additional facilities would you like?

What additional reports / data would you like?



# Where we are at in Quality Assurance

Sue Cohen  
National Quality Assurance Director



# Where we are at in England 2010/11

2, 465,899  
People with  
Diabetes

2,256,648  
offered screening

84% receive  
results in 3  
weeks  
KPI DR2

1,789,701  
People  
screened





# Quality Assurance Standards

- Better, but aware some programmes are still having problems collecting/analysing data
- Phase 2 – started, reviewing evidence
- We don't envisage making any changes for at least another year
- Working very hard to get guidance out on exclusions and suspensions to support objective 2 of the new QA standards



# EQA visits

- Striving for excellence!
- 25 programmes require visits – to be completed  
Aug 2012
- Clear protocol – no surprises!
- New EQA Leads – chair the visit
- Peer reviewers trained
- Assessing grading performance



# Assessing grading performance

- Fair assessment – based on whether programme is using protocols/ test & training/MDTs
- Sample – remote extraction
- Re-grading by ‘Grading College’
- Performance compared to acceptable programme sensitivity



# Guidance



Screening Programmes

Diabetic Retinopathy



## Management of Incidents within Diabetic Retinal Screening

Version 1, 9 August 2011

Handbook for the management of incidents including  
guidance on programme suspensions and 'look back'



Screening Programmes

Diabetic Retinopathy



NHS Diabetic Retinopathy Screening Programme Quality Assurance  
Standards Guidance Document

Version 1.5, Release 7, 29<sup>th</sup> June 2011

This document provides guidance on the Quality Assurance Standards  
for Diabetic Retinopathy (DR) screening programmes in the NHS

Supporting programmes

Where we are at in QA

All graders having 7&8

Grading criteria

Making some progress – getting there.....





**Where we  
are at in QA**



Still need to  
do some  
more work....



Failsafe



Data – quality



# Using data to support QA

- Data is really important in driving up quality
- Really good at identifying issues with performance
- Need data to assess outcomes from screening





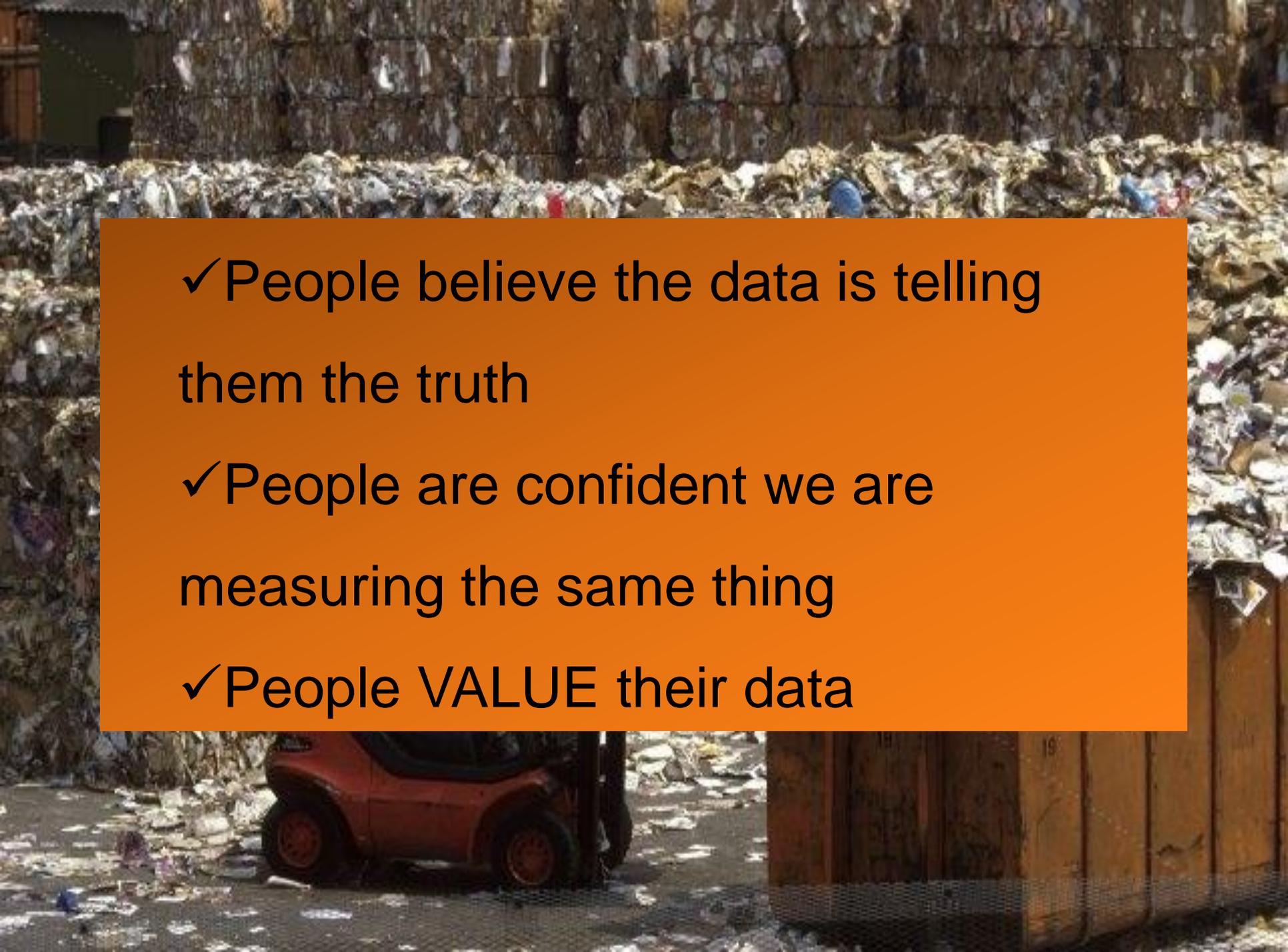
**Data**

**Information**

**Understanding**

**CHANGE!**



- 
- ✓ People believe the data is telling them the truth
  - ✓ People are confident we are measuring the same thing
  - ✓ People VALUE their data

# What are we doing?

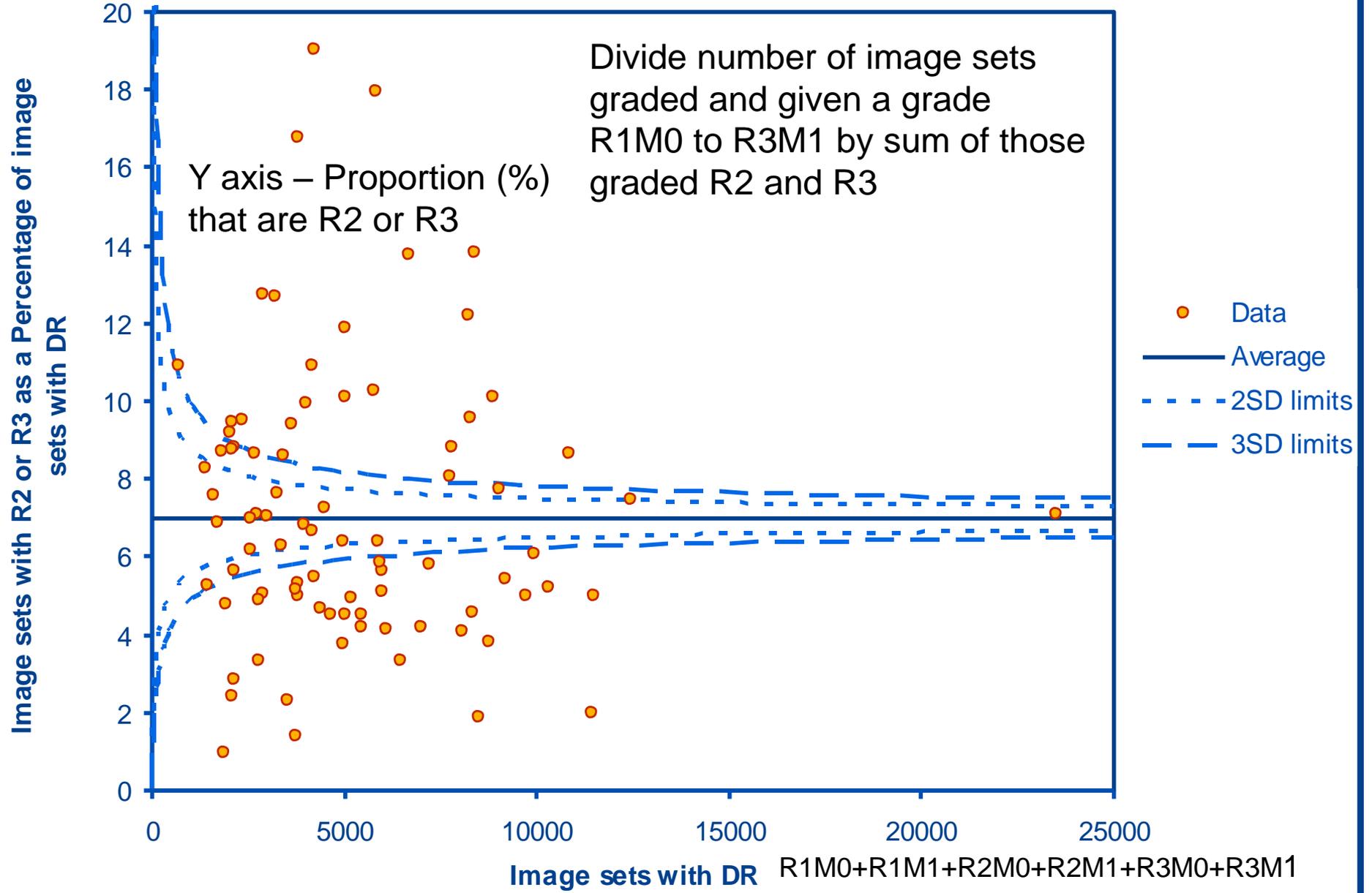
- Common pathway
- Unambiguous definitions
- Measure the same things
- Work with the software suppliers
- Use this data to inform what 'good' looks like and set standards

What do we do in the meantime?

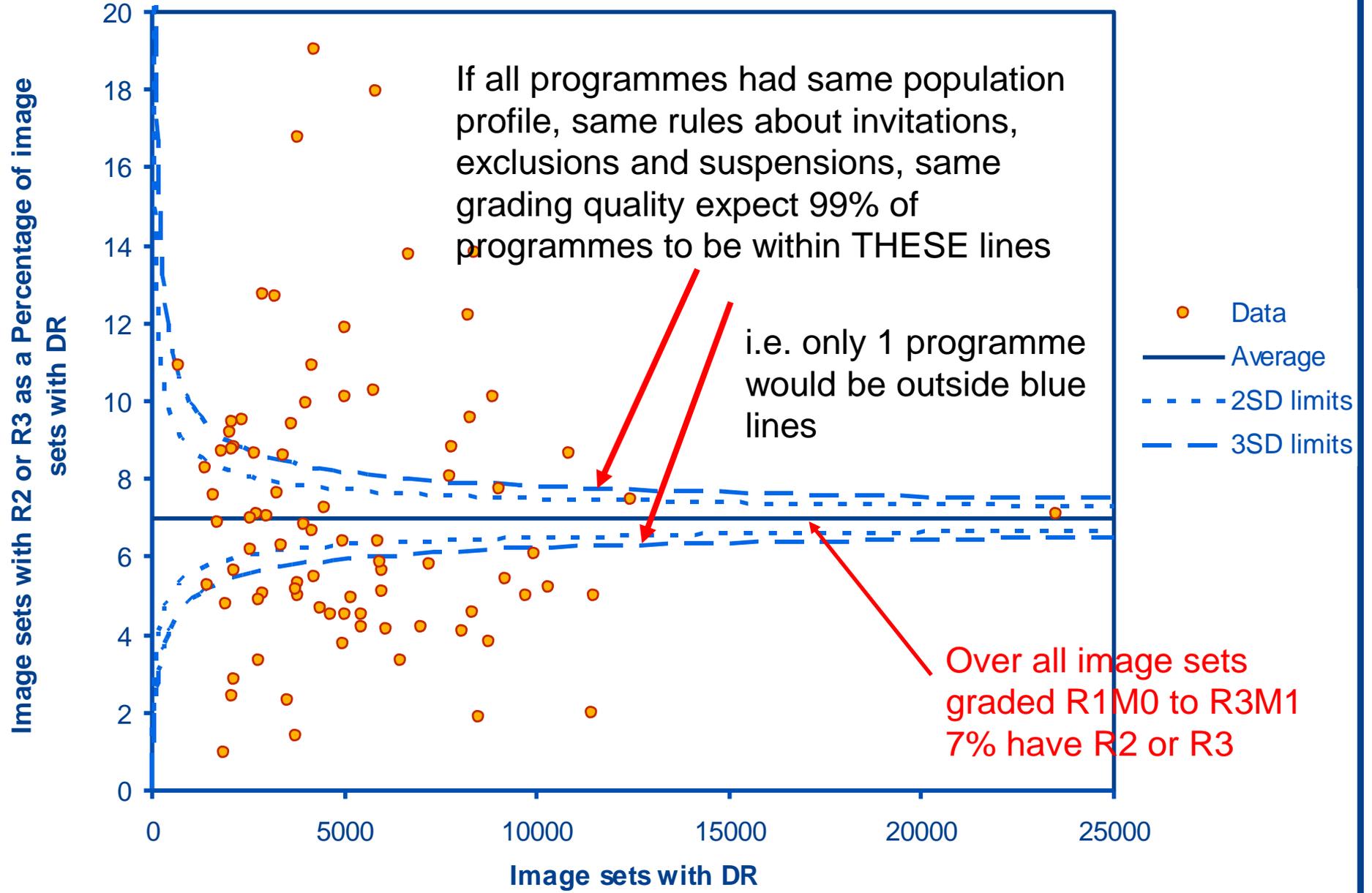
- Programmes can examine their own trends
- Look for outliers – not to performance manage programmes – but to understand difference



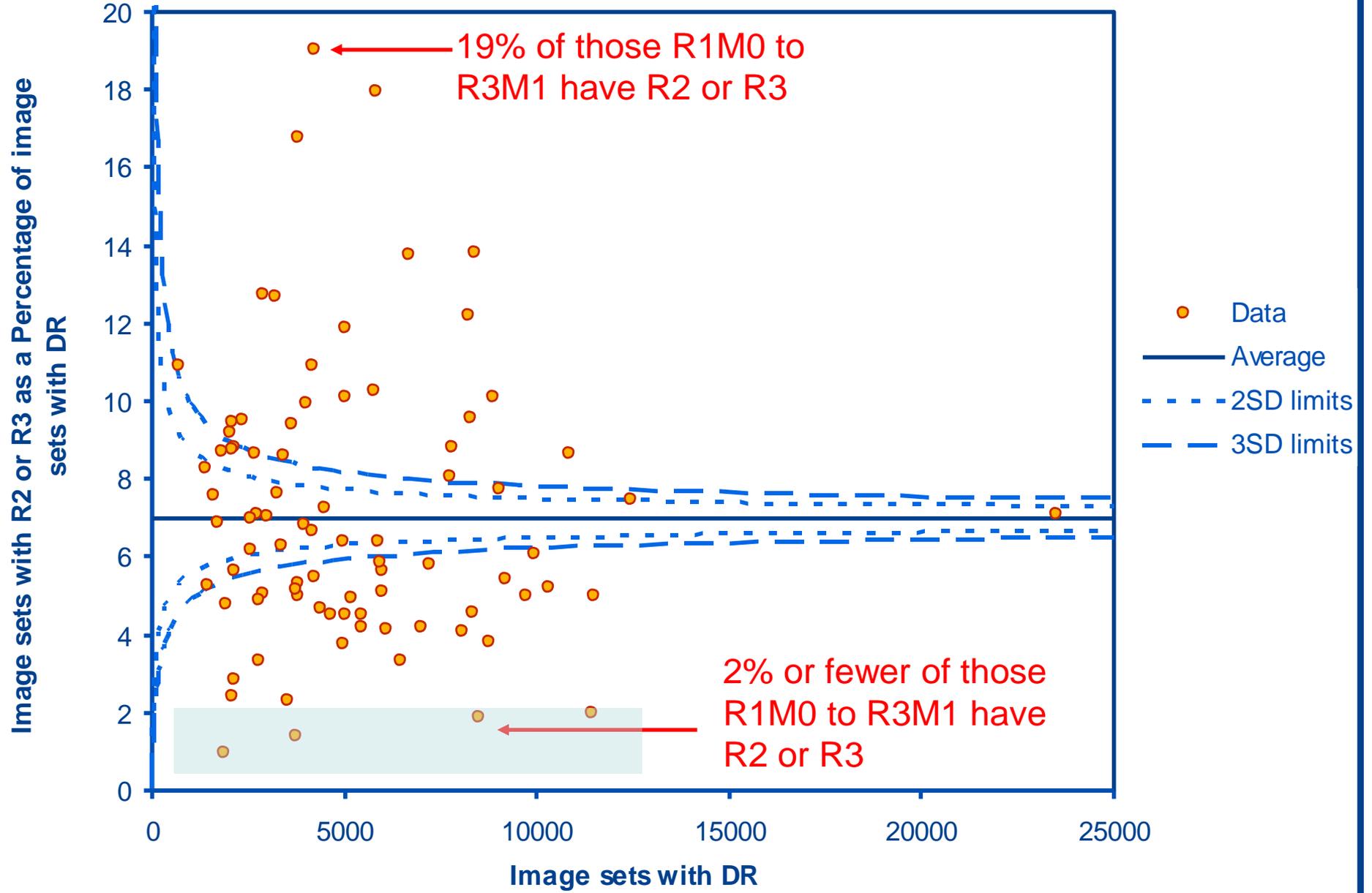
# Proportion of DR with R2 or R3 2008-2009



# Proportion of DR with R2 or R3 2008-2009



# Proportion of DR with R2 or R3 2008-2009



# Failsafe

- Stopping patients getting lost in the system
- We are spending a lot of time dealing with systemic problems in the system
  - Backlogs
  - IT
  - Interface
- Do it once and do it right!
- Review of failsafe to work smarter



# Thank you

- We have made considerable progress
- Continue to work together to deliver a programme that will make a real difference to people with diabetes

