emis care Diabetic Eye Screening Provider

Although the name EMIS Care is a relatively new one – we rebranded in April 2016 – you will have come across us before. Formerly working under the name of Medical Imaging (UK) Ltd, we have been at the forefront of innovating how patients with diabetes are cared for since we began diabetic eye screening over 25 years ago.

From our days as a pioneer in the mobile retinal screening model – back when digital photography was still in its infancy – we have grown to become who we are today, providing services to over 500,000 patients across England and the Republic of Ireland.

Diabetic eye screening is just one of several ophthalmic and health screening services that we offer. As a part of the EMIS Group – a collection of healthcare-focused companies that include EMIS Health, Patient.info and Egton – we are working to help clinicians and patients through a variety of different services.

Our DESP programmes and locations

From rural areas to urban centres, we are based all across England and are able to provide screening services to patients in a variety of different ways.

- **Arden, Herefordshire & Worcestershire** – our longest standing programme where we started off over 30 years ago. This programme was recently merged and now supports over 94,000 patients.
- **Bradford & Airedale** – a Quality in Care award-winning programme and the DESP area where we gather the most patient feedback, sampling 1 in 15 patients we screened last year.
- **Central Mersey** – a mixed screening model programme, where we work with both local optometrists and the local NHS trust.
- **Kent & Medway** – a head-to-head competitor for our largest programme – with another 94,000 patients cared for – this area uses a combination of fixed screening and self-contained mobile screening vans to reach patients.

"It is a fantastic service. It is important for me to know if something is wrong it will be picked up during screening and can be dealt with. It is peace of mind knowing this service exists. Once it is done I can forget about it till next appointment. Thanks to all people involved."

Patient quote from **Bradford and Airedale**

- **North of Tyne & Gateshead** – winner of a Healthwatch award, this is our most rural-based programme that is run through mobile screening sessions.
- **South West London** – we were recently commissioned to run this densely-populated programme. We also head-up a state of the art grading office in New Malden.
- **Birmingham, Solihull & Black Country** – where we run administration services for the DESP programme.

All of these areas feed into our Administration Centre based at our Worcester office, which acts as the heart of EMIS Care. Here our team provide administration to several diabetic eye screening programmes. Our Worcester office is also home to our Quality Management Team, who provide support and business intelligence to everyone involved in service delivery.

Our administration team boast some impressive statistics, booking over 318,000 appointments so far in 2016, whilst taking 330,000 incoming calls since 2015.

Patient care

Patient care is at the core of the service that we provide. Across our DESP areas, we have implemented several initiatives in order to ensure that patients have access to the best care and are satisfied with the attention that they are given.

"Appointment right on time, no waiting, cheerful staff, whole experience painless."

Patient quote from **North of Tyne and Gateshead**

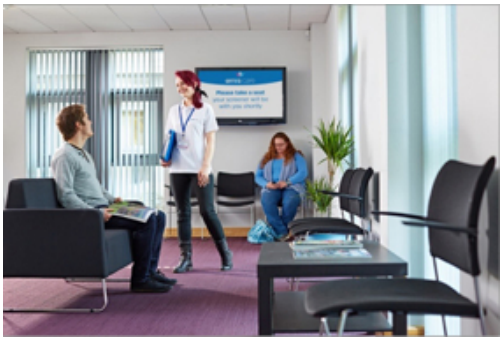
Analysing and improving

We consistently listen to patients to understand what they think about their care and to see if there are any ways to improve their experience. In Kent & Medway this takes the form of a Patient Champion Programme, where patient representatives attend meetings to give us views on service improvements. Through forums like these, we can gain important face time with patients outside of their screening appointments.

Surveys are also a key part of gaining feedback. For our Programme Managers like Denise Young at North of Tyne & Gateshead, this information is key to creating programme frameworks: *"This quarter we will be working towards analysing the survey results and forming an action plan on outcomes and quotes, so that we can address any patient issues. You said, we did!"*

Such initiatives have allowed us to gain key insight into making patients as happy as possible whilst in our care.

After surveying over 18,000 service users, over 99% thought the service was excellent or good, and over 99% would recommend the service to a friend or family member with diabetes.



Reaching as many patients as possible

It is key to us that patients are given an appointment in a timely manner and that they also attend these appointments. This way we can ensure that patients receive the care that they deserve, and that the effects of diabetes on a patient's eyesight is kept to a minimum. One of the ways in which we are achieving these goals is through CQUINS. Our Bradford and Airedale programme is leading the way under Programme Manager Suzanne Beshara, who is targeting those who are most at risk: "We are working on our CQUIN – improving access and service provision for people with learning disabilities and mental health issues."

North of Tyne & Gateshead are also currently completing a CQUIN in an attempt to engage patients and drive uptake of appointments. This project runs alongside their impressive service of offering 100% of newly registered patients an appointment within 12 weeks.

"Excellent customer care skills from lovely people." Patient quote from **South West London**

We are also looking into when and why patients may not come to DESP sessions. In Central Mersey, Programme Manager Kimberly Gallienne notes that, "We have looked into a group of patients who have not responded to DESP invitations or attended a booked appointment. Our experienced graders have been contacting these patients to encourage attendance for diabetic eye screening, establishing the reasons for non-attendance and answer any queries the patient may have."

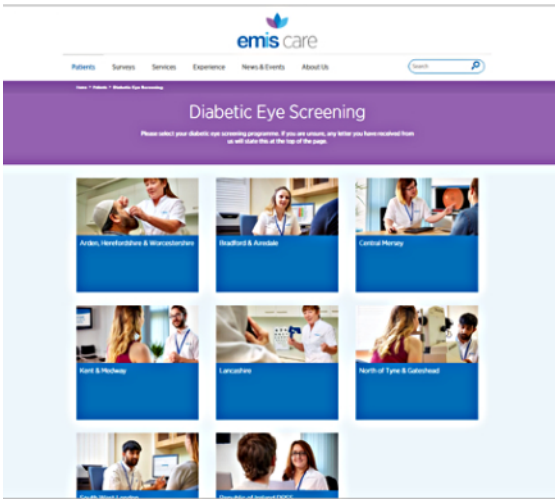
These projects run alongside mobile screening sessions and out of hours/ weekend appointments – like our work with local optometry stores in North of Tyne and Gateshead – to ensure that DNA rates are low and that as many patients as possible are reached.

Education

One way that we help our patients is to educate them about their condition and what they can do to best care for themselves. As a standard, all of our clinicians and screeners inform patients of ways to prevent diabetic retinopathy and deal with diabetes.

We are also working with Diabetes Essential in our Central Mersey programme in order to ensure that referrals are created and appointments are kept.

And it's not just patients that we are helping to inform. In Bradford & Airedale, we have begun trialling our apprenticeship scheme, where we are training administrators to become fully qualified.



The future

With the success of our projects across our current DESP areas, we are looking at how we can help even more patients in the future. This means setting our sites on our next DESP area: Lancashire. The process is set to begin in October 2016 and will end in April 2017, when we complete the service transition for the several areas that will form the programme.

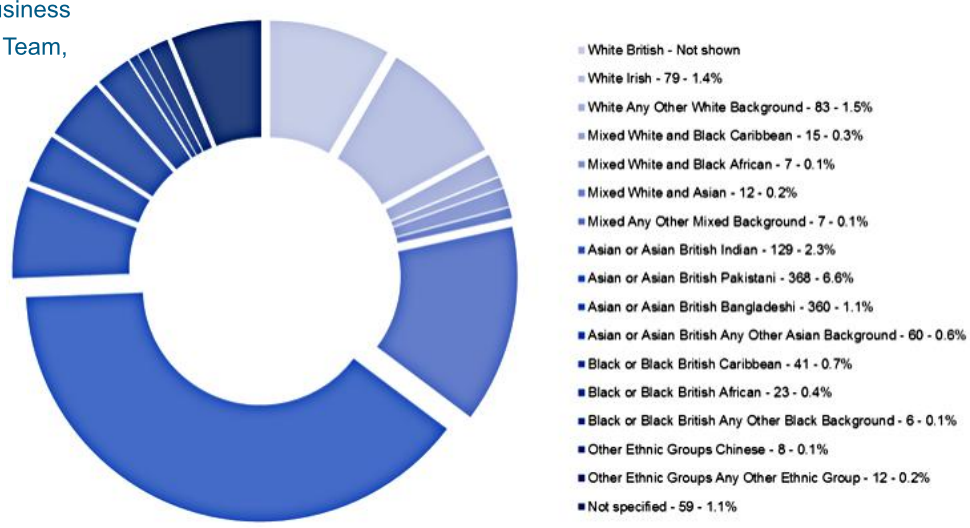
Once accomplished, we will be looking after over 78,000 patients in the area. With initiatives already in place - such as working with independent local optometrists and implementing community based screening services - we are looking forward to ensuring that even more patients with diabetes recieve the best care possible.

For more information about EMIS Care, visit *www.emiscare.com*
You can follow us on *twitter @emiscare* or like us on *facebook.com/emiscare*

"You said we did" campaign case study

Alexander Keep
Communications Manager & Marketing Business Partner, Contracts & Quality Management Team, EMIS Care

Our *"you said we did"* campaign gains important **feedback from patients** in order to support service improvements. We gather data through a variety of different ways, from recommendations by clinics and patients, to social media comments and feedback survey results. Through these different formats, we have been able to compile feedback from **6,000 responses**, helping us to create our aims for this year:



• Improving accessibility to make sure everyone can provide feedback

When reviewing data from our in-clinic 'Screening Survey,' we identified a lack of engagement from certain demographics. After further research, we discovered this was due to a translation/literacy issue.

We Did: We have ensured Google Translate available throughout the EMIS Care website and have purchased a translation module that integrates with our survey feedback software. We are also working with a translation firm to convert our surveys and feedback forms to suit our patients' needs.

• Helping patients know more about their data

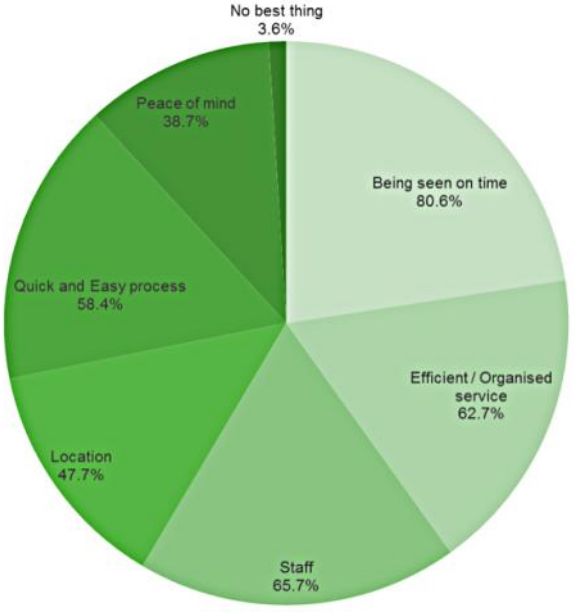
Patients have informed us that they want to know more about how their information is stored.

We Did: We have made the letters we send to new patients widely available from clinics and have shared the letters with local stakeholders. Patients can also visit a designated webpage which - since its deployment last month - has helped over 40 users. Patient letters now all include a footer message informing them of how to find out more information about their data, as well providing them with the new website link: ***www.emiscare.com/fair-processing-notice***.

• Improving peace of mind

In a multiple choice question, we asked patients: "What was the best thing about your visit?" 38.7% said peace of mind.

We did: To increase this statistic, we have started offering more support to patients outside of their appointments. On every dedicated DESP webpage, we offer live chat functionality through Facebook. This means that any patient at any time can speak to a clinically knowledgeable member of the team - 24/7. We have also started a pilot partnership with Diabetes Essentials - a diabetes education programme in our Central Mersey DESP. We want to empower patients - and by using this partnership as a template, we are looking to implement similar schemes with local services across all our sites in England.



• Helping patients to feel comfortable

We gathered feedback from one clinic where patients had highlighted that water facilities were not available.

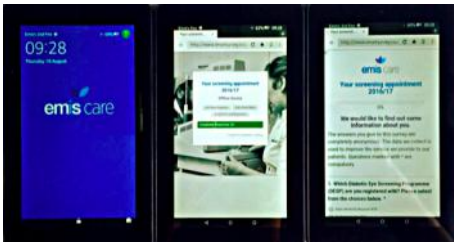
We did: In this particular clinic, we agreed a contract to install water coolers. After this initiative, we decided to implement further operational changes in all our programmes, ensuring that all patients have access to water in their waiting areas.

• Keep up the good work!

Over 99% of patients thought our service was excellent or good. In our surveys alone, we have received over 1200 compliments. The word "good" was used 487 times, "excellent" was used 297 times and "helpful" was used 139 times.

We did: We want patients to know we value their feedback. Their comments shape the service, which is why we launched this campaign.

To help collect their responses, we have also launched a feedback tablet pilot scheme in our Bradford & Airedale DESP. This allows us to gather feedback effectively, quickly and in a format that can be easily translated. Using just one tablet in a single month, the team gathered 539 responses. From those surveyed, 92.39% of patients were very happy with the service and 7.61% were happy with the service - that means 100% of patients were happy with their diabetic eye screening appointment. As a final note, 99.63% of those patients would recommend our service to a friend or family member with diabetes.



Characteristics and outcome of referable diabetic maculopathy

Dr Andrew Brown Clinical Lead
Staffordshire Diabetic Eye Screening Programme

Introduction

Diabetes causes 13.8% of blindness in the working population [1], with 11.9% being due to retinopathy, and is one of the leading causes of severe visual loss in the same population [2].

Sight threatening retinopathy will triple by 2050 when compared to 2000, with the amount of sight threatening disease quadrupling in the over 65s. This is partly due to longer survival rates due to more effective treatments and partly to increased prevalence and incidence of type 2 diabetes [3] .

A national programme screening for sight threatening diabetic retinopathy began in England in 2007, and was offered to all patients with diabetes twelve years of age and over, [4] with digital surveillance pathways being introduced in 2012 [5] to provide a pathway for monitoring stable patients with a referable grade in a community setting.

Since the burden of diabetic retinopathy on hospital eye services will rise significantly, the effectiveness of screening, referral and monitoring needs continual re-evaluation to ensure maximal efficiency. The purpose of this retrospective study is to review the characteristics of diabetic maculopathy referred to secondary care from an English Diabetic Eye Screening Programme in order to inform the use of the digital surveillance model to ease the growing burden on secondary care.

Method

Data was collected retrospectively for referrals made to a secondary care provider from October 2012 to April 2014. Those that have had previous eye clinic management were excluded. This period was selected because the national screening definition of maculopathy changed in September 2012, so referrals before October 2012 could potentially have different characteristics. Since the examination interval in national diabetic eye screening programme is at present twelve months, analysis of the outcome of patients with at least one year's follow–up was chosen.

The outcome of the first year's follow-up, the presence of pre-proliferative disease (R2 grade), whether the maculopathy was bilateral or unilateral and if unilateral, the degree of retinopathy in the fellow eye was obtained. The type of maculopathy was determined by re-examining the screening images obtaining the following categories:

- Maculopathy in association with R2 disease
- Maculopathy due to hard exudate within one disc diameter of the centre of the fovea
- Maculopathy due to the presence of a group of hard exudates in the macula region
- Vision of 6/12 or less with haemorrhage or micro-aneurysms within one disc diameter of the centre of the fovea

If two or more types of maculopathy were present in the same patient, the type closest to the top of this list was selected. Where available, patient's HbA_1C and serum cholesterol was recorded.

Outcomes were defined as:

- Discharged at first visit to screening
- Discharged at first visit to digital surveillance
- Discharged during the first year to screening
- Discharged in the first year to digital surveillance
- Monitored in the hospital eye service
- Treatment (laser or intra-vitreal therapy) in the first year

It was recorded if any of the patients progressed to proliferative disease allowing an analysis of the likelihood of such progression during the first year of referral.

Inferential analysis of this data using one-sample and two sample t-tests for parametric data, Whitney-Mann U tests for non paramateric data, together with Chi squared and Pearson Correlation analysis allows an examination of any relationship between medical risk factors, demographic factors and type of maculopathy, and outcomes.

Results

665 patients were referred to the diabetic retinopathy service between 1st October 2012 and 30th April 2014. 423 attended for the first time with a screening diagnosis of maculopathy without proliferative disease.

General Demographics

The gender profile of patients referred with maculopathy was:

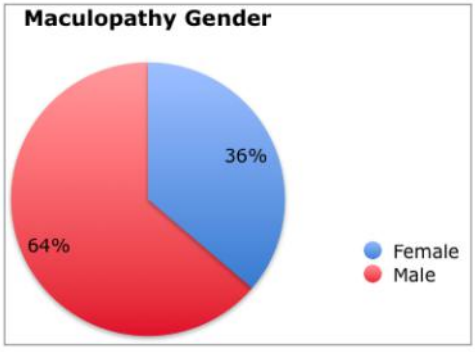


Figure 1. Maculopathy and Gender

The ethnicity profile ("whites", "other ethnic groups" and "unknown") was:

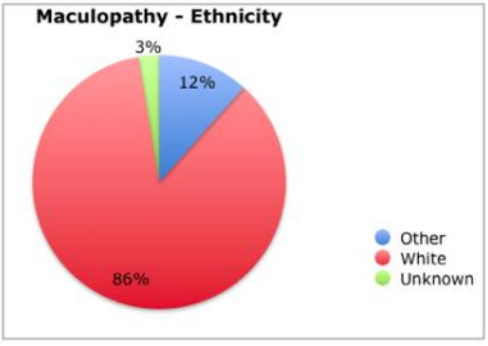


Figure 2. Maculopathy and Ethnicity

The average age for this group of patients was 60.10 years with a range of 19 to 93 years. **The age distribution was:**

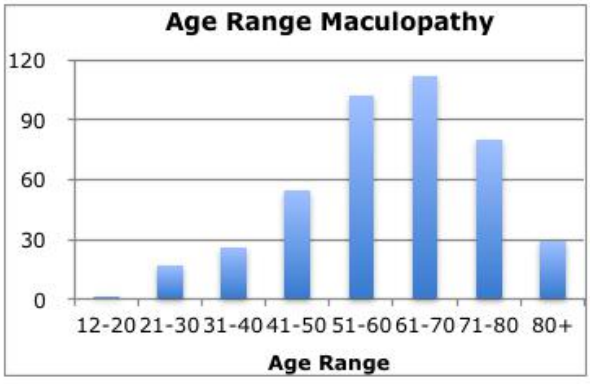


Figure 3. Maculopathy and Age range

The proportion of those with maculopathy alone compared with those with pre-proliferative disease was:

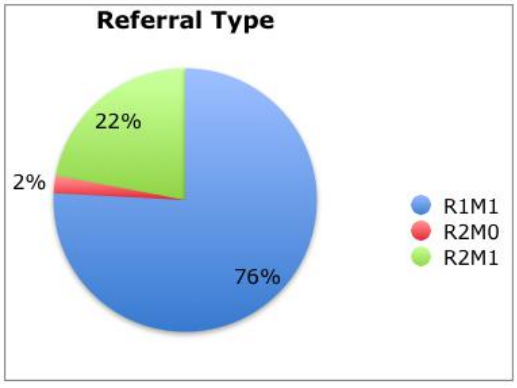
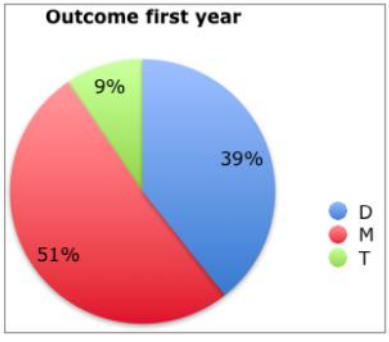


Figure 4. Referral Type

The majority of referrals have maculopathy alone, with 24% having pre-proliferative (R2) disease in either eye.

Referral Outcomes

The outcomes of the referrals were:



D = Discharged

M = Monitored

T = Treated

Figure 5. Outcome at one year

Of the patients discharged, the manner of discharge were:

D1 = Discharged to screening first visit

DS1 = Discharged to digital surveillance first visit

D = Discharged to screening after a period of monitoring in hospital clinic

DS = Discharged to digital surveillance after a period of monitoring in hospital clinic

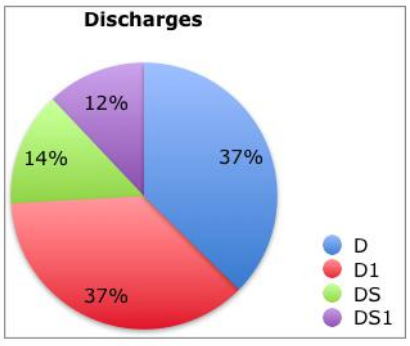


Figure 6. Discharge Modality

Patients discharged at first visit to screening may be regarded as a false positive referral. They were thought to have referable maculopathy at screening but this was not confirmed when further examination was performed and were discharged with a non-referable grade.

The positive predictive value (PPV) represents the proportion of subjects with a positive test who actually have the disease, and is a measure of a test's efficiency.

For the 422 patients referred with maculopathy (including pre-proliferative disease), 61 where discharged at first visit:

PPV=True Positive/(True positive + False Positive)=361/422=0.86=86%

If the patients with maculopathy alone are considered (a worst grade of R1M1) 59 patients out of 320 referred with this grade were discharged at first visit giving a PPV of:

PPV=True Positive/(True positive + False Positive) =261/320= 0.82=82%

This demonstrates a moderate PPV for the screening test for both groups of patients.

Co-existing pre-proliferative (R2) retinopathy

Of the 422 patients referred with maculopathy who attended their appointment, 102 (24.2%) had significant pre-proliferative disease (R2) in one or both eyes.

Of these, 15 (14.7%) were managed in the community compared with 151 (47.2%) of the patients without proliferative disease.

	R2 any Eye		Total
	No	Yes	
Hospital	151	15	166
Community	169	87	256
Total	320	102	422

Table 1. Maculopathy, R2 and management

Patients with significant pre-proliferative disease in either eye were significantly more likely to require hospital management than those without $X^2(1)=32.850$, $p<0.05$.

40 (9.5%) patients in this group required interventional treatment. 19 of these had significant pre-proliferative retinopathy (R2) whilst 21 did not.

	R2 any Eye		Total
	No	Yes	
Monitoring	299	83	382
Treatment	21	19	40
Total	320	102	422

Table 2. Maculopathy, R2 and treatment

Patients with significant pre-proliferative disease in either eye were significantly more likely to require interventional treatment than those without $X^2(1)=11.753$, $p<0.05$.

Of the 422 patients referred with maculopathy, 4 (0.9%) progressed to proliferative retinopathy. 3 of these patients had co-existing pre-proliferative disease at the time of referral.

	R3		Total
	No	Yes	
No R2	319	1	320
R2	99	3	102
Total	418	4	422

Table 3. Progression to R3

Patients with co-existent pre-proliferative disease were not statistically more likely to progress to proliferative disease $X^2(1)=3.237$ $p=0.072$, though a p value of 0.07 suggests a possible relationship, which could be investigated using a larger number of patients.

Bilateral Maculopathy

Of the 422 patients referred with maculopathy, 315 (75%) had maculopathy alone with no other significant retinopathy (i.e pre-proliferative retinopathy (R2) in either eye. 74 (23.5%) of these patients had bilateral disease (i.e. R1M1 grade in both eyes). In this group of patients 150 were discharged to community monitoring at some point, whilst 165 were managed in hospital (monitoring and/or treatment).

Considering whether bilateralism had an association with mode of management:

	Bilateral		Total
	No	Yes	
Hospital	108	57	165
Community	133	17	150
Total	241	74	315

Table 4. Bilateral Disease and management

Patients with bilateral disease were significantly more likely to require hospital based management $X^2(1)=22.280$, $p<0.05$.

Considering whether patients with bilateral disease were more likely to require treatment:

	Bilateral		Total
	No	Yes	
Treatment	12	9	21
Monitoring	229	65	294
Total	241	74	315

Table 5. Bilateral Disease and treatment

Patients with bilateral disease were not significantly more likely to require treatment than those with unilateral disease $X^2(1) =3.611$ $p=0.057$. A p value of 0.057 suggests a possible association that requires further investigation.

Diabetic Control

The average HbA_1C of the patients who attended with maculopathy was 70.80 mmol/mol.

The distribution of HbA_1C was:

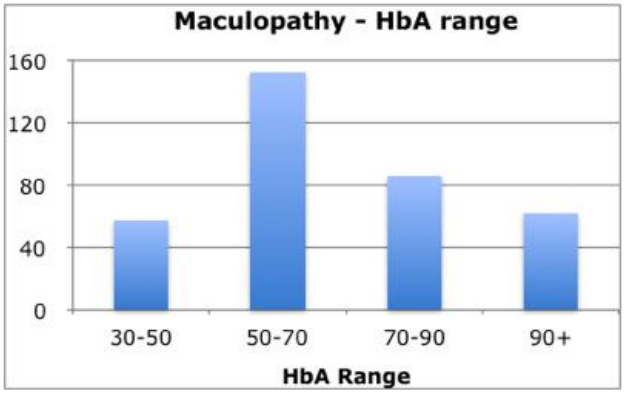


Figure 7. Maculopathy and HbA_1C

The proportion of patients at or below the HbA_1C of target (locally set) value of 53 mmol/mol was:

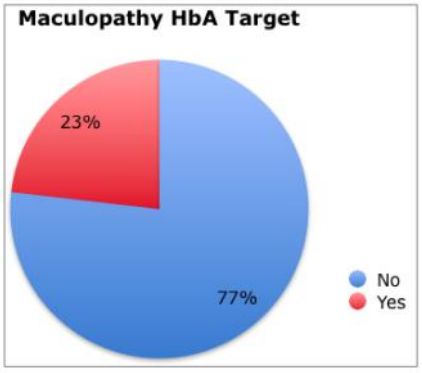


Figure 8. Maculopathy and Target HbA_1C

A one-sample t test shows the average HbA_1C level of the patients referred with diabetic maculopathy is significantly different to the national and local target for HbA_1C $t(537)=21.727$, $p<0.005$. The average serum cholesterol in patients with R2 was 4.00 mmol/L compared with 4.15 mmol/L in those without. A Whitney-Mann U test (the data is not normally distributed) shows there was no significant difference in serum cholesterol levels in patients with referable maculopathy between those with and those without pre-proliferative disease (R2) $U=8804.00$, $z=0.899$, $p=0.369$. The mean HbA_1C was 68.35 mmol/mol in the unilateral group and 69.82 mmol/mol in those with bilateral disease. A two sample test showed there was no significant difference between the HbA_1C levels between patients with unilateral and bilateral disease: $t(264)=-0.748$, $p=0.455$.

Serum cholesterol measurements were available in 236 patients in this group and the average value is 4.16 mmol/L . Those with bilateral disease had average cholesterol levels of 4.269 mmol/L, compared with 4.125 mmol/L in those with unilateral disease. A Whitney-Mann U test showed there was no significant difference in serum cholesterol levels between patients with bilateral and unilateral disease $U=4882.50$, $z=-0.072$, $p=0.943$.

Discussion

Patients with maculopathy tend to have poor control with higher HbA_1C levels than target. Patients with co-existing pre-proliferative (R2) disease tended to have worse control still, although those with maculopathy without R2 tended to have similar control regardless of whether the disease was unilateral or bilateral. Sub-optimal cholesterol levels did not seem to be an issue within this cohort of patient, and was not associated with the presence or absence of pre-proliferative disease. Some of these patients may be monitored in a community setting in the digital surveillance module, especially by programme deploying OCT scanning. It would appear that these patients do require further medical intervention, so enhanced pathways for GP referral to facilitate this should be considered.

Only a small number (10%) of patients referred required interventional treatment in the first year and a large number of patients were discharged without treatment (39%), with 49% of those discharged being discharged at first visit. When considering the requirement for hospital management the positive predictive value for maculopathy is between 86% and 82%, depending upon whether maculopathy and R2 or maculopathy alone is considered. A significant number of patients presently monitored in hospital could potentially therefore be monitored in a community setting, with greater use if the digital surveillance module, possibly with the use of OCT.

Patients with co-existing proliferative disease in either eye are significantly more likely to require interventional treatment, have poorer control (they have significantly higher HbA_1C) and were almost significantly more likely to progress to proliferative disease. If this type of patient is to be monitored in a community setting then more frequent review intervals might be advisable. Alternatively, the development of R2 disease in a patient being monitored in the community with maculopathy could prompt consideration of onward referral to secondary care.

23.5% of the patients with maculopathy alone had bilateral maculopathy. Although this type of patient was more likely to be monitored in hospital clinics the need for treatment was no more likely when compared with the group as a whole. It would appear that there is therefore potential for safely monitoring patients with bilateral maculopathy in the absence of pre-proliferative disease (R2) in a digital surveillance setting.

It is hoped that these findings stimulate further discussion and consideration of the most cost effective way of managing patients with referable diabetic retinopathy detected at eye screening.

References

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Screeners in Diabetic Eye Careers

Over the next several issues, we hope to bring to you a range of interviews of people who have developed a career in the Diabetic Eye Screening Programme. What challenges have they faced? What do they enjoy about their work? How did they start off and where are they now? What inspires them to share their story and continue in this field of work?

We start this segment presenting an interview with Rahila Bashir, who is a Senior Grader based at the Reading Centre at Moorfields Eye Hospital, City Road in London. She is also a research advisory panel member (RAP) for the National Institute for Health Research - Collaboration for Leadership in Applied Health Research and Care (NIHR CLAHRC) North Thames.

Q: What made you choose to go into an eye screening career Rahila?

A: I was a 27 year old KS1 primary school teacher and decided to move from the education sector into eye medicine which had become a developing interest of mine in the medical sector. But a lot of the jobs had entry requirements of high standard experience. Then, I came across a job advertisement for a medical administrator in a private ophthalmic company which was giving unexperienced applicants an opportunity for work with full training provisions and so it was a perfect opportunity at the right time for me. After nine months, I was promoted to a screener/grader and with continuing support was given full training and began to seek further opportunities.

Q: How different is it to other jobs you have done?

A: Very different. As a KS1 teacher, I also had other responsibilities and roles such as primary curriculum advisor, parental consultant, acting deputy head, child protection officer and course co-ordinator. But with screening and grading, I found it fairly repetitive yet each day is a new day. You see new patients, a new set of fundus image sets, amazing pathology, histology, lesions in the anterior and posterior segments and learn about many retinal eye diseases. There is so much to see and learn. As an independent eye screening clincian and retinal image grader for almost 8 full years, I would see up to 42 patients a day at satellite clinics. Taking pre-history details, measuring visual acuties, instilling drops, screening patients, assessing and triaging their retina status, managing an entire waiting area all by myself, it was all great!

Q: Can you tell us about some of your acheivements so far?

A: I was awarded with the Peter Hansell Scholarship in 2015. I received a nomination medal by NELFT for patient care in the excellence award category. I was also nominated for Diabetes UK inspire awards. I have been awarded by the local clinical commisioning chairman for receiving high volumes of patient compliments in clinical eye healthcare.

Q: Does your work allow you to explore other channels of interest?

A: Yes I believe it does. I know from personal experience that I have been able to look for other avenues and been successful due to my work in the eye screening profession. For example, I was the first guest speaker at the local Diabetes UK event. I am also a foundation trust member for Great Ormond Street Hospital for Children. I've worked with Alzheimer UK and Dementia UK charity events and have also completed training courses in Slit Lamp Bio Microscopy to help charities who run eye camps in countries affected by natural disaster and in third world countries. Designing leaflets on eye care and producing posters for global education exhibitions has also been an interest through work.

Q: You said you were a teacher before, any skills you carried over?

A: I think it would be my writing skills. In 2007, I was appointed as the UK Education Ambassador for a reading firm in Calgary, Canada. My primary education articles were later published in the middle east and as far as Hong Kong. Immediately in my new job, I began to write articles for the company and pharmaceutical newsletters. Very soon these were recognised by other journals who offered to print them and since 2011, I've been an official writer for various eye journals or magazines. I'm passionate about learning and sharing knowledge with others.

Q: You have mentioned a lot of positive acheivements, any failing moments?

A: Oh yes! And I find these are a learning curve. Everyday is a new day. You pick yourself up and move forward to better things. I've applied for jobs where I've not met the candidate criteria or I've not got the job because I don't have a photography degree. I remember when I applied for a particular scholarship. My application was unsuccessful one year but the following year I tried again and got it! It can be nerve racking for junior staff if EQA scores are low or City and Guild modules are failed. That is why due to my high score levels in both, I joined the grading college and also became a City and Guilds assessor to help others.

Q: Do you think screening allows opportunities for career progression?

A: I certainly think it does. I have seen many people come into the eye screening profession who are now certified clinical photographers, operation managers, failsafe officers, working for Glaucoma services or RNIB or even as business managers in large organisations which support diabetic eye screening programmes. There are plenty of opportunities for everyone and you just have to keep working hard and you'll achieve your dreams.

Q: Tell us a bit more about what motivates you to get up and come into work every morning?

A: I thoroughly enjoy my work. I am based in a department of exceptionally kind, friendly and highly qualified team members and it's a good feeling coming into work where you feel safe, appreciated, have a laugh and work together because you enjoy what you do and are achieving targets and aims which help patient's stay safe from losing their vision. Its very rewarding and like I said before, each day is a new day and it brings new ideas and contributions.

Q: You said your work was fairly repetitive so how important is continuity of education in your job role?

A: Very important. Job tasks being repetitive helps you improve yourself and become capable of passing on skills to others. I have noticed when training junior staff how relevant it is to educate yourself all the time. That is why I joined IMI, RPS, RCOP, RSM, BUOS, OIA & BARS just to name afew. After completing the City and Guilds Diploma in Retinopathy Screening, I then looked for an appealing prospectus and went to Warwick Medical School to complete the Msc in Health Science – Retinal Screening core module, Diabetic Retinopathy. I later returned to complete a new Master level paper at Medical School titled Public Health Screening. Furthermore, I also studied a course paper on Eye anatomy Dissection at the university of Sussex Medical School. Attending regular training and conferences has always been important to me. You educate yourself, your patients and share learning with your colleagues and this, I believe, is a valuable ongoing process towards being a better healthcare professional.

Q: Where do you see yourself in 5 years from now?

A: I am a family person but I also enjoy what I do so much that I think I'll still have close links to Diabetic Eye Screening Services. Even today feels like the first day! The same excitement and joy of achieving pinnacles of success. The same interest and commitment in learning about the retina and disease activites. The same dedication and concentration of meeting targets and deadlines. I think it's an amazing profession and I hope to continue growing my interest in ophthalmology. Many moments of small, positive interactions build an extroadinary career. Often people think that you have to fight your way to the top but I've seen positive working relationships in the workplace mount to great moments in the work environment. In the new year I'll commence my 10th year in diabetic eye screening services. The past eight to nine years were a mixture of clinics and grading and now I solely grade at different levels which is a huge task, but one which I continue to enjoy very much everyday. When you see patients go through the pathway and return to routine digital screening, you've been a part of that journey in helping save their eyesight. It's a rewarding feeling.

If you have a story to share, we would love to hear from you!

Please email us on *info@diabeticeyejournal.org* or directly to *readingcentre@moorfields.nhs.uk* where this interview took place.

Case Study of type 2 Diabetes Patient

by **Rahila Bashir** Senior Grader at Reading Centre MEH London

In November 2008, a 46 year old gentleman attended for a routine digital screening (RDS) (**figure 1**). His visual acuity was 6/6 for the right eye and only perception of light (PL) in the left eye. His left eye sudden vision loss was caused by an occular occlusion in August 2008. He had been seen once and was awaiting a second appointment at the hospital eye service (HES), but at some point was flagged as DNA and so was discharged from hospital in April 2011.

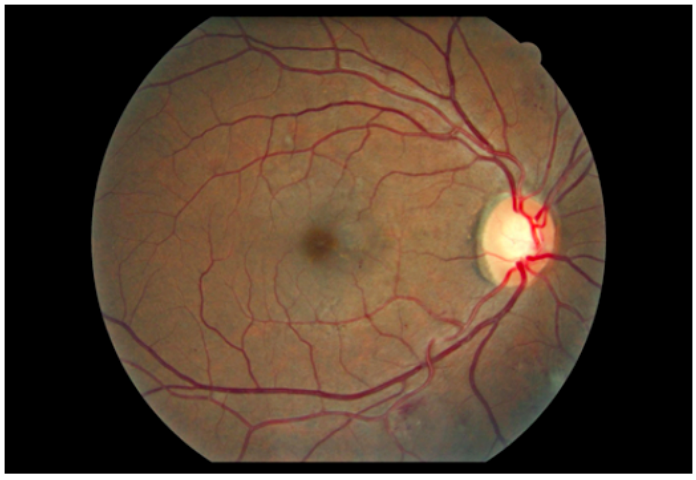


Figure 1a. Right eye macula view

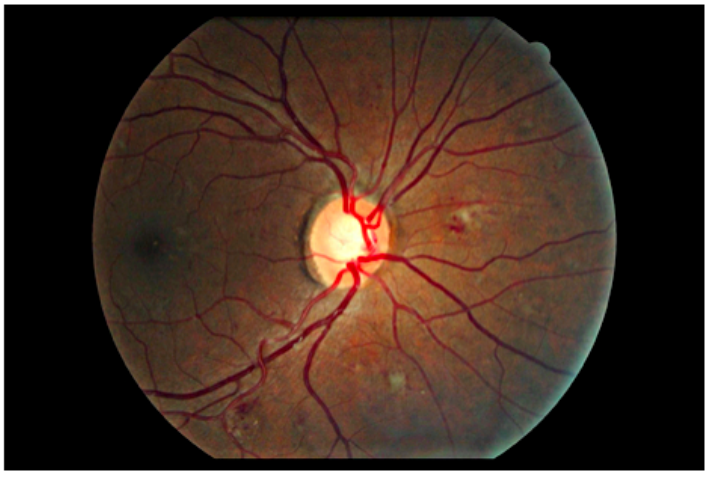


Figure 1b. Right eye nasal view

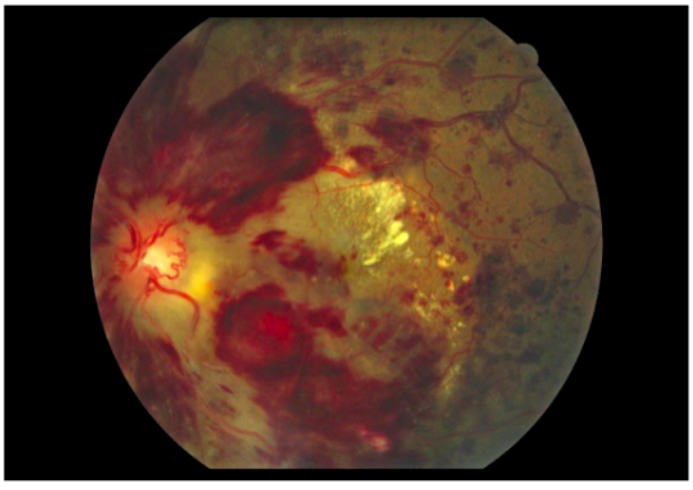


Figure 1c. Left eye macula view

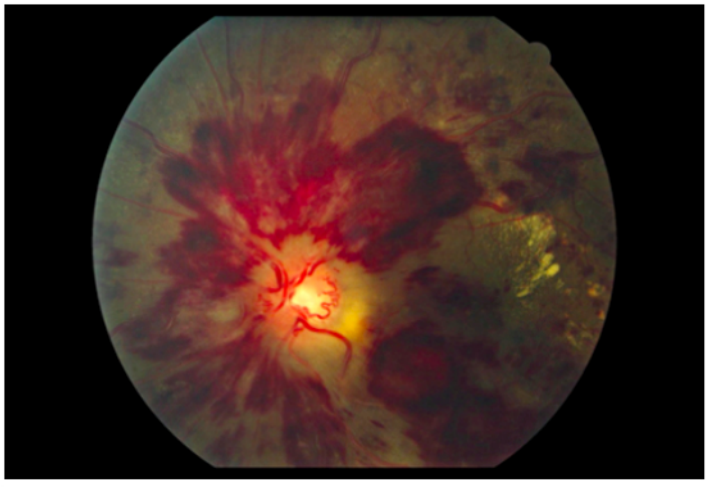


Figure 1d. Left eye nasal view

The patient returned for a routine digital screening in November 2011 (**figure 2**). His visual acuity was 6/5 in the right eye and 6/24 in the left eye. His in care of ophthalmology (ICO) notes stated that he had been treated at his local hospital with a course of six injections at intervals to the left eye and had been reinstated after his initial DNA, so was re-attending for reviews once every 6 months. In January 2013, he was finally discharged from the HES back to RDS as he had completed the course of treatment and all the required follow-ups to monitor and review his eyes.

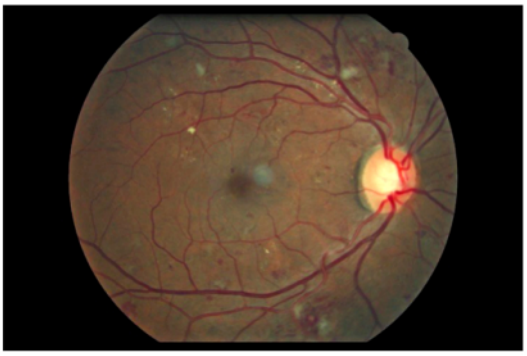


Figure 2a.
Right eye macula view

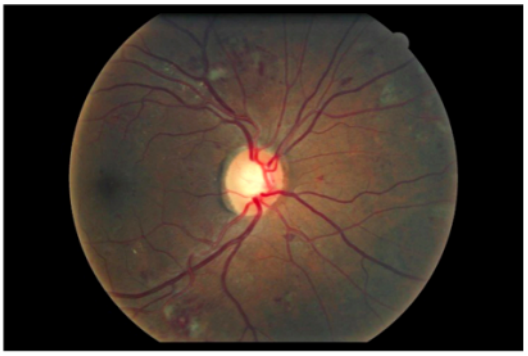


Figure 2b.
Right eye nasal view

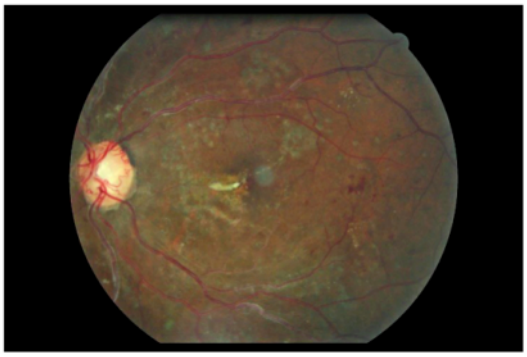


Figure 2c.
Left eye macula view

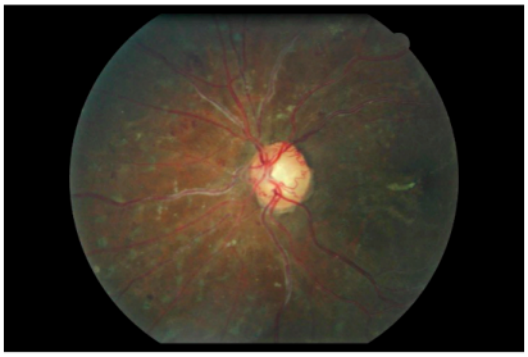
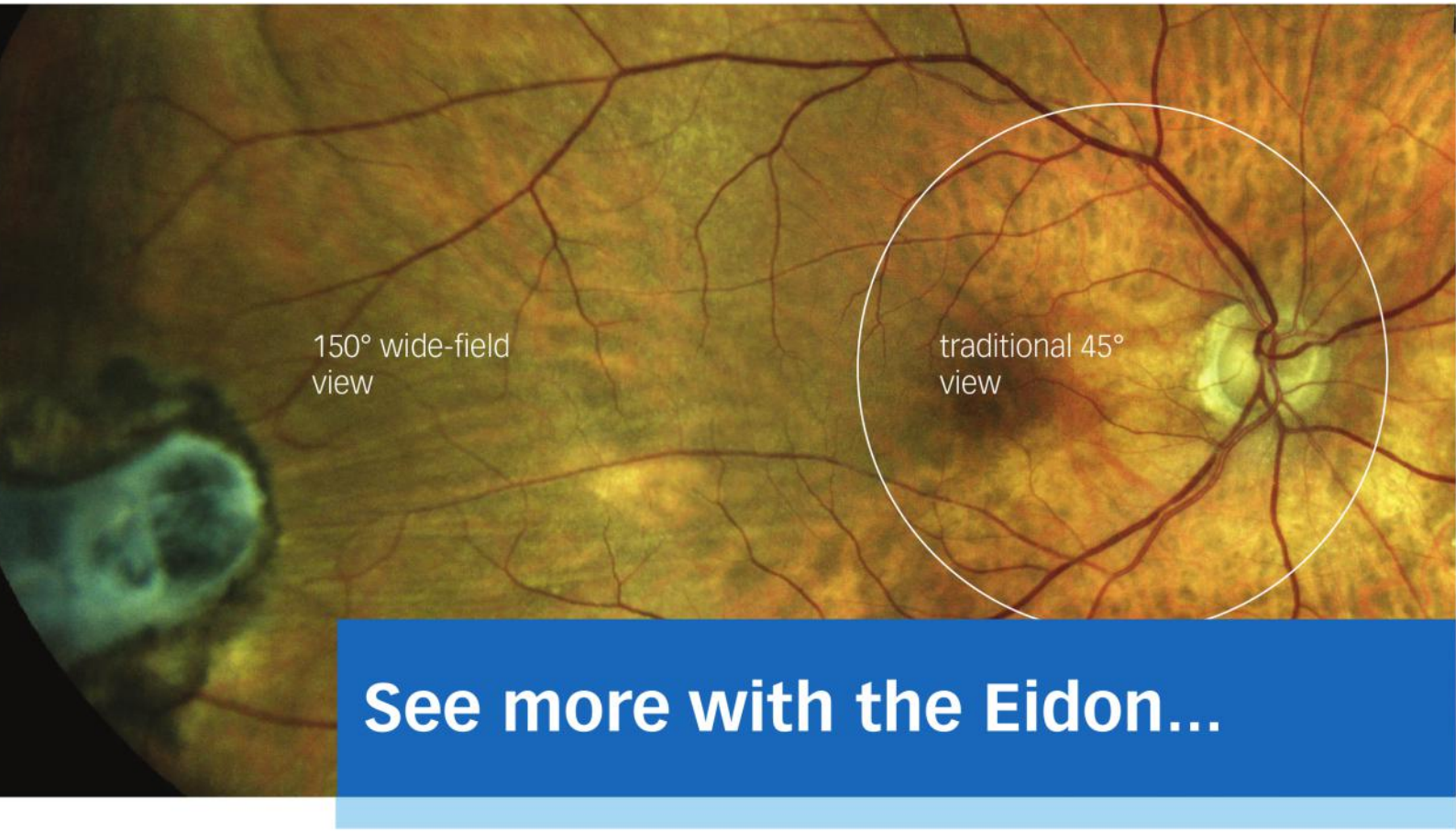


Figure 2d.
Left eye nasal view



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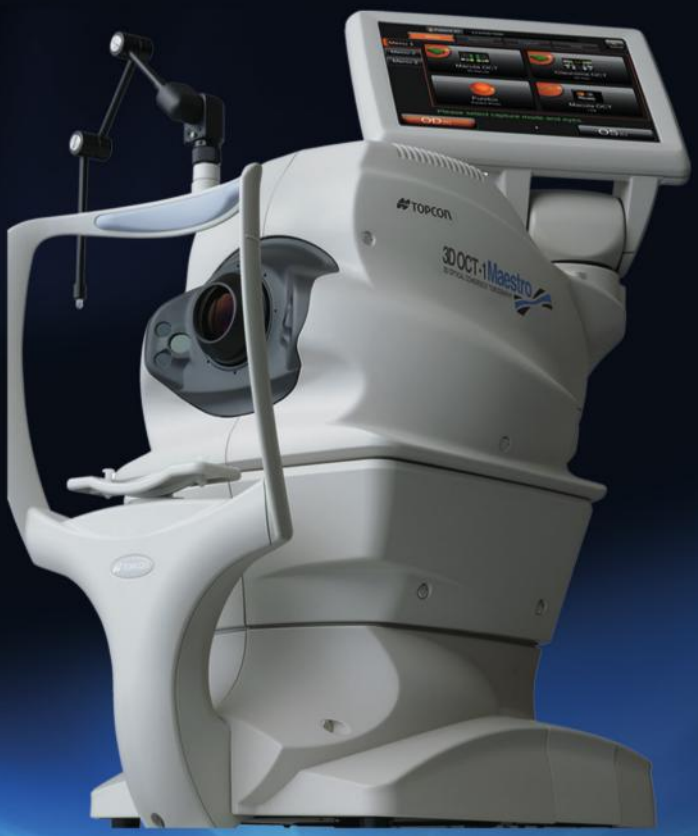

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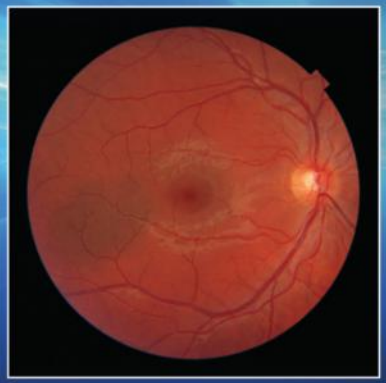

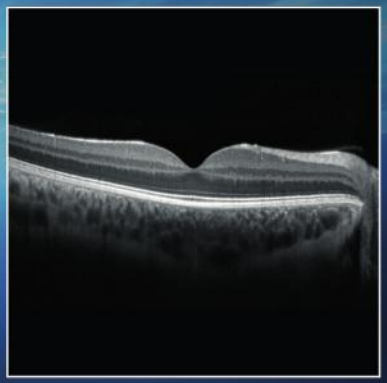

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