Diabetic Eye Screening Surveillance Pathways

Version 1.3 24 October 2012

Guidance for the management of the surveillance pathways in diabetic eye screening programmes
# Surveillance Pathways

<table>
<thead>
<tr>
<th>Project/Category</th>
<th>Pathway</th>
</tr>
</thead>
<tbody>
<tr>
<td>Document title</td>
<td><em>Surveillance Pathways</em></td>
</tr>
<tr>
<td>Version and date</td>
<td>Version 1.3 24 October 2012 <em>Software Supplier Guidance</em></td>
</tr>
<tr>
<td>Release status</td>
<td>Final</td>
</tr>
<tr>
<td>Author</td>
<td>David Taylor</td>
</tr>
<tr>
<td>Owner</td>
<td>David Taylor</td>
</tr>
<tr>
<td>Type</td>
<td>Guidance</td>
</tr>
<tr>
<td>Authorised By</td>
<td><em>NHS DESP National Programme Team</em></td>
</tr>
<tr>
<td>Valid from</td>
<td></td>
</tr>
<tr>
<td>Review Date</td>
<td></td>
</tr>
<tr>
<td>Impact</td>
<td></td>
</tr>
<tr>
<td>Audience</td>
<td><em>NHS DESP, commissioners, SHA Screening Leads, providers, GPs</em></td>
</tr>
</tbody>
</table>

## Distribution

<table>
<thead>
<tr>
<th>Name / group</th>
<th>Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Amendment history

<table>
<thead>
<tr>
<th>Version</th>
<th>Date</th>
<th>Author</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>V1.1</td>
<td>12 Oct 12</td>
<td>L Lacey</td>
<td>Update following supplier comments</td>
</tr>
<tr>
<td>V1.2</td>
<td>15 Oct 12</td>
<td>L Lacey</td>
<td>Change of name to Software Supplier Guidance</td>
</tr>
</tbody>
</table>

## Review / approval

<table>
<thead>
<tr>
<th>Version</th>
<th>Date</th>
<th>Requirement</th>
<th>Signed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Surveillance Clinics in Diabetic Retinopathy Screening

1 What is a DESP Surveillance Pathway?

The surveillance pathway manages patients between annual screening and referral to HES and is administered by the screening programme for call/recall through its management software. It should be under the supervision of a Medical Retina Specialist designated by the clinical lead.

2 Surveillance clinics

2.1 Digital Surveillance

Digital surveillance clinics allow more frequent supervision of some patients who the Clinical Lead considers have images that are not high enough risk to be supervised in HES but are at higher risk than the general screening population and in need of more frequent than annual imaging.

From April 2013, programmes should use the new surveillance pathway for any referable grades that are currently managed within the routine screening service either through the downgrading of screening grades or the use of 6 or 3-monthly recall intervals. Any patients currently managed in this way should be moved into the new surveillance clinics as soon as the new surveillance clinic software has been installed.

2.2 Slit Lamp Biomicroscopy (SLB) Surveillance

Slit Lamp Biomicroscopy is an examination technique for patients where adequate retinal examination cannot be obtained using digital photography. Cataract is the principal reason for this and may require either single or multiple SLB encounters until the opacity is removed. Some reasons for opacity may require permanent supervision to be provided in this way.

3 Surveillance Pathway

Pathways for referral into Surveillance are documented elsewhere.

3.1 Elements of a basic Surveillance clinic system

- Streamlined patient management capabilities between routine digital screening, digital surveillance and SLB surveillance modules
- Independent call and recall facilities for digital surveillance and SLB surveillance
- Early recall intervals of 3, 6, 9 and 12 months in surveillance to allow review before referral to HES
- A call and recall facility in SLB surveillance to manage ungradable outcomes from routine screening
- An ability to invite pregnant women for early re-screens in digital surveillance and SLB surveillance, and for these screens to be reportable separately.
- Facility to attach retinal images to a patient record on discharge from HES and Surveillance Ability to report both digital surveillance and SLB surveillance activity independently
- Failsafe functionality that provides alerts and triggers to users ensure safe management of patients
- Ability to record visual acuities at all surveillance encounters
- OCT is not part of the national pathway. Optional ability to record OCT outcomes (negative, positive and borderline) for those programmes wishing to use OCT

Programmes will be able to organise surveillance clinics to meet local needs as long as the basic facilities are provided. The software should allow programmes to specify clinic locations for routine screening, surveillance and a combination of both. The pathway in use should be dependent on the patient status and not the clinic location.

4 **Staffing a Surveillance clinic**

The Clinical Lead should supervise all surveillance clinic activity. However, responsibility of the activity can be delegated to senior staff as appropriate. The Clinical Lead for the programme will be responsible for training and supervising this staff group and putting in place protocols.

Staff running surveillance clinics should be line managed within the screening service.

Separate documentation describes competencies for SLB examiners.

5 **Status of patients in surveillance clinics**

Patients who are being seen in surveillance clinics are eligible for screening but suspended from receiving screening invitations until discharged back to routine annual screening. This is described in the DESP exclusions and suspensions guidance.

This activity should be separately accounted for from screening activity.

6 **Referral to a surveillance clinic**

Only the referral outcome grader (ROG) will have the option to refer to a surveillance clinic. The following groups of patients *may* be referred to a surveillance clinic according to local protocols under supervision of the Clinical Lead.

1. Patients with ungradable images to slit lamp biomicroscopy surveillance
2. M1 positive can be referred to either HES or digital surveillance
3. R2 positive can be referred to either HES or digital surveillance
4. R3S
5. Pregnant women.

Note: Slit lamp bio surveillance should not be used to review M1 patients.

Local protocols can be developed so that HES can discharge patients back to digital surveillance once they consider them to be stable.
6.1 Pregnancy

Pregnant women require photographic screening that is more frequent than annual screening. This should be provided in the surveillance clinic, unless they develop referable diabetic retinopathy when they should be referred to the HES.

Pregnant women with both type 1 and type 2 diabetes should be offered digital photography to national standards at (or soon after) their first antenatal clinic visit and again at 28 weeks’ gestation. If background diabetic retinopathy is found to be present, an additional screen should be performed at 16-20 weeks, and for at least 6 months post-partum.

7 R3S

Patients who are graded as R3S following discharge from the HES should be managed in digital surveillance pathway. Patients with stable treated retinopathy currently in routine annual screening should be graded as R3S at their next routine annual screen, have benchmark images taken and transferred to digital surveillance pathway for their next and subsequent routine appointments.

The initial grading of R3S in HES must be undertaken by an ophthalmologist. A benchmark image set must be taken and graded as soon as possible (and no longer than 3 months from discharge decision) by an ophthalmologist and attached to screening records. Patients can then be retained in surveillance if images show no significant change. When significant change is detected the final grade will become R3A or M1 and the benchmark set will become redundant.

8 Non Diabetic Retinopathy

Patients with Non Diabetic retinopathy or pathology should not be followed in surveillance clinics.

9 Discharge from Surveillance to Screening

Only patients who have a non referable grade should be discharged back into normal screening. The software should contain the ability for an image set to be attached to a patient record on discharge from Surveillance so that any existing retinal features are observable by graders.

10 Referral from Surveillance to HES

Patients whose risk increases while in surveillance and warrant referral to the HES should be referred according to national QA referral timelines.

11 Standards and Failsafe for Surveillance

See appropriate standards and failsafe documentation.

12 Examination quality in surveillance

See guidance on feature based grading forms.