UK National Screening Committee

NHS Screening Programmes

Diabetic Retinopathy

Annual Report

English National Screening Programme for Diabetic Retinopathy

April 2010 – March 2011

Contents

Executive summary

The English National Screening Programme for Diabetic Retinopathy (ENSPDR) made great strides during 2010-11 to improve the way screening is delivered throughout England.

In June 2010, the programme produced an action plan to take forward recommendations from the UK National Screening Committee's (UK NSC's) Review of Quality Assurance of ENSPDR that was published in May 2010. Many of the key achievements outlined in this report are the result of that action plan and will help to improve quality and reduce variability in the way screening is delivered in years to come.

During the year, the national programme implemented the guidance contained in the UK NSC document *A Framework for Governance for National Screening Programme advisory structures* and reviewed its committee structure and terms of reference. The new structure was finalised in February 2011 with an over-arching Programme Advisory Committee supported by five sub-committees.

One of the new sub-committees, the Grading and Assessment Committee, was set up to advise on the grading classification and assessment process of images. It was supported by the successful development of an online tool that enables an expert group of ophthalmologists to grade images and assist in the review of grading classifications.

In July 2010, a protocol was introduced to ensure national policy changes are checked for consistency, linked into software changes and implemented by local programmes in appropriate timescales.

The management structure of the ENSPDR national programme team was reviewed and the UK NSC held a consultation process over the proposed development of closer working links with the NHS Abdominal Aortic Aneurysm (AAA) Screening Programme within a national NHS (non-cancer) Adult Screening Programmes Centre.

Dr Sue Cohen was appointed National QA Director in 2010. A review of the evidence base for the National QA Standards was conducted and the first revision of standards was published. An expert reference group produced new guidance for External Quality Assurance (EQA) visits to ensure local programmes understand how they will be assessed during visits. The guidance detailed the number of peer reviewers required for EQA visits along with their roles and responsibilities. A revised schedule of EQA visits was developed and these visits will start in September 2011.

A communications strategy was developed in conjunction with hanover, the UK NSC's cross-programme press office provider, and the NHS AAA Screening Programme's communications lead. This strategy will inform the development of patient information materials during 2011-12 and beyond.

Workforce education and training delivered during 2010-11 included in-house training courses on public health and data interpretation for the programme's QA teams.

Development work continued on the national GP2DRS IT project that will manage the transfer of patient details from GP systems. GP2DRS will enable local screening programmes to access accurate and up-to-date lists of patients eligible for screening. It will cover the transfer of patients' demographic information, plus clinical details if required. Other benefits of GP2DRS will include:

- More patients can be contacted for screening
- Patient diagnoses will be better informed
- Patient care provided by GPs can be more quickly tailored in light of their results ▶

- Patient consent to data transfers can be better observed and respected

Other important IT developments included an options appraisal for the consolidation of IT contracts throughout England. Regional consultation was held on these consolidation proposals.

Department of Health figures demonstrate that the growing prevalence of diabetes in the general population presents significant challenges for ENSPDR going forward. During 2010-11, the total number of people in England with diabetes identified by GP practices increased by more than 120,000 to nearly 2.5 million. During 2011-12 and beyond, the national screening programme will need to consider new strategies to cope with these rising numbers.

Nearly 1.8 million people with diabetes – around 80% of those invited – took up the offer of screening during 2010-11. More detailed figures are included in *The year at a glance* section of this report.

Foreword

By Liz Henley
Chair of ENSPDR Programme Advisory Committee

I am pleased to introduce the 2010-11 ENSPDR Annual Report after an exceptionally busy and productive year.

This year has seen many achievements and the beginning of a number of new developments led by the ENSPDR national programme team. We hope this will bring about a new sense of identity for everyone involved in ENSPDR screening as part of a single, unified national screening programme. We wish to harness the expertise and enthusiasm of all our stakeholders to ensure we are constantly learning from the best and spread good practice and screening service improvements in order to provide the finest service to nearly 2.5 million people with diabetes in England.

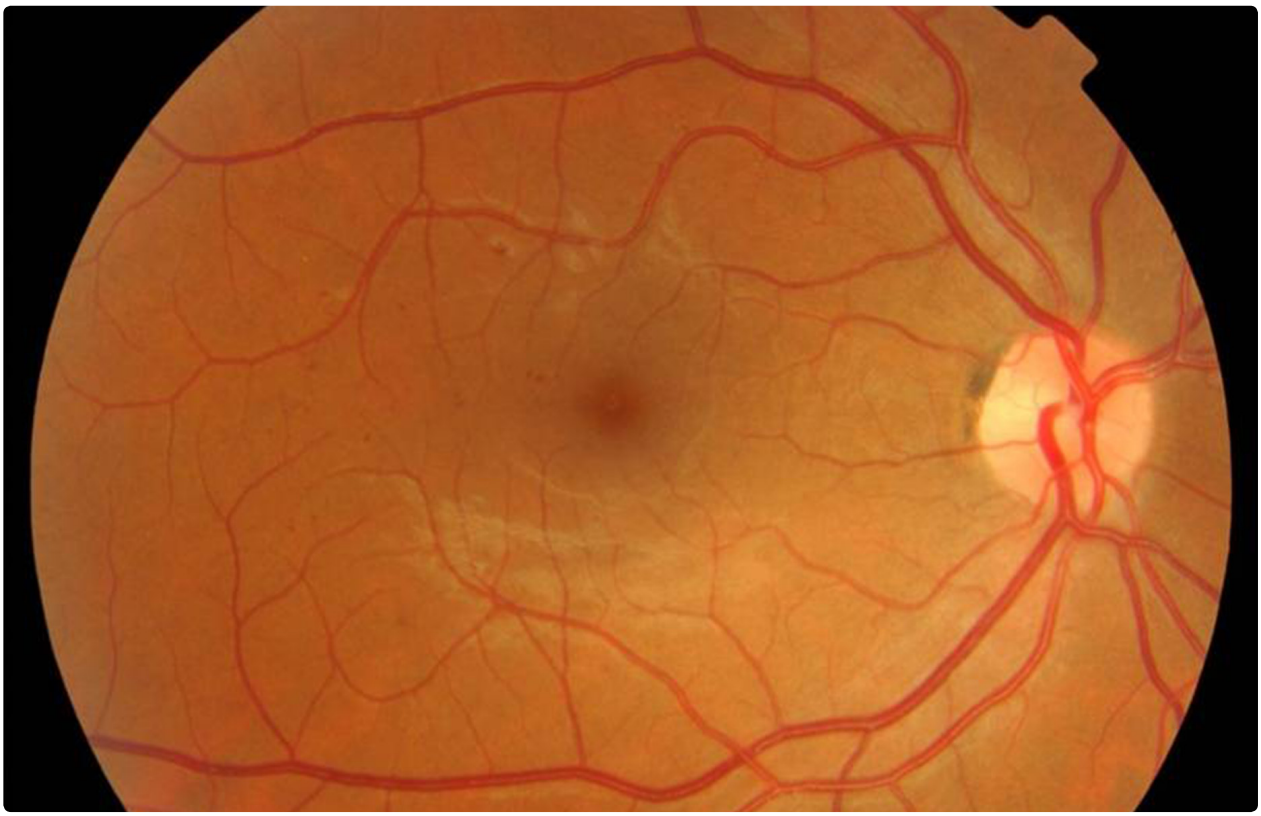
Continuous quality improvement has always been at the heart of screening programmes. During 2010-11, ENSPDR undertook a considerable amount of work to reflect on and review its external quality assurance processes. This work included a revision of the national Quality Assurance Standards, which underpin the programme, and the establishment of the Guidance for External Quality Assurance (EQA) visits. This work was completed with advice and assistance from expert groups, who gave freely of their time, for which we are extremely grateful.

We also reviewed the way our advisory committees work. We hope this has given an opportunity for many more people to be involved in shaping the work of the national programme. A new Grading and Assessment Committee was established and we anticipate recommendations from the review of grading classification will be available during 2011-12. The Camera, Software and Technical Committee was involved in an important options appraisal for the consolidation of IT contracts, while the Training, Education and Workforce Committee continued to advise on the development of the Test and Training set for graders.

You will all be aware of the Government's proposals to modernise the NHS. This will mean real changes for the way national screening programmes are developed and commissioned over the next two years. Any time of transition carries risk, but I know that during 2010-11 the building blocks for strong collaboration and working together were laid by the national programme team. This culture of mutual help and assistance will help us maintain focus on our core aim of reducing sight loss among people with diabetes through any future uncertainties.

I would like to take this opportunity to thank all members of staff in the ENSPDR national programme team, who are unfailing in their commitment to delivering the highest quality local diabetic retinopathy screening programmes.

Introduction



Diabetic retinopathy is the leading cause of blindness in the working age population and is increasing in the elderly.

The national screening programme has the potential to reduce the annual incidence of blindness in England by at least a third, which would result in more than 400 people per year being saved from sight loss.

ENSPDR was introduced in 2003 and aims to reduce the prevalence of blindness through the early detection and appropriate treatment of diabetic retinopathy.

Implementation across 91 local programmes covering the whole of England took place between 2003 and early 2008. The roll-out was overseen by the national programme team, based in Cheltenham, Gloucestershire, in conjunction with a Project Advisory Group and a group of sub-committees covering quality assurance, education and training, cameras and software.

Following implementation, national QA Standards were introduced, which programmes had to report against. EQA visits started in 2007.

In 2009, the UK NSC conducted a Review of Quality Assurance in ENSPDR, culminating in the publication of a report and recommendations in May 2010.

This annual report focuses largely on the considerable amount of hard work that has already been carried out to align ENSPDR processes with the recommendations in the UK NSC review. This included a temporary halt to EQA visits while the national programme team reviewed QA standards and developed comprehensive written guidance for EQA visits.

The year at a glance

During 2010-11, the prevalence of diabetes continued to grow in the general population. Department of Health figures[1] show that the total number of people with diabetes identified by GP practices in England rose by more than 120,000 – an increase of more than five per cent – to nearly 2.5 million. This huge growth in numbers presents considerable challenges for the national programme and will continue to do so in the years ahead.

Nearly 1.8 million people with diabetes took up the offer of diabetic retinopathy screening across England in 2010-11 out of nearly 2.3 million people who were offered screening – an uptake of 79%.

The Department of Health figures also reveal that more than 200,000 people with diabetes were excluded from screening. However, there was considerable regional variation both in the reported prevalence of diabetes and in the proportion of people with diabetes who were excluded from screening.

In addition to screening nearly 1.8 million people, key achievements during 2010-11 included:

- Production of an action plan to take forward recommendations from the UK NSC's Review of Quality Assurance
- Publication of revised ENSPDR Quality Assurance Standards
- National advisory committee structure and terms of reference reviewed and revised
- Review of national programme team's management structure
- New guidance for EQA visits

[1]Department of Health Vital Signs Monitoring, May 2011

Data sources and data quality

The ENSPDR collects data from a number of sources, including Department of Health Vital Signs Monitoring Reports and local programme annual reports.

There have been significant issues with the quality of data submitted by local programmes and the definition of data sets within the different programme management software systems. Considerable caution is therefore required in the interpretation of these figures. Data in this document are therefore presented at national and regional level only and a limited data set is provided.

Department of Health returns

The Department of Health collects data on a quarterly basis through the year, including the number of people with diabetes identified by GP practices plus the number excluded, offered and receiving screening.

Number of people with diabetes – prevalence

The number of people with diabetes continues to grow year on year. Much of this increase is due to lifestyle factors and some is due to the country's ageing population. In some cases, it also reflects improved identification of people with diabetes.

The number of people with diabetes identified by GP practices in England rose from 2,342,951 at the end of 2009-10 to 2,465,899 at the end of 2010–11. This represented an increase in just 12 months of 122,948 or 5.2%.

However, there was considerable regional variation. In the final quarter of 2010-11 alone, some Primary Care Trusts (PCTs) reported an increase of up to 12% in the number of people with diabetes while others reported no rise or even small decreases. ▶

Number of people offered screening

PCTs have a target to offer screening to 100% of people with diabetes aged 12 and over, except for those people who have been excluded from the screening programme.

Most PCTs achieved this target in 2010-11 thanks to the considerable hard work undertaken by local programmes. However, this target was not achieved in some cases where local programmes had been restructuring their service. In 15 out of 151 PCTs, screening was offered to less than 95% of the eligible population.

The number of people with diabetes excluded from screening varied considerably between PCTs – from 1.4% to 23.1%. People are usually excluded because they make an informed decision to opt out of the screening programme, have no perception of light in both eyes or because they have a condition that would make undertaking the screening or providing treatment impossible. The actual number of people excluded from screening varied between PCTs during 2010-11 from just 150 to 7,363. It therefore appears that in some areas people with diabetes may have been inappropriately excluded from screening.

Uptake and coverage

Uptake is the proportion of people offered screening who are tested. This provides an indication of how well local programmes give people an opportunity to take up the offer of screening through initiatives such as improving access and understanding why people do not attend appointments.

Coverage is the proportion of people with diabetes who receive a screening test. It is not possible to measure coverage accurately using the current programme management software. However, an estimate can be obtained by comparing the number of people who received screening with the total number of people with diabetes on a PCT list. This figure provides a better guide to the impact a programme will make in reducing the risk of visual loss in a population. A local screening programme with high uptake and a small number of exclusions will therefore have better coverage than one with the same uptake but more exclusions.

Using these figures, the ENSPDR coverage figure for the whole of England at the end of 2010-11 was 72.6%. However, it was less than 60% for seven PCTs and as high as 92% in one PCT.

During 2011-12, a range of activities will help to reduce these variations in the way retinal screening is delivered in England. The national programme will work with and support local programmes through external quality assurance visits and other initiatives.

2010-11 ENSPDR uptake and coverage

Quarter	Uptake %	Coverage %
1 April – 30 June	77.1	69.2
1 July – 30 Sept	77.8	70.7
1 Oct – 31 Dec	78.1	71.2
1 Jan – 31 Mar	79.3	72.6

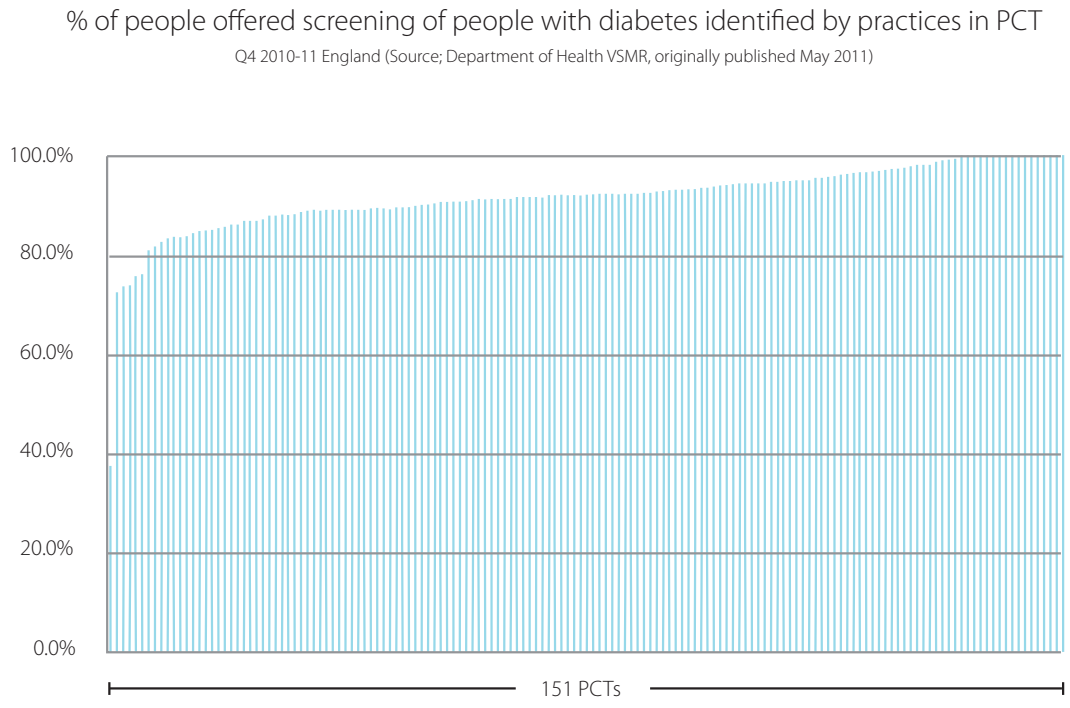
	Number in England at end of 2010-11
Number of patients with diabetes identified by practices in PCTs	2,465,899
Number of people with diabetes offered screening for the early detection (and treatment if needed) of diabetic retinopathy	2,256,648
Number of people with diabetes excluded from screening for diabetic retinopathy	225,281
Number of people with diabetes receiving screening for the early detection (and treatment if needed) of diabetic retinopathy	1,789,701

Performance by Strategic Health Authority (SHA)

SHA	Uptake %	Coverage %
North East	78.4	74.3
North West	81.1	74.2
Yorkshire and Humber	80.5	72.6
East Midlands	76.0	72.7
West Midlands	76.0	70.0
East of England	81.8	76.1
London	76.0	68.0
South East Coast	84.3	70.5
South Central	74.7	68.1
South West	85.1	80.8

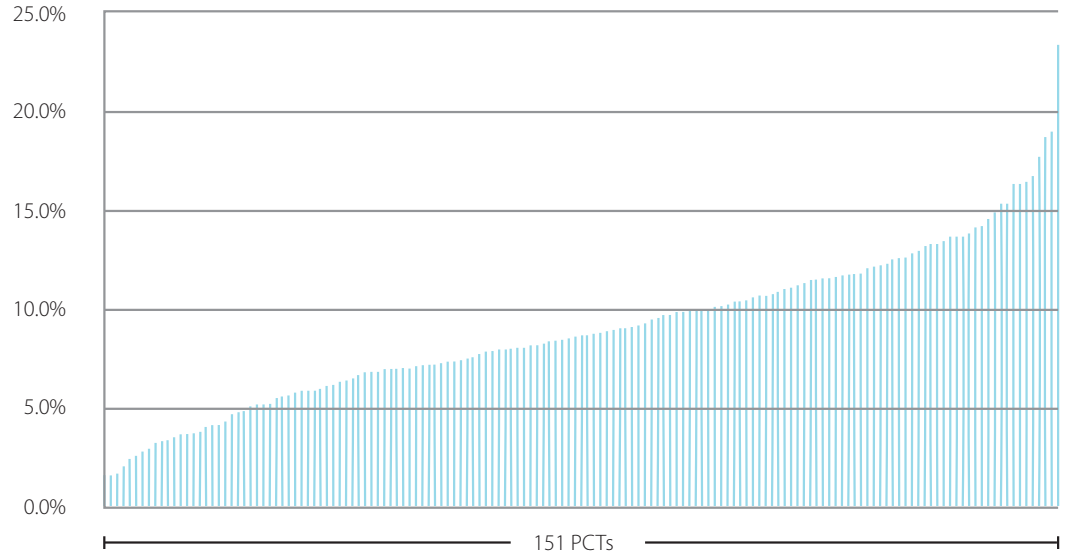
Performance by PCT areas

The following charts illustrate variations in performance between PCTs during 2010-11. Some PCTs were not functioning at 100% capacity and therefore did not offer screening to all their eligible population. ▶



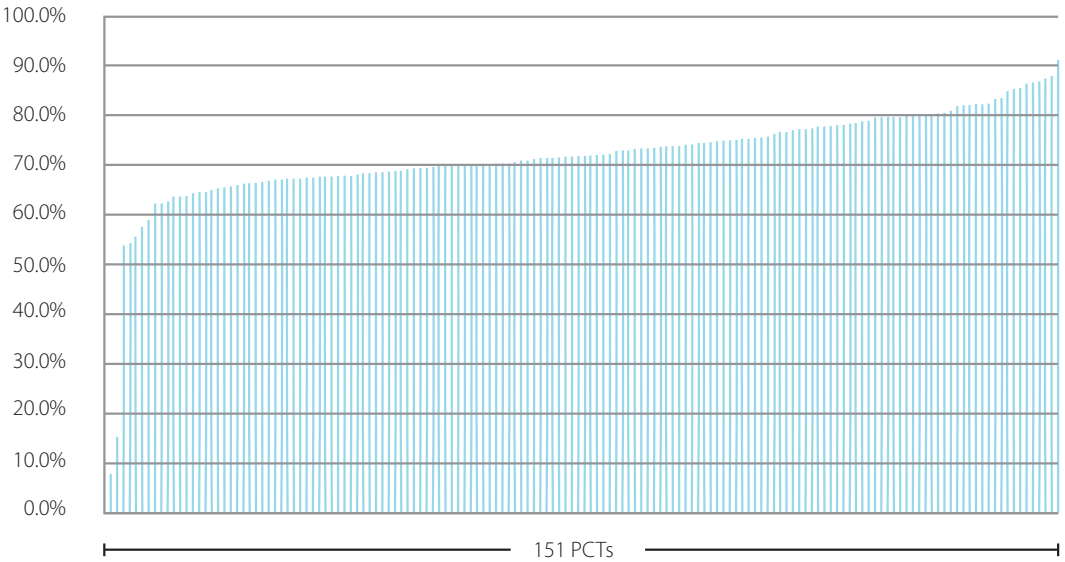
Exclusions as a percentage:
number of people excluded from screening/number people with diabetes by PCT

Q4 2010-11 England (Source; Department of Health VSMR, originally published May 2011)



Coverage as a percentage:
number of people receiving screening/number people with diabetes by PCT

Q4 2010-11 England (Source; Department of Health VSMR, originally published May 2011)



Yield and outcome data

Comparative data across programmes on the number of referrals to hospital eye services and the number of patients requiring laser or other treatments is not available using the current data management systems.

Background

The four UK nations were the first large countries in the world to introduce systematic national screening programmes for diabetic retinopathy. Diabetic retinopathy is the most common cause of blindness in the working age population. It is caused when diabetes affects the small blood vessels in the retina, the part of the eye that acts rather like the film in a camera.

Implementation of a national screening programme in England was announced in the 2003 Delivery Strategy for the National Service Framework for Diabetes. The UK NSC decided to recommend a systematic population eye-screening programme delivered to national standards after reviewing evidence which showed that screening could significantly reduce the prevalence of blindness through the early identification and effective treatment of the disease. It is estimated that screening could save more than 400 people per year from sight loss.

ENSPDR implemented across England between 2003 and early 2008. Screening involves digital photography of the retina followed by a systematic image grading process to identify the changes of sight-threatening diabetic retinopathy. Screening is offered annually to people with diabetes aged 12 or over.

In 2007, an EQA process was introduced and peer review visits of local programmes started across England. The National QA Standards were developed and local programmes measured against them. There are currently 91 local screening programmes in England and they submit an annual report each October. The aim of the EQA process is to ensure continuous improvement in the quality of services and to support that improvement.
In 2009, the UK NSC commissioned a Review of Quality Assurance in the ENSPDR that culminated in the publication of a report in May 2010 with recommendations to improve QA systems.

The review acknowledged that 'the implementation of a screening programme of this scope is a major undertaking and the progress that has been made is a testament to the commitment and enthusiasm of all those involved at every level'. However, it also identified a number of areas where QA could be improved and its recommendations were acted upon during the period of this report.

Vision and objectives

The aim of ENSPDR is to reduce the risk of sight loss among people with diabetes by the early detection and appropriate treatment, if needed, of diabetic retinopathy.

Sight loss has a significant impact, not just on the individual but on their family and community. It also has a considerable economic impact on society. As diabetic retinopathy is the leading cause of sight loss in the working population, the importance of the screening programme needs to be seen in this broader context.

The ENSPDR aims to provide a systematic and cost-effective screening programme that provides those people who have developed serious retinopathy with appropriate treatment, such as laser surgery. It also gives people with diabetes and their GPs information about very early changes in their eyes so they can take preventative action to stop serious retinopathy developing.

The programme has specific objectives to help deliver this vision. These include:

- Offering all eligible people with diabetes aged 12 and over regular eye examinations for diabetic retinopathy
- Detecting a high proportion of sight-threatening retinopathy at an appropriate stage during the disease process
- Ensuring diabetic eye disease is treated effectively and within an appropriate timescale once disease has been detected

For people with diabetes, the programme's objectives focus on integrating their screening and treatment for diabetic retinopathy with other aspects of diabetes care, such as the management of hyperglycaemia, hypertension and hyperlipidemia. This is to support the optimal management of diabetes and ensure patient information meets patient needs and supports patient education programmes.

In order to maintain quality, ENSPDR has objectives to ensure the screening workforce is appropriately trained and accredited and standards are set, alongside a quality assurance system to allow programme monitoring.

There is also an objective to review evidence regularly in order to make recommendations on policy developments and to make improvements in standards.

The patient perspective

Michael Watters is proof that screening works – his retinopathy had gone undetected for years and he was close to losing his sight in one eye when he was first screened.

Despite regular sight tests with an optician, it was not until he was screened that Michael discovered he had the disease and it was dangerously advanced in one eye.

He was invited for screening in 2001 by the local Gloucestershire Diabetic Retinopathy Screening Programme. Michael was then a 21-year-old graduate starting out on a promising career. He has had type 1 diabetes since he was seven and the damage to his eyes could have been developing for years.

Now, he urges others to take up the offer of screening. "I was very lucky," said Michael. "I was told I was close to losing my sight in one eye.

"I'm keen to share my experiences and encourage others to get checked out. Telling my story will be worthwhile if it means someone else will get the benefit of treatment.

"I'm fairly good at controlling my diabetes and I often visited the optician I was going to back then because I wear glasses, so I thought I was covered."

Michael was screened at his GP's surgery and within weeks started laser treatment. Eventually he had surgery on his left eye. The damage to his other eye was minimal.

"Mine was quite a bad case of retinopathy at the time and the operation did the trick," said Michael. "The doctors were great."

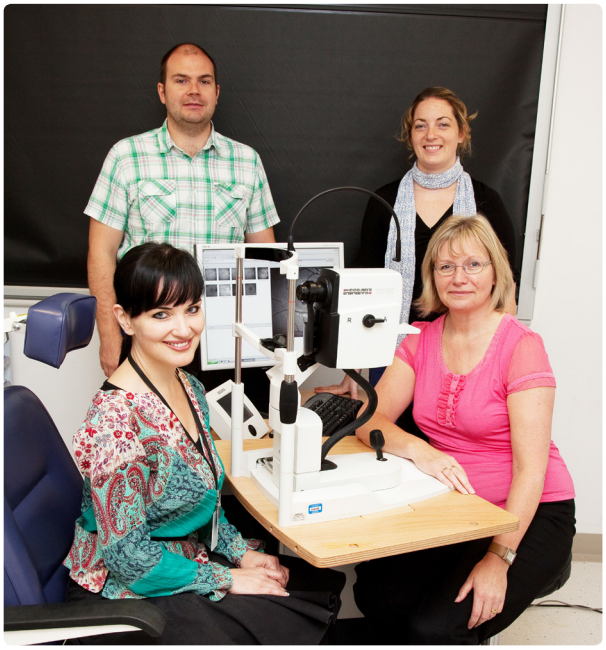
Michael had just started his first job when he had the operation. Managers at his then employer, building contractor Balfour Beatty, were supportive and, 10 years on, Michael is regional group maintenance manager for Tesco. He lives near Bristol.

His experience has made him take stock of life. Michael explained: "It made me take a hard look at myself. I was always careful about controlling my diabetes but am even more so now. I look after myself."

The professional perspective

Jenny Mason has two key roles in her local screening programme.

Not only is she a senior diabetic screener grader with Gloucestershire Diabetic Eye Screening Service, she is also the local programme's ophthalmic imaging manager, heading a team of five.



Jenny, front right, with Gloucestershire screening programme colleagues

Gloucestershire was one of the first areas to launch a local retinal screening programme using photography in October 1998, and Jenny has been involved almost since the start.

"There was no national programme then," said Jenny, who joined in 2001 and has seen the Gloucestershire programme go from strength to strength. "It was just me and Jan Hidden screening then and we had two cameras. Now there are 24 of us and eight cameras."

And the job certainly has its rewards. "It's extremely worthwhile. It's not just a project. You're actually helping to prevent people going blind," Jenny added.

Jenny covers all aspects of the screening process. In her managerial role, she organises clinics at GP surgeries and hospitals all over Gloucestershire, handles budgets and trains, teaches and mentors staff.

Behind the camera, as a senior grader, she travels to many of those clinics with a laptop and camera, talks patients through any fears or queries they have and screens them by taking images with a digital camera.

Jenny then returns to the programme offices at Gloucestershire Royal Hospital in Gloucester, uploads the images on to her computer and grades them according to whether there is any retinopathy and the degree of any damage.

But it isn't just down to Jenny or any other one person. She said: "One person grades the images and then a second grader looks at them without knowing the first decision. If they disagree, it goes to arbitration grading, which I do as well."

It's not just about pictures – Jenny and her team also have to find the words to guide people through the screening process and to help them manage their diabetes by changing their lifestyles.

"We try and point them in the right direction. Some are scared about coming for screening and then they do it and realise it's okay so they'll come back," she said.

"One of the most satisfying things is getting patients back on track. You have a patient who hasn't been for screening for some time. You take the images and they may show a lot of problems.

"You give them advice and get them to see an eye specialist and you get them back on track."

Policy update

The UK NSC's review of ENSPDR resulted in recommendations for improvements to the programme's existing quality assurance system.

During 2010-11, the national programme team worked to implement the recommendations of that review. A complete review of all programme policies and protocols was carried out. Out-of-date policy documentation was withdrawn and a formal review process put in place.

A revision of the national QA Standards was undertaken to ensure they are measurable and based on adequate evidence. A paper was presented to the QA Committee which included a recommendation to establish an expert reference group to undertake the revision. A revised set of standards was then released following a consultation process. Plans are in place to ensure the standards are formally reviewed annually in future.

A review of the EQA process and test set protocol also took place. This resulted in changes to protocols that were approved by the QA Committee and disseminated to all local programmes.

During 2011-12, the national programme team will focus on producing new policies and guidelines to put before the Programme Advisory Committee and for use in local programmes. Work will include a further review of the National QA Standards, a review of the classification of grading system and guidance on how to manage serious incidents, screening suspensions and conduct look-backs.

Performance and progress

2010-11 was a time for reflection and change following the Review of Quality Assurance in ENSPDR conducted by the UK NSC. An action plan was agreed following this review, which formed the basis of the objectives for the year, summarised below. Significant developments included:

- The establishment of a revised governance system, including a new committee structure
- A change in the management structure and the move to offices at Victoria Warehouse, Gloucester, shared with the NHS AAA Screening Programme
- The establishment of expert reference groups to advise on areas including Quality Standards, Pathways and the EQA visit process

Progress against recommendations of UK NSC's Review of Quality Assurance

Objective: Revision of National QA Standards to ensure they are measurable and based on adequate evidence.

Performance: Phase 1 of the review of National QA Standards was completed and the revised standards were due to be published in April 2011. The revised standards will help to improve the quality, collection and comparison of data from local screening programmes. The Phase 2 review of the standards has been postponed to allow sufficient time to undertake a thorough review and align with other software changes. ▶

Objective: Standards should be formally reviewed annually.

Performance: A full and formal review took place as part of the process to revise the National QA Standards.

Objective: Review of classification of grading system.

Performance: The system for classifying images according to degrees of retinopathy disease was reviewed by the Grading and Assessment Committee. Its recommendations to the Programme Advisory Committee aim to make the grading system clearer.

Objective: Introduction of document referencing system.

Performance: SharePoint, a new document referencing IT system, was put in place to facilitate the efficient running of ENSPDR. The system ensures all members of the national programme team have easy access to the latest versions of programme documents.

Serious incidents, suspensions and look-backs

Objective: Comprehensive written guidance and protocols to be developed for the management of serious incidents, suspensions and look-backs.

Performance: Policies were reviewed in conjunction with other national screening programmes. Written guidance for the identification and management of incidents within ENSPDR was drafted for review by the QA Committee. This guidance aims to ensure any harm is minimised and that the programme quality is enhanced by learning from incidents. A written protocol was also developed for the management of suspensions and look-backs and this protocol is also due to be reviewed by the QA Committee.

QA teams and visits communication

Objective: Improve public health skills and data interpretation.

Performance: Members of the National QA Team attended a dedicated public health training course during 2010-11. This course was specifically aimed at meeting the needs of the QA team in interpreting data and utilising public health skills when monitoring local programmes to ensure that the delivery of screening is safe and effective.

Objective: Develop protocol for EQA visits.

Performance: A new protocol was developed for external quality assurance (EQA) visits following the UK NSC's review of quality assurance within ENSPDR. The protocol gives guidance for local programmes as to what to expect during these visits, which provide a key forum for reviewing the screening pathway and assessing the effectiveness of the local programme.

Objective: Develop a clear action plan for improvement following EQA visits.

Performance: A system for implementing and tracking clear and concise local action plans following EQA visits was developed. This system will improve the national support given to local programmes in progressing action plans after visits.

Objective: Ensure communication is measured, professional and accurate at all times.

Performance: Guidance has been included in the EQA visit documentation to ensure communication between the national and local programme teams during and after visits is transparent, honest and consistent. This guidance will be included in training for peer reviewers, EQA Leads and QA team members.

Accountability, structures and governance

Objective: The Programme Advisory Board and QA sub-committee to be reviewed.

Performance: The ENSPDR committee structure was revised, including changes to the membership and terms of reference of the committees. The new Programme Advisory Committee is now supported by five sub-committees with clear remits to monitor and improve elements of the screening programme: Quality Assurance; Grading and Assessment; Training, Education and Workforce; Research and Data Management; Cameras, Software and Technical.

Objective: QA Committee governance arrangements to be revised.

Performance: The committee's terms of reference were reviewed and revised to make them clearer and more focused.

Objective: Review the management structure of the national team.

Performance: The UK NSC review of quality assurance in ENSPDR recommended the development of a national adult (non-cancer) screening programme centre bringing together the senior management tier of both adult programmes – ENSPDR and the NHS Abdominal Aortic Aneurysm (AAA) Screening Programme. Work started on this process in 2010-11 with the appointment of Anne Stevenson (NHS AAA Screening Programme Manager) as ENSPDR Interim Programme Manager and plans to establish a joint national adult programme centre in Gloucester.

Objective: Development of regional QA teams.

Performance: Stronger links were formed during the year between the National QA Team and the regions. The development of regional QA teams will be progressed when the national restructuring of the NHS and the development of Public Health England structures have been finalised during 2011-12.

Additional actions

Objective: Obtain comparable data for all local programmes.

Performance: The national programme commenced work to reduce and eliminate the variation in data quality between local programmes and IT system types. It worked with software suppliers on specific aspects such as key performance indicators and this work will help ensure that consistent measurement and comparison of programme data is possible.

Objective: Agree levels of sensitivity/specificity for screening test.

Performance: Work started on delivering this objective during 2010-11. Final agreement on levels of sensitivity/specificity for diabetic retinopathy screening will only be possible as part of the 2011-12 project to review and revise the entire screening pathway.

Objective: Education and training for programme management.

Performance: Plans were put in place to deliver a series of education workshops in 2011-12 that will help meet the specific needs of local programme managers throughout England.

Objective: Education and training for screeners and graders.

Performance: Work began on assessing the ongoing training needs of screeners and graders working within ENSPDR.

Objective: Consolidate IT contracts.

Performance: Consultation was undertaken in 2010-11 on the consolidation of IT system contracts for diabetic retinopathy screening programmes. This consultation included regional workshops, individual interviews and a questionnaire to all programmes. ▶

Objective: Move forward with the GP2DRS IT system project to deliver improvements in patient cohort identification.

Performance: During 2010-11 work started on the testing of a central database and user interfaces for the GP2DRS IT system that will improve the transfer of patient details between GP systems and local programmes. This will help ensure local programmes have up to date lists of everyone eligible for screening in their area. Meanwhile, the recruitment process was also finalised for the appointment of a GP2DRS Programme Manager.

Quality

Quality assurance is aimed at the maintenance of minimum standards and the continual striving for excellence. It achieves this through various activities, including:

- Assessment of local programmes against agreed national standards
- Analysing standardised data returns
- Peer review visits, external audit and specific investigations
- Advising on specific issues to ensure consistency of processes, such as standardised failsafe procedures
- Sharing good practice
- Identifying implications of local serious incidents for national screening activity, supporting improvements and disseminating learning
- Training, education and external quality assessment programmes

During 2010-11 the national QA team undertook a range of activities to improve quality within local programmes and to support programmes that had problems.

Revision of QA Standards

Considerable work was undertaken during 2010-11 to revise the national QA Standards. These standards were devised when ENSPDR was first set up but local programmes had reported difficulties in measuring performance using them. In 2010, the national programme team led a process of review, which included the establishment of an expert reference group to review the QA Standards.

The group acknowledged that any fundamental change to the standards would require software changes that would take time to implement. A two-phase process was therefore agreed, with the first phase limited to changes not requiring software alterations.

Following recommendations by the expert reference group, a consultation was held and the final ▶

changes were approved by the Quality Assurance Committee and Programme Advisory Committee. The revised Phase 1 QA Standards were due to be released in April 2011.

Online EQA Test Set

The Online EQA Test Set was started in 2009 and provided an important resource to support the continual professional development of graders. Considerable development work was undertaken on this resource during 2010-11 following useful feedback from local programmes about the reporting facility. A new Test and Training Set was therefore developed ready to be launched in April 2011.

EQA visits

There were seven EQA visits between April and June 2010. In July 2010, Dr Sue Cohen, the newly-appointed National QA Director, with the support of Dr Peter Scanlon, the National Programme Director, and Dr Anne Mackie, the UK NSC's Director of Programmes, decided to temporarily halt the EQA visits. This break enabled the National QA Team to undertake a review of previous EQA visits and focus on developing policies and procedures that built on the experience from the previous year.

An expert reference group was established to lead this work and guidelines for visits were developed with supporting documentation on assessment of grading processes and interpretation of data.

As EQA visits were not carried out during most of the year, a Self-Assessment Tool (SAT) was developed. All programmes that had not had an EQA visit were asked to complete the SAT by April 2011 and produce an action plan. This process helped programmes identify where they needed to take action in order to improve quality.

Serious incidents

There were 13 serious incidents reported during the year. They included a software incident that involved more than 30 programmes. These programmes were subsequently required to ensure that adequate failsafe processes were in place and this incident led to important learning for the national programme team about how to support local programmes through this kind of event.

Regional meetings

The National QA team held regional meetings across England during 2010-11. These were very positive in gaining feedback from local programmes on problems and issues as well as supporting the establishment of regional groups to share good practice and improve communication between the local programmes and the national programme team.

Newly-constituted Quality Assurance Committee

As part of a national review of governance of the programme, a new chair of the QA Committee, public health consultant John Rodriguez, from Kent, was appointed and the membership of the committee was strengthened.

Education and training

Qualifications

The City & Guilds suite of Level 3 Qualifications in Diabetic Retinopathy Screening continues to be appropriate for staff working within ENSPDR. The exact qualifications that staff are required to complete depends on their role.

The Level 3 qualifications are also a requirement for relevant staff working in the Scotland and Northern Ireland national programmes, which are administered along with the English candidates by the ENSPDR Education and Training Team. In Wales, they are administered through the Welsh City & Guilds centre.

The ENSPDR Education and Training Team manages the receipt and processing of more than 250 candidate units per month.

The number of screening staff completing all the City & Guilds units required for their job role increased during 2010-11.

Despite an increase in the frequency of Internal Verification Panel meetings to 12 per year, along with an increase in the number of panel members, there was insufficient capacity to deal with the demand for verification of candidates.

The ENSPDR Education and Training Team consequently initiated home-based verification of candidate units by panel members, which helped to meet the growing demand.

The newly established MSc in Health Sciences (Retinal Screening – Diabetes) was accepted by the University of Warwick and offered at its Medical School from September 2010. The course gives staff an exciting opportunity to gain a higher qualification and further develop their careers.

Overseeing of qualifications and workforce

The Education Expert Reference Group (ERG) continued to oversee the implementation of

	June 2010	December 2010
Number of screening programmes in England registered for qualifications	89	89
Number of registered active candidates in England, Scotland and Northern Ireland	1,986	1,958
Candidates with completed full award or all units as required for their job role	309	390
Registered assessors	408	456
Internal verifiers	11	21

qualifications and consider the future direction of all aspects of education, accreditation and qualification relating to the screening workforce in England.

The Education ERG met in June and December 2010 with the core group consisting of Dr Peter Scanlon (Chair), Dr Paul Dodson, Dr Deborah Broadbent, Steve Aldington, Susan Blakeney and Jacqui Mansell, who represented the British Association of Retinal Screeners. Membership of the ERG will increase in 2011-12 to ensure it includes suitable representation from all areas of England and all major stakeholder groups. The ERG will then be succeeded by the ENSPDR's new Training, Education and Workforce Committee.

The national DRS qualifications administrative centre, based in Gloucestershire, underwent two external verification reviews by City & Guilds during 2010-11 and was highly commended.

Workforce and education survey

A workforce and education survey was undertaken in September 2010 and revealed that a significant number of staff working as graders for local programmes in England had not completed the required qualifications.

ENSPDR therefore set a target for all relevant staff to complete their exams for Units 7 and 8 by the end of December 2011 and all written work on those units by mid 2012. During 2011-12, a series of regionally-based examination days will be held to support candidates taking Unit 7 and Unit 8 exams.

On-line EQA

The ENSPDR on-line EQA system, which provides monthly on-line grading testing for all staff in England, was reviewed during 2010 – its first full year of implementation. More than 1,400 people took at least one test during this period and more than 800 undertook all 12 available tests.

In December 2010, the Education ERG took over responsibility for overseeing the on-line EQA process from the EQA Committee. The on-line EQA process, renamed Test and Training, will be aligned more closely with that of continuing professional development during 2011-12.

Collaborative working

ENSPDR seeks to involve patients, charities and expert professional groups in the programme's ongoing development and monitoring.

During 2010-11, the national programme's committee structure was reorganised following a review that identified the need to strengthen accountability and governance structures.

The new structure came into force on 1 January 2011 with five sub-committees reporting to the over-arching Programme Advisory Committee, which replaced the Project Advisory Group.

One of the underlying principles of the restructuring exercise was that each group should seek to engage with stakeholders and make accountability real.

Each committee is expected to include all appropriate professional disciplines as well as patient representatives where possible. In addition, public health expertise should be available to all committees.

Patient representation

Alison Blackburn continued to represent patient interests nationally on the Programme Advisory Committee. She also represented the national programme at the annual conference of the Insulin Dependent Diabetes Trust in October 2010.

Alison uses her personal experience of diabetes and retinopathy to advise on how services can best meet the needs of patients and be accessible to all. She has regular contact with people with diabetes, which she uses to stress the importance of keeping eye screening appointments.

Since 2008, Alison has been an elected member of the UK Advisory Council of Diabetes UK. In addition, she runs a telephone helpline – the National Diabetic Retinopathy Network (0191 2741414) for people who have been diagnosed with diabetic retinopathy.

Locally, each retinal screening programme has a programme board that includes patient representation. Alison, who is Chair of the Newcastle Disability Forum, is a local patient representative on the retinal screening board that covers Newcastle-upon-Tyne, West Northumberland and Gateshead.

Stakeholders

ENSPDR works closely with Diabetes UK (www.diabetes.org.uk), the UK's largest charity devoted to the treatment and care of people with diabetes.

During 2010-11, Simon O'Neill, Director of Care, Information and Advocacy at Diabetes UK, continued to serve on the Programme Advisory Committee. Bridget Turner, Diabetes UK's Head of Policy and Care Improvement, was a member of the ENSPDR Quality Assurance Committee until midway through the year.

Looking ahead, the national programme aims to work with Diabetes UK to increase user involvement in the programme.

During 2010-11, ENSPDR also continued to work closely with NHS Diabetes (www.diabetes.nhs.uk), the national NHS organisation that provides a link between the Department of Health, commissioners, providers and clinicians to support improvements in diabetes services.

Gill Saunders, NHS Diabetes' Project Lead for Retinopathy, is a member of the Programme Advisory Committee and also sits on the local Bath and North East Somerset screening programme board. On 28 March 2011, Gill attended the first meeting of the ENSPDR Pathway Expert Reference Group.

Cross-programme working

National Programme Directors Dr Peter Scanlon (right, diabetic retinopathy) and Jonothan Earnshaw (AAA)

During 2010-11, the national programme team continued to work closely with the UK NSC as well as colleagues in other national screening programmes to share best practice.

This includes participation in two UK NSC cross-programme groups – the Public Information, Communications and Professional Development Group and the Cross Programme Quality Assurance Group. ▶

During 2011-12, ENSPDR will forge even closer links with the NHS AAA Screening Programme. Following a review by the UK NSC, the national teams of both programmes are joining forces in the new national NHS Adult (non-cancer) Screening Programmes Centre based in Gloucester. Both programmes will retain their identity and disease-specific expertise but will share common learning as well as operational processes and functions.

Data collection

Annual report data

Local diabetic retinopathy screening programmes continued to use the Electronic Annual Reporting System (EARS) successfully during 2010-11 to submit their annual report data to ENSPDR.

The national programme team investigated a collection of key data validation checks that are integral to EARS and used these to identify potential improvements to the quality of the data collected for annual reports. Issues identified fell into two main areas – programme errors, to be rectified through annual report training sessions, and software reporting errors, to be addressed through quarterly software supplier meetings.

At the end of 2010-11, the majority of local programmes had submitted their 2009-10 annual reports as required and they had been through the ENSPDR internal validation process.

Looking ahead, improvements to the quality of submitted data and the implementation of the revised national QA standards will enable ENSPDR to report nationally on key QA standards.

Key Performance Indicators

The UK NSC developed a catalogue of quarterly Key Performance Indicators during 2010-11 covering each of the national non-cancer screening programmes in England.

The purpose of the KPIs is to define consistent performance measures for a selection of public health priorities, using terminology that is clear and common across all programmes so performance can be understood, assessed and compared.

ENSDPR worked closely with the UK NSC to define its requirements for three KPIs – uptake, result notification times and time between consultation and treatment – to ensure they were both consistent with UK NSC definitions and ENSPDR annual reporting definitions and QA standards.

The first round of collection of this data, in December 2010, highlighted issues around the definition of the KPIs and their accuracy in reflecting local programme performance. In 2011-12, the ENSPDR will aim to eliminate inconsistencies in the interpretation of the report requirements so that programme data will be more accurate and useful.

Equality and equity

ENSPDR seeks to ensure that all people with diabetes aged 12 and over have access to a high quality screening service.

Good access to screening is provided across the country with local models designed to help patients attend a service. Screening may be provided from a mobile van or at local optometry practices, GP surgeries and clinics. The national programme team works with other organisations including Diabetes UK to find out what other steps could be taken to help patients attend screening appointments.

There is evidence that suggests uptake for screening for diabetic retinopathy is affected by deprivation and factors such as ethnicity. Local programmes in areas such as Tower Hamlets, with large black and minority ethnic populations, have worked hard to make sure they understand what might prevent patients from taking up screening and have put in place measures to improve uptake, such as phoning and texting.

People with diabetes may have other conditions or disabilities that can affect their ability to attend appointments. Local programmes continue to work hard to make provisions for people with disabilities so they can attend screening.

Nationally, ENSPDR has encouraged local programmes that have developed innovative approaches to increase uptake to share their knowledge and experience through educational events and newsletters. The national programme team is supporting research in this area so it can use this information to reduce inequalities in the future.

IT development

ENSPDR relies on many IT systems to deliver digital images of eyes for disease grading, to transfer data so quality can be assured and to manage the screening process efficiently and safely.

The GP2DRS project continued into its system development phase during 2010-11. This project will ensure all local screening programmes can receive accurate lists of patients with diabetes so they can be invited for screening. It is a complex project but one capable of ensuring that people with diabetes receive an invitation rapidly after diagnosis. It may be possible to apply the technologies used in GP2DRS to other national screening programmes where identifying the right people to invite for screening is essential.

The GP2DRS system comprises a central database capable of being viewed by each local programme via a web-based tool. Each programme will be able to see a list of patients in their area that will mean they will not need to use paper or fax alternatives in managing their cohorts. The central database is already operational and the user interface will be completed in 2011-12. Some GP system suppliers started testing their data downloads in 2010-11. The screening management system suppliers also began to develop reconciliation tools to allow data to flow into the screening systems automatically.

It is envisaged that some local programmes will begin to use the GP2DRS system at the end of 2011, with roll-out more widely across England taking place during 2012.

During 2010-11, the national programme team also started a comprehensive review of its IT systems and how well they can continue to support ENSPDR in the ▶

future. Following this review, the aim will be to produce a strategy that ensures delivery of high quality screening services in the next phase of the programme's development.

IT systems also support the delivery of training for staff working within ENSPDR. The Test and Training Application was enhanced in 2010-11 to deliver a fully-featured training system for graders around the country to test their grading skills and improve grading performance nationally.

ENSPDR also approved several new cameras for inclusion on the approved list of cameras used in the screening process. Strict standards are applied to all cameras capable of being used by screening programmes to ensure high image standards are maintained.

Information

Screening has important ethical differences from clinical practice because it targets apparently healthy people.

All screening involves a careful balance of risks and benefits. This places a particular burden on the quality and content of public information materials produced nationally as well as any information disseminated by programmes locally.

During 2010-11, ENSPDR identified the need to enhance existing communication channels and materials as part of a range of activities to improve quality and reduce variability in the way screening is delivered throughout England.

A communications strategy was developed in conjunction with hanover, the UK NSC's cross-programme press office provider, and the Communications Lead of the NHS AAA Screening Programme. This strategy will help to inform the development of public information and professional engagement during 2011-12 and beyond.

Patient information leaflets

The following three national patient information leaflets continued to be available in 2010-11 for local programmes programmes to send to patients with their screening invitations, following detection of background retinopathy or with a referral letter:

- Eye screening for people with diabetes – the facts
- Diabetic retinopathy – the facts
- Preparing for laser treatment for diabetic retinopathy and maculopathy

Some local programmes have also developed their own patient information materials.

Online resources

During 2010-11, the ENSPDR website www.retinalscreening.nhs.uk, continued to provide patients with information about retinal screening as well as contact details for local programmes. The site includes a facility for patients to email questions to the national programme and download copies of the national patient leaflets.

Information about the screening programme was also updated on health websites, including Map of Medicine (http://eng.mapofmedicine.com) and GP Notebook (www.gpnotebook.co.uk). ▶

Internal communications

ENSPDR continued to develop its internal information resources and communications infrastructure during 2010-11 with the expansion of the SharePoint IT platform for file sharing, document version control and internal announcements.

Press office

On 1 July 2010, the UK NSC appointed national communications consultancy hanover to provide a cross-programme press office function for the national non-cancer screening programmes in England.

Following its appointment, hanover provided communications advice, support and materials to both the ENSPDR national programme team and local screening providers following a number of serious incidents involving software issues.

Looking ahead

The delivery of ENSPDR's new communications strategy in 2011-12 will include the drafting, design and development of a new range of national patient information materials and the revamping of the national programme website.

In addition, gaps in stakeholder engagement will be identified and a new quarterly newsletter will inform screening staff and other health professionals and stakeholders connected with retinal screening throughout England.

Research

Support for high quality research is an integral element of the national screening programme and 2010-11 saw significant developments in this area. The UK Diabetes Research Network (DRN) Diabetic Retinopathy Screening Writing Group was set up in 2008 following a successful application by National Programme Director Dr Peter Scanlon and Professor Simon Harding.

The UK DRN provides a national infrastructure for large-scale research into diabetes and the following four topics were identified by the Writing Group to progress research projects:

- Health Economics
- Screening Intervals
- Screening Uptake
- Epidemiology

Extra researchers from different centres have been identified to take these topics forward and the following grant submissions were successful:

1. **Research for Patient Benefit Grant**. £219,885. Accepted and commenced. Title: *Improving low uptake of diabetic retinopathy screening in primary care: factors at the patient and GP practice level.* Peter Scanlon, Irene Stratton, Mike Whatmore, Jackie Sturt, Paul O'Hare.

2. **NIHR Programme Development Grant RP-DG-0709-10138**. £99,808. Accepted and commenced. Title: *Acceptability and effectiveness of risk-based intervals in screening for diabetic retinopathy – towards a personalised approach*. Simon Harding, Mark Gabbay, Paula Grey, Marilyn James, Irene Stratton, Deborah Broadbent, Tony Fisher, Jiten Vora, John Roberts, Marta Garcia-Finana, Paula Byrne. ▶

3. **Application for HTA Call no 10/66 on 'Screening intervals for diabetic retinopathy'** – Expression of Interest submitted September 2010. Title: *Development of a cost-effectiveness model for optimisation of the screening interval in diabetic retinopathy screening*. Peter Scanlon, Irene Stratton, Ramon Luengo-Fernandez, Jose Leal, Andrew Farmer, Richard Stevens, Paul O'Hare, Sobha Sivaprasad. A full proposal for this submission was due to be considered by the National Institute for Health Research Health Technology Assessment Programme's Commissioning Board in July 2011.

A new Research and Data Management Committee has been created following the review of the national programme's committee structure and terms of reference. This committee will advise on research needed to reduce the population risk of visual loss due to diabetic retinopathy and will ensure all data requests to the central data repository comply with information governance requirements.

After the screen

Screening involves digital photography of the retina followed by a systematic image grading process. Screening results are sent to individuals – and their GPs – within six weeks of their appointment.

The success of the screening programme depends crucially upon patients being seen and treated in a timely fashion if their screened image shows signs of sight threatening retinopathy that may require treatment. It also depends upon treatment for referred patients following best practice guidelines set out by the Royal College of Ophthalmologists.

Evidence[1, 2] shows there is a significant relationship between screening attendance and visual outcome. People with diabetes are more likely to have severe levels of retinopathy or suffer sight loss if they do not attend screening appointments.

Once a screened image has been graded as showing sight-threatening diabetic retinopathy, the patient is referred to an ophthalmologist. At this assessment, their pupils are dilated and their fundus – the interior surface of the eye – is examined. If it is considered that treatment would be beneficial, this usually takes the form of laser treatment. In cases of high-risk proliferative retinopathy, which involves abnormal vessels forming on the retina to a high-risk level, laser treatment reduces the risk of severe visual loss by 50% or more within a two-year period. Laser treatment is also given for maculopathy, when leakage occurs in the central macular area of the retina, threatening vision. For advanced cases of diabetic retinopathy, a vitrectomy operation may be performed to remove some or all of the vitreous humour – the clear gel that fills the space between the lens and retina of the eyeball.

An important aspect of treatment for all patients, even those with mild retinopathy, is improving control of their blood sugar and blood pressure. This can stop further retinopathy occurring and so prevent sight loss.

During 2010-11, ENSPDR held discussions with the Royal College of Ophthalmologists aimed at improving the reporting of required outcome data from ophthalmology departments following screening referrals. These discussions helped to clarify roles and responsibilities and there was a gradual improvement in outcome data reporting during the year.

1 Zoega GM, Gunnarsdottir T, Bjornsdottir S, Hreietharsson AB, Viggosson G, Stefansson E. Screening compliance and visual outcome in diabetes. *Acta Ophthalmol Scand* 2005;83(6):687-90.
2 Gray RH, Blades C, Jobson C. Screening Clinic Non-Attendance And The Risk Of Sight Threatening Retinopathy. *Eur J Ophthalmol*. 2009 19(3):510.

Governance and finances

The Department of Health holds the UK NSC's Director of Programmes, Dr Anne Mackie, to account for the implementation and delivery of national NHS screening programmes in England. Dr Mackie, in turn, holds National Programme Director Dr Peter Scanlon to account for the English National Screening Programme for Diabetic Retinopathy. Accountability is also exercised through the production of annual reports.

Dr Scanlon and staff working within the ENSPDR national programme team are hosted by the Gloucestershire Hospitals NHS Foundation Trust with a service level agreement between the Trust and the Department of Health.

The UK NSC's Review of Quality Assurance of ENSPDR published in May 2010 identified the need to strengthen the programme's accountability and governance structures. As a result, the ENSPDR committee structure and terms of reference were reviewed. The new structure was finalised in February 2011 with an over-arching Programme Advisory Committee (PAC) supported by five sub-committees.

The role of the PAC is to advise the UK NSC on the implementation, development, review and modification of retinal screening in England. It advises and receives reports from the ENSPDR national programme team on programme performance and ensures that screening for diabetic retinopathy is fully integrated with other aspects of diabetic and ophthalmology care.

The five ENSPDR sub-committees all report back to the PAC through their chairs. The QA Committee aims to ensure the programme is of high quality. It advises the National QA Director on the development and implementation of a QA strategy and also provides oversight of the delivery of the QA system in ENSPDR.

The Grading and Assessment Committee advises on issues relating to the grading of images and the assessment of screen-positive patients in order to ensure that grading and assessment are of high quality and cost-effective.

The Training, Education and Workforce Committee advises on the development, implementation and effectiveness of education, training and accreditation strategies.

The Camera, Software and Technical sub-committee is responsible for maintaining effective standards and processes for the adoption, integration and development of cameras and software for use within ENSPDR.

The final sub-committee is the new Research and Data Management Committee. This committee will advise on research needed to reduce the population risk of visual loss due to diabetic retinopathy and will ensure all data requests to the central data repository comply with information governance requirements.

The national programme team's management structure was also revised during 2010-11. In January 2011 a programme manager was appointed across both national non-cancer adult screening programmes to facilitate the development of a more cohesive approach within a shared national programme centre in Gloucester. ▶

2010-11 finances

National programme team staffing costs	£1,299,760
National programme team hosting and administration costs	£93,642
National programme team relocation costs	£83,451
QA costs, including EQA costs and central support costs	£256,468
Information systems development, including major interface project, enhancements to screening systems and improved outcome data reporting	£347,750
Website development work, including hosting charges	£31,896
Expenditure on consultants	£137,019

The main costs to ENSPDR during 2011-12 will relate to the development of the GP2DRS IT system and the development and implementation of training needs analysis across the screening pathway.

The national programme team works closely with Department of Health colleagues and the finance team at Gloucestershire Hospitals NHS Foundation Trust to plan expenditure and ensure ENSPDR achieves value for money.

Looking Ahead

ENSPDR has a number of objectives to work towards during 2011-12. Its focus will remain on the key objective of supporting the delivery of an integrated high quality service for patients with diabetes.

Work will continue on improving the delivery of clear and supportive guidance to local programmes, improving the way data is collected and reported, providing a robust evidence base to changes made in quality standards and ensuring that the screening workforce is competent and accredited. The national programme team will work closely with local commissioners and providers to help safely manage the transition of the retinal screening programme into the NHS structures and processes of the future.

Objectives for 2011-12 include:

Strategic review of the programme

- Review, revise and produce single screening pathway following evidence review, economic appraisal, stakeholder engagement and consultation
- Establish process to review key policy areas of screening intervals and automation
- Revise grading definitions to achieve appropriate risk/benefit for national programme
- Undertake review of costs and contract values for programme delivery; identify solutions to reduce demand and contain costs.

Managing commissioning and the transition into the new NHS structures

- Produce a single national service specification and a transitional plan to mitigate risks to local programmes and staff
- Produce contractual framework to cover relationship between all providers in the screening pathway and the national programme
- Work with providers and commissioners to understand local and national commissioning requirements, work towards consistency in commissioning specifications

Quality assurance

- Publish revised protocol for EQA visits and restart EQA visits following appointment and training of EQA Leads and Peer Reviewers
- Facilitate the development of regional groups and work towards regional QA structures
- Develop an evidence based approach to assess grading performance in programmes
- Develop a systematic approach to analysing and reporting regularly on available data
- Produce and disseminate guidance on the management of serious incidents

Update of guidance and operational policy documents

- Update ENSPDR Workbook
- Develop and release revised policies on failsafe and on exclusions and suspensions

Education, training and workforce

- Develop an overarching education and training strategy
- Conduct a fitness for purpose review of current qualifications
- Carry out a full training needs assessment across the entire screening pathway
- Develop and deliver training programmes for peer reviewers, QA team and programme managers
- Work in a cross-programme capacity to develop e-learning module for screening staff
- Investigate establishing continuing professional development system for staff
- Develop a workforce register

IT & data management

- Review overall IT strategy and make recommendations towards alignments of contracts and software
- Continue to progress the national GP2DRS IT project
- Begin revision of the dataset
- Develop strategies to improve data quality and collection

Information

- Develop new programme identity
- Launch new website
- Produce a clear and concise set of key messages
- Develop suite of new information materials for patients, families and professionals
- Continue to develop communication strategies for all stakeholders
- Ensure programme changes and updates are disseminated

Corporate/team

- Continue implementing organisational recommendations to ensure the effective running and development of the national programme team alongside the NHS AAA Screening Programme within Gloucestershire Hospitals NHS Foundation Trust
- Develop a more cohesive approach to working in partnership with other national NHS non-cancer screening programmes ▶

- Put in place formal policy review process, ensuring consistency with cross-programme policies and UK NSC oversight and governance
- Continue to manage the programme's finances effectively
- Continue to develop SharePoint IT platform as a document management tool
- Continue to work with EQA team to ensure appropriate skills and resources are in place to support local programmes

Further information and resources

Diabetes UK
Diabetes UK is the UK's largest charity devoted to the treatment and care of people with diabetes. It funds research, campaigns and helps people to live with the condition. More information about the charity's work and its support for the national screening programme can be found at www.diabetes.org.uk.

NHS Diabetes
NHS Diabetes is a national organisation supporting improvement in diabetes services. It works to raise the quality of diabetes care in England by supporting the healthcare community and people with diabetes. It helps to develop and support new guidelines, standards and systems designed to improve care. Formerly the National Diabetes Support Team, the organisation was relaunched in early 2009. Visit www.diabetes.nhs.uk for more information.

British Association of Retinal Screening
The British Association of Retinal Screening is an organisation for people who provide retinal screening services for people with diabetes. It provides an educational, representational and support resource for those involved in screening by using the internet and organising conferences and meetings. For more information, visit www.eyescreening.org.uk.

UK National Screening Committee (UK NSC)
The UK NSC advises Government Ministers and the NHS in the four UK countries about all aspects of screening and supports implementation of screening programmes. Its website is www.screening.nhs.uk.

Royal National Institute for the Blind (RNIB)
The RNIB is the UK's leading charity offering information, support and advice to almost two million people with sight loss. For more information, visit www.rnib.org.uk.

Insulin Dependent Diabetes Trust
The Insulin Dependent Diabetes Trust is an organisation for people living with diabetes run by people living with diabetes. It offers support to partners, parents and other members of the family. It raises awareness of important issues and provides information in non-medical language. Visit www.iddt.org.

Action for Blind People
Action for Blind People is a national charity with local reach, providing practical help and support to blind and partially sighted people of all ages. Visit www.actionforblindpeople.org.uk.

NSC UK National Screening Committee

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