

SECTION ONE - CATEGORY

Please put a cross in the box beside the category you wish to enter:

Best type 2 diabetes prevention initiative	<input type="checkbox"/>
Best screening/early detection initiative	<input checked="" type="checkbox"/>
Best initiative supporting self-care	<input type="checkbox"/>
Best integrated care initiative	<input type="checkbox"/>
Best emergency/in-patient care initiative	<input type="checkbox"/>
Best initiative managing complications associated with diabetes	<input type="checkbox"/>
Best safe care of patients initiative	<input type="checkbox"/>
Clinical service redesign	<input type="checkbox"/>
NHS Team of the Year working in diabetes	<input type="checkbox"/>
Community initiative of the year	<input type="checkbox"/>
Industry-led initiative of the year	<input type="checkbox"/>
Partnership working of the year	<input type="checkbox"/>

Note: Please complete a separate form for each entry and category you wish to enter

SECTION TWO – YOUR DETAILS

Title:	Mr
First name:	James
Surname:	Beckett
Job title:	Programme Manager
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SECTION THREE – ADDITIONAL CONTRIBUTORS

If entering a team/partnership category, or if there are other individuals to recognise, please list them here:

Additional contributor one:	Louis Bolter
Additional contributor two:	Peter Mitchell
Additional contributor three:	
Additional contributor four:	

SECTION FOUR – YOUR ENTRY

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Once you have completed this form, you may submit your application online by uploading this form when prompted.

Background/origin of the project:

Briefly provide the background to the initiative and explain why it was undertaken. From this the judges should be able to understand why there was a need for the initiative. Also state the month and year when it started.

“All screening programmes are complex, involving several different health professional groups, a challenging patient pathway, and thousands of individuals to be invited each year. Diabetic retinopathy screening is even more complicated because in no other national screening programme do patients have to be identified on the basis of a pre-existing condition, nor are people offered year-on year screening from the age of 12 until they die.”

GUIDANCE ON FAILSAFE IN THE DIABETIC RETINOPATHY SCREENING PROGRAMME Linda Garvican and Fionna O’Leary, October 2008

The biggest challenges currently facing most diabetes eye screening programmes is in patients of the screening programmes going unscreened because of a lack of communication between areas of the care pathway. The initiative of introducing failsafe into the diabetes eye screening service was intended to have the effect of making for a more robust care pathway and help to ensure that people with diabetes registered with GPs in the three areas of inner London receive diabetes eye screening to help prevent the development of sight threatening diabetic retinopathy.

One of the recommendations of the National Screening Committee’s External Quality Audit visit to Homerton University Hospital NHS Foundation Trust’s Diabetes Eye Screening Service was the introduction of failsafe into the programme. In Diabetes Eye Screening ‘Failsafe is a back-up mechanism which ensures that when something goes wrong in a system, processes are in place to identify what is going wrong and action follows to ensure that there is a safe outcome.’ A Failsafe Officer was appointed in March 2010 with the task of introducing failsafe throughout the programme and carry out audits.

The initiative involved auditing existing systems and processes, writing protocols for every area of the programme and working closely with Primary and Acute care to ensure that effective communication lines pass patient level information and clinical activity securely between stakeholders in a timely manner. This included a considerable amount of collaborative working with PCTs and other Trusts to improve communication and encourage best practice.

Objectives:

Explain what you hoped to achieve with the project, including what you wanted success to look like. This will help the judges determine whether you were successful.

The objectives of the programme were to improve uptake of diabetes eye screening amongst the populations that we screen and to ensure that the care pathway was robust. The result of this being that patients would not remain unscreened by the programme due to organisational oversight.

The measures of this success being the uptake of diabetes eye screening within the three areas and the use of failsafe audits to improve practice both in Primary Care and in Ophthalmology providers. These should be used to improve outcomes for people with diabetes.

Execution/implementation:

Use this section to demonstrate what you did. You can outline any methodology, analysis, monitoring, communication, staff and patient participation, and your overall approach in implementing the project. Judges will be looking to understand how you went about achieving your objectives.

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The initial process was to outline the entire care pathway for people with diabetes registered with GPs managed by City and Hackney PCT, Redbridge PCT and Barking and Dagenham PCT. By having a clearly defined care pathway, the areas where it was possible for patients to have fallen through gaps and gone without screening were more easily identified.

The areas most at risk were found to be:

- A. Accurate and timely referral from Primary Care
- B. feedback from Ophthalmology

These two areas were both addressed in a number of ways:

A) Accurate and timely referral from Primary Care

This process is usually carried out through regular (quarterly) data extraction from the databases of Primary Care providers. Outside of these data extractions referrals can be made to the programme's administrative team. In order to improve patient outcomes and communication between the screening service and primary care it was important to identify possible reasons why patients have not been included in the data extraction.

Audit:

The Failsafe Officer for the programme audited the laser books from the Ophthalmology providers referred to by the screening service. By auditing every patient who had received laser for diabetes related eye disease patients who had not been referred to the programme it was possible to identify root causes for failure in primary care to bring these patients to the attention of the screening service. The outcomes of these audits had implications both for primary care, as it highlighted the importance of improving the accuracy of coding in helping to ensure that the patients, and for Ophthalmology the importance of continuing to strive to improve the quality of data exchange between the screening service and Ophthalmology.

Audits were also carried out on the blind registrations due to diabetes eye disease which had been completed in the areas covered by the screening programme. These also identified areas where data extraction from GPs could be further improved, where patients who were already under the care of Ophthalmology had not been referred to the screening service.

Software implementation to improve communication

In order to reduce the risk of further occasions of non-referral from Primary Care the importance of improving the communication between GP surgeries and the screening service was identified. An effective way to implement this risk reduction was identified, allowing GPs to access their patients' information within the screening service's specialist diabetes eye screening software through a web-based application called GP Webview. This would then allow them to identify patients who had not been referred to the programme, and effective use of this resource would both improve GP surgeries performance in QOF as well as enabling them to ensure effective and timely referral to the screening service.

Caldecott Guardian approval was required to ensure that Information Governance standards were maintained and that patient level information was kept secure. After a trial period the Failsafe Officer of the programme conducted training sessions with practice managers in addition to providing a user guide for the system telephone support to troubleshoot any problems in start-up.

B) Feedback from Ophthalmology

The importance for the screening service of receiving regular accurate information of the clinical activity of their Ophthalmology providers is important for a number of reasons. To ensure that referral timelines are being adhered to, to confirm the grading accuracy within the programme and most importantly to ensure that anyone discharged from Ophthalmology is returned to the screening programme to ensure that they are return to the recall process for annual diabetes eye screening.

Audit

Failsafe Audits of laser books (recording all patients receiving photocoagulation for diabetes related eye disease) identified where Ophthalmology departments had treated patients but the clinical activity was not fed back to the screening service. The service continues to work with their Ophthalmology providers to further improve the data exchange process

Regular data exchange

The process of collecting the information of the clinical activity and feeding it back to the programme had begun before this period of the introduction of failsafe. The role of the Failsafe Officer in conjunction with the programme's Clinical Lead and Data Manager was to work with Ophthalmology providers in improving the quality of the data received from

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Ophthalmology. Through audit and interrogation of the specialist eye screening software it was possible to identify patients about whom information had not been received, and so this could be fed back to Ophthalmology providers to improve the reporting process.

Results :

Describe the outcome(s) of the project. In particular demonstrate the impact on staff and patient outcomes, against the original objectives.

Referrals from Primary Care:

GP surgeries using the GP Webview system have shown significant improvements in their performance against QOF. The most recent information list of all the people with diabetes registered with GPs managed by NHS City and Hackney showed a significant increase in the number of people with diabetes, we believe that this was at least in part due to improvements in data extraction process which meant more people were referred to the service than had previously been the case.

Feedback from Ophthalmology:

This year has seen significant improvement in both the quantity and quality of data received from Ophthalmology providers. We hope to continue to this process of raising the standards within the service of the coming year to ensure that we remain NSC compliant.

Thanks to accurate feedback from Ophthalmology patients now discharged from Ophthalmology are returned to the screening service more efficiently so that they can receive their annual diabetes eye screening. These patients who have previously been treated for signs of diabetes related eye disease are at a higher risk of developing further complications which is why it is so important that there are effective processes to return.

Evaluation:

Explain how you measured the success of your project.

The success of the project can be measured in the improved outcomes for patients, a significant number of people who had been unscreened due to a lack of feedback from Ophthalmology, and because of a lack of referral from Primary Care have now been screened to attempt to prevent avoidable sight loss due to diabetic eye disease. There have been improvements to the collection of the Single Collated List of people with diabetes, meaning that more people with diabetes are invited for diabetes eye screening.

The effectiveness of the failsafe policies and procedures introduced to the programme can also be measured in the uptake which the programme has achieved of its target population in the last financial year: NHS City and Hackney 85%, NHS Redbridge 84.4% and NHS Barking and Dagenham 85%. These are amongst the highest uptake rates achieved in a screening programme in an inner city area.

The programme continues to work with its Ophthalmology providers to improve the feedback and data exchange process to further reduce the risk for people with diabetes registered with GPs managed by areas covered by the screening programme.

Feedback:

Provide at least one quote from a customer/clinician/commissioner/patient confirming the impact/effectiveness of your initiative. All referee details will be kept confidential.

Referee details:

Name: John Anderson

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Position:	Consultant Diabetologist
Organisation:	Homerton University Hospital NHS Foundation Trust
Email:	john.anderson@nhs.net

Introducing failsafe processes has considerably reduced clinical risk in our diabetes eye screening programme. The failsafe process has detected patients who had previously fallen between gaps in the system, not had an annual screen, and thus been at risk of blindness. Many of these cracks have now been closed. The failsafe process has also identified small numbers of patients who have lost vision or needed laser treatment and who have never been known to the eye screening service, when all patients should have been known to the screening service. Detailed analyses of these cases has identified situations that have produced these anomalies and has allowed us to work with our ophthalmology colleagues, PCTs and Primary Care to reduce the risk of similar cases occurring in the future

Referee details:

Name:	Claire Lister
Position:	Practice Manager
Organisation:	Statham Grove GP Surgery
Email:	claire.lister@nhs.net

Allowing GP Practice staff to access information via GP Webview has given us an effective overview of patients' retinal screening and it has helped us achieve our QOF targets. The system is user friendly and provides real time, accurate knowledge of patients' attendance and their results. This enables us to act promptly when pathology is suspected. We can also proactively check future appointments to remind patients to attend, chase up non-attenders and check if referrals need to be made.

The primary care team can directly visualize the retinal photographs which has advantages for teaching of medical students and training of GP trainees.

Learnings:

One of the main aims of QIC is to enable learning and sharing of initiatives across the four nations for the benefit of diabetes patients. Use this section to outline any learnings that can be taken from the project and/or challenges faced along the way, that could be transferred to other teams and organisations in the field of diabetes care.

Key learning:

Communication is key in improving patient outcomes by allowing patients to be identified in different areas of the care pathway to reduce the risk of patients going unscreened.

Accuracy in coding at Primary Care is central to ensuring that all people with diabetes are referred for diabetes eye screening in a timely manner.

Not all patients who receive what is normally considered laser for diabetes will have diabetes.

Failsafe needs to be built in to every role in the programme not delivered by an individual, so it is important that every member of staff take responsibility for ensuring risk reduction within their own area of diabetes eye screening.

Innovation:

If applicable, explain what makes your initiative innovative or pioneering, and describe the impact of

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your initiative relative to the resources you used.

We believe that we were amongst the first screening programmes to conduct failsafe audits of laser books and blind registers to improve practice in diabetes eye screening.

We are also amongst the first to use a web based access application to close the gap between Primary Care and the screening service to ensure that patients requiring screening are referred to the service.

The resource for all this work came from a new appointment within the department (Failsafe Officer) and so was cost neutral for our commissioners, since the appointment of a Failsafe Officer was a recommendation by the NSC which the programme needed to make. We feel then that since there was no cost for the service that this work had a very positive impact for the areas in which we screen without additional costs.

SECTION FIVE – SUMMARY OF ENTRY

Provide a short summary of your full entry (max. 250 words). Please note that this may be reproduced by the QIC organisers if your entry is shortlisted, to promote the QIC finalists, including in print and online.

Brief summary:

The introduction of failsafe into the City, Hackney, Redbridge, Barking and Dagenham has had a significant impact on patient outcomes. It has reduced the risk of blindness due to diabetes thanks to closing the communication gaps between the different areas of the programme. By using audits to identify risks in the programme policies and protocols were introduced to improve practice and reduce the risk of blindness due to organisational oversight within the screening programme. Software communicating between primary care and the screening service was implemented and this was used to close the gap in communication between GPs and the screening service. The service continues to improve the process of exchanging data on clinical activity of its patients within Ophthalmology with three Acute Trusts.