



Guidance for Optometrists in relation to Diabetic Retinopathy Screening Schemes

August 2007

Over the last few years formal screening schemes designed to detect diabetic retinopathy should have been introduced across the UK. These will use digital retinal imaging, which will allow a record of the screening intervention to be retained for quality assurance purposes. The specification for these schemes is mandated by the National Screening Committee (NSC) and their Retinal Screening Workbook can be downloaded from www.nscretinopathy.org. The current version is 4.1 but do check regularly for updates.

Up until now many areas involve optometrists in screening using slit-lamp binocular ophthalmoscopy. Others used retinal cameras, whilst a substantial number had no screening at all. All areas have had to make changes to meet the required standards for the screening programme and even in Summer 2007 many areas are still struggling to implement a fully NSC compliant system. In some there will be no optometric involvement at all, whilst in others optometrists may provide imaging services, or grading services, or both.

What is “Screening”

Once formal screening schemes have been established nationally, the word “screening” in connection with diabetic retinopathy will imply a process that is quality assured to specified standards. From 1st January 2007, it will require digital imaging of an appropriate standard, with suitable viewing, storage and compression. Graders will have to grade at least a specified minimum number of patients. There will be some element of secondary grading and on-going audit to ensure that graders are competent. By 2008, all those involved in photography and grading will need to pass at least some modules of the C&G certificate in Retinal Screening. For more information on the C&G Certificate see:

http://www.aop.org.uk/uploaded_files/drs_and_nsf_blakeney_broadbent_12jan07.pdf

Screening will also imply a process that feeds data into the patient's health record. In the future it is hoped that, in addition to identifying sight threatening eye disease, the process will highlight patients who show a worsening of their retinopathy status (e.g., move from no retinopathy to mild background). It is the intention is to flag these patients up as needing additional encouragement to control their diabetes.

From 1/1/2007 it is inappropriate for any service which does not meet all the above standards to claim to be a screening service.

Areas with no optometric involvement in screening

If patients are being screened within a formal scheme, there is no requirement for the optometrist to also dilate the patient purely because of retinopathy. Indeed, to dilate a patient purely for forms sake, when they are already being screened elsewhere could be considered unkind (the drops sting), inconvenient (the patient may not be able to drive) and unnecessary (maybe they were screened last week). The College Guidelines (Feb 04) state:

17.02If the optometrist is not responsible for providing screening locally, he should advise the patient if this appears to be overdue.

*17.03 (b) Pupil dilation will normally be required for **screening** purposes (advising patients about photophobia and possible difficulties with driving). Pupil **dilation** and the use of relevant indirect methods **may** be appropriate in **other circumstances** where an inadequate view of the fundus would otherwise be obtained;*

*17.04 The above advice applies to routine practice. Where retinopathy screening programmes are in operation, specifically agreed protocols are likely to be in place and practitioners participating in such programmes should practice according to the requirements of their local protocol. Practitioners **may not need** to dilate for the sole purpose of retinopathy screening where alternative local screening arrangements are in place.*

This guidance makes clear that if a patient with diabetes has access to a screening programme, dilation is only required as the norm for screening purposes. Screening is a process which requires reporting and quality assurance, as well as examination of the fundus, and is not a function of a GOS sight test. By the end of 2006 all areas should have a screening scheme in place, so practitioners should feel comfortable that there will be no automatic obligation to dilate these patients as a part of a GOS sight test. There will continue to be a need to consider dilating them for the same reasons that you might consider dilating any other patient.

It is still a requirement under GOS regulations that after testing a patient with diabetes, the optometrists must "inform the patient's GP of the outcome of the test. This is often misinterpreted as requiring the optometrist to report the result of the retinal examination and sometimes GPs try to use this provision to plug gaps in screening service provision (see below re underfunded services and QOF points). The AOP provide a pro-forma with the required information at www.aop.org.uk/uploaded_files/pdf/notification_to_gp_04-04-04.pdf which you may use to report the outcome of the test to the GP.

If you believe that the patient has not been screened within the last 12 months, you should inform the patient that this should be carried out and note this advice on the patient's record.

It would not be appropriate to lead patients to believe that they have had their eyes screened during a GOS sight test since screening is a separate process.

Frequency of sight testing

The Memorandum of Understanding on GOS sight test intervals allows a patient with diabetes to have a sight test annually. This is a minimum interval, and does not represent an obligation to see such patients annually. You may feel that, with annual screening available, a sight test every two years is adequate. This is a matter for your professional judgement.

Areas where an optometric screening service has been replaced by mobile or centralised screening service

In some areas this may lead to some ill feeling, especially where optometrists feel that they did not get fair treatment of their bid to provide an NSC compliant screening service. However, little will be gained by allowing relationships with the PCT to break down as this relationship will become ever more important over the next few years and other more important optometric services e.g. PEARS type schemes, may be jeopardised as a result.

If a PCT commissioned a "cheaper" service than the LOC bid which then proves grossly under funded and requests more funding, the LOC could ensure that the PCT is reminded of the issues raised around the initial bidding process. There may also be considerable benefit to making the PCT aware that the optometric community and the LOC are willing to consider (for an appropriate fee) helping out the PCT if there prove to be gaps in their commissioned service.

See also the notes below on private "screening"

Areas where a non-optometric screening service is failing to deliver sufficiently regular screening to patients

There are a number of areas where the PCT has commissioned a screening service but significantly underestimated the capacity required to provide an adequate screening service. Usually this manifests itself as an increase in the screening interval offered to patients with quite a few schemes only able to offer screening every 2 years or more.

In such areas, the GPs will be rather unhappy as the %age of their patients who are screened affects their QOF points (Quality and Outcome Framework). These points awarded for providing mostly preventative medical procedures to their patients directly affect their annual practice income. Understandably, they will be upset if the PCT commissioned service fails to deliver the necessary level of screening. In these cases, GPs may attempt to use GOS tests to plug the gaps in the service without any additional funding

to the practices involved. This should be discouraged not least because a GOS test does not constitute screening even if dilated fundoscopy is performed.

If GPs seem to be attempting to use the GOS test in this way then it is probably best for the LOC to approach the LMC and discuss the issues with them. Often once the issues of GOS regulations and funding are explained, the LMC will be much more sympathetic. Ideally, the LOC and LMC could approach the PCT to discuss the shortcomings of the screening service and if appropriate offer an optometric based solution to help resolve the problems.

Optometrists involved in the screening process

In some schemes screening or image capture may take place alongside a GOS sight test, for the convenience of the patient. Where the number of practices involved in screening or image capture is restricted, it would be unethical to seek to persuade a person attending for screening to switch to your practice for a sight test if they would ordinarily be tested elsewhere. There are 4 possible situations:

1. Screening takes place in parallel with a sight test, with or without grading.
2. Screening stands alone (no sight test) and grading **is** performed at the same time.
3. Screening stands alone (no sight test) and grading **is not** performed at the same time and:
 - a. Photography is carried out by the optometrist.
or
 - b. Photography is carried out by a clinical assistant.
4. Grading is carried out by the optometrist independent of photography. (Photography has been performed elsewhere).

A concern is the position of the optometrist in relation to non detection or detection of pathology other than retinopathy. There is clearly no obligation to perform procedures other than those for which payment is being made, i.e. screening. Nevertheless, the optometrist is in a different position to that of a lay grader in that he or she has a greater knowledge of ocular conditions and their appearance. So the question is; what obligations or liability might arise:

The more obvious issues might include:

- Optic disc cupping
 - “Barn door” obvious glaucoma
 - more subtle but noticeably abnormal discs
- Tumours
- Pigmented lesions
- Visible retinal detachment

1. Screening in parallel with a sight test

This is the most straightforward. The sight test part of the process must conform to the regulations which require the optometrist to detect signs of pathology. Any signs of ocular injury or disease detected during the sight test should be reported, either using the traditional GOS18 route, or any alternative route agreed by local protocol. The parallel diabetic retinopathy screening outcomes should be reported using the protocols adopted by the screening scheme.

2. and 3a. (Photography alone by the optometrist, with or without grading)

In these cases the optometrist will see the images and will also see the patient. Obvious cases of pathology should be referred by an agreed route using an appropriate level of urgency. The same or a similar route is required in cases of urgent retinopathy (e.g. R3). Beyond this, if the optometrist spots an abnormality that requires further investigation then he or she should make the patient aware of the need for a proper examination in writing and make an appropriate note on the patient's records. The question is whether any liability attaches to the optometrist in cases of not so obvious pathology. The answer lies in the usual test of whether a reasonably competent optometrist would have spotted it whilst doing the same procedure, NOT whether it would have been spotted during a GOS test.

3b. (Photography alone by an assistant without grading)

This is slightly different. So long as it is agreed within the screening protocol that clinical assistants may be used, and that the optometrist may not see the images, the responsibility here should be the same as for a technician/photographer. If the optometrist does not see the images then no liability can attach to the optometrist. The NHS will hope to train photographers, technicians and lay graders to recognise obvious tumours and gross glaucoma. It should be remembered that the clinical assistant will need to have the appropriate modules of the C&G certificate in retinal screening.

4. Grading remote from capture

Here the optometrist does not see the patient and has no opportunity to communicate with them. The responsibility here would appear to be the same as a lay grader – namely to detect retinopathy and to flag any other gross conditions required by the screening protocol. However, the responsibility will be slightly higher than for a lay grader as the optometrist will have expertise. There should be some means of flagging up other problems which may require investigation or monitoring – this may simply require a sight test. This could be by notifying the patients GP, optometrist or the patient themselves. Ideally this should be automated by the system.

It is important to ensure that the patient is informed of the limitations of the screening process and this information should be provided in writing. The patient needs to understand that screening is not the same as a sight test, that it only screens for one condition, that other conditions can still arise and that a regular sight test is still advisable. Nevertheless, providing such information is not a protection against negligence if something obvious is missed.

Practitioners may feel it is unlikely that a patient found to have glaucoma would consider action against someone screening for a completely unrelated condition, and this is probably unlikely. The same may not apply to a retinal detachment of course, but liability should only attach if the detachment was apparent on the image.

Unfortunately it is not possible to provide definitive answers, or provide complete reassurance about any potential liability. Each case will turn on its own facts and will be judged as to whether any pathology was significant enough to put a reasonably competent optometrist doing the same procedure on notice.

Private “Screening”

In many areas, existing optometric screening schemes have been replaced by new NSC compliant schemes. It is almost inevitable that this will have reduced the number of practices and optometrists taking part either because a centralised service has been commissioned or due to the numbers of patients required to comply with the QA process. This may well create a degree of upheaval for both the patients and practitioners. It is likely that some patients will request a private “screening” for a variety of reasons: they may prefer not to attend the NHS service, they may find it inconvenient or they may wish to be reassured more frequently.

If a patient requests your opinion on the state of their retinas, it is entirely proper to provide it, so long as you are familiar and comfortable with the signs of Diabetic Retinopathy and the NSC and/or local grading criteria. However, it is extremely important that these patients must not be discouraged from also attending the NHS screening service in favour of a private arrangement. It would be best not to undertake this sort of private retinopathy unless you are sure that the patient also intends to attend the local NSC compliant service or has a full understanding of the risks and problems of opting out. It would be unethical to attempt to persuade a patient to use a private service in place of a local service run to NSC standards or to advertise such a service as an alternative to a proper screening service.

Any such private service does not meet the definition of “screening” (lack of QA etc etc) and should not be referred to as such. It may be better to refer to this as a “Diabetic Eye Health Check”, or “Retinopathy Assessment” rather than “screening”.

In an ideal world, any images from private retinopathy checks should be made available to the screening service in the interest of good integrated patient care. However the way the screening software seems to work, such transfer is likely to be extremely difficult and potentially very costly. Obviously if a screening service were to accept transfer of images, the patient would need to give consent for the optometrists to share the images and screening results with the screening service.

Practitioners should remember that, if a GOS sight test takes place alongside a diabetic retinopathy check, the regulations require that the GP be informed of the result of the sight test. If you have only performed a sight test and have not dilated specifically to check for retinopathy, then you should simply inform the GP that you carried out a sight test and did not dilate (see www.aop.org.uk/uploaded_files/pdf/notification_to_gp_04-04-04.pdf for a suitable report form). If you have carried out a diabetic retinopathy check, you should inform the GP of the results. There is no obligation under the regulations to inform the screening service as well but it is advisable to do so in the interests of courtesy and a better local rapport.

A retinopathy check such as this is not a part of a sight test, so you may charge for it privately. Don't forget to include the cost of your time spent preparing a report and transferring images, as well as material costs such as CDs.

Images should be retained and stored in the same way as your other patient records. The NSC is recommending 10 years, but the AOP advises retaining records for 12 years in the case of adults and for children until they are aged 25 and it is 12 years since you last saw them.

Professional Services Committee
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