Guy's and St Thomas' NHS Foundation Trust

A message from your new BARS President!

Samantha Mann

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St Thomas' Hospital & SELDESP lead

A message from your new BARS President!

Guy's and St Thomas' NHS Foundation Trust

- Who am I?
- What I think is important in Diabetic Retinal Screening?
- What vision I have for BARS over the coming years?

Who Am I?

NHS
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- Consultant Ophthalmologist for 12 years at St Thomas'
- Trained in London at Bart's Medical college (with my twin sister) before taking up ophthalmology and have been interested in Medical Retina and Diabetes ever since I worked with Tunde Peto at Moorfields eye Hospital (2001-2008).
- Since becoming the clinical lead in 2009 I have come to realise how important our role is in preventing blindness.
- Sadly one of my patients 'Danny' did lose sight from Diabetes as he was just too scared and failed to attend screening despite being invited. He then helped us to make a video stressing the importance of screening.

What I think is important in Diabetic Retinal Screening?

- 1. Improving access to screening with more emphasis on those more deprived
- 2. Increasing patient/ public awareness of why screening is important?
- 3. Providing a positive patient experience.
- 4. Stratifying screening according to risk to improve resource allocation

1) Improving access to screening

Index of Multiple Deprivation (IMD) against Uptake

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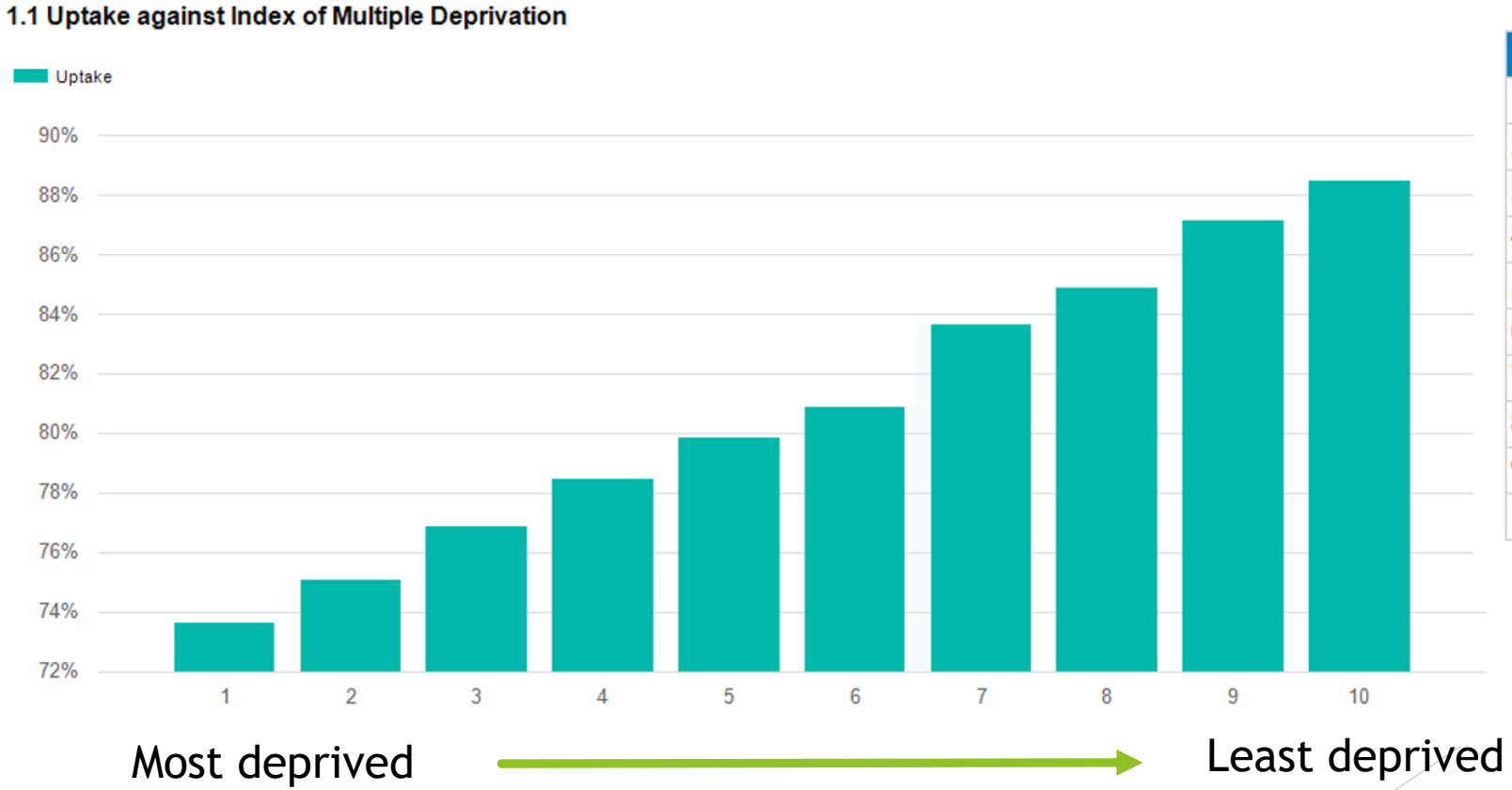
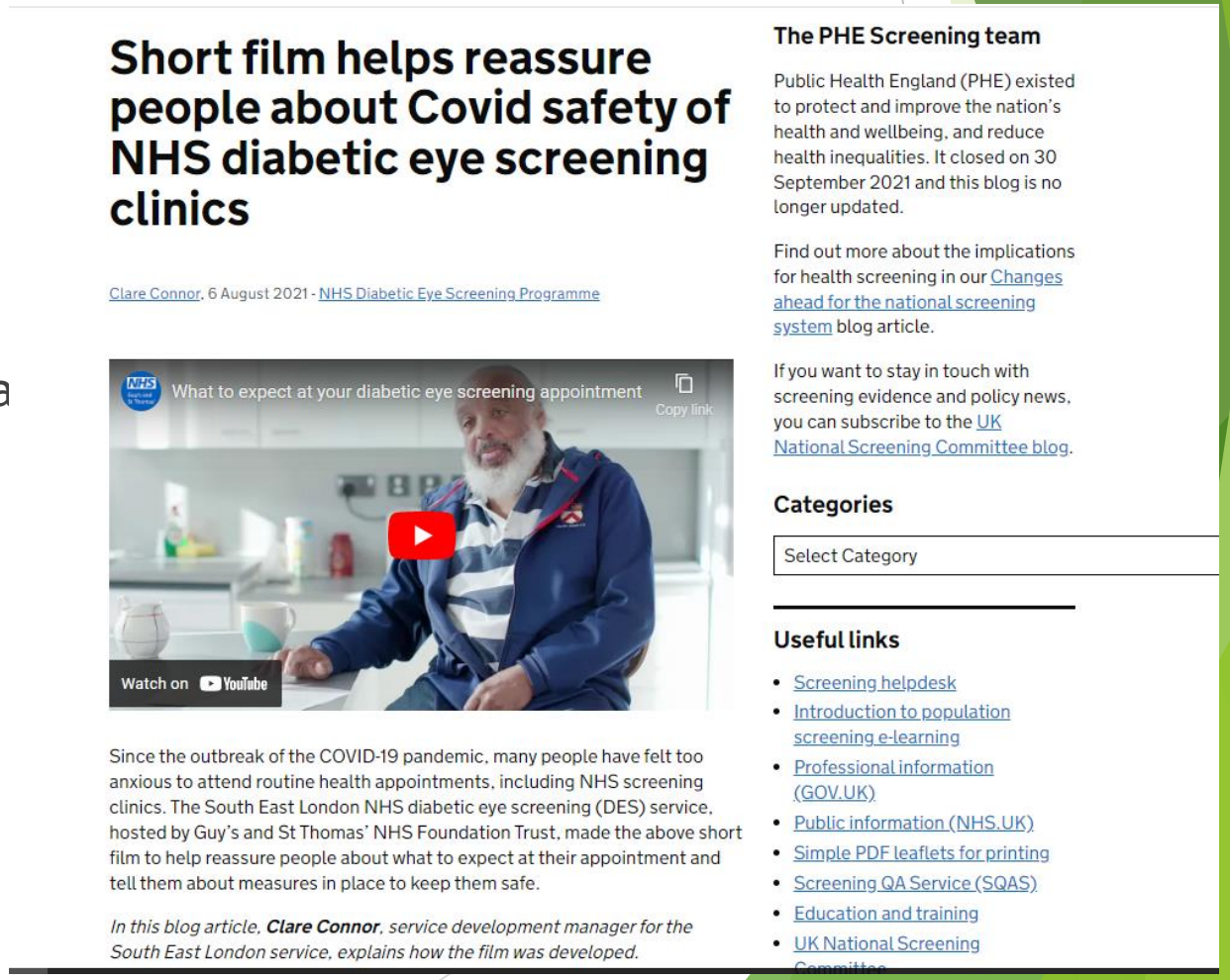
Importance of understanding barriers to attendance. Is it disability, language, out of the country, timing of appts, lack of understanding of importance of screening



IMD	Invited	Screened	Uptake
1	9616	7078	74%
2	15989	12003	75%
3	13698	10530	77%
4	9920	7781	78%
5	7832	6251	80%
6	5614	4540	81%
7	4441	3715	84%
8	4424	3755	85%
9	3990	3475	87%
10	3164	2798	88%

2. Increasing patient/ public awareness
Why screening is important? in a positive way

- Peter's story video
- Attending patient groups/ events
- Faith groups / Rastafari movement uk
- 'Food for purpose' black church initiative
- Diabetes UK – 'change lab' work- looking a barriers to attendance.



Short film helps reassure people about Covid safety of NHS diabetic eye screening clinics

Clare Connor, 6 August 2021 - NHS Diabetic Eye Screening Programme

Since the outbreak of the COVID-19 pandemic, many people have felt too anxious to attend routine health appointments, including NHS screening clinics. The South East London NHS diabetic eye screening (DES) service, hosted by Guy's and St Thomas' NHS Foundation Trust, made the above short film to help reassure people about what to expect at their appointment and tell them about measures in place to keep them safe.

*In this blog article, **Clare Connor**, service development manager for the South East London service, explains how the film was developed.*

The PHE Screening team

Public Health England (PHE) existed to protect and improve the nation's health and wellbeing, and reduce health inequalities. It closed on 30 September 2021 and this blog is no longer updated.

Find out more about the implications for health screening in our Changes ahead for the national screening system blog article.

If you want to stay in touch with screening evidence and policy news, you can subscribe to the UK National Screening Committee blog.

Categories

Select Category

Useful links

- Screening helpdesk
- Introduction to population screening e-learning
- Professional information (GOV.UK)
- Public information (NHS.UK)
- Simple PDF leaflets for printing
- Screening QA Service (SQAS)
- Education and training
- UK National Screening Committee

3. Giving patients a really positive experience every time they attend (DESP and HES)

- So they will come back!
- Spread the word to others
- Make friends with your diabetes patients

‘The clinician treated me with great kindness and understanding throughout and I came out feeling positive about my health condition for the first time in ages’

Patient feedback

Rank	Question No.	Question	Score	Questionnaires
1	15	Were you given enough privacy during your screening appointment?	99.40	416
2	16	Did you feel you were treated with respect and dignity during your screening appointment?	98.92	417
3	14	Did you have confidence and trust in the staff screening you?	97.73	419
4	13	During your visit were you treated with kindness and understanding?	97.72	417
5	5	If you needed to contact our administration team about your appointment; how helpful were the staff?	94.31	250
6	3	Was the eye screening appointment booked in for a time and date that was convenient to you?	94.15	505
7	10	How much information was provided with your initial invitation letter?	93.72	462
8	17	How would you rate the quality of the service given to you by the screening staff today?	91.63	418
9	9	Thinking about your getting to your appointment, how useful was the information provided, in helping you find the clinic?	91.51	470
10	19	Did you receive the results of your screening within the expected timeframe?	89.79	387
11	20	Thinking about your results letter, did it provide sufficient information for you to understand the outcome of your screening?	88.55	406
12	4	If you needed to contact our administration department about your appointment; how easy was it to contact the team?	86.56	259
13	11	How long after the stated appointment time did your appointment start?	85.97	499

Positive feedback on DNA letters to encourage attendance

Even if you have had your eyes screened before or have recently had your eyes examined by a doctor or optician it is still important to attend. If you are not sure if you need screening, or have any concerns about attending, please contact us. If you have recently made an appointment or have contacted us to discuss your attendance, please ignore this letter.

Here is some recent feedback from people who have attended our screening clinics:

"For several years, I ignored the letters you sent as I was too anxious to attend. In the end, I am so glad I did as it was quick and easy, and I was put at ease instantly. It was a huge weight off my mind."

"Covid safe. Felt very comfortable when I got there and my initial worries about going to the hospital went away."

"On time, no fuss, helpful information, professional staff. Kept correct distance from others, everything I touched was previously cleaned. Consistently professional, informative, helpful and polite"

"Very efficiently dealt with and little time lost. Very impressive. Masks were worn at all times and one felt very safe. As advised earlier the whole experience was very, very professional and could not be faulted."

Yours sincerely,

Dr Samantha Mann MD BSc MRCOphth
Consultant Ophthalmologist - Clinical Lead for the South East London DESP

4. Stratifying screening according to risk to improve resource allocation

- A. Patients with co-morbidities have a higher risk of retinopathy. Importance of liaising with diabetes teams / vascular / renal services in the hospitals
- B. Importance of developing OCT services in DESP
- C. Those over 80 without retinopathy are less likely to lose sight- possible upper screening limit.

A. Patients with co-morbidities- inpatients Case 1

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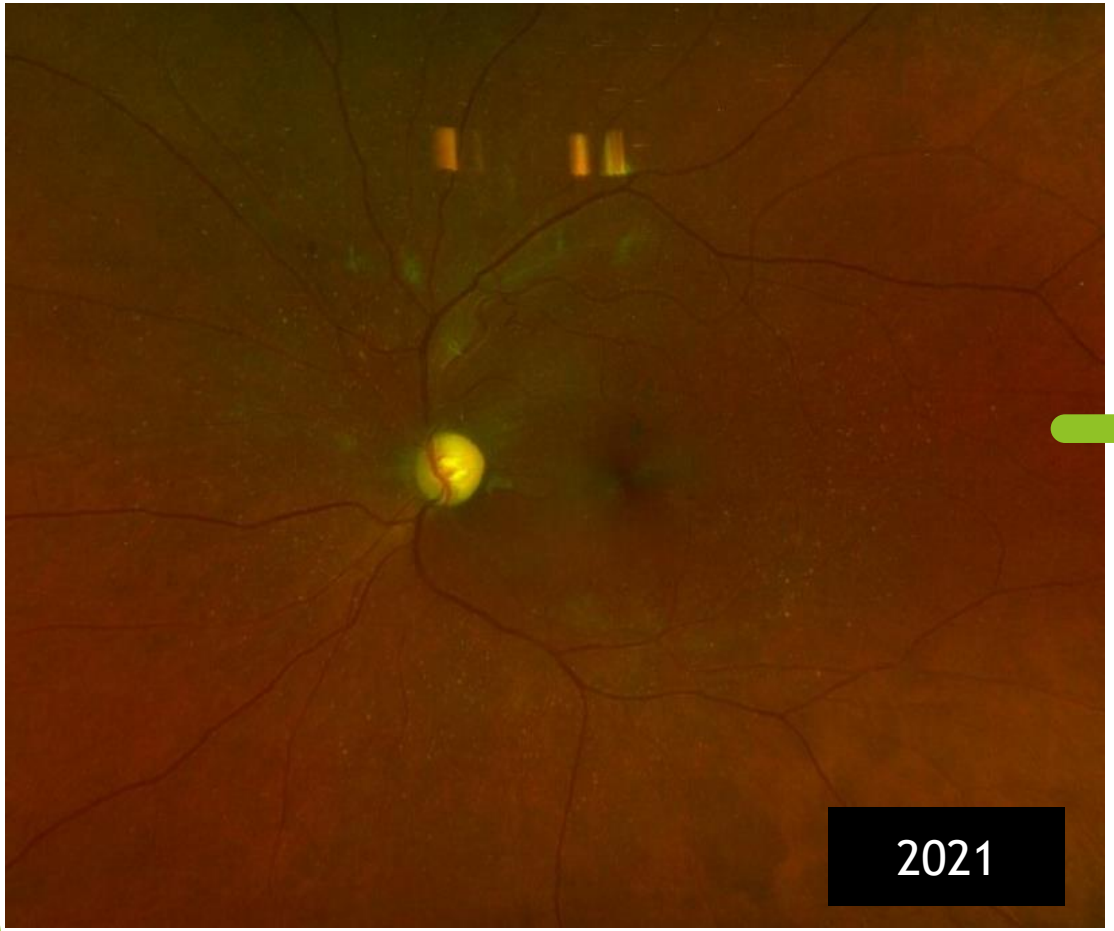
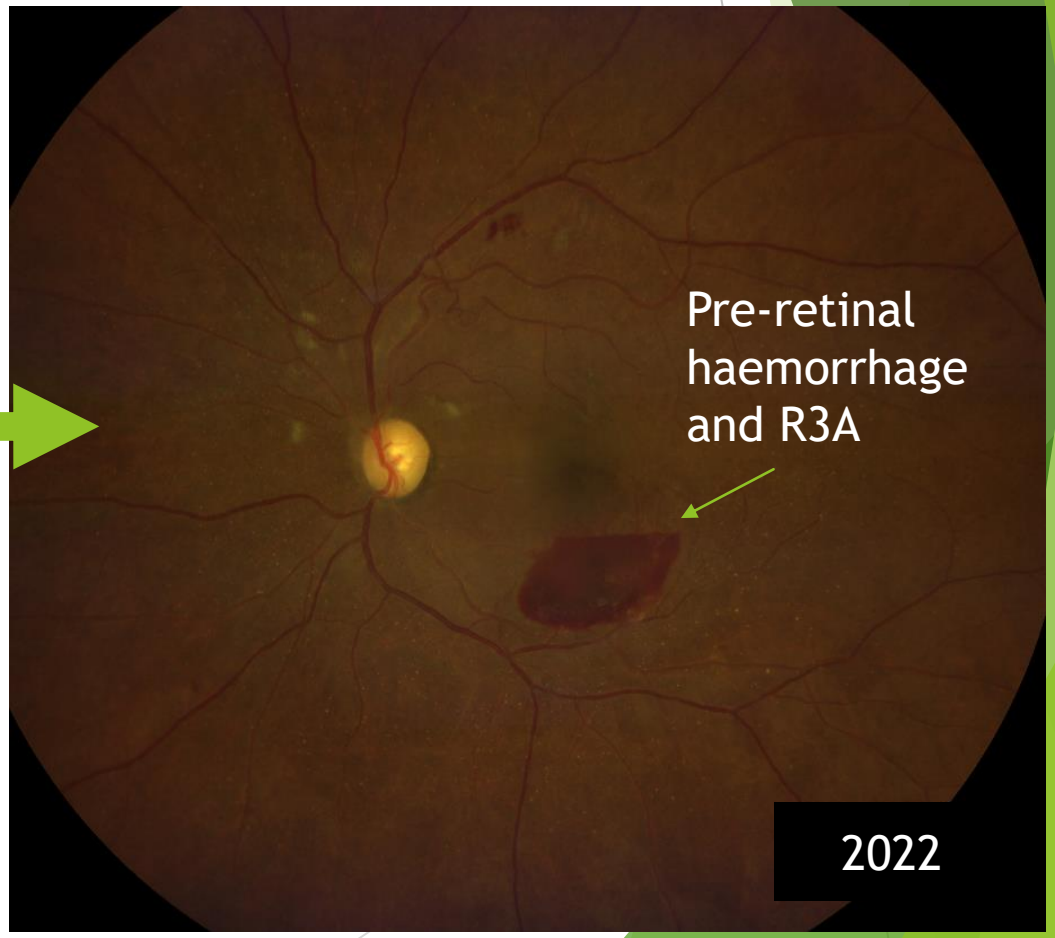
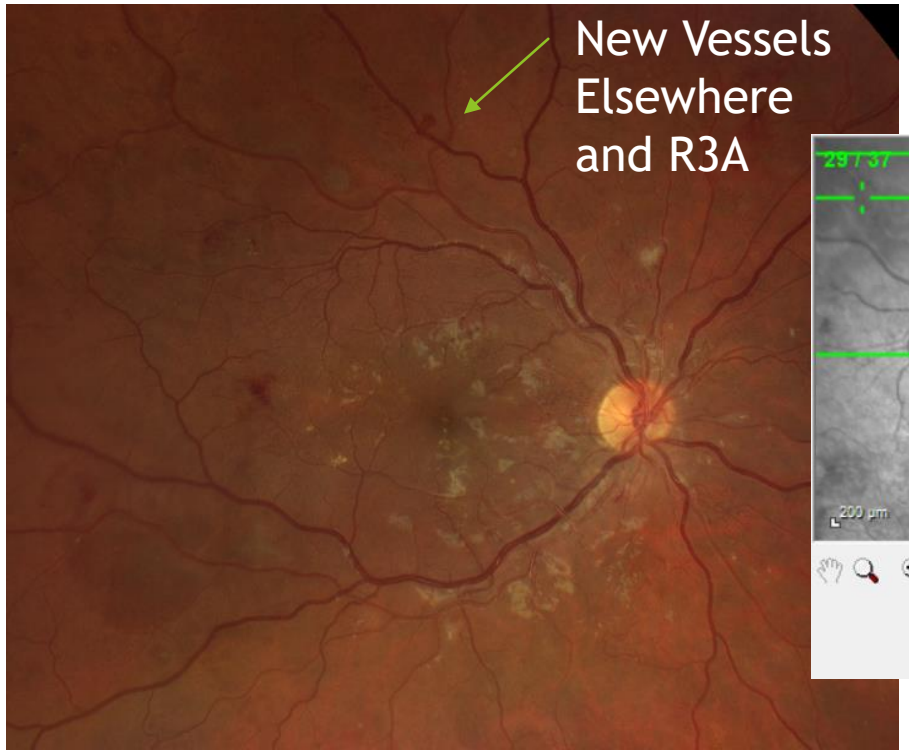
59 yr old male type 2 for 18 yrs - admitted for a foot amputation. Not been seen for 1 year DNA x2 in HES. Arranged to screen in clinic via the inpatient team from the ward

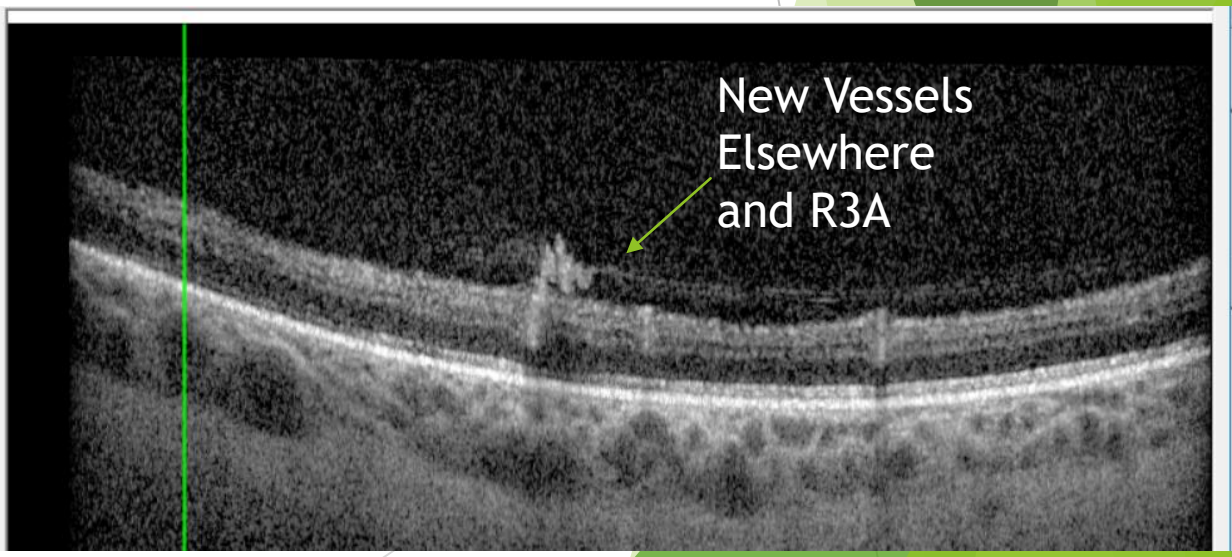




Patients with co-morbidities-inpatients Case 2

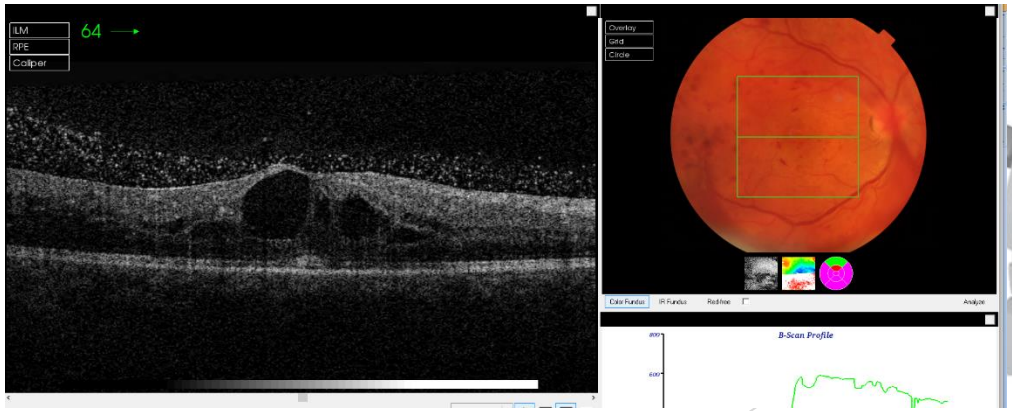
- 29 yr old female. Type 1 diagnosed age 16. Admitted recently with Diabetic Ketoacidosis and has declining kidney function. Vision 6/6 but not screened for over 2 years.
- Arranged with the inpatient team to screen her post discharge.



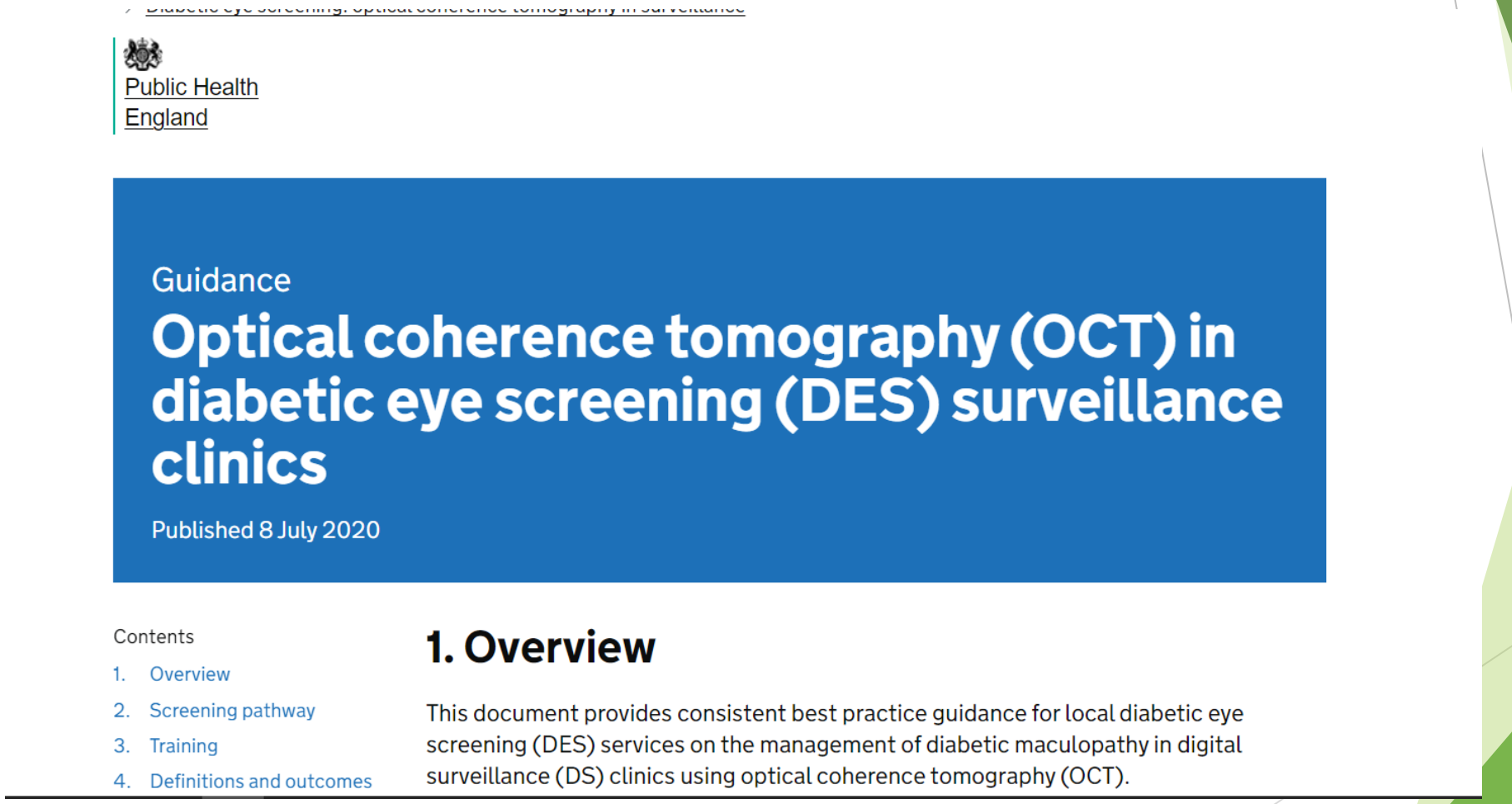


B. Importance of developing OCT services in DESP

- To help increase much needed capacity in Ophthalmology- due to burden of Anti-VEGF injections
- Most M1 patients do not need treatment- just monitoring for several years
- Upskilling of the workforce, to allow greater retention of staff
- May allow more cross over into ophthalmology at senior positions to help with virtual monitoring of patients
- AI and 2 yearly screening protocols will make this even more important



OCT guidance for DES surveillance on gov.uk



Public Health England

Guidance

Optical coherence tomography (OCT) in diabetic eye screening (DES) surveillance clinics

Published 8 July 2020

Contents

1. Overview

This document provides consistent best practice guidance for local diabetic eye screening (DES) services on the management of diabetic maculopathy in digital surveillance (DS) clinics using optical coherence tomography (OCT).

C. Those over 80 have very low levels of pathology (RCO poster)

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- All other screening programmes have a maximum age. Breast up to 70 and cervical screening up to 65. Balance of cost-effectiveness…

Prevalence of treatable diabetic retinopathy in those aged over 80 within the diabetic eye screening programme. Should we be routinely screening this cohort?

Joseph Treloar, Shireen Ognjenovic, Laura Webster, Samantha S Mann – South East London DESP

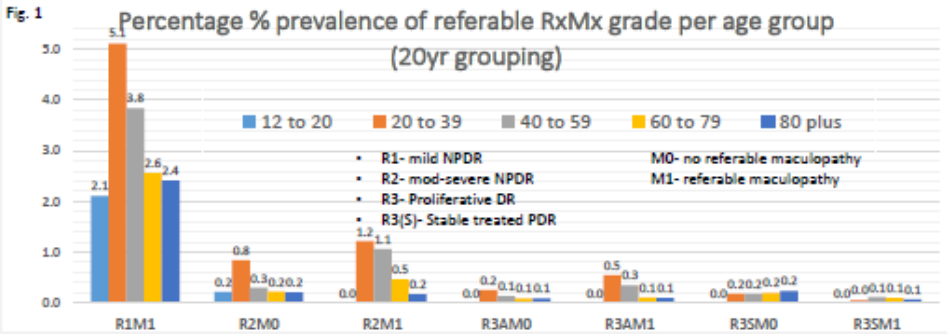
Guy's and St Thomas' NHS Foundation Trust

Purpose: This study evaluates the prevalence of treatable diabetic retinopathy and maculopathy in the over 80s population undergoing screening in the National Diabetic Eye Screening Programme to assess whether the current screening model in the UK is appropriate.

Introduction: Currently the Diabetic Eye Screening Programme (DESP) is the only UK National screening programme with no upper age limit. Although we know that retinopathy rates increase with duration of diabetes, retinopathy rates are highest in the working age population and then appear to stabilise (1). Previous studies have shown a low prevalence of sight-threatening diabetic retinopathy in the elderly (2,3). In the Oulu population study from Finland, it was concluded that the prevalence of sight-threatening retinopathy particularly Proliferative retinopathy in those above 70 was low (2). In Taiwan, although incidence of sight-threatening DR was higher in older men compared to women, the overall prevalence in >80s was also low (3). This cohort often have co-morbidities, so it is important to assess the value of screening. We evaluated the prevalence of referable diabetic retinopathy and maculopathy in the eye screening population over 80s in addition to the numbers who actually received treatment to assess whether the current screening model in the UK is appropriate given limited resources and the increasing ageing population.

Methods: In total, the number of patients with type 1&2 diabetes who had their eyes screened in the South East London – Diabetic Eye Screening Programme between 1st July 2017 and 30th June 2018 was 67,476. Of these 8,183 (12%) were aged 80 or over. This was a retrospective audit of all those with referable retinopathy in this cohort of patients. Data were collated from the Optomise v 4.7 screening software on gender, ethnicity, duration of diabetes, type of screening clinic, worse retinal grade and referral to hospital. Further information on any treatment given under the Hospital Eye Service was determined from individual hospital electronic patient records.

Fig. 1



Results: 7231 patients were seen in routine digital screening and 952 (12%) patients were seen in Slit-lamp biomicroscopy clinics due to cataract reducing the quality of the images. 289 out of a total of 8183 (3.5%) over 80 yr olds were graded with referable pathology and referred to Hospital Eye Services (HES). A total of 9/8183 (0.1% of cohort) patients required active treatment for their sight-threatening changes. Those requiring treatment were predominantly female (61.9%) and from Black, Asian and Minority Ethnic backgrounds (62.5%). 68 patients continue to be monitored in the HES and may progress to receive treatment in the future.

Fig. 3

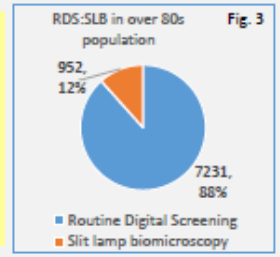
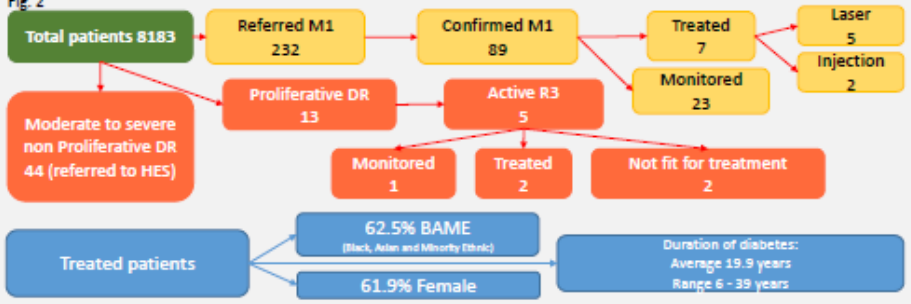


Fig. 2



Discussion. There are increasing numbers of patients with diabetes over 80 that require screening in the UK, but these results demonstrate that by age 80, those still under the diabetic eye screening programme, have a low prevalence of sight threatening disease. A small number of patients have previously received treatment for maculopathy or proliferative retinopathy (R3S) and remain stable . A very low number, develop referable pathology requiring referral and even fewer require treatment. Although 12% patients were seen in the SLB pathway with cataract, other pathways exist for cataract care outside of DESP. Co-morbidities are also higher especially with reduced mobility, and higher levels of cognitive impairment, making attendance and treatment often not possible. This study supports a review of current guidance, changing to an opt-in service for eye screening in the over 80s for those who have not yet developed sight-threatening retinopathy to allow resources to screen patients at greater risk.

References:
1. Klein R, Knudtson MD, Lee KE, Gangnon R, Klein BE. The Wisconsin Epidemiologic Study of Diabetic Retinopathy: XXII the twenty-five-year progression of retinopathy in persons with type 1 diabetes. Ophthalmology. 2008 Nov;115(11):1859-68. 2. Heli Hirvelä, Leila Laatikainen. Diabetic retinopathy in people aged 70 years or older. The Oulu Eye Study. British Journal of Ophthalmology 1997;81:214–217. 3. Lin J, Shau W, Lai M. Sex- and Age-Specific Prevalence and Incidence Rates of Sight-Threatening Diabetic Retinopathy in Taiwan. *JAMA Ophthalmol.* 2014;132(8):922–928.

If R0M0 at 80, very unlikely to loose sight from diabetic retinopathy

Vision for BARS/ Screening over the coming years

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- Operational
- To provide a forum for shared learning and experience
- Sharing good practice/ tips for improving screening uptake/ software issues/ experience of incidents/ shared learning/ ways to reduce non-attendance/ sharing protocols etc..
- Encouraging increased communication with Ophthalmology services and Diabetes services/ inpatient information to screen the highest risk patients especially when they DNA HES multiple times
- Look at levels of pathology/ effectiveness of screening over 80s

Vision for BARS/ Screening over the coming years

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- Educational
- As one of my screeners said 'wouldn't it be nice if we could have a mini bars throughout the year with several opportunities to share learning.
- More educational content- OCT interpretation courses etc..
- More Case studies- send out in Newsletters or through an educational platform for professional groups (i.e. Guild or use of e-learning websites) and presented at BARS.

And finally…….

- I would welcome your ideas on how to improve BARS
- I am looking forward to meeting/ getting to know many of you better
- And looking forward to being part of the BARS family….

- Samantha.mann1@nhs.net