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# NHS Diabetic Eye Screening Programme Update

## Screening intervals update

NHS England and PHE are currently discussing the possibilities regarding the implementation of **extended screening intervals** for low risk groups of patients with diabetes as recommended by the United Kingdom National Screening Committee.

Progress of the implementation is intrinsically linked to the development of a single national IT solution. Procurement of the IT solution is being led by PHE, with expectations that once procured NHS England will fund the revenue costs and PHE will fund the capital costs.

We cannot currently set a timeline for implementation of extended intervals until the funding for a single national IT solution has been agreed, this is ongoing. Preliminary plans suggest implementation is unlikely to happen during 2018 and will be through a phased rollout approach. Local providers are advised to continue business as usual until further notice.

PHE screening has been undertaking a scoping exercise and options appraisal to determine which option for a single IT software solution is best placed to support the implementation of screening intervals. This will form the basis of a joint PHE/NHSE business case.

In addition, to support the quality improvement work for NDESP, a PHE screening intervals implementation group and NHS England DES partnership board involving key stakeholders are progressing through a number of work streams to take this project forward.

These include:

- Grading – to seek assurance of consistent high quality grading in screening providers before implementation
- Communication – to ensure public and professionals have the information they need to understand the major changes involved
- Patient behaviour – to understand what influences patients to keep them engaged with the programme
- Operational challenges of rolling out extended intervals – including education and training for local providers
- Commissioning and implementation – to ensure the development of implementation plans across PHE Screening and NHS England DESP

Updates regarding the progress of the screening intervals project and the single national IT software solution will be published on the PHE screening blog, you can sign up for this using the link below:

<https://phescreening.blog.gov.uk/>

## Performance reports demonstrate programme grading quality to commissioners

NDESP commission Gloucester Hospitals NHS Trust to provide the TAT system for all national graders to take a monthly online test. Local DES programmes use the test results to monitor their graders' performance. They do this by generating programme reports and grader specific reports. Senior designated staff interrogate these reports and use the system to review TAT agreement and disagreements. Individual graders also use the system to look back at their own performance for self-reflective practice and CPD. We are continually thinking of ways to improve the system and make sure that it is user-friendly and reliable. Recently we cleaned up the system and removed some unused reports to optimise the loading of the most frequently used reports. This has made a difference to the how quickly reports are generated and loaded. We have had good feedback about this.

Programmes are now regularly downloading the grading management reports which uses a flagging system to monitor graders sensitivity and specificity to sight threatening disease. The screening quality assurance service (SQAS) is receiving these reports quarterly and asking programmes to report on any amber or red flags. It is important for managers to keep their programme TAT registrations up to date to make sure that graders who have left the service are not reported on. In most cases, programmes are presenting these reports to their commissioners at their programme board meetings. This has given programmes a method of reporting grading quality to commissioners.

## Download the new report for your CPD!



There is a new quarterly report available for individual graders and senior staff. This report is an overview of grading agreements, and sensitivity and specificity to STDR over a period of 12 months. This can be downloaded and saved to staff CPD portfolios. Staff starting work with a new programme will be able to evidence their grading quality with these individual reports.

These reports can be generated from the TAT home page by clicking on quarterly individual performance report > select date range > select grader > generate report.

Your feedback on the TAT system is important to us. Please contact Netsima [helpdesk@netsima.co.uk](mailto:helpdesk@netsima.co.uk) if you experience any technical problems. Any other queries should be emailed to the screening helpdesk [phe.screeninghelpdesk@nhs.net](mailto:phe.screeninghelpdesk@nhs.net).



# bars Education Update

One of the aims of the British Association of Retinal Screening is to play an active role in the education and development of screening staff, and earlier this year we announced our intention to explore the possibility of developing a new national qualification to complement the screening diplomas that already exist.

In March 2017, BARS conducted an Education Survey in order to help inform this project, and in the space of just three weeks, more than 280 people completed our online questionnaire. Both the level of response and the answers given confirmed what many of us had suspected: that there is undoubtedly an appetite for a new qualification and a desire amongst screening staff for increased learning, career progression and expansion of their current roles, but that many are frustrated by the lack of opportunities and unsure to what extent a new qualification can change that. More than half of those 280 respondents have been working in diabetic eye screening for more than 6 years, and there is clearly concern that a 'glass ceiling' exists in our profession.



Phil Gardner

BARS Council has formed an Education Sub-Committee to focus on this project, and we are fortunate to be able to draw on a wealth of experience in the field of eye screening training and education. We are under no illusions: the scope for career progression in the field of retinal screening has always been limited and BARS cannot easily change that. We believe, however, that whilst no qualification can offer a guarantee of career progression, BARS may potentially 'add value' to an individual, increasing their knowledge and skills, allowing them to demonstrate their desire for self-improvement, and ultimately, we hope, opening doors to new opportunities. **We intend to approach this from a number of angles.**

**Firstly**, in order to provide a solid foundation for all our future work on education, we are looking to develop a common competency framework for retinal screeners and graders. The Royal College of Ophthalmologists, in conjunction with other stakeholder groups, has produced such a document for ophthalmic HCPs, and representatives of BARS Council will shortly be meeting with Mike Burdon, the President of RCOphth, to discuss our ideas for the development of a similar framework for screener/graders.

**Secondly**, we plan to develop the BARS website to offer a range of online learning and development resources. One aspect of this will be to provide an e-portfolio which can be used by members to record evidence of their continual professional development (CPD). We hope this will prove useful to all members, regardless of whether or not they undertake any further qualification.

**In tandem with this**, we intend to provide access to online learning materials such as journal articles, interactive presentations, courses and quizzes. Our intention is that members will be able to earn BARS CPD points for completing these activities, and this will be documented in their e-portfolio. Our ultimate vision is for BARS to award certifications in a variety of topic areas and at different levels, and that members will achieve these by accumulating a set number of points in a given area within a stated period of time. There will be a certain amount of freedom for members to choose which activities they complete in order to earn the required number of points, as well as freedom to choose which certifications they undertake.

Andrew Brown



Tunde Peto

Karen Whitehouse

Grant Duncan

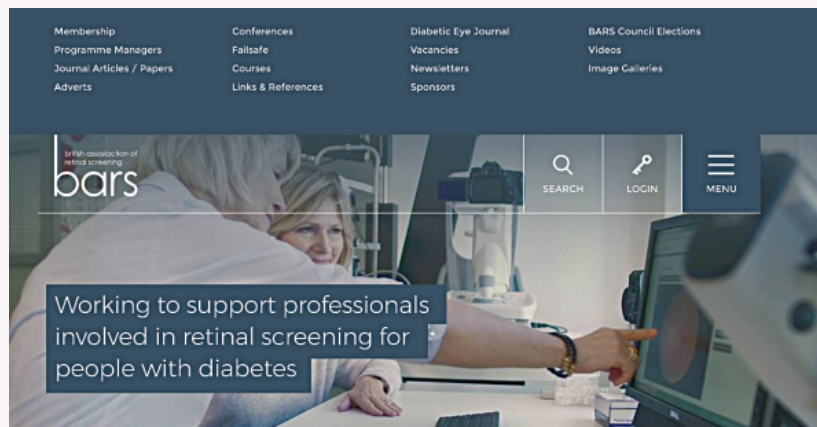
Whilst learning will primarily be done online for practical reasons, we have every intention of incorporating study days and workshops where possible, and the Slit Lamp sessions at this year's conference have demonstrated the demand for such resources. By allowing members to focus only on those areas which interest them, or which they feel will prove useful, and providing the freedom to take on as much or as little as they wish, we hope that all BARS members will be able to benefit from this. Turning our vision into a reality will undoubtedly take time, and is therefore likely to be delivered in stages. BARS Council is made up of volunteers who give up their spare time to work on projects such as this, but whilst we can't guarantee an exact timescale, we can promise that every effort will be made to deliver something worthwhile and beneficial to all.

BARS members will receive regular updates on the progress of this, and other projects, so if you have not yet joined the association, you can do so for free by visiting the BARS website at [www.eyescreening.org.uk](http://www.eyescreening.org.uk).

# 'A New Look and New Opportunities'

Since its inception back in 2001, the mission statement of BARS has been *“Working to support professionals involved in retinal screening for people with diabetes”*, and anyone who has visited the association’s website at [www.eyescreening.org.uk](http://www.eyescreening.org.uk) will have seen that strapline featured prominently at the top of every page.

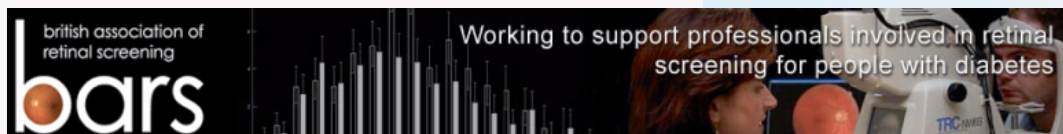
The BARS website is 15 years old this year and, like many of us, is beginning to show its age and in urgent need of a facelift. At the end of last year, the decision was made to redesign the site to give it a fresher, more modern feel, and we were keen to involve our members in this process if possible. Since introducing an Artistic category to our annual Photography Competition in 2014, we have been consistently amazed by the depth of talent and level of skill that exists amongst BARS members in the area of graphic design, so with that in mind, we launched a competition inviting members to submit a new design for our website. At the time, we didn’t know what – if anything – we might receive, and if we’d end up with the graphical equivalent of Boaty McBoatface, but as it transpired we needn’t have worried. At our quarterly meeting in March, Richard Bell, the BARS Webmaster presented the competition entries to the rest of council, and I think I can speak for us all when I say that we were blown away by the standard of the submissions. It proved difficult to choose between them, so much so that we decided to use elements of two members’ designs.



The overall competition winner was Vicki Prior, a Senior ROG Grader with Health Intelligence, but the new BARS website will also feature aspects of the design submitted by Barbra Hamill, an Image Grader with the Northern Ireland DESP. As I write this, work is underway behind the scenes to make Vicki and Barbra’s designs a reality, with the aim of launching the new-look BARS website at this year’s conference on 21st September.

The dated look of the website might be going, but one thing which will remain is that mission statement, which is as true today as when the original BARS website was launched in 2002. One way that BARS Council is working to support screening professionals is in the area of education – further details of which can be found on the page opposite – but in addition to long term projects, we’ve launched various

initiatives in 2017 aimed at offering new opportunities to those working in diabetic eye screening.



This year’s conference features a number of firsts. In addition to the launch of the new website, we are holding Slit Lamp Workshops for the first time, allowing small groups to experience an SLB taster session led by the BARS President, Professor Tunde Peto, alongside experienced slit lamp examiners from BARS Council. The response to these sessions has been overwhelming, with places filling up within days, and we will undoubtedly be holding further sessions in the future. This year’s Poster Competition also marks a first, offering the winner an opportunity to present their work at the 2018 EASDec Meeting and have it considered for publication in the European Journal of Ophthalmology.

Another worthwhile initiative has been the introduction of the BARS Bursaries. This year, for the first time, BARS is providing two fully-funded places at conference for individuals who would not otherwise have the chance to attend. This opportunity was specifically targeted at those DESPs which have sent the fewest delegates to conference in the past five years, and the managers of those programmes were invited to nominate members of their team who they felt would benefit from attending the BARS Conference and deserved an opportunity to do so. The response we received was enthusiastic, highlighting not only the dedication of screening staff and the amazing work they do, but also the difficulty many managers face when it comes to securing funding for their team to attend conferences. Selecting just two individuals from amongst those nominated proved an almost impossible job, and has demonstrated the need for BARS to continue with initiatives like this wherever possible. This year’s recipients of the BARS Bursaries are Janine Kerr of the Sunderland & South Tyneside DESP and Valeriya Simonova from the Berkshire DESP, and both will be writing about their experience in the next issue of the Diabetic Eye Journal.

As I near the end of my first year as Chairman, I would like to offer my thanks to all of those on BARS Council for their hard work in bringing these projects to fruition, and to BARS members for responding so enthusiastically to our endeavours.

**Phil Gardner**, BARS Chairman

## Retinoschisis and the Diabetic Retinopathy Viewpoint



**Paul Sullivan**  
Consultant Vitreoretinal Surgeon

Moorfields Eye Hospital NHS Foundation Trust

**Evgenia Anikina**

Fellow in Vitreoretinal Surgery

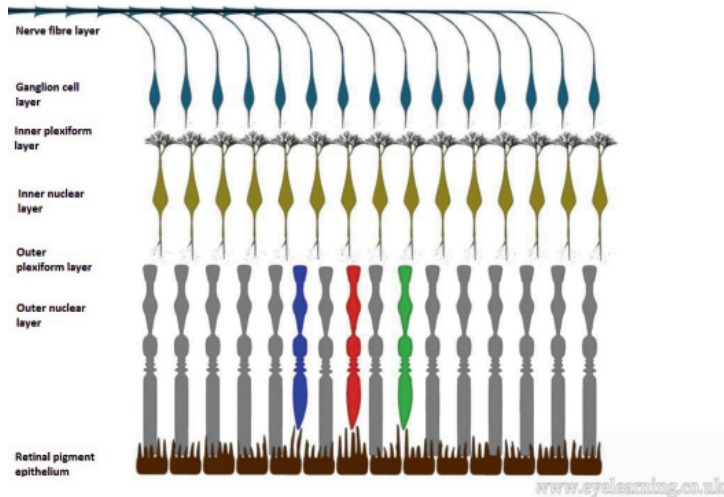


### Introduction

Retinoschisis is a common retinal finding in the general population, which can both pre-date and co-exist with diabetic retinopathy. We review the current knowledge of this condition, its presenting features and the clinical findings which help to identify it among a plethora of other retinal signs in diabetic patients.

### Pathophysiology and Natural History

The human retina is composed of many layers (**Figure 1**). A condition where splitting of the retinal layers occurs, usually at a single interface, is termed retinoschisis. The two layers that result are called the inner and outer leaves of the retinoschisis, adjacent to the vitreous face and the retinal pigment epithelium (RPE) respectively. The cavity between these layers is filled with a thick fluid composed mainly of hyaluronic acid.



**Figure 1:** Retinal layers in human eye.

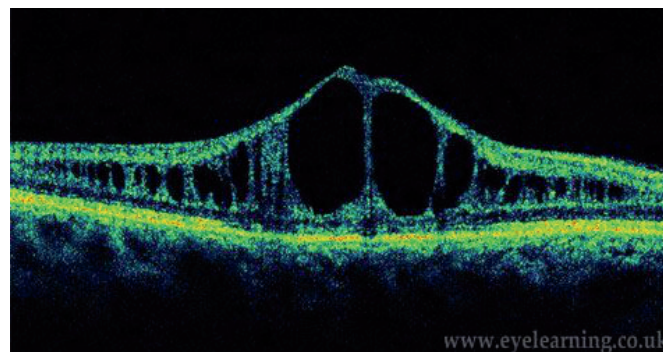
If Optical Coherence Tomography (OCT) is performed on an schitic area of retina, retinal tissue is always seen to be present adjacent to the RPE and constitutes the outer leaf. A layer of retinal tissue lies some distance away (the inner leaf) and the intervening space can sometimes be seen to contain columnar connections between the leaves. These cellular connections are formed by Muller cells; whose axons span most of the retinal thickness.

The anatomical level of the split varies; however, it usually falls in either one of two retinal regions. This gives rise to the classification of retinoschisis according to the level of the split. In degenerative retinoschisis (the more common variety) the split is at the level of the outer plexiform layer. In reticular retinoschisis it is just deep to the nerve fibre layer. This distinction does not affect the patient's symptoms or clinical management.

The aetiology of acquired retinoschisis is unknown. It typically occurs adjacent to areas of microcystoid degeneration in the peripheral retina and is presumed to arise from coalescence of the cysts with loss of the intervening Muller cell columns<sup>1</sup>. (**Figure 2**)

**Figure 2:**

Microcystoid degeneration in the peripheral retina shown on OCT scan.



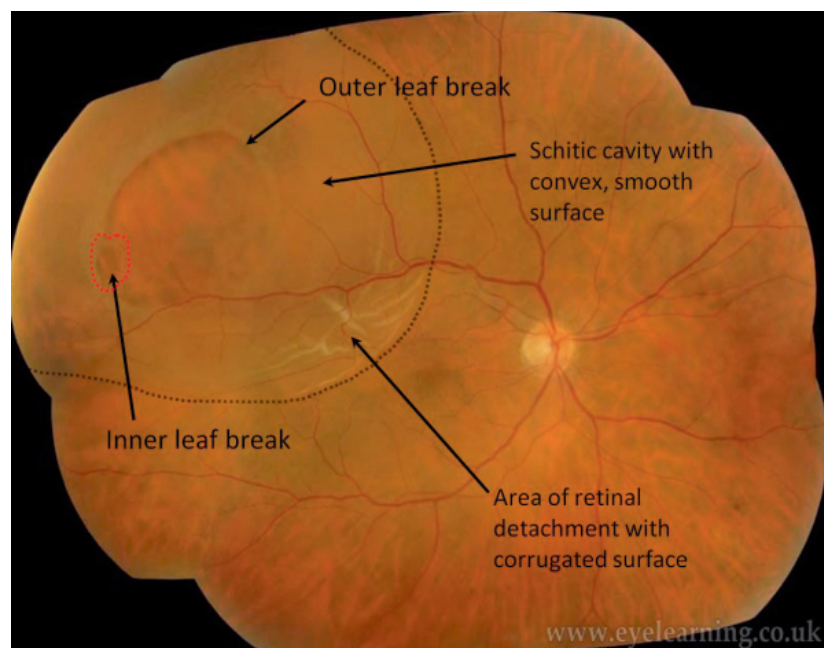


Acquired retinoschisis is very common. In the Copenhagen Eye Study<sup>2</sup>, the prevalence was 3.9% in the screened population. It is typically bilateral, affecting the infratemporal retinal quadrants, although it can also present unilaterally or in other areas of the retina. A rarer form of congenital retinoschisis (X-linked retinoschisis, XLRS) is a consequence of a mutation in the RS1 gene which encodes the protein retinoschisin. Here, the schisis can be more extensive and can be seen to progress to rhegmatogenous retinal detachment with greater frequency<sup>3</sup>.

Retinoschisis in XLRS is usually of the reticular sub-type. Retinoschisis may also occur secondary to other disease processes. Examples include optic disc pit maculopathy, myopic foveoschisis and tractional schisis in cicatricial diabetic retinopathy.

Retinoschisis only rarely leads to visual problems. Most cases have a chronic course, with little change in symptoms and little to no progression of the size of the schisis throughout life. One situation where retinoschisis may change (usually progressing, although occasionally regressing) is in the case of the concurrent development of rhegmatogenous retinal detachment (RRD). One of the retinoschisis patients in the Copenhagen Eye Study developed a retinal detachment. This eye had undergone cataract surgery so the retinoschisis may have been incidental. In Norman Byer's long term follow up of 123 individuals there were no cases of progressive retinal detachment requiring treatment, although 12 patients had limited progression. Macular involvement in retinoschisis is also exceptionally rare unless a retinal detachment develops.

There are 2 patterns of retinal detachment in retinoschisis, both requiring the development of retinal breaks. Breaks can occur in the inner or outer leaves of the schisis, or both and the pattern of breaks dictates the pattern of presentation of the detachment. Outer leaf breaks tend to be large with opaque rolled edges. Inner leaf breaks are often very small and difficult to localise, especially in a reticular form of schisis with a very thin and transparent inner leaf. (Figure 3).



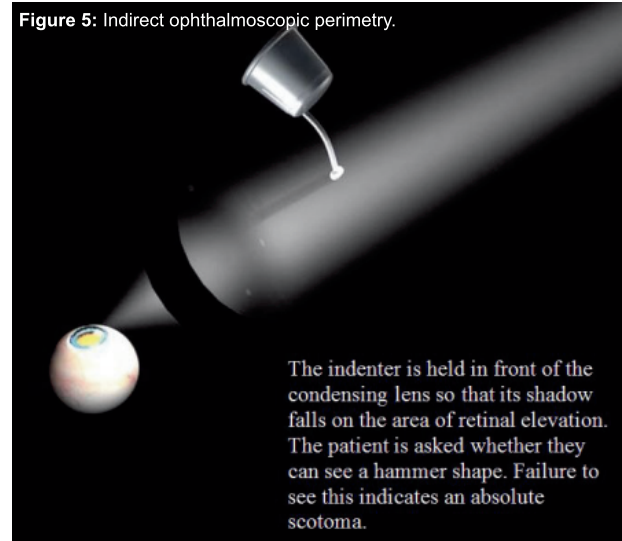
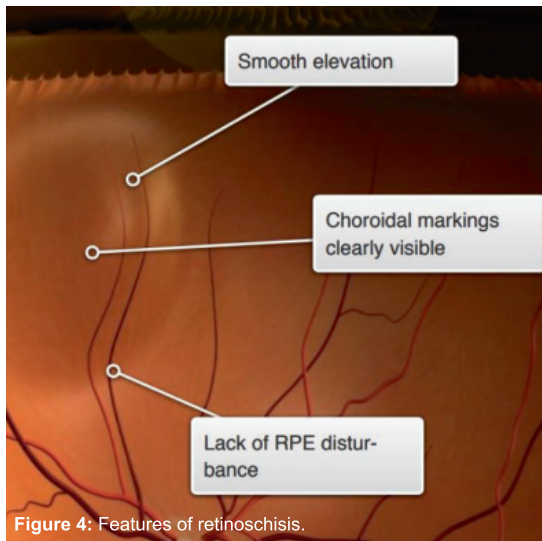
**Figure 3:** Inner leaf breaks in a reticular form of schisis.

If holes are present in both inner and outer leaves of the schisis a progressive retinal detachment may develop as there is a connection channel from the preretinal to the subretinal space. Patients usually present with symptoms of a progressive scotoma, which is not seen in uncomplicated retinoschisis. In non-progressive 'schisis detachments' the development of an outer leaf break allows the hyaluronic acid in the schisis cavity to move to the subretinal space. Although this results in a retinal detachment, this is typically limited and non-progressive as there is no continued recruitment of fluid possible from the main vitreous cavity as no direct connection exists. Eventually the hyaluronic acid may be cleared from the subretinal space leaving an attached retina. There may be some associated RPE hypertrophy due to the transient retinal detachment.

## Diagnosis and Clinical Features

The diagnosis of retinoschisis is often made incidentally, as patients are frequently unaware of any visual problems. Routine optometrist review or diabetic retinal screening can pick up this asymptomatic condition and a sound knowledge of the features that differentiate it from a retinal detachment help prevent undue worry to the patient associated with an urgent referral.

## Other Lesions



Features useful in differentiating retinoschisis from retinal detachment are illustrated in **(Figure 4)**. Other features or investigations which may be useful are:

1. Absolute scotoma over the schitic area due to interruption of the retinal neural pathway. This may be demonstrated by indirect ophthalmoscopic perimetry **(Figure 5)**. An alternative in the absence of an indirect ophthalmoscope is to use the smallest possible slit lamp beam on a bright setting (usually a spot of <1mm). Asking the patient to look at a suitable target without moving their gaze, under direct view using a fundus lens, slowly advance the small slit lamp beam from normal retina to the schitic area and back and ask the patient to tell you at which point the light disappears and then reappears. This should correspond with the observed boundary of the schisis. If they continue to see the light spot, then a relative scotoma exists, which suggests a retinal detachment rather than a retinoschisis.
2. Refractive status. Patients are almost never myopic and usually hypermetropic. The exceptions are patients with XLRS, who can be myopic and also the secondary forms of retinoschisis, in whom a range of refractive statuses can be noted.
3. The laser uptake test is now rarely performed, however directing a spot of retinal laser at a schitic area will produce uptake and a visible spot, whereas the same manoeuvre over a detached retina will not.
4. Optical Coherence Tomography is now widely available and is the best differentiator of retinoschisis and retinal detachment, as anatomical features can be readily seen. In practice, it can be difficult to achieve a reasonable quality scan of the affected area, as retinoschisis often presents very peripherally.

## Treatment

Because retinoschisis is frequently asymptomatic and usually follows a chronic and non-progressive course, treatment is not required in the majority of cases. Visual loss is rare. Regular clinic surveillance is also not usually recommended, beyond the original diagnostic visit unless there are specific concerns about possible progression risk. Once a patient is aware of the condition, self-monitoring for an enlargement of the scotoma or the appearance of new scotoma is advocated.

Retinopexy is ineffective in preventing the extension of the schisis cavity and may cause outer leaf breaks and retinal detachment. Prophylactic treatment of retinoschisis with outer leaf breaks and asymptomatic schisis-detachments is unnecessary for similar reasons.

If a rhegmatogenous retinal detachment develops, observation can often be the management of choice in the first instance. Many combined schisis-detachments can remain stable or even regress over time, as is the case in absence of inner leaf breaks. Surgical outcomes of schisis-detachment repair are notably poorer than those of typical RRD<sup>4</sup>.

Should progression be noted, in particular if the macula is threatened or detached, surgical intervention is required. Buckling surgery is possible where the outer leaf break is peripheral. Usually the break is quite posterior, however, and a vitrectomy is technically easier. Hence in most UK centres, a vitrectomy, retinopexy and gas tamponade is usually the procedure of choice. The posterior hyaloid may remain attached in these cases, as opposed to the majority of "classic" u-tear rhegmatogenous retinal detachments and induction of a posterior vitreous detachment may need to take place as the first operative step.



Maximal practicable internal drainage of both the sub-retinal fluid and the hyaluronic acid-rich fluid between the leaves of the schisis needs to be performed intra-operatively to facilitate retinopexy. The fluid from the schitic cavity can be very viscous due to the high hyaluronic acid content and complete flattening of the retina intra-operatively may be challenging for this reason. Occasionally the removal of the whole inner leaf of the retinoschisis may be required to facilitate retinal flattening, although this is not usually necessary. Laser or cryotherapy retinopexy is delivered to any inner leaf breaks and outer leaf breaks and scatter PRP is occasionally performed over the whole area of schisis.

Retinoschisis detachments with proliferative vitreoretinopathy (PVR) have a poor prognosis. Star folds are difficult to peel from the thin inner leaf without causing further breaks. A large inner leaf retinectomy is therefore usually required in these cases, with silicone oil tamponade.

## Diabetic Retinoschisis

Although idiopathic retinoschisis as described above can co-exist with diabetic retinopathy in the same eye, it can also be caused by diabetic tractional changes. Such secondary tractional retinoschisis can present very variably and often doesn't follow the typical schisis patterns, both in its behaviour and its localisation and hence also in the patient's symptoms<sup>5</sup>.

OCT scanning can be vital in determining the presence and extent of schisis in these scenarios and differentiating it from solely cicatricial tractional elements, vitreous haemorrhage and tractional retinal detachment. Management follows similar general principles, in that an isolated schisis does not necessarily require intervention, however an assessment always needs to be made on a case by case basis and in the diabetic retinopathy patient the threshold for regular monitoring is much lower. An associated tractional retinal detachment likewise mandates a reassessment of the likelihood of progression and the risks and benefits of surgical intervention.

A recent study<sup>6</sup> showed similar success with surgery in both isolated tractional retinoschisis and isolated tractional retinal detachment in diabetic population groups. Preoperative best-corrected visual acuity (BCVA), postoperative BCVA and improvement in visual acuity showed no significant difference between the two cohorts. Management decisions in these patients remain to be made based on individual patient factors and presenting pictures.

## Key Points

- Retinoschisis is a common, asymptomatic, idiopathic retinal condition
- It is typically described in hypermetropic eyes and much caution is required in diagnosing retinoschisis in the myopic population
- Progression of the retinoschisis and visual loss are very rare
- Any unusual presenting features should warrant a referral to an ophthalmology clinic. A number of typical symptoms and signs are described to help stratify patients.
- Regular clinic monitoring of idiopathic uncomplicated retinoschisis is not required. Patient self-monitoring is advocated
- Treatment is usually reserved for cases of relentless progression, which typically occurs following the development of a sub-type of schisis-detachment
- Outcomes of surgery are good, however do not quite reach the primary retinal reattachment rates of uncomplicated RRD
- Diabetic tractional retinoschisis is a type of secondary retinoschisis and the management decisions for each patient with the condition need to be made on a case by case basis
- Surgery for diabetic retinoschisis may equal the success rates of surgery for diabetic tractional retinal detachment, both in anatomical and visual acuity terms

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# Here come the Clinical Champions

Diabetes UK is committed to developing programmes and tools to support healthcare professionals improving diabetes care. **Dr Susan Aldridge**, Editor of Diabetes Update, introduces two of the charity's award-winning initiatives – the Clinical Champions programme and the Information Prescriptions and invites the retinal screening community to get involved.



At Diabetes UK, our extensive work with the healthcare system has taught us that lack of clinical and health system leadership is the single most significant cause of poor-quality diabetes care. It is healthcare professionals, who are best placed to understand the challenges facing their local healthcare system. But, all too often, they tell us they feel alone, helpless, and demoralised in face of a vast bureaucracy and constant upheaval in the NHS. Diabetes UK's Clinical Champions programme was designed to identify clinicians (including those involved in diabetic eye care) with the passion, skills and position to make a real difference to diabetes care in their community and to give them a package of support to turn their ideas into reality.

## What is Diabetes UK's Clinical Champions programme?

The Clinical Champions programme and its delivery is a unique partnership between Diabetes UK, Novo Nordisk and Ashridge Business School. Once selected, our Champions are in post for two years, during which time they attend four 24-hour residential sessions at Ashridge Business School, where they cover topics such as influencing without authority, different leadership models and building individual and team resilience. Not only does this training enable the Champions to drive change across local health systems, it also provides a safe space in which they can reflect and network with like-minded colleagues.

The Champions also meet twice a year at Action Learning Sets, where they discuss their plans for change with their colleagues and are supported through the challenges they face.



Since launching in 2014, the programme has recruited 65 Clinical Champions from across the UK, including consultants, GPs, dietitians, podiatrists, diabetes specialist nurses, practice nurses and, of particular interest, **Andrew Crowder**, Head of Programme for Diabetic Eye Screening Wales, the first person from the retinal screening community in the UK to take on the Clinical Champion role says:

*"I would certainly encourage more healthcare professionals from retinal screening to apply. The personal development side has been really important. I've seen the confidence and knowledge growing among the whole Clinical Champions peer group. You can see it happening, like a light bulb going on. You get the confidence to take on a challenge. The Clinical Champions programme is a vehicle for making things happen in diabetes care."* (for more, see **Case Study box**)

Following the success of the Clinical Champions programme, we have launched a Professional Leadership Alumni for those who have graduated from this and our Tomorrow's Leaders programme for diabetes nurses and dietitians. This opportunity will enable our Champions to continue networking with one another and developing their leadership capabilities, as well as maintaining a strong relationship with Diabetes UK.

In June, we were delighted to announce that our Clinical Champions programme won the Excellence in Practice Gold Award from the European Foundation of Management Development, joining other award winners such as Mars and Nokia. This international recognition clearly shows the power of our programme, the continuing success of our Clinical Champions and our strong partnership with Ashridge Business School and Novo Nordisk, as we all work together to improve the care of people living with diabetes.

## Clinical Champions' achievements

A major benefit of bringing together Clinical Champions from across community, primary and secondary care is that it enables unique multidisciplinary working among clinicians appointed from across the diabetes care pathway. This has the advantage of enabling people to step outside of local hierarchies and rivalries and really engage with the changes needed across diabetes care.

A number of our Champions have worked with local stakeholders to develop innovative community models to support their patients with diabetes and improve the care they receive. These models see specialist teams working alongside GPs and practice staff, meaning people with diabetes are seen closer to home and can begin to manage their condition outside of the hospital setting. Importantly, these models of care support patients to manage their condition on an ongoing basis, meaning they are able to avoid complications. The guiding principal of locally led change has resulted in the Champions delivering a remarkable breadth of projects that have significantly improved diabetes care.

**Dr Mayank Patel**, one of the Clinical Champions and a diabetologist at Southampton General Hospital.

### Broad themes have included:

- increasing skills of clinical colleagues
- better integrating care
- improving patient safety
- building clinical networks
- tackling variation.



### Below, we list some specific achievements.

- 1:** One diabetes specialist nurse has developed a new training initiative for inpatient nurses. Over 1000 nurses have since been trained using this initiative, and audit data shows this has led to a significant improvement in diabetes care.
- 2:** Another diabetes specialist nurse went from 'hitting a brick wall' with GPs about diabetes treatment for elderly patients, to successfully implementing new guidelines for patients over the age of 75.
- 3:** As a result of the Clinical Champions programme, another healthcare professional led his diabetes network to standardise the rules for drug prescriptions between different clinical commissioning groups. This has resolved inconsistent and dangerous decisions about patients' medications and made prescribing fairer.
- 4:** One of our Clinical Champions has secured funding for a new role of Schools Educator in Wales – a post now filled – to deliver training and support to schools caring for children with diabetes.

Our Clinical Champions have told us about the three-way impact that the programme has. First, simply giving healthcare professionals the title 'Clinical Champion' has given them the authority to implement change where before they felt ignored. Second, the training and support of the programme has enabled them to manage the often complex changes involving multiple organisations and countless staff. And, finally, the programme has supported the Champions to tackle tough challenges resulting from financial pressures as the NHS comes under unprecedented strain.

**Beth Stout**, Clinical Champions Manager, says: *"It's fantastic to see the impact of the programme – both in terms of the direct improvements the Champions make to local diabetes care, but also in their development as leaders who galvanise others to deliver the best possible care. This tells us that the impact of the programme will continue beyond each two-year cycle. We have just recruited 20 new Clinical Champions from across the UK, after our most competitive recruitment process to date. We'll be recruiting for our next cohort in March 2018."*

For more information about the programme and how to apply, visit [www.diabetes.org.uk/clinical-champions-networks](http://www.diabetes.org.uk/clinical-champions-networks)



## Case study

### Andrew Crowder: The impact of the Clinical Champion role in diabetic eye screening



The catalyst for my becoming a Clinical Champion was a Professional Groups meeting at the Diabetes UK Professional Conference last year. Bridget Turner [Diabetes UK's Director of Policy, Campaigns and Improvement] was chairing the meeting and remarked that there had never been anyone from eye care in the Clinical Champions programme. So, I felt compelled to take on the challenge!

I believe there are two aspects to the impact of being a Clinical Champion on my work in the Diabetic Eye Screening Wales programme.

- **First**, although our programme is one of the best when it comes to quality, we need to improve access and uptake. The Clinical Champion title has given me more presence, status and confidence when dealing with a challenge. Specifically, it conveys more leverage when dealing with people outside our immediate organisation. As we are an all-Wales programme, it helps when I negotiate with all the Local Health Boards for more clinic space and capacity to carry out our programme.

This has resulted in a 7.0% increase in clinic provision, 6% increase in clinic invitations and a 4.6% increase in patients screened over the last 12 months, compared with figures for the previous 12 months. That translates to 5,796 more patients screened in 2016/17 than in the previous year. I've also been working with diabetologist Dr Sam Rice, a Clinical Champion from the 2015/2017 intake and Diabetes Lead for Hywel Dda Health Board. We have been able to unlock access to screening in a new diabetes centre in Llanelli. This is particularly significant as it puts retinal screening alongside the wider diabetes multidisciplinary team, creating a 'one stop shop' for diabetes care for the first time in Wales. We have also introduced a five day, fixed screening site in Newport City Centre, which is an optimal model for a large urban area.

- **Second**, although I have long experience in NHS management, when I first moved into diabetes care, I was struck by how diabetes care is siloed – with diabetic eye screening being almost an 'orphan' within the system. But we have our patients for life. If background retinopathy is suddenly detected after years of 'no change', we know that something has changed and alarm bells should be going off in the patient's wider care team. This does not happen consistently.

I am talking to Local Health Boards about how we can make care more integrated, starting with our retinal screening database, which has records of everyone with diabetes in Wales. We can do things like identifying DNA 'hot spots' and getting more help in there. We also want to get our screening records to those healthcare professionals who need to see them, like the diabetes specialist nurse. And, finally, all our national screening programmes are now together in Public Health Wales, we have lots of new opportunities. For example, we can use all the programmes to promote the others and train all our staff to deliver important lifestyle messages.



## Information Prescriptions

Diabetes UK has developed a practical tool called Information Prescriptions to support diabetes management. Information Prescriptions are a short, easy-to-read and clinically accurate resource aimed at helping the healthcare professional and people with diabetes to make decisions together about the treatment and self-management of the condition. This tool includes actions to reduce the risk of complications and a space for setting individual behaviour change goals needed to meet those health targets.

The Information Prescriptions are embedded in clinical IT systems, which means they are quick to use. Clinicians receive electronic alerts prompting them to intervene with patients who are at higher risk of devastating complications, such as amputation or loss of sight.

Clinicians say that this is changing their behaviour, prompting them to intervene more proactively and highlighting patients who have slipped through the net for many years. Data from clinical system EMIS Web shows that use of the Information Prescriptions is rising steadily and they have now been used in over 82,000 clinical consultations. The Information Prescriptions tool won a Quality in Care Diabetes award (Diabetes Collaboration Initiative) in 2016.

There are Information Prescriptions available on:



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