

Success Story (QiC award winner 2011)

Implementing failsafe in retinopathy screening at Homerton Hospital

The challenge

The biggest challenge facing most diabetes eye screening programmes is that patients are not screened because of a lack of communication between different areas of the care pathway. The National Screening Committee's External Quality Audit recommended for Homerton University Hospital NHS Foundation Trust's diabetes eye screening service to introduce failsafe mechanisms to ensure better identification of patients in need of retinopathy screening.

The aim

The aim of the programme was to ensure patients would not be left unscreened by the programme due to organisational oversight and to ensure the care pathway was robust, leading to improved uptake of diabetes eye screening.

What did they do?

A Failsafe Officer was appointed in March 2010 whose role was to undertake audits to identify where there were problems with current systems and then introduce failsafe throughout the programme, and monitor its impact. 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 patient level information and clinical activity was communicated securely between different care areas in a timely manner.

The first step was to outline the entire care pathway and highlight areas where it was possible for patients to fall through gaps and go without screening. The areas most at risk were found to be accurate and timely referral from primary care and feedback from ophthalmology.

To improve communication between primary care and the screening service, a software solution has been implemented which allows GPs to access their patients' information from the screening service, and identify those who have not been referred to the programme.

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. To improve this, the failsafe officer worked with the screening programme clinical lead and data manager ophthalmology providers to improve the quality of the data received from Ophthalmology. Through audit and interrogation of the specialist eye screening software it has been possible to identify patients about whom information had not been received, feed back to the ophthalmology providers to improve the reporting process.

What happened?

GP surgeries using the new software 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 one PCT showed a significant increase in the number of people with diabetes. It is thought this is at least in part due to improvements in data extraction process which meant more people were referred to the service.

Additionally, there have been significant improvements in both the quantity and quality of data received from ophthalmology providers. Thanks to more accurate data, patients discharged from ophthalmology are returned to the screening service more efficiently so they can receive their annual diabetes eye screening.



Key outcomes

- ✓ Improve communication between screening programme and primary care and ophthalmology
- ✓ Audit identified areas where patients could fall through gaps
- ✓ New software enables primary care to identify patients who need to be referred for screening

Find out more about this case study at www.diabetes.nhs.uk