

BRITISH ASSOCIATION OF RETINAL SCREENING NEWSLETTER

June 2013

Working to Support professionals involved
in retinal screening for people with diabetes

CHAIRMAN'S UPDATE: THE YEAR AHEAD



As you all know I took over the role of Chair person at the last BARS conference. I attended my first BARS conference 11 years ago in Torquay, Devon. There were no more than 40 people attending that conference, which if memory serves me correctly was only the second BARS conference. How things have changed since those early days. Our attendance figures for conferences are considerably

higher and the world of diabetic eye screening has changed beyond comprehension. I think its fair to say that this year will bring even more changes, what with the new pathway and the massive changes within the NHS I wonder where we all be in 10 years time.

As a Programme Manager myself, I know that we are all concerned about our budgets especially as

we are all being expected to do more for less. Our patient cohort continues to increase in size and just as quickly, our budget reduces.

It is the aim of the BARS council to try and assist the screening programmes where we can.... but with regret that does not include bolstering your budgets with more funds.

But we can help in other areas such as training and education. We have over the last year, supplied cheap educational courses to assist programmes with their City and Guilds Training and we are discussing various options with a University to buy University places at a reduced cost.

As always if you have any suggestions please either email us or let a member of the council know.

I also want to wish you all the best for this difficult year and hope that BARS can help you all in some way.

Mark Histed

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DIABETIC EYE SCREENING TODAY

Brief News



PROGRAMME SPOTLIGHT: BRIGHTON

THE YEAR 2013 MARKS A QUARTER OF A CENTURY OF DIABETIC EYE SCREENING IN BRIGHTON. BACK IN 1988, A FULL YEAR BEFORE THE ST VINCENT DECLARATION, A SMALL GROUP OF OPHTHALMOLOGISTS AND DIABETOLOGISTS BASED AT THE ROYAL SUSSEX COUNTY HOSPITAL WERE ALREADY MAKING PLANS TO LOOK DIABETIC PATIENTS IN THE EYE WITH A VIEW TO REDUCING BLINDNESS.

Thanks in part to a charitable donation, two Kowa fundus cameras had been acquired in late 1987, and the following year, a 67-year-old man with type-2 diabetes became the first person ever to be screened for diabetic retinopathy in Brighton. It was none other than Sir Harry Secombe, star of The Goon Show, king of Sunday night TV, and President of the British Diabetic Association (now Diabetes UK). Sir Harry was in town to open a new diabetes ward at the hospital, so as he cut the ribbon over the glucagon fridge, a young diabetologist cut a deal behind the scenes, and asked if he'd like to pose for an altogether different photograph.

Patient confidentiality precludes me from revealing Sir Harry's results, but rumour has it that he was sent home with a blood glucose monitor and the name of a good ophthalmologist. Sadly, we failed to follow him up in subsequent years, so in addition to being our first patient screened, he also became our first failsafe incident. His screening set the ball rolling, however, and soon patients were being referred for routine retinal photography from the Diabetes Centre at the Royal Sussex County Hospital, and via a few interested local GPs.

Images were captured on Polaroid film by qualified medical photographers, and then graded by an ophthalmologist from the Sussex Eye Hospital. Patients were recalled every two or three years, and walk-in clinics were introduced. In contrast to the current situation, the numbers being screened were in the hundreds rather than thousands, and when Nick White arrived to head up the Medical Photography department in 1995, a total of 1400 patients had been screened in the preceding year.

Up until this point, ophthalmologists had taken sole responsibility for the grading of photographs, but as more GPs began to refer their diabetic patients, and numbers increased, it was decided to expand this role. Nick was trained in the dark art of retinopathy

grading by an ophthalmologist, and as the use of Polaroids was phased out, he switched to the fundus camera at the Sussex Eye Hospital, and was soon spending his days stooped over a light box, studying retinal photographs on slide film with a magnifier, before ticking the features he could see on a blue card and stapling it to the patient's notes – a stark reminder for anyone who feels that the new TAT sets are slow and time-consuming.

As the century came to a close, the Millennium Bug threatened to wipe out civilisation as we knew it, but as it transpired, the only true victim of Y2K was the Brighton Diabetic Retinopathy Screening Programme. As the world woke up on 1st January 2000 to find that planes hadn't fallen out of the sky and we'd all stockpiled tins of beans for nothing, someone in Sussex was pressing a button on a keyboard and getting a blank screen.

The software being used at the time was called Abies (think scabies, only more flaky), and a problem had first been identified back in 1998, when patients on a two-year recall found themselves being marked down for screening in the year 1900. This anomaly was dealt with via an old-fashioned card-filing system, but as the new millennium dawned, we not only waved goodbye to the twentieth century, but to the entire functionality of Abies.

With our screening software outdated in a very literal sense, we moved over to HISL Vector's Diabeta3 programme, which we still use to this day. Photos continued to be taken on film, but as the number of patient records reached a critical mass and filing cabinets began to slide open on their own, it became clear that computerised modernisation would be cheaper than fixing the sloping floors, and in October 2002 the decision was made to go digital. One of the original Kowa cameras had already gone up in smoke, and we needed better technology before we burnt down the entire hospital.

A Topcon digital fundus camera, complete with JVC camera unit, was installed in the Diabetes Centre at the Royal Sussex County Hospital, and shortly afterwards a charitable donation enabled us to install a camera outside of Brighton for the first time, at the Princess Royal Hospital in Haywards Heath. In our first year of digital retinal photography, those two cameras screened a total of 2,228 patients.

The following years saw expansion on a grand scale, and with the introduction of the national programme in 2003, retinal screening moved away

from Brighton's medical photographers and into the hands of dedicated screener/graders. A total of five PCTs came on board, with new cameras being added in Lewes, Horsham and Crawley. By 2005 we were screening approximately 7,500 patients a year. In 2006, this almost doubled within twelve months to more than 13,000.

The late noughties saw the introduction of national EQA visits, with programmes all over the country passing their inspections with flying colours. Mostly amber for pause and red for stop. Ours took place in October 2009, and after eleven nail-biting months waiting for our final report, we received the news that we could all keep our jobs. We celebrated by advertising for three new screeners and some admin staff.

Ten years after going digital, we successfully screened 24,000 patients in one year from a total register of around 32,000. The programme now employs eleven screener/graders, three of which are part-time, with the possibility of another trainee swelling our ranks this year. We also draw on the assistance of probably the world's only fully qualified screener/grader who's available one day a week on bank.

We currently own a total of nine Topcon cameras, with Nikon now replacing the old JVC units, and between them they cover sixteen different locations across central Sussex. Three are based in Brighton & Hove, with the remaining six used to screen patients as far afield as Crowborough and East Grinstead, at a mixture of hospitals, health centres and GP surgeries. All screeners are also trained to grade, with new recruits becoming full disease graders after a year in post, and the successful completion of units 7 and 8 of the City & Guilds Diploma.

Screeners work alone, with an average of 30 patients booked into a full day's clinic, and a total of 3 – 3.5 days in clinic per week. The remaining time is spent grading. With a DNA rate of around 12-13%, we collectively screen and grade approximately 500 patients a week. In the past year, screeners have begun taking weekly OCT clinics at the Sussex Eye Hospital in an effort to expand their skills, and we also have monthly group training sessions with an ophthalmologist.

During a quarter of a century of retinal screening, we've seen a lot of significant changes (not all of them diabetic), with undoubtedly many more to come. The aim is for people with diabetes in Sussex to retain enough sight to see them with us. Those ophthalmologists and diabetologists back in 1988 had a far-reaching vision, and our goal is to give that to our patients.

SCREENERS AND GRADERS REGISTER

The team responsible for the City and Guilds qualification in Diabetic Retinal Screening continues to be hosted and managed by the Gloucester Hospitals NHS Foundation trust on behalf of the Diabetic Eye Screening Programme.

As the national programme has matured local programmes are to be congratulated on the numbers of staff who now hold grading qualifications. Considerable numbers of people have obtained individual units or combinations of units towards certification or diploma status and DESP now faces increasing difficulty in monitoring the workforce to ensure that it has met aspirations to have all those engaged in providing retinal screening, properly qualified and accredited.

This means knowing at any given time which members of programmes are actively working, what their qualification status is and as the programme moves forward will need to monitor whether they are maintaining skills by participating appropriately in CPD .

It is planned that a simple database system will be created in 2013 which will interface with City and Guilds data, recording which modules, certificates and diplomas are held and where a grader is currently working . In its first iteration it will allow graders who can grade unsupervised to be recognised and be more easily reconciled with returns from local programmes at annual report time and in preparation for EQA visits.

At a later stage the database will generate and record a unique PIN number for all those who meet the minimum requirements for grading.

Future screening software will eventually be modified to require a valid PIN to be registered against an individual's log on before grading can take place.

The database is only intended to record those who have passed the appropriate units and is not intended to be a professional register so inclusion will be a record of past qualifications and will not be an indicator of current fitness to grade.

David Taylor, on behalf of the NHS DESP

FAILSAFE FORUM

As most may be aware the Failsafe Forum is active and available for any Failsafe related queries that may be on your mind. We have certainly been through some changes over the last few years, however there are more to come this year which involve OPDR and Biomicroscopy. This will undoubtedly lead to new challenges, as we probe into the operations of each criteria along with software issues and questions. Hopefully we will all pull together as screening services and help each other through the challenges in a positive manor, which will lead to smooth methodical patient care.

The Failsafe Forum was started to encourage all parties to interact and share information, which will hopefully reassure and produce a system that lowers risk to patients and therefore creating a more robust service. With new pathways introduced, it may be a good time to communicate with others. If you have questions/answers that you would like to share and which may help others please post to failsafeforum@gmail.com

If you wish to be added to the Failsafe Forum mailing list please contact paul.hopkins@ulh.nhs.uk

PROGRAMME MANAGERS FORUM

The next BARS Programme Manager meeting has been scheduled for Tuesday June 18th 2013. The venue for the meeting will be Warwick Medical School at the University of Warwick in Coventry.

The meeting will be chaired by Grant Duncan (BARS Councillor) and will begin at 13:00. The first confirmed speaker is Andrew Taylor Personal Tutor for Research Degrees, Taught Degrees & CPD Programmes and a Senior Teaching Fellow at Warwick. He will outline details of the Eye Modules that run at the university with particular focus on the Diabetic Retinopathy Screening qualifications they offer. Andrew will talk for about fifteen minutes followed by a further fifteen minutes for Q&A.

Next, Luke Rollin, screening manager at Calderdale & South Kirklees DESP will speak about his experiences of the first year on the Warwick Masters programme. Again the session will be for half an hour with equal time for Luke's presentation and Q&A.

Finally, David Taylor, National Quality Assurance Team Leader has agreed to talk about the GAA Pilot. David's session will last for a further hour with a talk entitled "Towards Improved Grading", followed by half an hour for discussion and a QA session.

Finally, Dr Peter Scanlon, national Programme Director will give a presentation outlining the National Institute for Clinical Excellence (NICE) Technology Appraisal guidance 274 – Ranibizumab (Lucentis) for treating diabetic macular oedema. Peter will also discuss how this guidance might impact diabetic eye screening programmes. Again, this talk will be followed by a short Q&A session.

AOB is scheduled for 16.00, and we aim to close the meeting shortly after.

We hope you can join us for what promises to be a very informative meeting. Please feel free to email me at grant.duncan@1stretinalscreen.com with any suggestions for additional items to be included on the agenda.

I'm going to the BARS Conference and I want to present a poster but I don't know how!

The hardest part is deciding what you want your poster to be about. Once you've done that, the rest is relatively easy, if you follow some simple guidelines.

Firstly, a word about consent and patient confidentiality – if you are going to present an interesting case, you MUST obtain the patient's consent, in writing, that they are happy for their images to be displayed for others to see. An explanatory phone call, followed by a pre-written consent letter and SAE for them to sign and return should be adequate. All images must be anonymous, and all text should be free of anything which could identify the patient, eg. avoid names, even made-up ones – “Mr Smith...” should be replaced with, “A 42 year old man...”

Size and orientation – A0 and portrait. Please note that it's not easy to visualise something this big on a computer screen, so one method is to type up your text in a Word document, before copying and pasting it into a PowerPoint slide, where you can add your images and/or diagrams.

You should have:-

Title - this should state simply what the poster is about – for example, “Type 2 Idiopathic Macular Telangiectasia”

If you want to, you can provide further information in a smaller font on the next line down:-
“A variety of signs seen in routine retinal screening images”

Authors - start with the surname, followed by initials, then any professional letters after the name. eg. Bloggs, J, MSc., Tipps, PG, BA. If your poster is a team effort, listing the authors alphabetically should avoid unpleasantness!

Introduction – this should be a short paragraph explaining WHAT your topic is about, with references if these are appropriate. For example, if your poster is about a patient who presented at screening with unusual pathology, you could say something along the lines of:-

“XYZ is a relatively rare disease which can be symptom-free, but be visible on retinal imaging. A 30 year old woman screened positive with XYZ. This was confirmed at grading as true positive and she was referred routinely to HES, where OCT and fluorescein angiography confirmed the finding. Treatment was ABC and she was subsequently monitored by HES for 12 months, before being returned to screening. We present pre and post treatment images, which clearly show the effect that screening can have”

Background - this is where you say WHY you are presenting this

topic. You want to attract a passing reader, so you are aiming to make it relevant, but using pictures to paint a thousand words, because this will be far more eye-grabbing than the words themselves - words require effort on the part of the reader.

Think about WHY you are presenting a poster. The most likely reason is that you have something that you want to share with others because you think it will interest and inform or educate them. Is it a patient who presented at screening as a newly diagnosed diabetic so they've not been seen before and they had something which made you run for the textbooks? Is it a known patient who presented with interesting new pathology? Is it a patient whose disease progression shows unusual trends?

You might then mention the incidence of the disease and reference where you got your facts and figures from. References should be kept to a bare minimum though, and if you list them numerically, put the number in superscript from the Insert (Reference) pull down menu in Word after you've mentioned it, eg. Type 2 IMT has been reported to have an increased prevalence in patients with Diabetes . This will automatically start a list at the bottom of your document which you can fill in, starting with author, title of article, title of publication, and publication date. These need to be typed in a very small font so they don't take up too much room at the bottom of your poster – nobody reading your poster will be checking your references! A word of warning – if you add a reference afterwards, having decided to expand your introduction, the reference numbers will automatically reset themselves in the body of text, but you will need to manually correct the list at the bottom. Another reason for keeping it short – aim for no more than 3-4.

Does your poster have to be about a patient? No – for example, have you or your Programme produced any initiatives which you think have improved your service, or helped with training, and you think it would benefit the wider community of retinal screeners? You may have audited your results and found some interesting trends. Posters covering these topics need pretty pictures and diagrams – for example, photographs, tables and simple graphs which show the trends clearly.

Style – it is worth thinking carefully about the colour of your poster – some backgrounds can make the text hard to read. A black background looks dramatic, especially with retinal images on it, but can make coloured text “disappear”. There is a lot of style choice in PowerPoint

Summary/Conclusion – not needed if your poster is presenting a patient. If your poster is not a case presentation, but a “story” of something you did in your Programme, a short summarising sentence will suffice.

MY POSTER TITLE
My poster's subtitle which explains a little more
By Bloggs, F Phd, Good, B RCOph, Ball, I MRCPG

INTRODUCTION
This is a block of text that initially describes the condition or method that we are trying to present. This is a block of text that initially describes the condition or method that we are trying to present. This is a block of text that initially describes the condition or method that we are trying to present.

BACKGROUND
This bit explains a the particular patient in question and why we are presenting this case. This bit explains a the particular patient in question and why we are presenting this case. This bit explains a the particular patient in question and why we are presenting this case. This bit explains a the particular patient in question and why we are presenting this case. This bit explains a the particular patient in question and why we are presenting this case. This bit explains a the particular patient in question and why we are presenting this case.

Patient A Patient B

Some more details.
This bit explains a the particular patient in question and why we are presenting this case. This bit explains a the particular patient in question and why we are presenting this case. This bit explains a the particular patient in question and why we are presenting this case. This bit explains a the particular patient in question and why we are presenting this case.

In Conclusion.
Here is the summary. Here is the summary. Here is the summary. Here is the summary. Here is the summary.

References
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Anyshire NHS Hospital Trust
Diabetic Eye Screening Service
01234 567890

BARS: OTHER NEWS

NEXT ISSUE:

We aim to produce two newsletters per year and are in need of relevant articles from screening services. If you have something you'd like BARS council to consider for its newsletter please contact us at the email below.

We are keen to promote the sharing of best practice and if your service has conducted a recent audit or spot of research that has highlighted something interesting, why not share it with the rest of the diabetic eye screening community, we may all learn something from it that will benefit our patients.

PUT YOUR CHARITY EVENT FORWARD!

BARS would like to support a charity nominated by one of our members at the annual conference. For your chance to boost the funds for your good cause, email Susanne.kelly@buckshealthcare.nhs.uk with a very brief description of your fundraising plans and details of where the money raised will go (250 words maximum). We would love to hear about it at the BARS conference. If you are not attending or prefer not speak out we let everyone know what you are up to at the dinner on Saturday evening. Applications will be reviewed by the BARS council at the next meeting, so please get in touch by the end of 30th June 2013.



13th Annual BARS Conference

BARS Council are pleased to announce that we are ready to take bookings for our 13th Annual Conference, which this year sees the conference returning to the Gosforth Park Hotel in Newcastle on the 26th & 27th September 2013. The BARS conference in 2009 was held within this hotel and we received very encouraging feedback from the attendees about the hotel, the food and the hotel staff so we decided that it was well worth a return visit.



On another positive note we have been able to reduce the cost of attendance this year and it is therefore cheaper to attend than last year. We have been working hard behind the scenes and have got a good mixture of subjects for the presentations and we are running a photographic competition that screeners can enter with the possibility of winning an iPad.

The Royal College of Ophthalmologists Education Dept/Professional Standards have awarded our conference 7 CPD points - category B. This will be beneficial for medical staff attending.

Please see the conferences page on our website for more information and the required forms for attendance at conference and also the entry forms for the photo competition and the call for papers and posters.

BARS Council look forward to seeing you all in Newcastle.

We are already working on the conference for 2014 and if you have any ideas for presentations or know of anyone, including patients, who may wish to talk on a relevant subject please let us know.

For more information go to the Conference section of the BARS website.

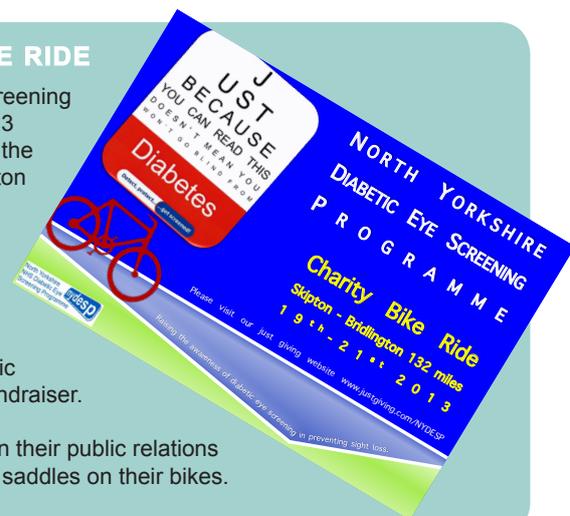


CHARITY CYCLE RIDE

The North Yorkshire Screening Programme is doing a 3 day cycle ride across the region in June (Skipton to Bridlington is the intended route).

They're aiming to call at GP practices and medical centres, leaflet drop, etc. The aims are to raise awareness of Diabetic Retinopathy, to team build and also as fundraiser.

BARS Council wishes them all the best on their public relations venture and hope they have some comfy saddles on their bikes.



Contact Us

Use the below email if you have an idea for the BARS Website or Newsletter



webadmin@eyescreening.org.uk

If you have a question relating to membership of BARS please contact Alison Simpson:-



alisonsimpson@nhs.net



Our Facebook Link
<https://www.facebook.com/bars.bars.33>

