



The ROYAL COLLEGE of
OPHTHALMOLOGISTS

Quality Standard Self-Assessment Tool

Diabetic Retinopathy Services

The Royal College of Ophthalmologists champions excellence in care. In order to provide the best care for patients, and to generate improvements in care, it is important to be able to measure the quality of clinical services provided. In addition, measuring quality provides quality assurance data for patients, regulators and commissioners. There are many possible ways of measuring service quality including clinical audit, outcome measures and patient surveys.

The College's Quality and Safety Group provides a set of simple self-assessment tools for a number of clinical services: cataract, glaucoma, adnexal, medical retina (including age-related macular degeneration [AMD]), diabetic retinopathy, vitreoretinal surgery, neuro-ophthalmology, children and young adults and adults with learning difficulties. The tools focus on service provision not outcomes and do not attempt to assess every aspect of service but try to focus on a small number of key areas. It is not expected that most clinical services will answer 'Yes' to all of the question, and the results should be used in conjunction with other methods of quality assessment to support learning and improvement.

Please send feedback on the form and how you have used it to assess and change your services to [Beth Barnes](mailto:beth.barnes@rcophth.ac.uk), Head of Professional Support beth.barnes@rcophth.ac.uk.

Diabetic eye disease is very common and there is a national screening programme to detect and refer treatable diabetic retinopathy to hospital eye services. The diabetic retinopathy (DR) standards in this document apply to how the hospital service provides care and interacts with the community and screening services to ensure safe care and adherence to national guidelines. The document should be read in conjunction the quality standards for medical retina services.

1. Consultant leadership:

There is a nominated eye unit clinical lead for the DR service with the role defined and specific time allocated in their job plan. The job description includes liaison with the clinical lead(s) of the national diabetic eye screening programme(s) and responsibility for the hospital eye service DR audit and failsafe:

YES NO

Comments/reasons for non-adherence:

2. There is a system and the necessary staff and infrastructure for logging new referrals of patients with DR and tracking their attendance, appointments and treatments in line with standards of the national diabetic eye screening programme. There is evidence of review of this data and action if required:

YES NO

Comments/reasons for non-adherence:

3. There is a system and the necessary staff and infrastructure for ensuring that patients with active proliferative DR (R3A, Scotland R3, R4) and sight-threatening diabetic maculopathy (M1A, Scotland M2) are assessed and treated within the time frame stipulated by the national diabetic eye screening programme. There is evidence of review of this data and action if required:

YES NO

Comments/reasons for non-adherence:

4. Assessment and treatment in clinics:

All patients with a diabetic retinopathy grade of R2, R3A or M1A (Scotland R3, R4 and M2) are assessed and treated in clinics with access to retinal imaging, intravitreal injection and laser treatment facilities in appropriate time scales:

YES NO

Non-Medical clinical staff who assess and treat patients with DR have documented competencies, training and work to a protocol in managing DR:

YES NO

There is a departmental protocol for the management for DR based on College, NICE or other recognised national guidance:

YES NO

Patients have access to vitreoretinal surgery, within a local network if required:

YES NO

Comments/reasons for non-adherence:

5. The DR service routinely has access to referral letters from, and photographic images taken at, community DR screening encounters:

YES NO

Comments/reasons for non-adherence:

6. Specialist investigations are available:

- Retinal photography YES NO
- Retinal OCT YES NO
- Fundus fluorescein angiography YES NO

Comments/reasons for non-adherence:

7. Information and advice (written and/or verbal) about diabetic eye disease and managing risk factors is available for patients in the eye clinic. The patient, diabetologists and/or GP should be aware that the patient has developed ophthalmic complications of diabetes:

YES NO

Comments/reasons for non-adherence:

8. The hospital DR service has a mechanism for ensuring the screening programme, GP and patient are notified of the visual acuity, retinopathy grade and pathway status of each patient within the DR service:

YES NO

Comments/reasons for non-adherence:

9. Follow up

The service has evidence that patients are reviewed in line with College and NICE guidelines on DR and related therapy:

YES NO

The service regularly monitors adherence to clinic requested timing and has no significant “follow up backlog” or appointment delays (follow up and treatment appointments occur within 25% of the planned interval, including following hospital initiated cancellations):

YES NO

There are no serious incidents of visual harm due to delayed follow up reported in the last 12 months:

YES NO

Note details of any serious incident in brief:

10. There is a policy for do not attend (DNA) patients, cancellations, rescheduling and discharge that considers vulnerable groups, communication with primary care physicians and the local screening programme, and ensures clinician input into decisions on timing of rebooking or discharge:

YES NO

Comments/reasons for non-adherence:

11. Audit and feedback

Care outcomes and audited, using recognised national standards, and used for quality assurance and to improve services (e.g. timing to assessment and laser treatment from referral; adherence to NCIE criteria for intravitreal injections; complication rates for intravitreal injections):

YES NO

Audit of certifications for sight impairment (CVI) due to DR is carried out in every 1-2 years and should include an analysis of whether the sight loss could have been prevented and whether the patient was registered with the screening programme:

YES NO

Audit of patients with less than ideal outcomes (e.g. undergoing vitrectomy for DR, visual loss to LogMAR 0.50 or worse due to DR, advanced diabetic retinopathy) to identify treatment failures and/or other modifiable factors:

YES NO

DR patients have access to an ECLO: YES NO

Comments/reasons for non-adherence:

Action Plan

| Issue identified | Action to be taken | Who will lead action | Date for completion |
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