NHS
Wigan Borough
Clinical Commissioning Group

MEETING: Governing Body – Open Meeting **Item Number: 9.2**

DATE: 25 February 2014

REPORT TITLE:	**NHS Diabetic Eye Screening Programme (DESP) Incident**
REPORT AUTHOR:	**Helen Cooper**
PRESENTED BY:	**Julie Southworth**
RECOMMENDATIONS/DECISION REQUIRED:	**For Information**

EXECUTIVE SUMMARY

Wigan Borough Clinical Commissioning Group (WBCCG) was alerted to an incident in the Diabetic Eye Screening Programme (DESP) at Wrightington Wigan and Leigh NHS Foundation Trust (WWLFT) on 23 April 2013 by the Screening and Immunisation Lead at Public Health England (PHE) Greater Manchester Area Team (GM AT).

The initial report advised that five (5) WBCCG Practices had been audited and 54 patients had not been invited for screening. A wider audit to include all WBCCG practices has since been undertaken. The data has been analysed and validated, a further 492 patients have been identified with an incomplete screening record.

Monthly MiQuest queries have been set up for each Practice to validate the diabetes register, November 2013 saw a 100% return from WBCCG Practices

WWLFT DESP team in conjunction with PHE will finalise and share completed Root Cause Analysis (RCA) with recommendations and actions. WBCCG will assist as required with the recommendations identified in the action plan

WWLFT DESP team have provided the WBCCG Head of Primary Care Quality and Clinical Director for Quality a breakdown by Practice of affected patients this will assist in identifying any trends and facilitate the sharing of lessons learned with member Practices.

FURTHER ACTION REQUIRED:	

NHS DIABETIC EYE SCREENING PROGRAMME (DESP) INCIDENT

1 Introduction

Wigan Borough Clinical Commissioning Group (WBCCG) was alerted to an incident in the Diabetic Eye Screening Programme (DESP) at Wrightington Wigan and Leigh NHS Foundation Trust (WWLFT) on 23 April 2013 by the Screening and Immunisation Lead at Public Health England (PHE) Greater Manchester Area Team (GM AT).

This was highlighted as a patient safety incident as defined by the NPSA (National Patient Safety Agency) and reported on the Strategic Executive Information System (**STEIS**) serious untoward incident system.

A failure in the stage of the pathway of the screening service was identified and following guidance in the National Framework for Reporting and Learning from Serious Incidents the incident required further investigation. All parties involved with the reporting and managing incidents in the screening programme have complied with the existing national guidance and local polices as referred to above, particularly in regard to the new commissioning arrangements since April 2013.
Advice was also taken from the Regional Quality Assurance team in regard to specific expert opinion and support, including advice on the 'look back exercise'

2 Background

The aim of the DESP is to mitigate the risk of sight loss amongst people with diabetes by the prompt identification and effective treatment if necessary of sight threatening diabetic retinopathy. Diabetic retinopathy is a complication of diabetes and is the leading cause of blindness in the working population in the developed world. Diabetic retinopathy, if left untreated, can lead to sight loss. By promptly identifying and treating the disease, these effects can be reduced or avoided completely.

Diabetic eye screening is just one component of diabetes care; the screening programme should be integrated with routine diabetes care. All patients with diabetes are invited annually for retinal screening. Providers of DESP are required to undertake systematic validation and cleansing of data.

3 Context

Ashton, Leigh & Wigan Diabetic Eye Screening programme has found gaps in its cohort of patients registered on its Single Collated List (SCL). There was a

breakdown in the pathway from GP referral to the Trust Diamond/Twinkle diabetic register and further breakdown of the electronic interface from Diamond diabetic register to the local screening programme Optomize database. These pathway failures have been investigated and failsafe measures and recommendations put in place to address these and prevent a re-occurrence.

The investigation found 492 patients unknown to the screening programme, with 27 patients with referable diabetic retinopathy and requiring further clinical investigation.

4 Actions taken

A Serious Incident (SI) Board was convened by Billies Moores, Area Team Screening and Immunisation Lead on 2 May 2013. Relevant stakeholders were invited and Terms of reference of the board were discussed and agreed.

Immediate data validation of all remaining GP practice lists was carried out using electronic validation via MiQuest queries with the assistance of the Commissioning Support Unit (CSU). However challenges in regard to data sharing agreements and Information Governance issues resulted in time delays to the start of the process.

Practices have with the support of the CSU team set up MiQuest queries that enable the Practices to submit monthly data to the DESP with 100% return from Practices November 2013 - January 2014

A wider audit to include all WBCCG practices has been undertaken with input from WWLFT DESP team and CSU Data Quality IT Leads. This data has been analysed and validated and resulted in 492 patients being identified with an incomplete screening record and were unknown to the ALW DESP. A data cleansing exercise was carried out to identify any patients who were being screened elsewhere or receiving treatment / assessment for Diabetic Retinopathy from another Hospital Eye Service.

All eligible patients have been invited for immediate screening. The 492 unknown patients have been absorbed into the ALW DESP and those that needed clinical review or treatment have been referred for assessment / treatment by WWL ophthalmology. Of these patients 27 have referable diabetic retinopathy the full clinical outcome of these patients is awaited.

WWL DESP have implemented processes and failsafe's to ensure the interface between Diamond and Optomise is checked on a daily basis.

Dr Sakir Patel, Lead GP for Quality Assurance for the Wigan Borough CCG, undertook an exercise to scope the challenges within practice. There appeared

to be no single referral system to the Diamond register. Diabetic review / monitoring systems differed within practices in regard to both Type 1 and Type 2 diabetes.

WWL DESP team have provided the WBCCG Head of Primary Care Quality and Clinical Director for Quality a breakdown by Practice of affected patients this will assist in identifying any trends and facilitate the sharing of lessons learned with member Practices.

5 Recommendations

The area team are to close the incident on the Strategic Executive Information System (StEIS).

WWL DESP team in conjunction with PHE will share completed RCA with recommendations and actions.

WBCCG to assist as required with recommendations identified in the action plan