



Guidance for Optometrists in relation to Diabetic Retinopathy Screening Schemes

June 2004

Over the next few years formal screening schemes designed to detect diabetic retinopathy will be 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. At present many areas involve optometrists in screening using slit-lamp binocular ophthalmoscopy. Others use retinal cameras, whilst a substantial number have no screening at all. Most will have to make changes to meet the required standards for the screening programme. In some there will be no optometric involvement at all, whilst in others optometrists may provide imaging services, or grading services, or both.

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.

If you believe that the patient has not been screened within the last 12 months, you should inform the patient and their GP 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.

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 with 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.

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

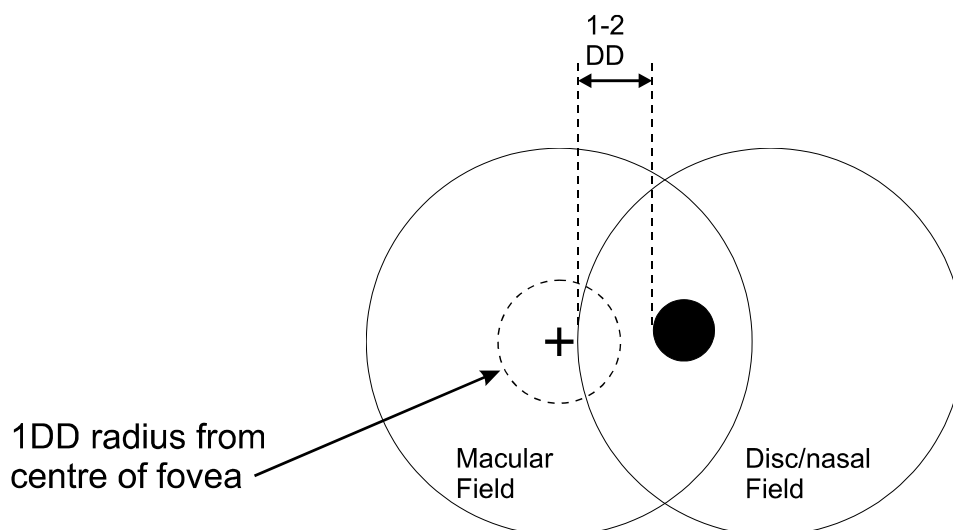
Some patients will request a private screening for a variety of possible reasons. They may prefer not to attend the NHS service, they may find it inconvenient or they may wish to be reassured more frequently. Whilst patients should not be discouraged from attending the NHS screening service in favour of a private arrangement, if a patient requests your opinion it is entirely proper to provide it, so long as you are familiar and comfortable with the grading criteria.

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. It will require digital imaging of an appropriate standard, with suitable viewing, storage and compression. Graders will have a national qualification and will 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. 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.

All of this suggests that unless a private process is to the same standard, and is similarly quality assured, it might be unwise to refer to it as “screening”. It may be better to refer to this as a “Diabetic Retinopathy Check”, rather than “screening”. One should also consider if it is possible for a private process to feed information into the system in a manner that is useful for the other health professionals involved, and in a way that benefits the patient.

Practitioners, preferably through the Local or Area Optometric Committee, could establish the data set required by the local screening service and a suitable manner in which to provide it. At its most basic this will be the retinopathy grade for each eye, ideally together with fundus photographs (1 for each eye in Scotland, 2 for each eye elsewhere in the UK). Grading should adhere to local protocols, but these are likely to be based on the grading scale developed for the National Screening Committee. Practitioners should familiarise themselves with these grading protocols and screening outcomes on the NSC site at www.nscretinopathy.org.uk – 2003 – Grading and QA.

Required fields for England, Wales and NI:



Secondary grading is a “second pair of eyes”. All images graded as containing signs of retinopathy, together with 10% of those graded as normal are checked by the secondary grader. Supplying the fundus photographs from a private check to the screening service should ensure that secondary grading takes place in the same way as for NHS screening. Trusts and GPs should be encouraged to include data from private retinopathy checks and may be reminded that it will be harder for them to meet their targets for population coverage if they do not do so. If they refuse to do so then you should inform your patient of the fact, and provide the results and images to the patient instead. It is quite possible that a GP may wish to accept the data even if the PCT’s screening service does not.

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
Revised: 23rd June 2004