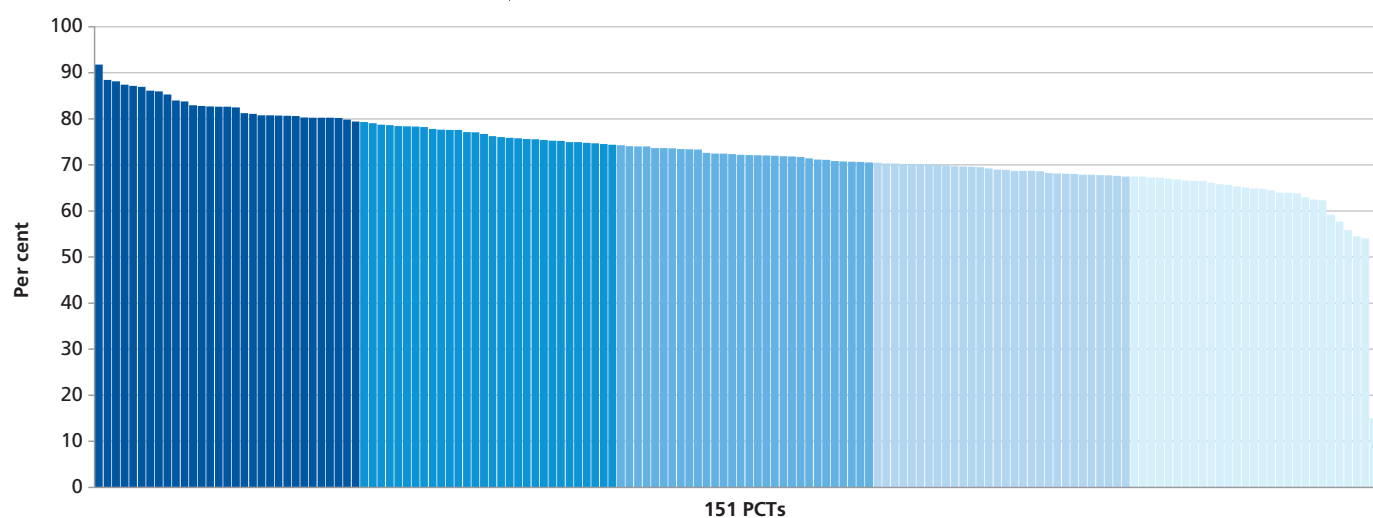
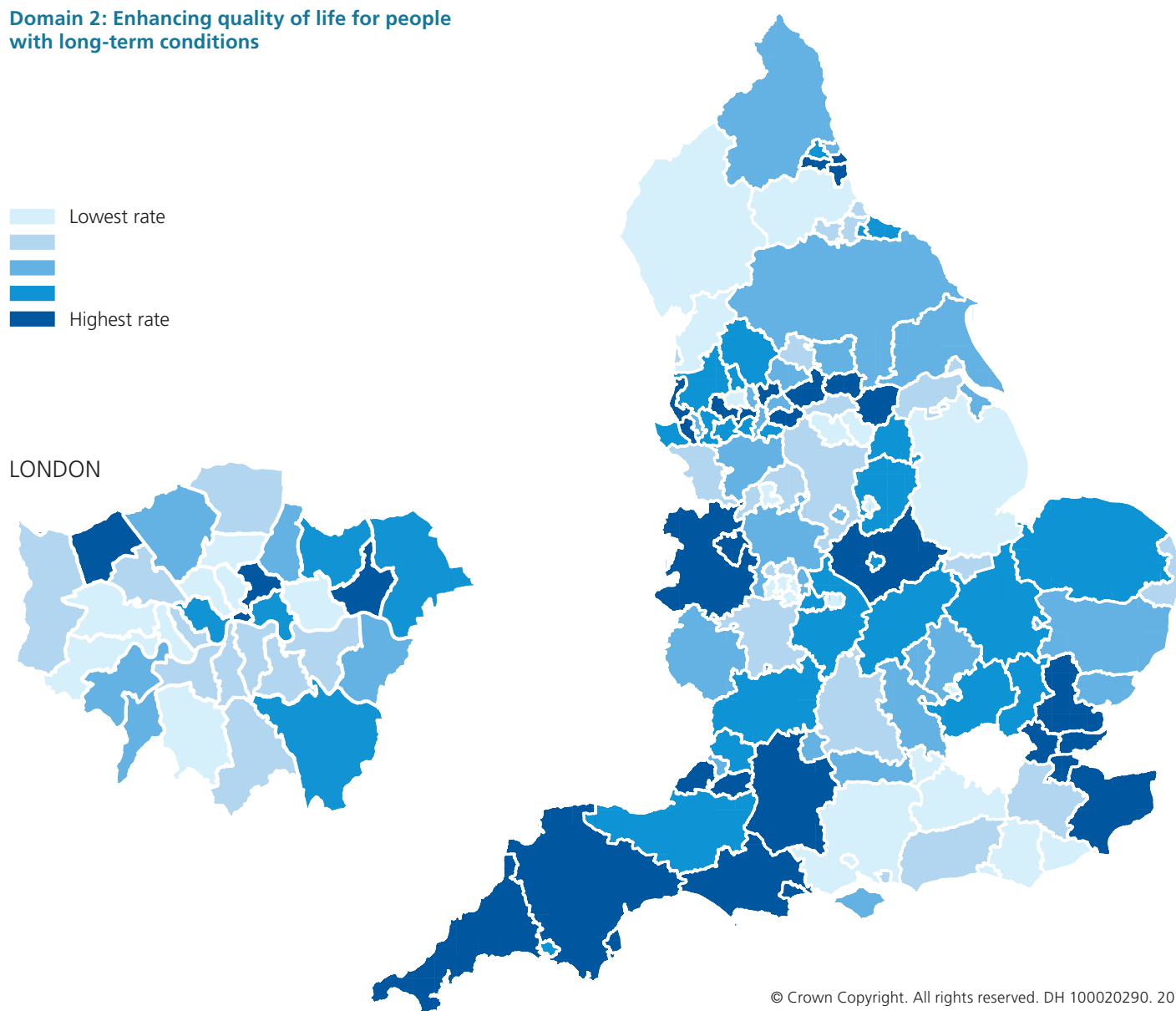


PROBLEMS OF VISION

Map 21: Percentage of the diabetic population receiving screening for diabetic retinopathy by PCT

January–March 2011

Domain 2: Enhancing quality of life for people with long-term conditions



Context

As people with diabetes are 25 times more likely than the general population to become blind¹ and the early stages of diabetic eye disease often do not present with any symptoms, the English National Screening Programme for Diabetic Retinopathy (ENSPDR) is important for the early detection of people with diabetes who should be referred to an ophthalmologist at the point when treatment is most effective and preventable sight loss can be avoided. Early diagnosis and treatment prevents up to 98% of severe vision loss: the earlier treatment is received, the more likely it is to be effective.²

The ENSPDR was rolled out across the country in 2006, and there are national quality standards in the National Screening Committee (NSC) Workbook, *Essential Elements in Developing a Diabetic Retinopathy Screening Programme*.³

For an initial screening test:

- The minimum standard is 70% for the eligible population taking up the offer.
- The achievable standard is 90% for the eligible population taking up the offer.

For a repeat screening test:

- The minimum standard is 80% for the eligible population taking up the offer.
- The achievable standard is 95% for the eligible population taking up the offer.

The data for this indicator are collected quarterly as part of the Department of Health Integrated Performance Measures Monitoring.⁴ The indicator is a “snapshot” of patients during the quarter: it records the latest update on any instance of a screen (via digital photography) on a patient’s notes in the past 12 months during the recording period (January to March 2011), divided by all those patients with diabetes (in the quarter) who were eligible for screening.

Magnitude of variation

For PCTs in England, the percentage of the diabetic population receiving screening for diabetic retinopathy ranged from 7.4% to 91.8% (12-fold). When the five PCTs with the highest percentages and the five PCTs

with the lowest percentages are excluded, the range is 57.7–87.0%, and the variation is 1.5-fold.

This degree of variation in the uptake of screening is of great concern, particularly as the indicator is associated with national quality standards (see “Context”).

It is possible that different factors influence both uptake and delivery of the service for initial and repeat screening.

For this indicator, the aim should be not only to reduce variation but also to improve performance such that all PCTs meet the minimum standard and work towards meeting the achievable standard.

Options for action

Commissioners and providers should ensure that the minimum standard for both the initial and repeat screening tests is met universally.

Each local screening service should analyse their data annually and benchmark them against the national quality standards.

Screening services meeting the achievable standard should publish details of their service operation to enable those whose performance is not as good to identify learning points and thereby improve performance.

In areas where standards are not being met, local factors leading to low uptake should be identified, and solutions that have proved effective in other areas should be investigated, such as offering patients viable choices when booking appointments, texting appointment reminders, and translating patient information.

In all areas, data quality should be assessed to ensure that records are accurate.

RESOURCES

- English National Screening Programme for Diabetic Retinopathy (ENSPDR). <http://www.retinalscreening.nhs.uk/pages/>
- ENSPDR Commissioning Toolkit. <http://www.retinalscreening.nhs.uk/pages/default.asp?id=7&slD=90>

 **See what Right Care is doing in ophthalmology on page 32**

1 National Society to Prevent Blindness (1980) Visual Problems in the US: data analysis definitions. Data 74 sources, Detailed Data Tables, Analysis, Interpretation. New York.

2 Access Economics (2009) Future Sight Loss UK 1: Economic Impact of Partial Sight and Blindness in the UK adult population. RNIB. http://www.rnib.org.uk/aboutus/Research/reports/2010/FSUK_Report.doc

3 <http://www.nscscreening.org.uk>

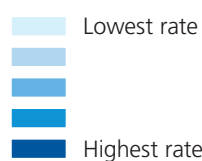
4 Department of Health. Integrated Performance Measures Monitoring. Report on Primary Care Trust and NHS Trust performance against plans to address selected health priorities relating to the NHS Operating Framework. <http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Perfomancedataandstatistics/Integratedperformancemeasuresmonitoring/index.htm>

PROBLEMS OF VISION

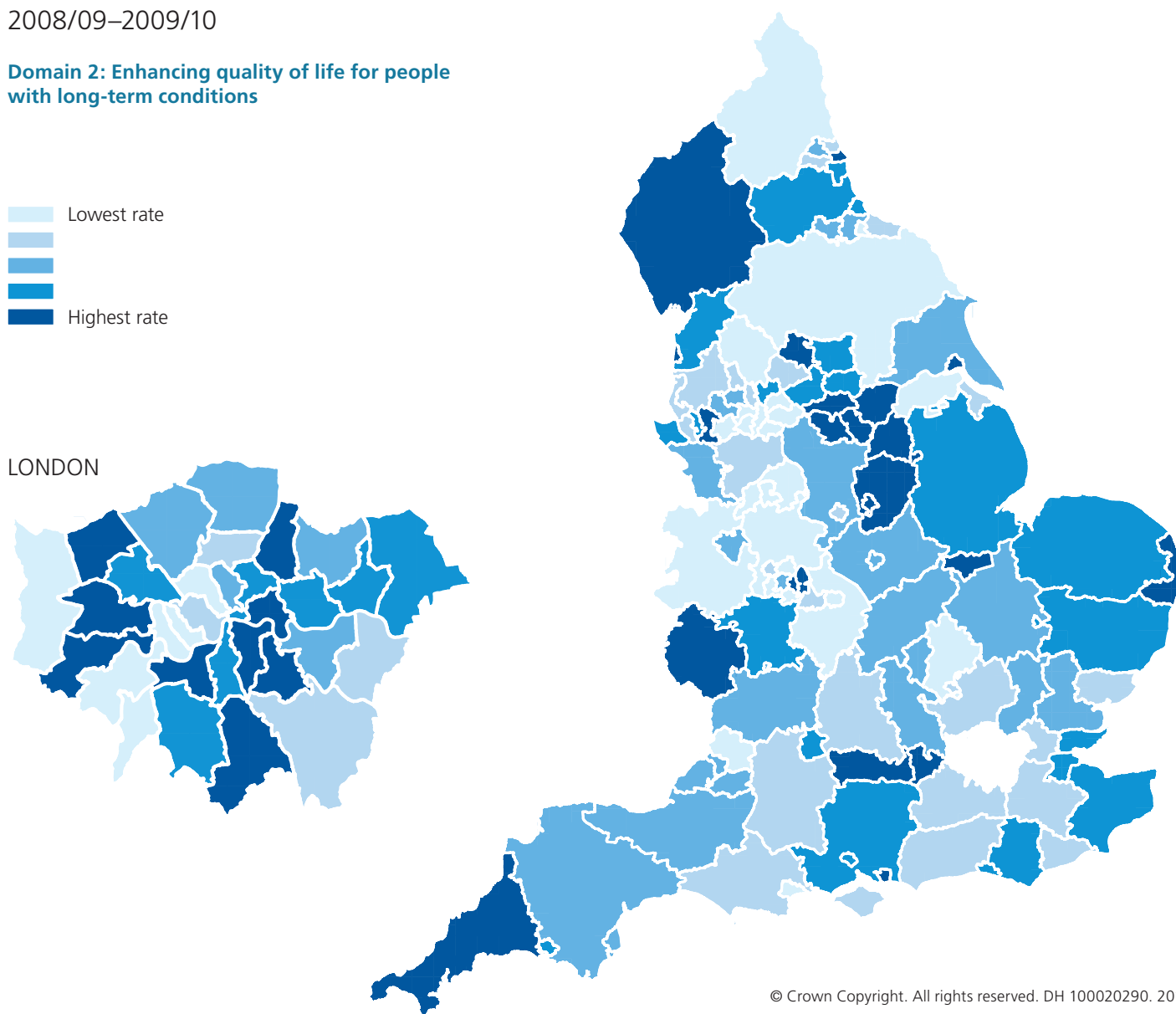
Map 22: Rate per population of certificates of vision impairment (CsVI) issued with a main cause of diabetic eye disease by PCT

2008/09–2009/10

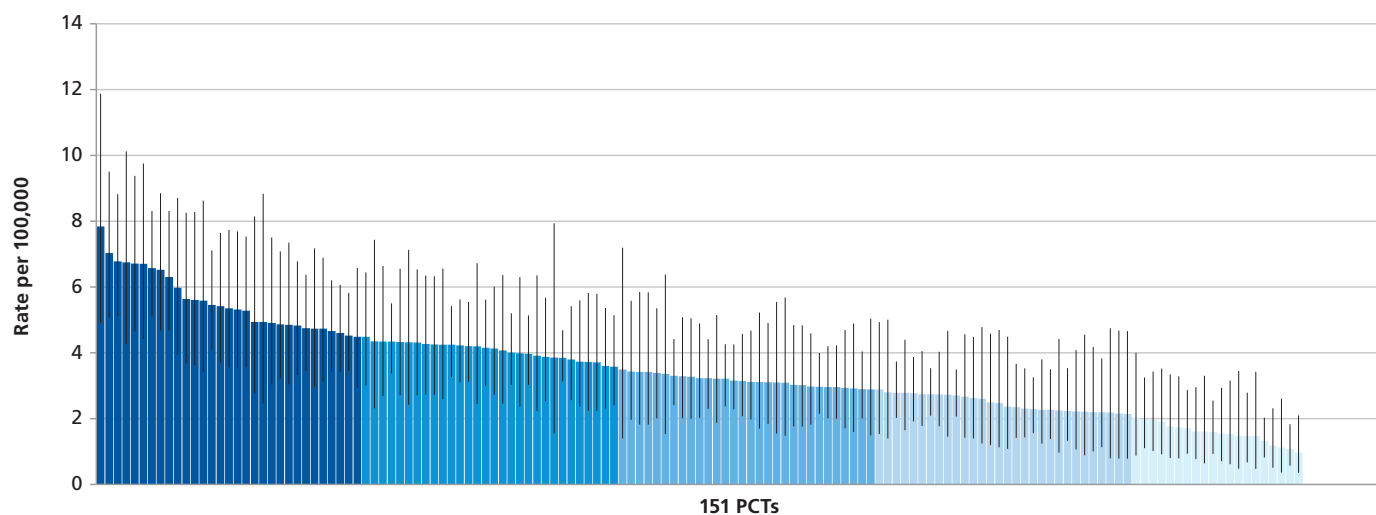
Domain 2: Enhancing quality of life for people with long-term conditions



LONDON



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Context

People with diabetes are 25 times more likely than the general population to become blind.¹ In England and Wales, diabetic eye disease is the leading cause of blindness in adults under 65 years.² Early stages of diabetic eye disease often do not present with any symptoms. However, early diagnosis and treatment can prevent up to 98% of severe vision loss: the earlier treatment is received, the more likely it is to be effective.³ Improved control of the diabetes and its risk factors can prevent the onset and the development of diabetic eye disease and sight loss.

The National Screening Committee (NSC) Workbook, *Essential Elements in Developing a Diabetic Retinopathy Screening Programme*, includes quality standards for diabetic retinopathy screening services:

To reduce new blindness due to diabetic retinopathy within five years: the minimum standard is 10%; the achievable standard is 40%.⁴

The Certificate of Vision Impairment (CVI) is discussed in clinic with patients who meet the criteria for sight impairment, completed with patient consent by a consultant ophthalmologist, and sent to local authority social services. This return is mandatory. Local authority social services update their vision impairment register and offer the patient additional services.

A copy of the CVI goes to the Certifications Office, Moorfields Eye Hospital NHS Foundation Trust, for epidemiological analysis. This return is voluntary, but compliance is good. Data held by the Certifications Office provide more details on the incident causes of registration.⁵ Data from the 2008/09 and 2009/10 CsVI held by the Certifications Office have been used for this indicator.

Magnitude of variation

For PCTs in England, the rate per 100,000 population of CsVI issued with a main cause of diabetic eye disease ranged from 1.0 to 7.8 (8-fold variation).⁶ When the five PCTs with the highest rates and the five PCTs with the lowest rates are excluded, the range is 1.5–6.7 per 100,000, and the variation is 4.6-fold.

This high degree of variation is of concern in an indicator measuring a preventable cause of sight loss, which is supported by a national screening programme. However, caution is necessary when interpreting this variation due to the small numbers in each PCT.

Data from the CsVI could be used together with the data on screening uptake (see Map 21) to provide important information on the care of people with diabetes and eye diseases in a local area.

Options for action

Commissioners and providers should analyse local data annually and benchmark them against those from other areas. Where there are high numbers of people who are sight-impaired from diabetes but low screening uptake, this should trigger action to improve services.

For this indicator, the aim should be not only to reduce variation but also to improve the quality and consistency of data collection. Performance against the NSC's quality standards for reducing blindness due to diabetic retinopathy cannot be assessed adequately until there is reliable data collection. Commissioners and providers should investigate how to improve the overall quality and consistency of CVI data collection.

RESOURCES

- › The identification, referral and registration of sight loss: action for social services departments and optometrists, and explanatory notes. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4083553
- › Form CVI: explanatory notes for consultants ophthalmologists and hospital eye clinic staff. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4083552
- › Identification and notification of sight loss. http://www.dh.gov.uk/en/Healthcare/Primarycare/Optical/DH_4074843

 **See what Right Care is doing in ophthalmology on page 32**

1 National Society to Prevent Blindness (1980) Visual Problems in the US: data analysis definitions. Data 74 sources, Detailed Data Tables, Analysis, Interpretation. New York.

2 Bunce C (2006) BMC Public Health 6:58. doi:10.1186/1471-2458-6-58. <http://www.biomedcentral.com/1471-2458/6/58>

3 Access Economics (2009) Future Sight Loss UK 1: Economic Impact of Partial Sight and Blindness in the UK adult population. RNIB. http://www.rnib.org.uk/aboutus/Research/reports/2010/FSUK_Report.doc

4 <http://www.nscetinopathy.org.uk>

5 <http://ecvi.moorfields.nhs.uk/Default.aspx>

6 Data from 10 PCTs have been removed.