Auckland DHB
Chief Executive's Office
Level 12
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Ph: (09) 630-9943 ext: 22342
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19 March 2021

[redacted]

[redacted]

[redacted]

Re: Official Information Act request – Wait Times/Backlogs: Diabetic Eye/Retinal Screening

I refer to your Official Information Act request dated 13 January 2021. You clarified your request on 22 February 2020 to read:

1. **Reports and minutes since 1 July 2020 regarding wait lists or wait times for diabetic eye/retinal screening, or about ethnic prioritisation for retinal screening**

   Please see attached documentation, some of which has been redacted to protect the privacy of persons under Section 9(2) (a) and commercially sensitive information under Section 9(2)(b) (ii).

2. **Correspondence (internal and external) since July 1 2020 involving ophthalmologists raising examples of, or concerns about the risk of, patients losing vision while waiting for screening or treatment, and which has been sent to or shared with clinical and hospital leaders (such as any clinical governance group, or a clinical team leader)"**

   So, if a hospital ophthalmologist has emailed a governance group or team leader or chief executive, or if such correspondence has been sent on to them.

   There was no correspondence relating to concerns raised about vision loss whilst waiting for screening or treatment.

   The only concerns raised about potential vision loss were in regard to the Northern Region Diabetic retinal screening triage tool and related to questioning the use of ethnicity rather than vision loss as a prognostic indicator.

   There is however good evidence emerging which has been submitted for formal publication which supports ethnicity as a reliable prognostic indicator. As it has not yet been published we are unable to provide this.

You are entitled to seek a review of the response by the Ombudsman under section 28(3) of the Official Information Act. Information about how to make a complaint is available at www.ombudsman.parliament.nz or freephone 0800 802 602.

Please note that this response, or an edited version of this response, may be published on the Auckland DHB website.

Yours faithfully

Ailsa Claire, OBE
Chief Executive of Te Toka Tumai (Auckland District Health Board)

AUCKLAND WAITEMATĀ ALLIANCE LEADERSHIP TEAM

INFORMATION PAPER

Title of the paper	**Auckland and Waitematā DHBs Diabetic Retinal Screening Update**
Author	Leanne Kirton, Project Manager, Dr Carol Barker, Public Health Physician
Endorsed by	Tim Wood, Deputy Director Funding
Purpose of the paper	To update Auckland Waitematā ALT regarding the current status of the Auckland and Waitematā DHBs Diabetic Retinal Screening programme
Meeting date	3 December 2020

AUCKLAND AND WAITEMATĀ DHBS DIABETIC RETINAL SCREENING UPDATE

Recommendation:

That the Auckland Waitematā Alliance Leadership Team

- **Receive** this report

And

- **Note** current retinal screening coverage rates and decline over the current year
- **Note** the number of people living with diabetes not currently engaged with retinal services
- **Note** short term - medium term initiatives (next 12-18 months) to improve retinal screening coverage
- **Note** plans to redesign retinal screening services (18-24 month plan)

Prepared by: Leanne Kirton, Project Manager & Dr Carol Barker, Public Health Physician, Auckland and Waitematā DHBs
Endorsed by: Tim Wood, Deputy Director Funding, Auckland and Waitematā DHBs

Glossary

DHB/s – District Health Board/s
DSLA – Diabetes Service Level Alliance
MoH – Ministry of Health
NGO – Non Government Organisation
PHO – Primary Health Organisation
RSCGG – Retinal Screening Clinical Governance Group

1. Executive Summary

Diabetic retinopathy is a chronic eye disorder which causes visual impairment and blindness in people with diabetes. Diabetic retinopathy can be detected by retinal screening where the retina is photographed and assessed for signs of disease. People with disease can then be referred for treatment to reduce the risk of visual loss. The Ministry of Health (MoH) recommends people with diabetes undergo regular diabetic retinal screening.

The MoH target for diabetes retinal screening coverage is 90%. Retinal screening coverage for Auckland and Waitematā District Health Boards (DHBs) is well below this target, and has fallen further over the past nine months. Two year coverage for Auckland DHB is 49% (as at October 2020), down from 57% in December 2019, with Māori coverage at 45% and Pacific coverage at 43%. Two year coverage for Waitematā DHB is 46% (as at October 2020), down from 56% in December 2019 with Māori coverage at 42% and Pacific coverage at 46%.

In addition, since December 2019, the number of adults not currently engaged[1] with diabetic retinal screening or relevant ophthalmology services has increased. For Auckland DHB this equates to 11,447 people, up from 9,471 in December 2019, of these 11,447 people 1,346 are considered highest risk (priority one) based on ethnicity and latest HbA1c. For Waitematā DHB the number of adults not currently engaged with the retinal screening or relevant ophthalmology service is 10,498 people, up from 8,093 in December 2019, of these 10,498 people 682 are considered highest risk (priority one) based on ethnicity and latest HbA1c.

It is therefore evident that there is significant unmet need for diabetic retinal screening within our Districts and this has been compounded by COVID-19. There are several activities currently underway to improve diabetic retinal screening coverage and improve equity of outcomes particularly for Māori and Pacific people. The Metro Auckland Diabetic Retinal Screening Data Match Project aims to improve screening rates in the short to medium term while the Auckland and Waitematā Diabetic Retinal Screening Service Redesign Project aims to provide longer term improvements.

The Metro Auckland Diabetic Retinal Screening Data Match Project aims to improve diabetic retinal screening coverage and equity of coverage to enable early detection and treatment of preventable diabetic eye disease. This will be achieved using regular data matching of DHB diabetic retinal screening and ophthalmology data with Primary Health Organisations (PHO) data to identify people with diabetes who are not engaged with diabetic retinal screening services so they can be referred by their GP/primary care provider. The data match process stratifies patients by risk, so those with the highest risk can be prioritised for referral. This project is underway, and several data match cycles have already been completed (March 2019, December 2019 and October 2020). A planned data match in April 2019 was not completed due to the COVID-19 Response.

In addition, a new service model for the diabetic retinal screening service has been developed through extensive stakeholder and community engagement and consultation. Unfortunately this was unable to be progressed at the beginning of this year due the need to focus on the COVID-19 response. Now the COVID-19 response is in a more settled phase, the project can be re-activated with implementation due within the next 18 to 24 months. The development of procurement and business plans for Auckland and Waitematā Board approval are underway.

2. Purpose

The purpose of this paper is to highlight current diabetic retinal screening coverage rates and, in particular, the declining coverage that has occurred since the start of the recent pandemic. The

[1] Not currently engaged is defined as no record of a retinal screen attended in the last 2 years or scheduled in the next 1 year and no record of a relevant ophthalmology appointment attended in the last 1 year or scheduled in the next 1 year or being returned to GP for repeated DNA/being uncontactable and no subsequent contact with services. Most of these people will need a referral from primary care however some are being followed up by screening services. The project team are working with providers to ensure PHOs receive accurate lists of patients who need a retinal screening referral.

paper outlines steps to improve screening coverage in the short to medium term, along with a longer term strategy to operationalize a diabetic retinal screening service redesign to improve service quality, efficiency and accessibility. It is anticipated that this service redesign will not only improve screening coverage but will also improve equity of outcomes by creating a service which better meets the needs of Māori and Pacific people and underserved populations.

3. Background

3.1 Diabetic retinopathy

Diabetic retinopathy is a chronic eye disorder which causes visual impairment and blindness in people with diabetes. All people with diabetes are at risk of developing diabetic retinopathy. Risk increases with duration of diabetes, poor diabetic control, being unable to access health services, pregnancy, uncontrolled hypertension and renal impairment[2]. Approximately 20-25% of New Zealanders living with diabetes have some form of diabetic retinopathy, with 10% having sight-threatening retinopathy.[3] [4] [5] Māori and Pacific people living with diabetes have higher incidence of moderate and severe diabetic retinopathy and are less likely to access screening compared with New Zealand Europeans.

Diabetic retinopathy is often asymptomatic, with symptoms only arising at the advanced stage. Fortunately, diabetic retinopathy can be detected by retinal screening where the retina is photographed and assessed for signs of the disease. People with disease can then be referred for treatment to reduce the risk of visual loss. There is good evidence that diabetic retinal screening and subsequent treatment reduces preventable blindness in people with diabetes and that retinal screening is cost effective. [6]

The MoH recommends that all people with diabetes undergo regular screening for diabetic eye disease. The MoH's target for diabetic retinal screening coverage is 90% for all ethnicities. This target assumes that 10% of people with diabetes are ineligible for screening (eg already under ophthalmology care for treatment of disease, are blind or have some other life limiting condition). Diabetic retinal screening should be conducted as part of an organised screening programme, in which all activities along the screening pathway are planned, coordinated, monitored and evaluated. The standard screening interval is two years. For low risk individuals, this screening interval can be extended to three years and for higher risk individuals the interval is shortened.

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[2] Ministry of Health, Diabetes retinal Screening, Grading, Monitoring and Referral Guidance. 2016, Ministry of Health Wellington.

[3] Coppell, K.J., et al., The quality of diabetes care: A comparison between patients enrolled and not enrolled on a regional diabetes register. Primary care diabetes, 2011. 5(2): p 131-137

[4] Frederikson, L.G. and R. J. Jacobs, Diabetes eye screening in the Wellington region of New Zealand: characteristics of the enrolled population (2002-2005). The New Zealand Medical Journal (Online), 2008. 121 (1270)

[5] Papali'i-Curtin, A.T. and D.M. Dalziel, Prevalence of diabetic retinopathy and masculopathy in Northland, New Zealand: 2011-2012. The New Zealand Medical Journal 2013. 126 (1383)

[6] Jones, S. and R.T. Edwards, Diabetic retinopathy screening: a systematic review of the economic evidence. Diabetic Medicine, 2010. 27(3): p. 239-256

3.2 Current Diabetes Retinal Screening Services within Auckland and Waitematā DHBs

Auckland DHB currently provides services via two contracted providers:

- Auckland DHB Diabetes Service, providing screens at Greenlane Clinical Centre
- Auckland Eye, providing screens at five locations, as outlined in Figure 1, below

Waitematā DHB also has two contracted providers:

- HealthWest, providing screens at Totara House, Whanau House, and The Fono Henderson. Note: the Fono site is not currently operational due to their COVID response plans
- Comprehensive Care, providing screens at seven locations, as outlined in Figure 1, below.

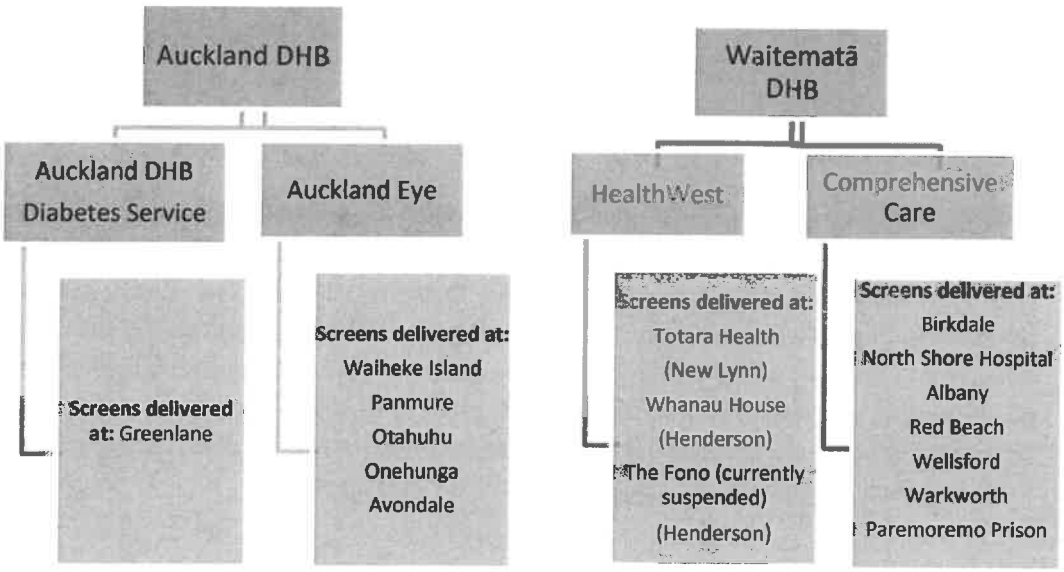

Figure 1. Contracted Diabetes Retinal Screening Providers

3.3 Current state of retinal screening coverage as at 30 September 2020

For Auckland and Waitematā DHBs diabetic retinal screening coverage is well below the MoH target of 90%, and has fallen further over the last nine months. Two year coverage for Auckland DHB is now 49%, down from 57% in December 2019, with Māori coverage at 45% and Pacific coverage at 43%. Two year coverage for Waitematā DHB is now 46%, down from 56% in December 2019 with Māori coverage at 42% and Pacific coverage at 46%.
For Auckland DHB coverage at three years is 59% for the total diabetic population, 57% for Māori and 53% for Pacific. For Waitematā DHB coverage at three years is 59% for the total

diabetic population, 55% for Māori and 58% for Pacific. Further detail on the diabetic retinal screening coverage can be found in Table 1.

Table 1: Diabetic retinal screening coverage by DHB of practice and ethnicity

DHB of practice	Ethnicity	Percentage screened in past 2 years	Percentage screened in past 3 years
Auckland	Māori	45%	57%
	Pacific	43%	53%
	Asian	52%	62%
	Other	51%	60%
	Total	**49%**	**59%**
Waitematā	Māori	42%	55%
	Pacific	46%	58%
	Asian	46%	60%
	Other	46%	60%
	Total	**46%**	**59%**

3.4 Number of adults not currently engaged with diabetic retinal screening or relevant ophthalmology services

Since December 2019, the number of adults not currently engaged with diabetic retinal screening or relevant ophthalmology services has increased. For Auckland DHB this equates to 11,447 people, up from 9,471 in December 2019, of these 11,447 people 1,346 are considered highest risk (priority one) based on ethnicity and latest HbA1c. For Waitematā DHB the number of adults not currently engaged with the diabetic retinal screening or relevant ophthalmology service is 10,498 people, up from 8,093 in December 2019, of these 10,498 people 682 are considered highest risk (priority one) based on ethnicity and latest HbA1c. Further detail on the unmet need for diabetic retinal screening services can be found in Table 2 and 3.

Table 2: Number of adults enrolled with an Auckland or Waitematā PHO and coded as diabetic who are not currently engaged with diabetic retinal screening or relevant ophthalmology services, by DHB of practice and ethnicity.

	Ethnicity				
DHB of practice	Māori	Pacific	Asian	Other	**Total**
Auckland	838	3,576	4,105	2,928	11,447
Waitematā	1,090	1,475	2,638	5,295	10,498
Total	**1,928**	**5,051**	**6,743**	**8,223**	**21,945**

Table 3: Number of adults enrolled with an Auckland or Waitematā PHO, coded as diabetic and not currently engaged with diabetic retinal screening or relevant ophthalmology services, prioritised by ethnicity and HbA1c, by DHB of practice.

DHB of practice	Priority based on ethnicity and HbA1c (1=highest priority)				No HbA1c	Total
	1	2	3	4		
Auckland	1,346	3,088	2,811	1,928	2,274	11,447
Waitematā	682	1,784	1,757	4,505	1,770	10,498
Total	**2,028**	**4,872**	**4,568**	**6,433**	**4,044**	**21,945**

3.5 Number of people lost to follow up from relevant ophthalmology services

Currently, there are 260 adults that the relevant ophthalmology service has not be able to follow-up with, 198 of these sit within Auckland DHB while 62 of these sit within Waitematā DHB. These are people returned to GP from relevant ophthalmology treatment services due to repeat DNA or being uncontactable, and who have no record of subsequent contact with services. These people may have active diabetic eye disease and are at increased risk of losing their sight.

4.1 Short term solutions to improve low coverage and high unmet need (12-18 months)

We currently have a number of strategies underway to improve diabetic retinal screening coverage and improve equity in the short term.

4.2 The Metro Auckland Diabetic Retinal Screening Data Match Project

The Metro Auckland Diabetic Retinal Screening Data Match Project aims to improve diabetic retinal screening coverage and equity of coverage to enable early detection and treatment of preventable diabetic eye disease. This will be achieved using regular data matching of DHB diabetic retinal screening data with PHO data to identify people with diabetes who are not engaged with diabetic retinal screening services so they can be referred by their GP/primary care provider. The data match process stratifies patients by risk, so those with the highest risk can be prioritised for referral. This is a collaborative project, between the DHBs and PHOs, and several data match cycles have already been completed (March 2019, December 2019 and October 2020). A planned data match in April 2019 was not completed due to the COVID-19 Response.

4.3 The use of prioritisation frameworks to ensure those at highest risk are referred in first and screened first

Given the unmet need for diabetic retinal screening services a consistent, clinically safe and equitable approach is needed to ensure those at highest risk of disease are referred and screened first.

The Northern Region Diabetic Retinal Screening Clinical Governance Group have developed a prioritisation framework for the diabetic retinal screening data match project to ensure those at highest risk of developing or having undiagnosed diabetic eye disease are referred into screening services first. Risk is determined by ethnicity and diabetic control (HbA1c). DHB analysts use the prioritisation framework to assign people who need a referral a priority score which is then added to the PHO patient lists so practices know who to refer in first.

4.4 Improving DNA rates and operationalising 3 yearly recalls

Providers will continue to work on reducing their DNA rates through improving their clinic booking processes. This includes contacting patients who have not confirmed their appointment the week of their appointment. However, these activities have been hampered due to the recent COVID-19 lockdown periods causing a number of clinics to be cancelled.

The Funder will work with current providers to identify how to implement a three year recall period for people at lower risk of developing diabetic eye disease as per MoH guidance (currently IT capacity limits our ability to implement this recall option).

4.5 Monitoring and clinical governance

The Northern Region Diabetic Retinal Screening Clinical Governance Group was formed to provide clinical oversight and governance of the delivery of retinal screening services to people living in the Northern Region. This Group is responsible for reviewing the enablers, metrics and performance of the different screening services, including monitoring diabetic retinal screening coverage and the number of people living with diabetes who are not known to diabetic retinal screening services This Group will also monitor service waiting lists and the impact of implementing the triage framework. The triage framework is applied by DHB data analysts so that primary care knows which patients to refer first to retinal screening services. This Group regularly report to the Diabetes Service Level Alliance (DSLA) and Auckland Waitematā Alliance Leadership Team to ensure performance is transparent.

Moving forward, the governance group for the Auckland and Waitematā diabetes retinal screening service will include Māori and Pacific representatives. This may include consumers, health professionals, or health administrators.

5.1 Longer term solutions to improve low coverage and address high unmet need (18-24 months)

A substantial body of work has been completed to define a new model of care for diabetic retinal screening services within Auckland and Waitematā Districts. The proposed model of care has been informed by international and local best practice guidelines and evidence, along with consumer and stakeholder engagement and consultation. This work has enabled consensus to be reached on how the new model will be configured. There have been two key decision points during this process. The first was in 2016, where through the Auckland Waitematā Alliance Leadership Team, a mandate was obtained to:

1. Develop a single, consistent retinal screening service across both districts (Auckland and Waitematā DHBs)
2. Implement a service framework which allows for a variety of service delivery approaches ranging from a single provider through to multiple providers working in a collaborative fashion
3. Develop a central coordination and administration hub, supported by a central retinal screening register
4. Implement a model where the majority of screening is community based and delivered through a mix of fixed and mobile sites
5. Develop an overarching robust clinical governance framework with clear lines of accountability. This is to operate over both districts
6. Implement a single cohesive screening service with clear roles, responsibilities and reporting lines operate across both districts
7. Implement a consistent screening pathway
8. Secure suitable provider/s are identified through an open and contestable procurement process
9. Ensure a sustainable, consistent contracting and funding approach, that incentivises improved coverage, is applied to the new service across both districts
10. Ensure a single fit for purpose screening software package is used by the provider at all screening sites across both districts
11. Ensure the service is responsive to population and community needs and address inequities
12. Ensure detailed demand/capacity modelling work is undertaken and used to better inform future contract volumes and resourcing of the screening service

A revised service model, which incorporated the key aspects outlined above, was then developed and explored through consultation process with key stakeholders and consumers. From this consultation, a new model of care was developed in more detail and twelve recommendations were presented and endorsed by DSLA in December 2018. This was the second key decision point in the project's journey. These twelve recommendations are divided into key topics and are as follows:

Locations

1. The new service model will offer diabetes retinal screening at a significantly expanded range of screening locations than is the case under the current service model. Service users requiring a primary screen will have the option of attending any primary screening site that is convenient to them.

2. Primary screening will be offered at locations that take into account ease of access and travel time for service users, as well as the availability of public transport and free parking.

3. The service model will include screening locations regarded as trusted, familiar, and easily accessible to Māori. This may include, for example, general practices with a high proportion of Māori enrolees, Māori health providers, and marae.

4. The service model will include screening locations regarded as trusted, familiar, and easily accessible to Pacific people. This may include, for example, general practices with a high proportion of Pacific enrolees, Pacific health providers, and churches.

5. Where general practices with a high proportion of South Asian enrolees are amenable to having a visiting diabetes retinal screening clinic at the practice, the service model will facilitate this. The service model will also facilitate screening at mosques and temples where practicable.

6. Primary screening will be offered at locations that take into account the distribution of diabetes prevalence across the catchment area.

7. A travelling service will cover prison clinics and selected locations, such as rural locations and venues that have high value as culturally accessible sites, where fixed sites are not feasible. (Screeners and equipment will be transported to these sites to enable the set-up of temporary screening clinics.)

Hours of operation

8. The service model will include the offer of appointment times in evenings and weekends.

Māori and Pacific representatives on the governance group

9. The governance group for the Auckland and Waitematā diabetes retinal screening service will include Māori and Pacific representatives (which may be consumers, health professionals, or health administrators).

Further involvement of general practices with a high proportion of Māori, Pacific, or South Asian enrolees

10. Where general practices with a high proportion of Māori, Pacific, or South Asian enrolees are willing to assist with the invitation and booking process for their enrolees, the service model will facilitate this involvement.

11. Where general practices with a high proportion of Māori, Pacific, or South Asian enrolees are willing to assist with communicating a screening result of mild retinopathy to their enrolees, the service model will facilitate this involvement.

Grading

12. Whilst the **image capture** component of the screening test will be offered at a significantly expanded range of locations, the central administration hub will have responsibility for the oversight of **grading** for all images.

All above recommendations were well socialised amongst key stakeholders and endorsed by the DSLA. It is now time to incorporate the feedback provided, update the modelling undertaken to date, and obtain Board approval to implement the revised service model.

5.2 The *OptoMize* Project Upgrade

OptoMize is a Patient Management System (PMS) that will support the proposed new diabetic retinal screening service model by promoting a common regional approach and implementing a shared PMS across the region. A current project is underway to ensure that all existing providers are able to use the upgraded *OptoMize* version (at this stage 4.5). In addition, the project will support the proposed new service model by;

- implementing a regional *OptoMize* solution for Auckland DHB, Waitematā DHB and Northland DHB, with a view to including Counties Manukau at a later date
- implementing common business processes across the Region.

5.3 Artificial intelligence to grade photos

A novel approach to improving efficiencies within the diabetic retinal screening services is the introduction of artificial intelligence to grade photos. It is expected that the use of artificial intelligence in the grading of photos will release grading staff to undertake other duties within the service. However, this technology is still being trialled so it is still uncertain when this will be available to support efficiencies within the retinal screening service.

6. Conclusion and next steps

The purpose of this document is to ensure Auckland Waitematā ALT members are aware of current diabetic retinal screening coverage rates and equity issues, along with the strategies underway to improve these issues in the short to medium term (12 - 18 months). It is to also ensure that all Alliance members are aware of the diabetic retinal screening service redesign project and next steps.

Given the recent decline in diabetic retinal screening coverage it is imperative that all PHOs support the diabetic retinal screening data match project. Through HealthSafe PHOs can download lists of people with diabetes, enrolled with their PHO, who are not currently engaged with diabetic retinal screening services. PHOs can then work with practices to contact these people and generate a referral for their local diabetic retinal screening service. Patient lists from HealthSafe are prioritised to enable practices to contact and refer those at highest risk first. In addition, we will ensure efforts are galvanised to implement our new retinal screening service without delay. Our proposed model of care is expected to help improve our retinal screening coverage rates and address screening equity issues across both Auckland and Waitematā districts. Next steps are as follows:

- Develop a procurement plan, which will need to include service specifications for all service components. This will need sign-off from Auckland and Waitematā Boards.
- Develop a business plan which integrates 2019 consultation feedback. This will need to include updated demand modelling and obtain sign-off from Auckland and Waitematā DHB Boards.
- Ensure there are on-going linkages with other strands of the diabetes work programme to ensure timelines are aligned.

Priscilla Philip (ADHB)

From: Samantha Titchener (ADHB)
Sent: Monday, 05 October 2020 16:23
To: Ole Schmiedel (ADHB)
Cc: Jackson Cutting (ADHB); Kelly Gray (ADHB)
Subject: re Retinal Screening Strategic Direction
Attachments: 2019 model for retinal screening regional model.DOCX

Hi Ole

Firstly apologies for the e mail I would have preferred to contact you for a discussion but note you are on leave. I have attached a paper which you will be familiar with re an integrated model for Retinal Screening for ADHB and WDHB that was completed and endorsed by the board in 2019. We need to discuss this and the direction signalled by ADHB for retinal screening that includes;

- A central hub
- Multiple access points for retinal imaging at dispersed locations
- An outreach service

I had not been briefed on this paper and the direction until last week so I am keen to meet with you to discuss. I will ask Kelly to set a time up for yourself to meet with Jackson and I for discussion.

Kelly- Please can you put in an hour for myself, Ole and Jackson to discuss Retinal Screening Model, for next week.

Thanks

Samantha Titchener
Director | Community and Long Term Conditions Directorate
[redacted]
Auckland District Health Board | Level 4 | Building 31 | Auckland City Hospital

Haere Mai Welcome | Manaaki Respect | Tūhono Together | Angamua Aim High

Diabetes Retinal Screening Service

Diabetes Retinal Screening

An Integrated Service for

Auckland District Health Board

and

Waitematā District Health Board

2019

Diabetes Retinal Screening Service

Document Draft:	Version 1.3 [5 April 2019]
Prepared By:	**Joy Christison** – Project Manager, Primary Care, Planning, Funding and Outcomes, Auckland and Waitematā District Health Boards **Carol Barker** – Public Health Physician, Planning, Funding and Outcomes, Auckland and Waitematā District Health Boards **Eirean Gamble** – Programme Manager, Primary Care, Planning, Funding and Outcomes, Auckland and Waitematā District Health Boards
Input Provided By:	**Tracy Walters** - Portfolio Manager, Māori Health Gain, Planning, Funding and Outcomes, Auckland and Waitematā District Health Boards **Maria Lafaele** – Project Manager, Primary Care, Planning, Funding and Outcomes, Auckland and Waitematā District Health Boards **Jean Wignall** – Health Outcomes Analyst, Planning, Funding and Outcomes, Auckland and Waitematā District Health Boards **Michael Walsh** - Epidemiologist, Planning, Funding and Outcomes, Auckland and Waitematā District Health Boards **Leani Sandford** - Pacific Health Portfolio Manager, Pacific Health Gain, Planning, Funding and Outcomes, Auckland and Waitematā District Health Boards **Raj Singh** – Project Manager, Asian Migrant and Refugee Health Gain, Planning, Funding and Outcomes, Auckland and Waitematā District Health Boards
Business case endorsed by:	**Tim Wood** – Deputy Director, Planning, Funding and Outcomes, Auckland & Waitematā District Health Boards **Debbie Holdsworth** – Director, Planning, Funding and Outcomes, Auckland & Waitematā District Health Boards
Service model endorsed by:	**Northern Region Diabetes Retinal Screening Clinical Governance Group** (Auckland and Waitematā membership) **Auckland and Waitematā Diabetes Service Level Alliance**
Next steps:	Subject to approval, a consultation period will commence on 14 June 2019 and conclude on 9 August 2019.

Diabetes Retinal Screening Service

Contents

Diabetes Retinal Screening Service

Abbreviations

Abbreviation	Description
ALT	Alliance Leadership Team
DHB	District Health Board
GP	General Practitioner
GST	Government Service Tax
HbA1c	Glycated Haemoglobin
IT	Information Technology
PHO	Primary Health Organisation
RFP	Request for Proposals
VDR	Virtual Diabetes Register

1. Purpose

This document sets out the case for a redesign of diabetes retinal screening services and proposes procurement processes to achieve the desired result. There are several drivers for change, but chief among them are the need to:

- achieve equitable screening coverage for Māori and Pacific people living with diabetes
- make gains against the Ministry of Health screening target of 90% screening coverage for people living with diabetes who are enrolled with a Primary Health Organisation (PHO).

This business case provides data, analysis, and information to assist decision makers to:

- assess the drivers for change
- select a course of action.

2. Background

2.1 Diabetic Retinopathy

In New Zealand approximately 20-25 percent of people with diabetes have some form of diabetic retinopathy.[1] Retinopathy threatens vision, or has already destroyed sight in 10% of people with diabetes.[2] The following excerpt summarises the clinical presentation of diabetic retinopathy:

> *Diabetic retinopathy ... occurs when diabetes mellitus damages the tiny blood vessels inside the retina, and usually affects both eyes. At first, microaneurysms occur. As the disease progresses, some blood vessels that nourish the retina are blocked. There are two ways that vision loss occurs:*
>
> - *proliferative retinopathy: if many blood vessels are blocked, and several areas of the retina are deprived of their blood supply, signals are sent to grow new blood vessels, which may be abnormal and fragile, growing along the retina and along the surface of the clear vitreous gel that fills the inside of the eye. These blood vessels have thin, fragile walls that, if they leak blood into the centre of the eye, result in blurred vision and blindness.*

[1] Ministry of Health. 2016. *Diabetic Retinal Screening, Grading, Monitoring and Referral Guidance*. Wellington: Ministry of Health.
[2] Health Navigator New Zealand. Accessed 04.01.19. https://www.healthnavigator.org.nz/health-a-z/d/diabetic-retinopathy/

- *macular oedema: fluid can leak into the centre of the retina – at the macula, causing swelling and blurred vision. This is more likely to occur as the disease progresses. About half of people with proliferative retinopathy also have macular oedema.*[3]

Regular retinal screening and subsequent treatment of disease can prevent vision loss and blindness. Treatment includes laser treatment and medications injected directly into the eye. Screening is important because diabetic retinopathy causes no symptoms in its early stages.

In addition to early detection and treatment facilitated by retinal screening, the risk of diabetic retinopathy progressing can be reduced by:

- maintaining good glycaemic control
- managing hypertension
- addressing lifestyle factors, especially stopping smoking, being physically active, and having a heathy diet
- reducing blood lipid levels as part of overall cardiovascular health.[4]

2.2 Current provider configuration

Auckland DHB currently provides services via two contracted providers:

- Auckland DHB Diabetes Service, providing screens at Greenlane Clinical Centre
- Auckland Eye, providing screens at five locations, as outlined in Figure 1, below.

Waitematā DHB currently also has two contracted providers:

- HealthWest, providing screens at Totara House, Whanau House, and The Fono (Henderson)
- Comprehensive Care, providing screens at seven locations, as outlined in Figure 1, below.

(Note: HealthWest commenced screening at The Fono, Henderson in November 2018, in response to findings from consumer interviews conducted by Planning, Funding and Outcomes in 2018 to inform the redesign of diabetes retinal screening services.)

[3] Access Economics Pty Limited. 2010. *Clear Focus – The economic impact of vision loss in New Zealand in 2009.* Canberra: Access Economics Pty Limited.

[4] Best Practice Advocacy Centre New Zealand. 2010. Screening for diabetic retinopathy in primary care. *Best Practice Journal.* Accessed 04.01.19 https://bpac.org.nz/BPJ/2010/August/retinopathy.aspx

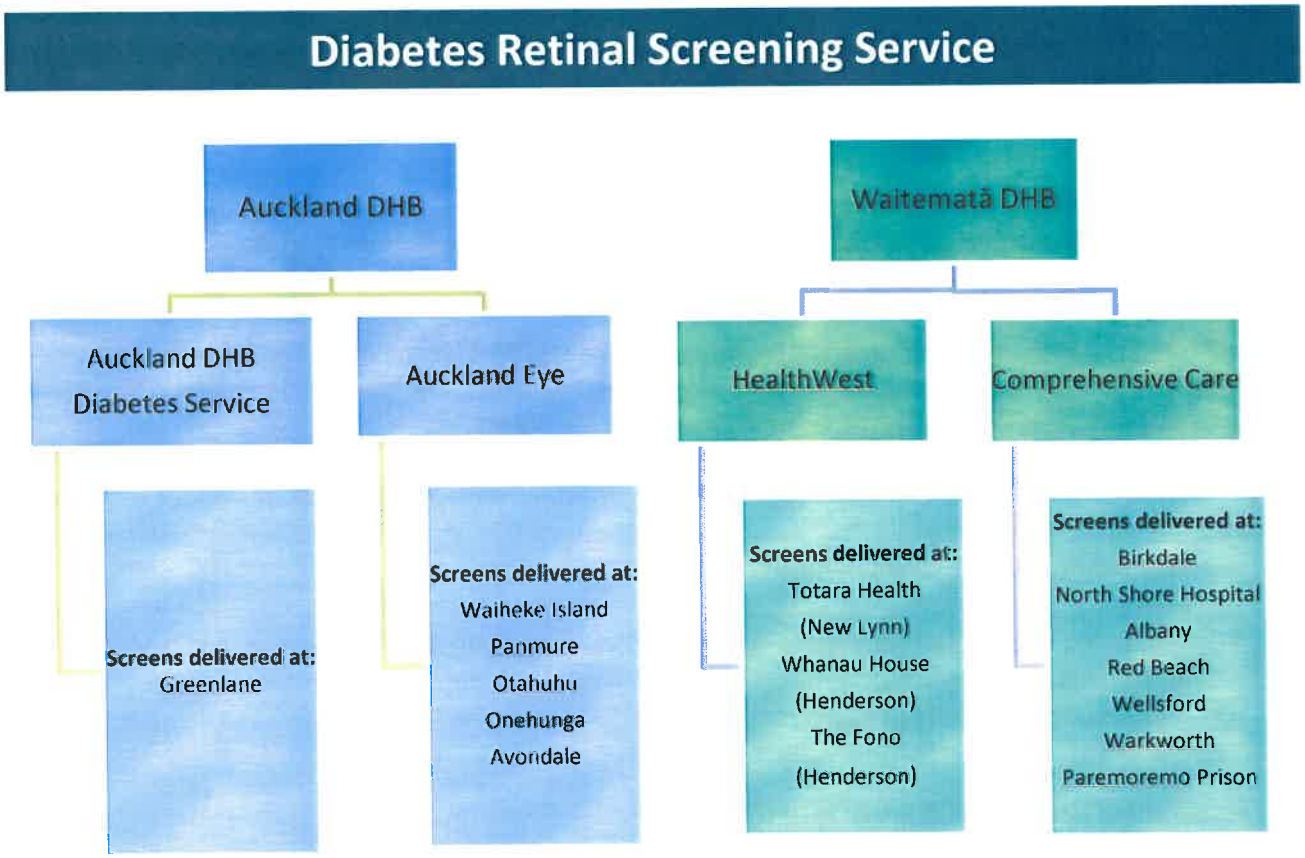

Figure 1. Contracted Diabetes Retinal Screening Providers

2.3 Current pathway for Auckland and Waitematā DHBs

Referral

Primary care clinicians are responsible for referring people to the service. A small number of referrals come from secondary care eg diabetes, paediatrics, obstetrics, and medicine.

Triage

Referrals are triaged by service providers to ensure they meet the service criteria. Auckland DHB triages all referrals for Auckland DHB and Auckland Eye. Waitematā DHB receives e-referrals and forwards these to the appropriate provider. Both Waitematā providers also receive referrals and triage these.

Appointment scheduling

Providers allocate patients' appointments (Auckland Diabetes Centre is introducing patient centred booking).

Screening test

A digital photograph is taken of the retina by one of the contracted providers.

Screening result (grade)

The retinal photograph is graded by each provider according to presence/absence of disease.

Screening outcome

Determined by the screening result, outcomes include routine recall or referral for treatment or photo monitoring.

Documenting and communicating results

Screening results and outcomes are communicated by contracted providers to the patient, General Practitioner (GP), and any other referring health professionals in writing. Preliminary results may also be discussed with the patient at the time of screening.

2.4 Previous work

This business case is underpinned by a considerable body of work which has supported previous internal and external documents, particularly:

- *Diabetic Retinal Screening, Grading, Monitoring and Referral Guidance* (2016) Ministry of Health
- *Review of Retinal Screening Services: Summary Report* (2016) presented to Auckland Waitematā Alliance Leadership Team (ALT) (based on a 2015 review of retinal screening services in Auckland and Waitematā DHBs conducted by Carol Barker, Public Health registrar)
- *Essential Components for a Retinal Screening Service* (2018) Carol Barker, Public Health Physician, Auckland and Waitematā DHBs.

In October 2017 the Auckland and Waitematā Alliance Leadership Team (ALT) approved the recommendation that a single cohesive diabetes retinal screening service be established for both districts. The recommendation specified a central co-ordination and administration hub, with the majority of the screening tests to be provided in community based clinics, close to where people with diabetes live and work.

3. The drivers for change

3.1 Equity is an important goal for diabetes retinal screening

Disproportionate distribution of diabetes

Diabetes is diagnosed at a proportionally higher rate in some ethnic groups. A 2016 study of 738,687 people in the Auckland region found that 19.5% of Pacific people, 17.4% of Indian, 12.3% of Māori, and 5.9% of the remainder (New Zealand European and other ethnicities combined) had a diagnosis of diabetes. This study also identified a deprivation gradient, with people living in the most deprived quintiles more likely to have a diagnosis of diabetes than people living in less deprived quintiles.[5]

[5] Warin B, Exeter, D, Zhao, J, Kenealy, T, Wells, S. 2016. Geography matters: the prevalence of diabetes in the Auckland Region by age, gender and ethnicity. *New Zealand Medical Journal,* 129 (1436) 25-37.

People from Māori and Pacific populations on average develop diabetes at younger age than people from non- Māori and non-Pacific populations.[6] The duration of diabetes is one of the most significant risk factors for the development of, and the rate of progression of diabetic retinopathy.[7]

Disproportionate distribution of sight threatening diabetic retinopathy

Diabetic retinopathy is a progressive disease that can advance from minimal and mild grades that are not associated with an immediate threat to loss of vision, through to higher grades of sight threatening disease. The burden of sight threatening diabetic retinopathy in New Zealand is distributed disproportionately across ethnicities. The key studies that evidence this are summarised below.

A 2003 Waikato audit of a population of 8,172 people who attended diabetes retinal screening reported that Pacific, Indian, and Māori people had a higher prevalence of vision threatening retinopathy (at 4.9%, 4.6%, and 4.3% respectively) than Europeans (2.5%).[8]

A 2013 Northland study of a diabetes retinal screening population of 5,647 found that, compared to Europeans, Māori had a higher prevalence of non-proliferative diabetic retinopathy (7.8% compared to 3.6%) and a higher prevalence of proliferative diabetic retinopathy (0.5% compared to 0.3%).[9]

A 2017 Wellington region study of 12,667 people presenting for the first time to the retinal screening service found the prevalence of sight-threatening diabetic retinopathy for Pacific, Asian, Māori, and European people to be 3.4%, 2.7%, 2.4%, and 1.8%, respectively.[10]

While the findings for the studies outlined above evidence a disproportionate burden of sight threatening retinopathy for people who are engaged with a diabetes retinal screening service, the disproportionality may be greater for those who are not well engaged with a screening service. A 2007 South Auckland study of 458 randomly selected household survey participants with known type 2 diabetes found that the prevalence of moderate to severe retinopathy was 16% in Pacific people, 13% in Māori, and 4% in Europeans.[11]

3.2 Coverage is an important goal for diabetes retinal screening

Ministry of Health target

Screening provides the opportunity to detect and treat asymptomatic disease before it progresses to visual impairment and blindness. The Ministry of Health target for diabetes retinal screening coverage is 90% for all ethnicities. This target takes account of the fact that all people with diabetes should be screened, except

[6] Joshy G, Simmons D. 2006. Epidemiology of diabetes in New Zealand: revisit to a changing landscape. *New Zealand Medical Journal,* 119 (1235)

[7] Ministry of Health. 2016. *Diabetic Retinal Screening, Grading, Monitoring and Referral Guidance*. Wellington: Ministry of Health.

[8] Reda E, Dunn P, Straker C, Worsley D, Gross K, Trapski I, Whitcombe S. Screening for diabetic retinopathy using the mobile retinal camera: the Waikato experience. *New Zealand Medical Journal.* 116 (1180):U562.

[9] Papali'i-Curtin A, Dalziel D. 2013. Prevalence of diabetic retinopathy and maculopathy in Northland, New Zealand: 2011-2012. *New Zealand Medical Journal,* 126 (1383), 20–8.

[10] Frederikson L, Jacobs R. 2008. Diabetes eye screening in the Wellington region of New Zealand: characteristics of the enrolled population (2002-2005). *New Zealand Medical Journal*, 121(1270):21-34.

[11] Simmons D, Clover G, Hope C. 2007. Ethnic differences in diabetic retinopathy. *Diabetic Medicine*, 24(10),1093-8.

for those who are already under ophthalmology care and those who have other co-morbidities preventing screening.[12]

Current performance

A preliminary analysis of the Virtual Diabetes Register (VDR) data, summarised in Table 1, below, indicates that diabetes retinal screening coverage falls significantly below the Ministry of Health target of 90% for both Auckland and Waitematā District Health Boards.

Table 1. Retinal screening coverage for people domiciled in Auckland DHB and Waitematā DHB identified as having diabetes and enrolled with a PHO in the 2017 VDR (all ages)

			Screened in last 2 years		Screened in last 3 years	
DHB	Ethnicity	People with diabetes, 2017 VDR, enrolled with a PHO	Number	Percentage	Number	Percentage
Auckland	**Total**	**24,586**	12,588	51.2%	13,617	55.4%
	Maori	1,802	854	47.4%	950	52.7%
	Pacific	5,991	2,616	43.7%	2,929	48.9%
	Indian	3,964	2,303	58.1%	2,466	62.2%
	Other Asian	4,395	2,553	58.1%	2,711	61.7%
	Other	8,434	4,262	50.5%	4,561	54.1%
Waitematā	**Total**	**28,173**	13,996	49.7%	16,977	60.3%
	Maori	2,341	1,028	43.9%	1,272	54.3%
	Pacific	3,993	1,793	44.9%	2,238	56.0%
	Indian	2,477	1,317	53.2%	1,599	64.6%
	Other Asian	4,387	2,313	52.7%	2,758	62.9%
	Other	14,975	7,545	50.4%	9,110	60.8%

Coverage in other DHBs is variable, but some DHBs are consistently meeting the Ministry of Health expectation.

[12] Ministry of Health. 2016. *Diabetic Retinal Screening, Grading, Monitoring and Referral Guidance*. Wellington: Ministry of Health.

4. Developing the new service model through stakeholder engagement

4.1 Building consensus for the new service model (phase one)

A review of diabetes retinal screening services undertaken in 2015 by Carol Barker, Public Health Registrar, included engagement with a range of stakeholders (retinal screening providers, clinicians, consumers, primary care representatives, general practitioners, and funding managers). This review underpinned the subsequent report (*Review of Retinal Screening Services: Summary Report 2016*) presented to Auckland Waitematā Alliance Leadership Team (ALT) in October 2017. The key findings were:

Services closer to home
Community based services that deliver screening at a time and location convenient to the patient was seen as the most important step to improve access and participation.

Strong governance and clear roles, responsibilities and accountabilities
The review highlighted concerns regarding lack of governance, lack of 'ownership' of retinal screening service and fragmented lines of accountability as retinal screening sits across Diabetes and Ophthalmology within the DHB and multiple external providers, restricting effective governance, leadership and service improvements.

Low coverage
The review highlighted the need to improve retinal screening coverage rates in order to meet the Ministry of Health requirement of 90% coverage for all ethnicities.

Focus on equity
The review found Pacific people were over-represented amongst people who did not attend allocated screening appointments, suggesting current services were not adequately serving Pacific people. Stakeholder interviews stressed the importance of retinal screening services being more responsive to Māori, Pacific and low income groups to ensure services improve rather than worsen health inequities.

Supporting participation
A screening register to identify people who require additional support and follow up through outreach services was suggested to support participation and improve equity of coverage.

Capacity gaps
Improving coverage and equity of coverage will require additional screening capacity to provide the additional screening required to reach 90% coverage for all ethnicities.

Need for greater collaboration between providers and between providers and treatment services
The review highlighted concerns providers were operating in silos creating a fragmented system with poor communication and limited flow of information and learnings. The review recommended improved collaboration and communications across stakeholders through joint education sessions and meetings to share learnings and develop service improvements.

Integration of retinal screening with other health interventions
The review highlighted examples of providers using retinal screening appointments as an opportunity to optimise diabetes care. For example, Auckland Diabetes Centre provides smoking cessation advice and

diabetic nurse review and HealthWest links screening clients with other services eg green prescription and diabetes education.

Workforce
The workforce, including screeners, graders and ophthalmologists, was reported as committed and passionate about delivering high quality services. The review recommended measures to support workforce development through peer review, mentorship, and education activities.

Issues with OptoMize
The retinal screening review and a subsequent healthAlliance high level gap analysis highlighted a number of concerns regarding OptoMize (Version 3.1).

(Note: issues with OptoMize are being addressed through a separate regional project, supported by healthAlliance.)

The Alliance Leadership Team approved the following recommendations concerning the future diabetes retinal screening service:

- a single, consistent retinal screening service is provided across both districts
- the service framework to allow for a variety of service delivery approaches ranging from a single provider through to multiple providers working in a collaborative fashion
- a central coordination and administration hub is an important component of this service and is supported by a central retinal screening register
- the majority of screening is community based and delivered through a mix of fixed and mobile sites
- an overarching robust clinical governance framework with clear lines of accountability is established across both districts
- a single cohesive screening service with clear roles, responsibilities and reporting lines operates across both districts
- suitable providers are identified through an open and contestable procurement process
- a sustainable, consistent contracting and funding approach that incentivises improved coverage is applied across both districts
- a single fit for purpose screening software package is used by the provider at all screening sites across both districts
- detailed demand/capacity modelling work is undertaken to better inform future contract volumes and resourcing of the screening service.

4.2 Building consensus for the new service model (phase two)

A paper outlining the essential components of a diabetes retinal screening service (authored by Carol Barker, Public Health Physician) was endorsed by the Northern Region Diabetes Retinal Screening Clinical Governance group in August 2018. Essential components for a diabetes retinal screening service include the following focus areas, key enablers, and five essential components outlined in the National Screening Unit Quality Framework for Delivering Screening Programmes[13]:

Focus Areas

Areas that require a strong focus throughout the screening pathway:

- equity
- quality assurance and failsafe processes
- monitoring and evaluation.

Key enablers

Enablers to support activities along the entire screening pathway:

- clinical governance and retinal screening team structure
- information technology systems
- workforce development
- funding and demand modelling
- communications and collaboration.

Five essential components for delivering a screening programme

1. *A central agency to lead and coordinate the screening programme*
This includes:

- leadership on equity
- ensuring the use of evidence based information and research
- developing a policy framework, standards, and indicators for the screening programme
- quality management systems
- appropriate use of resources and new technology
- workforce development.

2. Clinical governance
This includes:

- ensuring partnership between clinical governance and management
- consumer centred partnerships

[13] National Screening Unit. 2004. *National Health Promotion: Framework and Implementation Planning Guide for Screening Programmes.* Wellington: National Screening Unit.

- governance at a national level and service provision level.

3. Infrastructure and systems
This includes:

- information and IT systems
- privacy and confidentiality of information
- fit for purpose population registers
- recruitment and retention of people in the screening programme
- safe information sharing across providers.

4. Monitoring and evaluation
This includes:

- programme monitoring and evaluation using accurate ethnicity data
- individual performance monitoring
- provider relationships and contract monitoring.

5. A Quality Cycle
This includes:

- consumer feedback processes
- risk management systems
- incident management systems
- implementation of any monitoring review recommendations
- public reporting
- regular internal and external audit.

4.3 Building consensus for the new service model (phase three)

Building on the findings of the 2015 consumer focus groups, a further round of consumer engagement was undertaken in 2018 which aimed specifically to engage:

- Māori people eligible for diabetes retinal screening
- Pacific people eligible for diabetes retinal screening
- people eligible for diabetes retinal screening who had never attended a diabetes retinal screening appointment or who had missed several screening appointments.

These aims were achieved.

A number of health service providers were asked to identify clients who were not well engaged with the retinal screening service and to invite them to be interviewed by a member of the Planning Funding and Outcomes team. As shown in Table 2, below, the interview locations were Te Ha Oranga (Wellsford), Whānau House (Henderson), The Fono (Henderson) and the diabetes clinic at Waitakere Hospital. In the majority of cases Māori interviewees were matched with a Māori interviewer and Samoan and Tuvaluan

interviewees were matched with a Samoan interviewer. Ethnicity, gender, age range, and interview location data are presented in Table 2, below.

Table 2. Interviewee Ethnicity, Gender, Age Range, and Interview Location

Ethnicity	
Māori	10
Samoan	8
Tuvaluan	1
NZ European	3
Total	**22**

Gender	
Female	15
Male	7
	22

Age Range	
30-44	6
45-59	7
60+	9
Total	**22**

Interview Location	
Te Ha Oranga	7
Whānau House	4
The Fono	8
Waitakere Hospital	3
Total	**22**

In addition to the consumer interviews, a further round of 14 stakeholder interviews was conducted in late 2018 with members of the Northern Region Diabetes Retinal Screening Clinical Governance Group and PHO clinical representatives. Following these consumer and stakeholder interviews, a suite of recommendations providing further detail for the service model was endorsed by the Auckland and Waitematā members of the Northern Region Diabetes Retinal Screening Clinical Governance Group in October 2018 and the membership of the Auckland and Waitematā Diabetes Service Level Alliance in December 2018. The specifics of these recommendations are presented below in blue font.

Recommendation One: Expanded service/provider location

The new service model will offer diabetes retinal screening at a significantly expanded range of screening locations than is the case under the current service model. Service users requiring a diabetes retinal screen will have the option of attending any screening site that is convenient to them.

Screening will be offered at locations that take into account ease of access and travel time for service users, as well as the availability of public transport and free parking.

The degree to which the location of a diabetes retinal screening clinic can present a barrier to screening is well reported in the international literature. A recently published systematic review of barriers to and enablers of diabetic retinopathy screening attendance reviewed sixty-nine primary studies with locations in the USA, UK, Asia, Australia, Canada, Europe, and South America. The most frequently reported barriers related to the accessibility of the screening clinic, including issues with transport (eg lack, cost, poor quality) and distance to the screening clinic.[14]

Local providers are aware of the barriers presented by a limited range of locations, as shown in the following excerpt from provider correspondence in June 2018:

> *We are receiving at least 30 complaints a month from clients regarding the limited locations from which we deliver retinal screening .... we really would like to offer another option eg Westgate.*

[14] Graham-Rowe E, Lorencatto F, Lawrenson J, Burr J, Grimshaw J, Ivers, N, Presseau, J, Vale, L, Peto, T, Bunce, C, and Francis J. 2018. Barriers to and enablers of diabetic retinopathy screening attendance: a systematic review of published and grey literature. *Diabetic Medicine,* (35) 1308-1319.

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Location, coupled with a lack of transport was the most frequently identified barrier in the 2018 consumer interviews. Many of the interviewees had been referred to the screening service, allocated appointment times for screening appointments, and were motivated to attend, but were unable to make it to the venue. Clinic locations at a distance from home or work, or necessitating a long drive in peak hour traffic presented problems.

> *The reasons why I missed my last two appointments is because I didn't have any transport and couldn't find anyone that was available to take me to my eye appointments.*

> *I originally started at Waitakere Hospital but now because I think I'm domiciled at Avondale now they transferred me to Greenlane.... and it sort of put me back a bit, oh my god, that's a long way to go just for an eye check. The worst part for me was against the traffic as well 'cause a lot of times it was in the morning.*

> *I haven't been able to attend any of my appointments. The last appointment was last month and I missed it because I didn't have any transport....I would like to be able to attend all my appointments. My eye sight I can feel it's getting worse but hard for me to get to these appointments as I don't always have anyone in my family to take me. I am a solo mother and it's just hard for me.*

A number of interviewees lived in and around Henderson. Of this group, those who were invited to a screening appointment in Henderson were usually able to attend the appointment. Henderson and Ranui based interviewees who were invited to a screening appointment in New Lynn or Greenlane often did not attend because of difficulties with transport.

> *The procedure is very straight forward but getting there is the problem as I need to wait for my daughter to take me to my appointment [at New Lynn].... It was hard trying to find someone to drive me there, especially as they emphasise having someone to accompany you to your appointments.*

Several interviewees raised the cost of car parking when asked what prevented them from attending or what was difficult about attending.

> *Parking is a big thing for me as I am a single mum and I can't afford to spend much money on carparks. I have to think if I need money to buy my kids food or use it to pay for my carpark.*

Interviewees also spoke about the difficulty they had finding a parking space when they arrived at their clinic locations.

Two issues were raised in relation to using public transport to get to and from screening appointments: feeling less than confident about the logistics of using public transport due to blurry vision following eye drops, and the fact that the appointment and the round trip could not be completed in time to collect children after school.

> *I've missed a few appointments in the past, solely because I couldn't find a ride to my appointments and someone that can be there to drive me home. Also it will be challenging for me to get to these appointments on the bus and come back on time to walk to get my kids from school.... Location of the clinics will be a big thing for me to be able to attend all my*

appointments. My GPs and nurses are doing a fantastic work to refer me for eye checks but I have never been able to get to all my appointments in the past because they were either in New Lynn or Greenlane. Distance is a problem for me.

The service model will include screening locations regarded as trusted, familiar, and easily accessible to Māori. This may include for example, general practices with a high proportion of Māori enrolees, Māori health providers, and marae.

The service model will include screening locations regarded as trusted, familiar, and easily accessible to Pacific people. This may include, for example, general practices with a high proportion of Pacific enrolees, Pacific health providers, and churches.

Where general practices with a high proportion of South Asian enrolees are amenable to having a visiting diabetes retinal screening clinic at the practice, the service model will facilitate this. The service model will also facilitate screening at mosques and temples where practicable.

It was very apparent at the interviews that took place at the Fono that the interviewees would readily engage with the retinal screening service if it was offered at the Fono, a location that was familiar to them, easy to access, and associated with a trusted provider. For some interviewees, the last time they had a diabetes retinal screen was several years ago when a service was offered at the Fono.

I would prefer my eyes checks service to be done here at the Fono.

... since transport is always a problem for me, I would prefer if the service was delivered here at the Fono. I can catch a bus or walk here.

It will be easier if eye check appointments can be done here at the Fono....Fono is not far from us so I can bus in instead of waiting for my sister to drive me as she has to work at night then get home, have a sleep, then she will be able to drive me to my appointment.

Highly recommend to have these eye checks clinics deliver at the Fono. I will definitely be coming to appointments and have my eyes checks. It's easier for me to get to and from work to attend appointments.

The importance of a sense of connection with a trusted provider was also expressed strongly by Māori interviewees. General practices with a high proportion of South Asian enrolees are included within the scope of this recommendation due to the high burden of diabetes and diabetic retinopathy for this ethnic group.

Site selection will take into account the distribution of diabetes prevalence across the catchment area.

Prevalence mapping using the 2017 Virtual Diabetes Register, as shown in Figures 2 to 7[15], below, indicates that the distribution of locations would benefit from some degree of tailoring to where screening services are likely to be in high demand. Service planners should also bear in mind that substantial housing

[15] The maps in Figures 2-7 were created by Michael Walsh, Epidemiologist, Planning, Funding and Outcomes, Auckland and Waitematā DHBs.

developments are underway that will increase the population in Whenuapai and Huapai, in the northwest of Auckland.

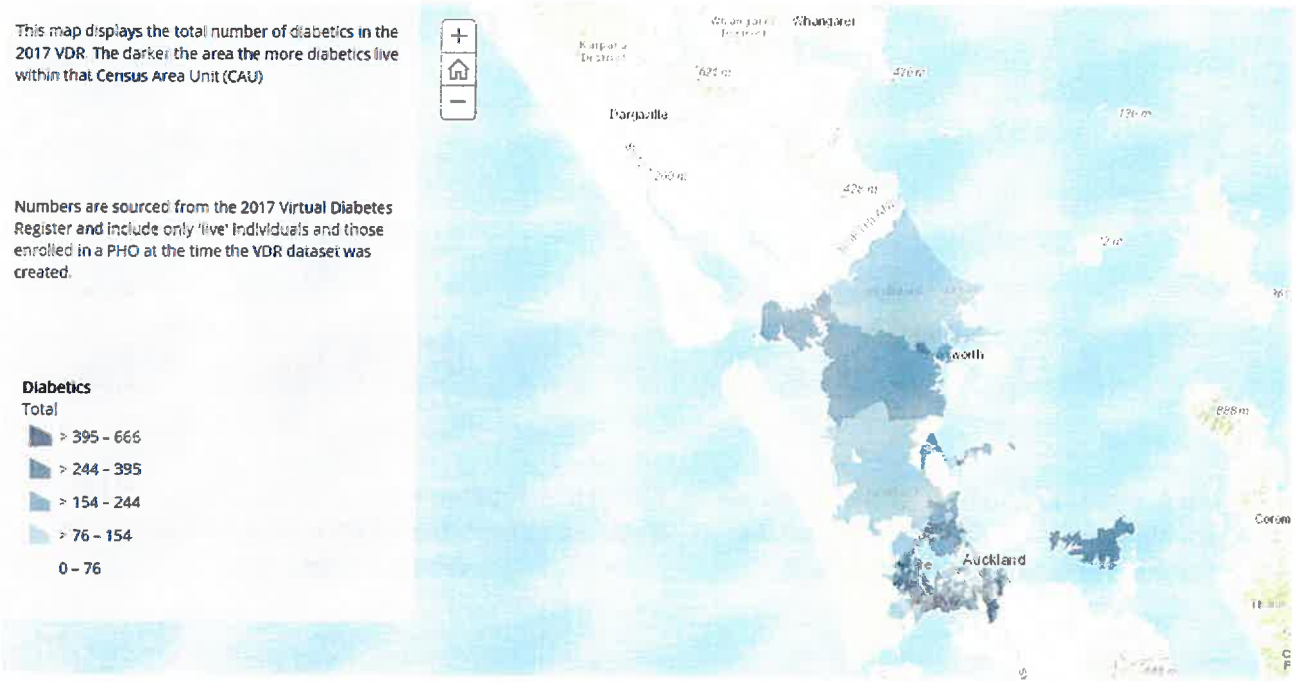

Figure 2. Total Number of diabetics by Census Area Unit: total catchment

Figure 3. Total number of diabetics by Census Area Unit: urban catchment

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The geographical distribution pattern varies significantly for specific ethnicities. Figures 4-7, below, for example, show that the geography of Māori living with diabetes is more dispersed and encompasses rural locations to a far greater degree than the geography of Pacific people living with diabetes.

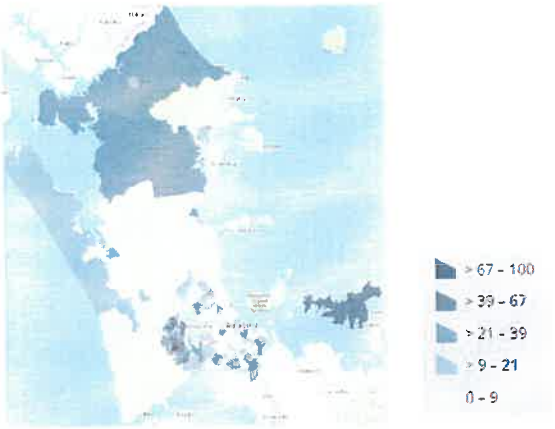

Figure 4. Estimated number of Māori people with diabetes as reported by the VDR, by census area unit: total catchment

Figure 5. Estimated number of Māori people with diabetes, as reported by VDR, by census area unit: urban catchment

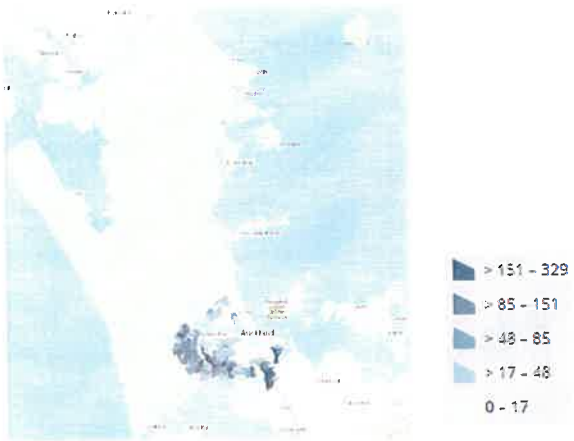

Figure 6. Estimated number of Pacific people with diabetes, as reported by VDR by census area unit: total catchment

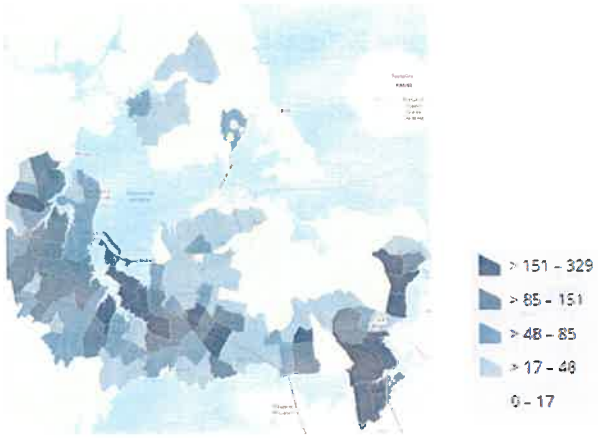

Figure 7. Estimated number of Pacific people with diabetes, as reported by VDR, by census area unit: urban catchment

A travelling service will cover prison clinics and selected locations, such as rural locations and venues that have high value as culturally accessible sites, where fixed sites are not feasible. (Screeners and equipment will be transported to these sites to enable the set-up of temporary screening clinics.)

Regardless of how many fixed sites are made available for diabetes retinal screening, some venues, such as Auckland Prison (Paremoremo), Mt Eden Corrections Facility, rural locations, or venues that have high value as culturally accessible sites, will require a travelling service. It is therefore necessary to factor travelling service provision into the planning for the new service model.

Recommendation Two: Extended hours of operation

The service model will include the offer of appointment times in evenings and weekends.

Extended hours of operation will facilitate access for those who cannot attend during business hours due to work commitments, as well as those who rely on family members who are not available during business hours. Competing demands such as work commitments and the presence or absence of support from family members emerged as important themes in the systematic review of barriers and enablers undertaken by Graham- Rowe et al[16]. They were also raised in the 2015 focus groups and in the 2018 interviews with consumers:

> *I never went because I was working and it's hard for me to take time off work to attend my eye check appointment.* (Diagnosed with diabetes eight years ago, and has never had a diabetes retinal screen.)

For most of these interviewees, help from sisters, brothers, sons, daughters, grandchildren, or friends was a critical part of their strategy for getting to a diabetes retinal screening appointment. The availability of this help was often limited by work or study commitments, and this limitation has important implications for the hours of availability for screening checks.

> *I want to be able to attend all my appointments and I want to have my eyes regular checked, however if I need to travel to New Lynn or Greenlane for it then it becomes such a problem for me as I can't get to them without looking for someone to drive me and everyone's working.*

The importance of tailoring a diabetes retinal screening service to the needs of those engaged in full time employment (and particularly to the needs of lower wage workers with limited flexibility) was also raised in key stakeholder interviews.

Recommendation Three: Māori and Pacific representatives on the governance group

It is recommended that the governance group includes Māori and Pacific representatives (which may be consumers, health professionals, or health administrators).

Māori bear a disproportionate burden of health loss associated with diabetes, and as Treaty partners have an interest in being at the table to help to rectify this. Of all ethnic groups represented across Auckland and Waitematā DHBs, Pacific people bear the greatest disproportionality in terms of health loss associated with diabetic retinopathy.

Recommendation Four: Involvement of general practices with a high proportion of Māori, Pacific, or South Asian enrolees

Where general practices with a high proportion of Māori, Pacific, or South Asian enrolees are willing to assist with the invitation and booking process for their enrolees, the service model will facilitate this involvement.

[16] Graham-Rowe E, Lorencatto F, Lawrenson J, Burr J, Grimshaw J, Ivers, N, Presseau, J, Vale, L, Peto, T, Bunce, C, and Francis J. 2018. Barriers to and enablers of diabetic retinopathy screening attendance: a systematic review of published and grey literature. *Diabetic Medicine,* (35) 1308-1319

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Where general practices with a high proportion of Māori, Pacific, or South Asian enrolees are willing to assist with communicating a screening result of mild retinopathy to their enrolees, the service model will facilitate this involvement.

For many of the Māori and Pacific people interviewed in 2018, a sense of connection with a trusted health provider was an important determinant of whether or not they would receive the care they needed.

> *...feeling like is that I'm just there for them to take that picture. If they were a little more empathetic you know then I wouldn't have a problem. It's like see ya next time see ya. Like a slap in the face with a wet glove. Basically you're in there and out. They don't have that connection with me. When I come here (Whanau House) they wonderful.*

The theme about connectedness was so important to some Māori interviewees that they moved beyond the discussion about diabetes retinal screening to discuss how a sense of connection was lacking with mainstream general practitioners or the hospital system.

> *See up the doctors I don't think they are as helpful personally as Te Ha. I might feel like that because I am Māori....*
>
> *You just a number I think. NHI number. You get to know it, yeah.*

Once a sense of connection has been established, this has a positive effect on all aspects of the patient journey, and it keeps people engaged with the service. It became evident through the interview process, that if a familiar and trusted health service provider was to handle, for example, the bookings and reminders for diabetes retinal screening, this would have a positive effect on attendance at diabetes retinal screening appointments.

This last point was also raised in an interview with a key stakeholder, who cited an example (from a different DHB) where the invitation and booking process for diabetes retinal screening at a marae functioned well when managed by a Māori provider, but met with limited success after being subsumed by the DHB's central booking process.

A diabetes retinal screening result indicating mild retinopathy presents an opportunity for a review of current medication and a conversation with the service user about modifiable risk factors. Bringing the conversation about the result "home to general practice" has the potential to maximise the health gain that could be triggered by considering and communicating the screening result. Stakeholder interviews showed there may be willingness among Māori providers to trial this approach. The qualitative data gathered from consumer interviews with Pacific people also points towards the value of trialling this approach with Pacific providers.

General practices with a high proportion of South Asian enrolees are included within the scope of this recommendation due to the high burden of diabetes and diabetic retinopathy for this ethnic group.

This recommendation is designed to signal that the offer of trialling greater involvement should be extended to willing providers. It is not intended as a mandatory or universal roll out of this approach.

Recommendation Five: Centrally managed grading

Whilst the **image capture** component of the screening test will be offered at a significantly expanded range of locations, the central administration hub **will** have responsibility for the oversight of **grading** for all images.

Confidence and simplicity

A service model with a centrally managed grading service that is subject to consistently applied quality assurance and failsafe processes provides confidence that:

- the assigned grades are accurate, and
- all service users are followed up appropriately.

Where grading is distributed among a number of independently operating screening units, the visibility of grading quality is reduced, and the training and accreditation processes for graders becomes more operationally complex.

Poised to leverage greater efficiency

Several of the key stakeholders interviewed were cognisant of technological advances in diabetes retinal screening that are likely to radically change the face of service provision in the near future. One such technological advance is the scope for machine learning to be harnessed to grade images as an integral part of the diabetes retinal screening pathway. A number of published studies have demonstrated that deep learning algorithms can achieve promising levels of sensitivity and specificity when tasked with grading colour fundus photographs of various stages of diabetic retinopathy.[17,18,19]

A service model based on images being uploaded to a central hub for grading would be well placed to leverage the efficiencies and the potential improvements in accuracy that could be gained from forthcoming developments in computerised grading of diabetic retinopathy.

5. Specifying the new service model

The mandatory Ministry of Health service specification for diabetes retinal screening services forms the basis of the specification for the overall service. The essential components and service elements developed through engagement with consumers and other stakeholders (outlined section 4, above) will also form part of the service specification.

There is a tension between two strong drivers for the redesigned service. For reasons outlined in section 4, equity and coverage are important goals. International literature reviews on the subject of barriers to diabetes retinal screening and recent local interviews with consumers confirm that a different approach to access points for screening is required. Ideally, access points will be predominantly in the community, close to where people live and work, with adequate free parking and extended hours of operation. Catering for these requirements may lead to a very distributed screening workforce, and this in turn could present challenges for adequate quality assurance and consistency of grading approaches and grading outcomes.

[17] Gulshan, V, Peng L, Coram M. 2016. Development and validation of a deep learning algorithm for detection of diabetic retinopathy in retinal fundus photographs. *Journal of the American Medical Association*, 316(22), 2402-2410.
[18] Grewal, P, Oloumi, F, Rubin, U, Tennant, M. 2018. Deep learning in ophthalmology: A review. *Canadian Journal of Ophthalmology*, 53 (4).
[19] Fleming, A, Philip, S, Goatman, K, Prescott, G, Sharp, P, Olson, J. 2011. The evidence for automated grading in diabetic retinopathy screening. *Current Diabetes Reviews*, 7(4):246-52.

Diabetes Retinal Screening Service

Quality assurance is an important aspect of all health services and is a particularly important consideration for a screening service.

Having taken into account feedback from a broad range of stakeholders, this business case proposes that the tension between quality assurance drivers and equity and coverage drivers is resolved through a service model that facilitates retinal image capture at a broad range of access points whilst assuring consistency and quality by having all final grades assigned by a central hub.

The proposed elements of the new service model are as follows:

- a central hub
- multiple access points for retinal imaging at dispersed locations
- an outreach service.

Functions of the central hub include:

- receiving referrals
- checking eligibility
- ensuring clinical modifier information has been provided (eg glycaemic control and blood pressure)
- triaging referrals
- monitoring and administering recall intervals
- having responsibility for the oversight of all grading
- retaining all clinical details (including images and grades)
- providing first level follow up for people overdue for screening
- managing quality and failsafe processes
- providing slit lamp examinations for screening candidates whose retinas are not amenable to photographic image capture.

Functions of access points for retinal imaging include:

- visual acuity tests
- photographic image capture of the retinas
- showing the images to the service user
- explaining the reason for image capture and outlining what can be seen in the service user's retinal images
- education about diabetes and eye health.

Functions of the outreach service include:

- all functions of access points outlined above, to be provided:
    - at Auckland Prison (Paremoremo) and Mt Eden Correction Facility
    - at rural locations
    - at sites designed to maximise coverage for high priority populations, such as:
        - Māori providers
        - marae

  - Pacific providers
  - churches, temples and mosques
  - general practices with a high proportion of Māori, Pacific, or South Asian people living with diabetes
- intensive follow up for people significantly overdue for screening.

Across the catchment of Auckland DHB, diabetic retinal screening services are currently delivered from six fixed sites and seven mobile sites. When the new service model has been implemented, diabetic retinal screening services will be delivered from approximately 25 fixed sites and 15 mobile sites across the catchments of Auckland and Waitematā DHBs. Attendees will be able to choose any site that is convenient for them.

The redesigned service model will offer a consumer oriented pathway, with consumers choosing the screening location that is most convenient for them, and booking a time and date for their screening appointment that best suits their schedule. Most people will follow a straightforward pathway (described below as the "Common Pathway"). Some may need more contact from the screening service (including contact from the outreach part of the service) before a screen is booked and completed. This second pathway is described below under the heading "Supported Pathway".

Diabetes Retinal Screening Service

Common pathway

- A general practitioner refers an individual to the diabetes retinal screening service.
- The central hub confirms the individual's eligibilty to receive the service, then sends a letter to the individual, advising that they are due for a diabetes retinal screen. The letter has information about the location and contact details for all retinal imaging providers across the Auckland DHB and Waitematā DHB regions (including fixed and mobile sites).
- The individual contacts a retinal imaging provider of their choice to book an appointment at a time and date that suits them. (They will be able to get an evening or weekend appointment if they would like one).
- The individual attends the appointment at either a fixed or mobile site and a photograph of the retina is taken.
- The retinal imaging provider shows the photograph to the individual and explains what can be seen.
- The retinal imaging provider sends the photograph to the central hub for grading.
- Health professionals at the central hub grade the image and decide what needs to happen next.
- The individual is referred to a hospital eye department if necessary, otherwise they are advised how long it will be until they need to go back to a retinal imaging provider for another photograph.
- If there are changes in the retina that indicate that the individual and/or their general practitioner needs to take actions the individual will receive a phone call from a staff member at the central hub to explain this.
- The individual will receive a letter from the central hub with grades and information about the length of time until the next screen (or information about the referral to a hospital eye department if the individual has been referred).
- The individual's general practitioner will receive the grades and information about the length of time until the next screen (or information about the referral to a hospital eye department if the individual has been referred).

Diabetes Retinal Screening Service

Supported pathway

- A general practitioner refers an individual to the diabetes retinal screening service.
- The central hub confirms the individual's eligiblity to receive the service, then sends a letter to the individual, advising that they are due for a diabetes retinal screen. The letter has information about the location and contact details for all retinal imaging providers across the Auckland DHB and Waitematā DHB regions (inlcuding fixed and mobile sites).
- If the central hub has not received an image upload from a retinal imaging provider within three weeks of the individual's due date for screening, staff at the central hub will phone the service user to provide information about the screening service and offer help with the booking process.
- If the central hub has not received an image upload from a retinal imaging provider within six weeks of the individual's due date for screening, staff at the central hub will refer the individual to the outreach service.
- The outreach service makes contact with the individual, provides information, and assists with the booking process.
- The individual attends the appointment at either a fixed or mobile site and a photograph of the retina is taken.
- The retinal imaging provider shows the photograph to the individual and explains what can be seen.
- The retinal imaging provider sends the photograph to the central hub for grading.
- Health professionals at the central hub grade the image and decide what needs to happen next.
- The individual is referred to a hospital eye department if necessary, otherwise they are advised how long it will be until they need to go back to a retinal imaging provider for another photograph.
- If there are changes in the retina that indicate that the individual and/or their general practitioner needs to take actions the individual will receive a phone call from a staff member at the central hub to explain this.
- The individual will receive a letter from the central hub with grades and information about the length of time until the next screen (or information about the referral to a hospital eye department if the individual has been referred).
- The individual's general practitioner will receive the grades and information about the length of time until the next screen (or information about the referral to a hospital eye department if the individual has been referred).

6. Service volumes

6.1 Current contracted volumes

Auckland DHB purchased 12,268 screens for the 2018-19 financial year.

Waitematā DHB purchased 8,560 screens for the 2018-19 financial year.

6.2 Volumes required to achieve equity and coverage

The 2017 Virtual Diabetes Register (VDR) and 2017 Statistics New Zealand medium population projections were used to estimate population projections for people with diabetes living in Auckland and Waitematā DHBs.[20] The VDR algorithm identifies people as having diabetes from inpatient, outpatient, laboratory and pharmaceutical data collections. The VDR is collated annually in March and national and regional diabetes prevalence estimates are calculated based on the number of people on the VDR as at 31 December of the previous year. In 2016, the Ministry of Health revised the VDR algorithm; data outlined below reflects application of the new algorithm to years prior to 2016.

The projected number of people with diabetes is determined by changes in the rate of diabetes in the population and changes in population size and composition. According to the VDR there continues to be a year on year increase in the number of people with diabetes. However, as shown in Figure 8 and Table 3, over the past four years, the rate of diabetes, as calculated by comparing the VDR with Statistics New Zealand annual population projection, has been relatively stable.

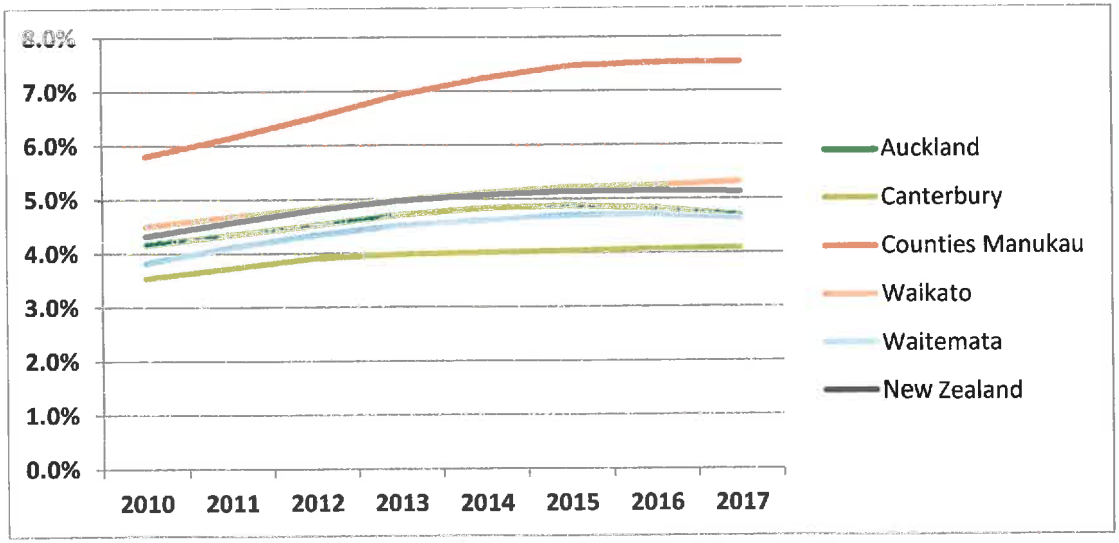

Figure 8: Crude rate of diabetes for residents of large DHBs, 2010-2017

20 The prevalence analysis and projections for this business case were provided by Jean Wignall, Health Outcomes Analyst, Planning, Funding and Outcomes, Auckland and Waitematā DHBs.

Table 3: Crude rate of diabetes for Auckland DHB, Waitematā DHB and New Zealand, 2010-2017

Crude rate of diabetes	2010	2011	2012	2013	2014	2015	2016	2017
Auckland DHB	4.2%	4.3%	4.5%	4.7%	4.8%	4.9%	4.8%	4.7%
Waitematā DHB	3.8%	4.1%	4.3%	4.5%	4.6%	4.7%	4.7%	4.6%
New Zealand	4.3%	4.6%	4.8%	5.0%	5.1%	5.1%	5.1%	5.1%

Population projections for people with diabetes living in Auckland and Waitematā DHBs

Projections below were calculated by taking the diabetes prevalence in 2017 by ethnicity (Māori, Pacific, Asian and Other) and five-year age bands, and applying this to the Statistics New Zealand medium population projections, for people resident in Auckland and Waitematā DHBs. This gives a projection of the number of people with diabetes if prevalence remains stable for the next five years (as is has for the past four years) and only the population size, age, and ethnic mix changes. Ideally Indian would be projected as a separate ethnic group, however, the population projections do not provide these figures. Projections in Table 4, below, are for the enrolled population (as identified on the VDR) and include all ages.

Table 4: Projected numbers of people with diabetes, 2020/21 to 2024/25

DHB of domicile	Financial Year				
	2020/2021	2021/2022	2022/2023	2023/2024	2024/2025
Auckland DHB	27,910	28,791	29,688	30,597	31,551
Waitematā DHB	32,150	33,205	34,265	35,351	36,452
Total	**60,060**	**61,996**	**63,953**	**65,948**	**68,003**

Patients with unknown ethnicity were reallocated pro-rata to those with known ethnicity.

Having established the projected population of people with diabetes in Auckland and Waitematā DHBs, the next step is to establish the number of retinal screens per annum required for Auckland and Waitematā DHBs to meet the Ministry of Health coverage target. This target requires 90% of people with diabetes enrolled with a PHO who are domiciled in the DHB to undergo regular retinal screening. The recommended frequency of screening for each individual varies according to clinical risk and presence of diabetic eye disease. Intervals may be 6, 12, 24 or 36 months for the general population and 3 months for pregnant women.

Analysis of historical retinal screening outcome data was undertaken to estimate the number of screens per year required for Auckland and Waitematā DHBs to achieve 90% retinal screening coverage for five financial years commencing 2020/2021. Analysis was undertaken using retinal screening outcome data for Auckland DHB (11,579 individuals from July 2016-December 2018) and Waitematā DHB (16,419 individuals July 2016-December 2018).

The Ministry of Health guidance on screening intervals for different screening outcomes[21] and the Auckland and Waitematā retinal screening clinical pathway were applied to historical outcome data to establish the proportion of people screened who require 6, 12, 24 and 36 month screening cycles. Screening cycle proportions were then applied to the projected populations of people with diabetes for Auckland and Waitematā DHBs to provide screens per year for 2020/21-2024/25 as detailed in Table 5, below.

21 Ministry of Health. *Diabetic Retinal Screening, Grading, Monitoring and Referral Guidance*. Wellington: Ministry of Health.

Diabetes Retinal Screening Service

Table 5: Projected number of screens per financial year to ensure regular retinal screening for 90% of people with diabetes in Auckland and Waitematā DHBs

Financial Year	Auckland DHB*		Waitematā DHB**	
	Projected population with diabetes	Screens per year	Projected population with diabetes	Screens per year
2020/2021	27,910	16,641	32,150	16,547
2021/2022	28,791	17,166	33,205	17,090
2022/2023	29,688	17,701	34,265	17,636
2023/2024	30,597	18,242	35,351	18,195
2024/2025	31,551	18,811	36,452	18,761

*based on 0.596 screens per person per year
**based on 0.515 screens per person per year

Application of current guidance to historical outcome data resulted in a greater proportion of the Waitematā DHB population requiring longer screening intervals compared with Auckland DHB. For example, 38.9% of the Waitematā DHB retinal screening population require three yearly screening compared with 30.9% for Auckland DHB. Conversely 12.8% of the Waitematā population require annual recalls compared with 20.6% for Auckland DHB. These differences resulted in a lower screen per person per year for Waitematā DHB compared with Auckland DHB and likely reflect lower burden of disease in Waitematā DHB.

It should be noted that this demand modelling has been informed by local outcome data for people who are currently engaged in the retinal screening service. The new model of care aims to improve retinal screening coverage which will result in people being screened who have not previously had regular screening. This group may have a higher burden of diabetic eye disease resulting in higher frequency of screening and higher annual screening volumes.

7. Funding allocation and pricing

[redacted]

Diabetes Retinal Screening Service

[redacted]

[redacted]

Diabetes Retinal Screening Service

Diabetes Retinal Screening Service

[redacted]

[redacted]

22 2017 Virtual Diabetes Register, people with diabetes, enrolled with a PHO.
23 Virtual Diabetes Register, PHO enrolled.
24 Assuming screeners apply the Ministry of Health guidelines for recall intervals.

[redacted]

8. Governance and monitoring

Governance for all three aspects of the redesigned diabetes retinal screening service will be provided by a governance group convened expressly to provide oversight of the combined Auckland and Waitematā diabetes retinal screening service. The governance group will include service users, Māori and Pacific representatives, clinical expertise (including the lead ophthalmologist for the service), management for each of the contracted providers, and representatives from Funding, Planning and Outcomes.

The Auckland and Waitematā Diabetes Retinal Screening Governance Group will have responsibility for:

- reviewing quarterly monitoring reports which include Ministry of Health *Diabetic Retinal Screening, Grading Monitoring and Referral Guidance* indicators:
    - screened population demographic data (age, gender, ethnicity)
    - proportion of people with diabetes screened (within the last two years and within the last three years)
    - timely assessment of risk for people newly diagnosed with type 2 diabetes
    - proportion of sight-threatening diabetic retinopathy at first presentation
    - assessment of screening process (image quality; number of people requiring a clinical assessment)
    - outcome grades
    - retinal screening programme quality (the number of people with diabetes seen in speciality ophthalmology).
- ensuring that continuous quality improvement activities are embedded in each aspect of service provision
- maintaining oversight of, and acting as an escalation point for clinical risk within the service
- ensuring an appropriate level of accountability for all providers and the funder
- evaluating the success of the programme against the key targets of:
    - 90% of enrolled Māori living with diabetes within the catchment areas of Auckland DHB and Waitematā DHB have been screened within the last 2-3 years as clinically indicated

[25] Virtual Diabetes Register, PHO enrolled.
[26] Assuming screeners apply the Ministry of Health guidelines for recall intervals.

- 90% of enrolled Pacific people living with diabetes within the catchment areas of Auckland DHB and Waitematā DHB have been screened within the last 2-3 years as clinically indicated
- 90% of enrolled South Asian people living with diabetes within the catchment areas of Auckland DHB and Waitematā DHB have been screened within the last 2-3 years as clinically indicated
- 90% of people living with diabetes who are enrolled with a PHO within the catchment areas of Auckland DHB and Waitematā DHB have been screened within the last 2-3 years as clinically indicated.

The governance group will have a tight focus on accountability for the Auckland and Waitematā service. Its remit will be different from the broader remit of the Northern Region Diabetes Retinal Screening Clinical Governance Group, which spans Northland, Waitematā, Auckland, and Counties Manukau DHBs.

9. Service benefits

The redesigned diabetes service will improve both equity of coverage and overall coverage for people living with diabetes within the catchment areas of Auckland and Waitematā DHBs. Improved coverage facilitates timely treatment of diabetic retinopathy. This will in turn lead to a reduction in vision loss and a reduction in inequitable outcomes.

There is a substantial body of evidence demonstrating that screening for diabetic retinopathy is a cost effective means of preserving vision for people living with diabetes.[27]

10. Next steps

The timeline for proposed next steps is set out below:

Action/Event	Date
Consultation process commences	14 June 2019
Consultation process concludes	9 August 2019
Auckland DHB and Waitematā DHB Executive Leadership Team meetings (submit consultation analysis and request approval to release Request for Proposals (RFP))	September 2019
Auckland DHB Finance, Risk, and Audit Committee Meeting (submit consultation analysis and request approval to release RFP)	16 October 2019
Waitematā DHB Audit and Finance Committee (submit consultation analysis and request approval to release RFP)	23 October 2019
Auckland DHB Board (submit consultation analysis and request approval to release RFP)	6 November 2019
Waitematā DHB Board (submit consultation analysis and request approval to release RFP)	13 November 2019
Approach the market	Late January 2020

[27] For example: James, M. Turner, D. Broadbent, D. Vora J. Harding S. 2000. Cost effectiveness analysis of screening for sight threatening diabetic eye disease. *British Medical Journal,* 320:1627-31.

Diabetes Retinal Screening Service

Deadline for submissions	Early March 2020
Submissions shortlisted, further information/ interviews requested where required, panel recommends preferred provider/s	Early April 2020
Deadline for papers to finance committees	Early April 2020
Auckland DHB Finance, Risk, and Audit Committee Meeting (request for approval to engage preferred provider/s)	May 2020
Waitematā DHB Audit and Finance Committee Meeting (request for approval to engage preferred provider/s)	May 2020
Auckland DHB Board (request for approval to engage preferred provider/s)	June 2020
Waitematā DHB Board (request for approval to engage preferred provider/s)	June 2020
Agreement/s finalised in discussion with preferred provider/s	July 2020
Agreement request process completed	August 2020
Provider/s receive agreement/s	September 2020
Agreement/s executed	October 2020
Service establishment phase	November 2020 – February 2021
Transition/handover phase	March 2021
New diabetes retinal screening services fully functional	1 April 2021

11. Interim catch up programme

A number of measures are being undertaken to improve retinal screening coverage in the current model of care (pending the longer term solution through the redesigned model of care described above).

11.1 Regional retinal screening data match

Auckland, Waitematā, and Counties Manukau DHBs have agreed to undertake a regional data match to improve retinal screening coverage. This will involve matching Auckland, Waitematā, and Counties Manukau DHB retinal screening data with the HealthSafe diabetic dataset (ie people enrolled with metro Auckland PHOs and coded as diabetic whose data are uploaded for quarterly diabetes indicator reporting). The retinal screening data match will be undertaken using the Metro Auckland Data Sharing Framework. The project includes two stages; stage 1 is expected to commence in March 2019.

Stage 1: Understand the quantum of people who are not known to retinal screening services

Stage 1 will describe the quantum and characteristics (eg age group, ethnicity, HbA1c, PHO) of people with diabetes enrolled with metro Auckland PHOs who are not known to retinal screening or relevant ophthalmology services. This data will inform service planning to ensure services have capacity to screen and if needed treat the unscreened population. Data from stage 1 will also provide a baseline to monitor retinal screening coverage over time, including by ethnicity.

Stage 2: Identify, prioritise and refer individuals for retinal screening

Stage 2 will generate lists for each PHO of patients who are coded as diabetic and not known to retinal screening or relevant ophthalmology services (ie people who should be offered a referral for screening). Lists will be provided to PHOs and will be prioritised by ethnicity and clinical risk factors to ensure a strong focus on clinical risk and equity.

11.2 Other measures to improve retinal screening coverage

IT enablers

An upgrade of the retinal screening patient management system OptoMize is being undertaken. This upgrade will address OptoMize limitations identified in previous reviews and will support improved data collection required for Ministry of Health reporting.

A project to implement retinal screening e-referrals for Waitematā DHB is underway and due for completion in March 2019; retinal screening e-referrals have already been implemented for Auckland DHB.

New screening location

Regular retinal screening clinics have been reinstated at The Fono Medical Centre. This is in response to consumer feedback received during interviews conducted in October 2018.

Priscilla Philip (ADHB)

From: Eirean Gamble (WDHB)
Sent: Wednesday, 23 September 2020 07:41
To: Allan Moffitt; Kate Moodabe (Personal); 'Kate'; Tracy Walters (tracy.walters@tehaoranga.co.nz); Ole Schmiedel (ADHB); Raj Singh (WDHB); Stuart Jenkins (WDHB); Shayne Wijohn (WDHB); Sue Pearson; Tim Wood (WDHB); Sara Aprea; Faimafili Tupu (ADHB); Andre George; Rawiri McKree Jansen (Rawirimj@nhc.maori.nz); 'Melanie Beattie'; Pauline Sanders; 'Tana Fishman'; Lis Cowling (WDHB); Carol Ennis; Piripi McLean (WDHB); Simon Young (Medicine) (WDHB); 'HinaL@alliancehealth.org.nz'; Samantha Titchener (ADHB); 'Siobhan Matich'
Subject: RE: First DSLA meeting post lock down

DSLA Minutes 16 Oct 20 draft....

Hello everyone

Please find attached the draft minutes from last weeks DSLA meeting. See you all on 21 October at our next DSLA meeting

Cheers

Eirean

PLEASE NOTE: I am only working part time and my current hours are Tuesday 0800 to 1600, if your request is urgent and outside these hours please contact Lis Cowling [redacted]

Eirean Gamble I Programme Manager, Primary Care I Planning Funding & Outcomes I Auckland & Waitematā District Health Boards
Level 1, 17 Shea Terrace, Private Bag 93-503, Takapuna
[redacted]

Waitemata District Health Board
Best Care for Everyone

-----Original Appointment-----
From: Eirean Gamble (WDHB)
Sent: Wednesday, 12 August 2020 1:55 p.m.
To: Eirean Gamble (WDHB); Allan Moffitt; Kate Moodabe (Personal); 'Kate'; Tracy Walters [redacted] Ole Schmiedel (ADHB); Raj Singh (WDHB); Stuart Jenkins (WDHB); Shayne Wijohn (WDHB); Sue Pearson; Tim Wood (WDHB); Sara Aprea; Faimafili Tupu (ADHB); Andre George; Rawiri McKree Jansen [redacted] 'Melanie Beattie'; Pauline Sanders; 'Tana Fishman'; Lis Cowling (WDHB); Carol Ennis; Piripi McLean (WDHB); Simon Young (Medicine) (WDHB); 'HinaL@alliancehealth.org.nz'; Samantha Titchener

(ADHB); 'Siobhan Matich'
Subject: First DSLA meeting post lock down
When: Wednesday, 16 September 2020 1:00 p.m.-3:00 p.m. (UTC+12:00) Auckland, Wellington.
Where: WDHB P&F Meeting Room - 17 Shea Terrace (WDHB); https://waitematadhb.zoom.us/j/97685784389

Hello everyone

We have cancelled the August DSLA meeting but booked this meeting as an additional one in September.

This meeting will aim to provide everyone with an update on the 5 priority projects and to restart the DSLA meetings post COVID lockdown. However, I will send an agenda one week prior to this meeting. If you would like to add anything to this agenda please let me know.

If you are no longer your organisations DSLA rep can you please let me know who is and I will forward the invite to this person.

Please note this meeting will be held via zoom but we have also booked the meeting room at PFO if you would like to travel there.

Take care
Eirean

Minutes

Auckland Waitematā Diabetes Service Level Alliance Team (DSLA) Meeting

MEETING DETAILS	
Date and Time	Thursday 20 February 2020, 1330-1530
Venue	P&F Meeting room, Level 1, 17 Shea Terrace, Takapuna
Present (members)	Allan Moffitt (Chair), Carol Ennis, Kate Moodabe, Piripi McLean, Sue Pearson, Sara Aprea, Raj Singh, Andre George, Hina Lutui (only attended the first hour), Ole Schmiedel, Simon Young, Siobhan Matich, Stuart Jenkins,
In attendance	Eirean Gamble (secretariat), Carol Barker (Public Health Physician, A/WDHB), Michele Garret (Podiatry Professional Clinical Leader A/WDHB), Lis Cowling (Senior Programme Manager A/WDHB), Samantha Titchener (ADHB)
Apologies	Rawiri Jansen, Tracy Walters, Shayne Wijohn, Faimafili Tupu, , Tim Wood,

<table>
<tr><th>Item</th><th>Discussion</th></tr>
<tr><td>1. Welcome, Apologies, Introductions</td><td>• Welcome to Siobhan and Hina
• Guests include Carol, Michele, Lis, Samantha
• Apologies include Rawiri Jansen, Tracy Walters, Shayne Wijohn, Faimafili Tupu, Tim Wood,</td></tr>
<tr><td>2. February 2020 DSLA meeting minutes

Action points:</td><td>Minutes from February 2020 accepted as a true and accurate reflection of the meeting.
Motioned for approval: Allan
Seconded: Piripi

<table>
<tr><th>Action point</th><th>By</th><th>Timeline</th><th>Status</th></tr>
<tr><td>Ole to circulate February 2020 RDFAG minutes relating to</td><td>Ole</td><td></td><td>Ole will provide the most recent meeting minutes for circulation</td></tr>
</table>
</td></tr>
</table>

	Amputation Audit to members.			
	Tracy to recruit Paul and Danielle to Co-Design Working Group and RDFAG, respectively.	Tracy		Danielle has been invited to be part of this and Paul invited to be part of the Podiatry forum Added post meeting: Danielle is unable to accept consumer rep role.
	AH+ to share learning's from journey to achieve priority clinical indicators at April DSLA meeting.	Hina	Move to Oct/Dec meeting	
	ADHB & WDHB self-assessment of quality standards for diabetes care for MOH			Completed, no feedback received from MoH
Telehealth and learning from Covid-19	Ole provided a summary of two audits undertaken by ADHB diabetes service. One of patients and one of staff to ask what worked regarding consults during COVID ie via phone, video and face to face. Findings: Patients preferred telephone consults, especially during COVID– this aligned to an audit undertaken by NZSSD. Reasons were convenience, safe and practical aspects ie time commitment for appointment was less. Barriers were access to video, data and room that was conductive for these appointments, when people return to work this became even more pronounced Providers preferred face to face NZSSD audit looked at pre, during and post COVID and had similar results. ADHB completed more telehealth and face to face during lockdown WDHB i3 undertook a survey and found patients preferred telehealth appointments during lockdown and attendance via this modality was very high. This was mainly due to people being at home. As people went back to work the ability to connect with patients via telehealth decreased. Comprehensive Care, ProCare health coach, health psych and dietitians and some podiatrists used telehealth with good			

	effect in primary care during COVID Total Healthcare have had 41,000 virtual consults since March Piripi used telehealth during COVID and had good response with this – patients looked forward to these sessions and this helped maintain relationship and contact during lockdown Sue reported feedback from consumer groups that older adults enjoyed the telehealth appointments during COVID. Sue asked if it was possible for patients to be able to select what type of appointment they would like in the future ie face to face, telephone, zoom/video consult. Sue is currently running zoom group sessions and these are well attended by people across Auckland Issue during level 4 was access to labs but this issue has since resolved but new issue of patients only able to access labs if they have a face mask has developed Silver lining access to e-labs and e-prescriptions has come out of COVID for secondary services Need to look a options of using telehealth going forward to support improved access to services
Update on Priority Projects: • **Metro Auckland Retinal Screening Data Match Project.** • **Diabetes Outcomes Co-Design Project** • **Podiatry update**  Foot improvement project.pptx	**Metro Auckland Retinal Screening Data Match Project –provided by Carol Barker** Not a lot has happened since last update (February 2020) due to COVID but we are reenergizing the project and hopeful to get back on track. Updates: - We are in process of adding an additional quality check step to ensure the lists provided to the PHOs are accurate. This step is a small sample of NHI, of those we think need a retinal screen, will be provided to providers to ensure these patients are truly not known to service. This is to ensure we are not missing something and included people know to service in the lists. Carol is currently getting permissions to be able to do this. Retinal screening providers are happy to undertake this check. Aim is this check to occur in October with lists going to PHO to push to their practices come November 2020. It is expected this lists will be updated and provided to PHOs every quarter. - Service planning project is underway to help identify how to support services when demand exceeds capacity. The Governance group are developing a framework that provides a safe way to prioritse referrals and this will be used by all providers in the Northern Region

Diabetes Outcomes Co-Design Project
The co-design project was put on hold due to Covid19 from March 2020. Both planning and funding team and the codesign team were redeployed to support the Covid-19 response. The PHOs teams were significantly involved with the primary care Covid-19 community response.

A tentative restart date was scheduled for October 2020 however with Covid-19 surge and move to Level-3 in August; most of the primary care team were redeployed again to Covid-19 response. Due to this significant under resource and capacity the co-design project is pause until further notices.

Concern was raised re the slow progress and that the forward momentum has been halted.
Question asked: if we could release Maria in mid-October could we re-start the co-design project mid/late October –
Action point: Kate will check with her practice teams and get back to Lis

Group requested: a stop and pause and get an update on learning to date – invite the practice and rethink on where to here. Need to identify who should be around the table during this discussion; can we include patients in this discussion and those practices who declined to be involved?
Action point: Eirean to organise this discussion/workshop

Podiatry update – provided by Michele Garret
Presentation provided on project to date
<u>Activities undertaken</u>

- Foot Protection Service Standards developed and working to develop an implementation plan for the next 5 years. Focusing on low hanging fruit first and data is one of these.
- Auckland HealthPathways – being updated, waiting on final feedback
- E-referrals for community podiatrists to be able to refer patients to secondary service, this will improve timely access to services. Free for podiatrists to access this
- Competency Framework developed and feedback has been sort from this group and the working group is collating the feedback. Next steps will be how to implement this.
- CPD programme and training, continuing via zoom during COVID times and these are well attended with 40-50 podiatrists attending. AUT are delivering a high risk foot clinic which supports the students to get experience in this area

	• Foot screening education a working group has been formed to support improved foot screening to develop modules for online learning for foot screening and this will be hosted by NZSSD and will be free to access. Currently the modules are going through the testing phase. Aim to have these available by the end of the year. Next step will be to evaluate the impact/effect of these modules • High risk foot services data and service indicators are being developed. HRC grant has been submitted to further this work <u>Still to do:</u> • difficult to define effectiveness as we are data poor but this is a work in progress • Credentialing framework – a simple credential framework to sit with the service standards and competency framework • Amputations, referral behavior – only about 1/3 people who experience a diabetes related lower limb amputation have seen the High Risk foot services, POAC serious events are also reflecting this. Need to work on improving this by having a clear pathway across primary and secondary services. • Orthotic services – addressing equity of access issues <u>Next steps:</u> - Model of care for foot services - What will happen to the in-remission cohort if the interim podiatry role not continued - Need to have continued clinical governance and leadership - Service cohesion across the Northern Region **Action point: Michele will come to DSLA with a proposal for next steps – October/December meeting** Sue made the plea that we need to have more and better foot care education. This was seconded by Piripi. Discussion re: - Foot screening linked with eye screening – issue of getting the results to primary care - Some of this work will be/is being shared nationally ie service standards, model of care, etc.
Audit of Diabetes Related Lower Limb Amputations in the Northern	Discussion regarding this audit - Simon asked if this would be published as there is good data that should be shared – Michele and Sarah are looking

Region 2013 – 2016. Discussion of insights from this document to guide future activities.	to publish in the NZ Medical Journal - Sue raised the need for patient education but ensure that patients understand this education as health literacy is often an issue. This was seconded by Piripi - This audit highlighted that there are some patient and system issues affecting amputation risk/rates but key is that the journey to amputation can be quite quick. - Calculators to identify risk could be used but often these patients are presenting to primary care acutely and another approach to reduce amputation risk/rate could include whanau to empower them to support their family members with diabetes ie check your whanau feet . But we need a cohesive national approach but we can still do some exciting initiatives locally
Other business	**New diabetes medications being funded later in the year** Need to have clear messaging and education to support the appropriate use of these medications to improve patient outcomes **Wing Cheuk Chan's report** **Action point:** Simon to send to Eirean to share with the group update on DM prevalence trends frc TestSafe update 2020_v2.pptx Understanding the heterogeneity of diab The need for better focus on primary and
Meeting closed at 1450 **Next meeting:** 21 October 2020 WDHB P&F Meeting room, Level 1, 17 Shea Terrace, North Shore Zoom meeting: https://waitematadhb.zoom.us/j/914400951	

Action points

Action point	By	Timeline
Ole to circulate February 2020 RDFAG minutes relating to Amputation Audit to members.	Ole	ASAP
AH+ to share learning's from journey to achieve priority clinical indicators at April DSLA meeting.	Hina	October/December meeting

Co-design: **Group requested:** a stop and pause and get an update on learning to date – invite the practice and rethink on where to here. Need to identify who should be around the table during this discussion, can we include patients in this discussion and those practices who declined to be involved.	Eirean to organise this discussion/workshop	
Michele will come to DSLA with a proposal for next steps for podiatry	Michele	October/December meeting
Simon to send Wing report to Eirean to share with the group	Eirean	Attached to minutes

Northern Region Diabetes Retinal Screening Clinical Governance

Minutes

MEETING DETAILS	
Date and Time	Wednesday 02 September 2020 0800 to 0900
Venue	Zoom
Present	Samantha Titchener, Tracy Molloy, Stephanie Emma, David Squirrell, Ole Schmiedel (chair), Carol Barker, Dene Coleman, Janice Kirkpatrick, Lorraine Bailey, Ros Moffit, Tahira Malik, Tracy Walters, Barbara Miller, Sarah Welch, Helen Liley,
In attendance	Eirean Gamble, Tim Wood, Lis Cowling
Apologies received	Carol Ennis, Simon Young, Edward Pattinson, Aroha Hudson, Brandon Orr-Walker,

Item	Discussion
Welcome, Introductions and Apologies	Welcome to Janice Kirkpatrick, replaces Brian Millen as she is the Diabetes Operations Manager at Waitematā DHB
Minutes from August meeting **Action points:**	Minutes from 11 December 2019 accepted as a true reflection of the December meeting Accepted: David S Seconded: Stephanie

Action	By	Outcome
Retinal screening data match draft monitoring and	Carol to redraft framework based on group's guidance.	Deferred to October meeting

Northern Region Diabetes Retinal Screening Clinical Governance Minutes

	reporting framework		
	Retinal screening coding and clinical terminology update	Request re HL7 format to be forwarded to Optomize upgrade team (see Action point in Other Business below)	? Eirean working to see if this was completed
	Eligibility for screening in WDHB	Emi to collect eligibility criteria from international guidelines, the Primary Care Handbook, and Health Pathways. DSLA to review the relationship between a diagnosis for type 2 diabetes and the eligibility criteria for diabetes retinal screening, with a view to improving alignment between the two .	Completed
Update on OptoMize	Tim provided the below update: The OptoMize project manager has been deployed to COVID and healthAlliance have put all projects on hold Vendor ready to engage in process when Tim last spoke to them Budget carried over to this year but still need some work to secure the budget for Auckland DHB migration **Key issue:** project manager resource required to support this project is not available at this time and this is the rate limiting step at this time, Still planned to have two phases, phase 1: Northland DHB, Waitemata DHB and Auckland Eye. Not expected for phase 1 to occur until next year		
Quality check on retinal screening data match patient lists	The whole working group has been pulled into COVID resulting in delays in undertaking the data match. Aim for the next data match to occur in November 2020 at which time will be provided to the PHOs Additional quality control step is being added to ensure patients on list going to PHO are truly not known to service. Screening providers will be provided with a small sample of NHIs (approx. 50 NHI) to review to		

Northern Region Diabetes Retinal Screening Clinical Governance

Minutes

	ensure that these patients are truly not known to the service. This will allow the list to be more accurate and if required the data capture will be further refined **Action point:** Carol will work through the process to gain the relevant permissions to undertake the above step to facilitate a data check in October before Novembers data match
Opportunity for providers to share any learnings or processes they have developed to safely manage demand from the COVID lock down. These learnings can also help providers think about how to manage any future demand from the retinal screening data match project. COVID impact on DRS.pptx Covid Response - Retinal Screening Auc COVID response.xlsx WDHB Covid 19 Impact.docx	How was retinal screening affected by COVID National response was to temporarily cease all retinal screening activities during level 4 COVID lockdowns Update from each providers **Counties – see attached presentation** Learning: Community health worker did a pre-appointment phone call screens and this action has resulted in a significantly reduced DNA rate The recent data match project has been very helpful as it has helped identify those at high risk of eye disease and prioritise their screening **Questions** Should P1 be seen during lockdowns? They probably don't need to see an SMO in ophthalmology but should be seen by screeners as the impact of not seeing them is potentially greater than other risks - Need a regional consensus and process for how this can happen - Need a plan for levels 1-4 for this group going forward and dovetailing it to the hospital alert system green, orange red where appropriate - - this group needs to develop a framework and submit this the regional chief executives of the respective DHB's.**Action point:** Barbara can send through information on the national framework for breast screening during COVID and this could be used as a starting point.

Northern Region Diabetes Retinal Screening Clinical Governance

Minutes

Ophthalmology: treated through all levels – this is due to the hospital alert levels being different from the community alert levels

" Covid 19 working group" Role of this group is to recommend safe and workable clinical recommendations for retinal screening during possible future Covid-19 lockdown measures –and put them forward to achieve a consistent approach across metro Auckland if not regionally

- A small sub group to work on this
- This could be used in other scenarios outside of COVID ie workforce issues and data match
- Barbara supportive that Northland should be part of this.
- Need to apply an equity lens – need to serve Maori and Pacific better

Action point: this group to develop a prioritization framework and guidance on when patients should be screened ie when should P1s be seen and who/how to apply this framework ie new vs follow up
Sarah W, Stephanie, Barbara and David D, David S to be part of this group
Barbara has someone who can help with an equity lens but Tracey W will also help with this.
Eirean will email group asking for members to be part of this group
This group to meet and undertake and finish this work within 2-3weeks
Framework to come back to governance group for acceptance

Ros provided a summary of the Auckland DHB experience – see attached document

Tahira presented on the Waitemata DHB experience – see attached document

- HealthWEST identified access to venues during lock down an issue in being able to screen

Barbara reported having similar issues as those discussed today

Northern Region Diabetes Retinal Screening Clinical Governance

Minutes

	Discussion: having recall appropriate to clinical risk will help ensure we are seeing those with greatest need, this will need to be included in the prioritisation framework Outcome: future retinal screening model needs to be able to be flexible to accommodate surges in demand
Meeting closed at 0900	
Next meeting: 7 October 2020 0800 to 0900 via Zoom	

Action points

Action point	By whom	By when
this group to develop a prioritization framework and guidance on when patients should be screened ie when should P1s be seen and who/how to apply this framework ie new vs follow up	Sub-group	Sarah W (ADHB), Stephanie (CMDHB), Barbara and David D (NDHB, David is not able to attend but will comment on final recommendations), David S (ADHB), Ros M (ADHB) and Tahira (WDHB) offered to be part of this group Barbara has someone who can help with an equity lens but Tracey W will also help with this. Eirean will email group asking for members to be part of this group This group to meet and undertake and finish this work within 2-3weeks Framework to come back to governance group for acceptance
Barbara can send through information on the national framework for breast screening during COVID and this could be used as a starting point.	Barbara	ASAP to inform sub working group prioritization framework
Quality check on retinal screening data match patient lists	Carol	Once released from COVID work

Future meeting agenda items

Northern Region Diabetes Retinal Screening Clinical Governance Minutes

Retinal screening data match draft monitoring and reporting framework

- Carol B

Update Terms of Reference – Eirean (aim for the October or December meeting)

Workplan – Eirean (aim for the October or December meeting)

Northern Region Diabetes Retinal Screening Clinical Governance

Minutes

MEETING DETAILS	
Date and Time	Wednesday 07 October 2020 0800 to 0900
Venue	Zoom
Present	Tracy Molloy, Stephanie Emma, David Squirrell, Dene Coleman, Janice Kirkpatrick, Anne-Marie, Carol Ennis, Simon Young, Samantha Titchener, Lorraine Bailey, Tahira Malik, Barbara Miller, Helen Liley, Tracy Walters
In attendance	Eirean Gamble,
Apologies received	Brandon Orr-Walker, Carol Barker, Ole Schmiedel, Ros Moffit, Sarah Welch, Edward Pattinson, Aroha Hudson,

Item	Discussion
Welcome, Introductions and Apologies	Welcome
Minutes from August meeting **Action points:**	Minutes from 2 September 2020 accepted as a true reflection of the December meeting Accepted: Helen Seconded: Stephanie

Action	By	Outcome
this group to develop a prioritization framework and guidance on when patients should be screened ie when should P1s be seen and who/how to apply this framework ie new vs follow up	Sub-group	Draft framework for endorsement today

Northern Region Diabetes Retinal Screening Clinical Governance Minutes

	Barbara can send through information on the national framework for breast screening during COVID and this could be used as a starting point.	Barbara	completed
	Quality check on retinal screening data match patient lists	Carol	Aim for presenting to the December meeting
Eligibility for screening in WDHB	Discussion about this, as unclear if this action point was completed. **Action point:** Eirean to liaise with the diabetes CD across metro Auckland asking them to confirm what is a diagnosis of what is type 2 diabetes that can be used to accept people into the retinal screening services across the region ie one or two HbA1c. Then we will take this to DSLA and the Counties Manukau Long term conditions clinical governance group for endorsement and then put this on health pathways Barbara happy for DSLA to make call and accept the decision		
prioritization framework and guidance on when patients should be screened by community providers	Discussion re version 6 and changes discussed made to version 7.  Community Diabetic Retinal Screening v7. Current version		

Northern Region Diabetes Retinal Screening Clinical Governance

Minutes

	Community Diabetic Retinal Screening v6. Previous version for reference. **Action point:** group to review and endorse via email **Action point:** Eirean to liaise with NHCC to get HealthWEST, Auckland Eye, Auckland DHB and Comprehensive Care to receive communication from NHCC Barbara reported that Northland able to screen at level 3 Need to have an offline conversation re: Waitemata providers ability to screen during level 3
When to start eye screening Paed patients with diabetes	Question raised by colleagues in Christchurch as to when to screen Paediatric patients. David's recommendation is that we move from the MoH guidelines age of screen from 10 to 11 regardless of age of diagnosis as per the new Australasian Endocrinology group guidelines. But if diagnosed after the age of 11 they would be screened from diagnosis. Screening interval of every 2-3 years based on diabetic control. This is an informal agreement and will wait for the review of the new Australasian Endocrinology group guidelines David has already polled the Diabetologists and they agree with this change Rationale: Children do not get retinopathy until puberty and will only affect a small number of people **Action point:** Health Pathways will be updated after the review based on the new Australasian Endocrinology group guidelines has occurred

Northern Region Diabetes Retinal Screening Clinical Governance Minutes

	Eirean to update MoH via an email Screening providers to start screening paeds from 11years.
Meeting closed at 0900	
Next meeting: 7 October 2020 0800 to 0900 via Zoom	

Action points

Activity	Action point	By whom	By when
Eligibility for screening in the Northern Region	Eirean to liaise with the diabetes CD across metro Auckland asking them to confirm what is a diagnosis of what is type 2 diabetes that can be used to accept people into the retinal screening services across the region ie one or two HbA1c. Then we will take this to DSLA and the Counties Manukau Long term conditions clinical governance group for endorsement and then put this on health pathways Barbara happy for DSLA to make call and accept the decision	Eirean	ASAP
prioritization framework and guidance on when patients should be screened by community providers	group to review and endorse via email Eirean to liaise with NHCC to get HealthWEST, Auckland Eye, Auckland DHB and Comprehensive Care to receive communication from NHCC Barbara reported that Northland able to screen at level 3	ASAP ASAP	
When to start eye screening	Health Pathways will be updated after the review based on	Helen	When guidelines reviewed

Northern Region Diabetes Retinal Screening Clinical Governance

Minutes

Paed patients with diabetes	the new Australasian Endocrinology group guidelines has occurred Eirean to update MoH via an email Screening providers to start screening paeds from 11years.	 Eirean Screening providers	 ASAP ASAP

Future meeting agenda items

Retinal screening data match draft monitoring and reporting framework

- Carol B

Update Terms of Reference – Eirean (aim for the October or December meeting)

Workplan – Eirean (aim for the October or December meeting)

Diabetic Retinal Screening

The Northern Region Diabetic Retinal Screening Clinical Governance triage prioritisation working group have developed the following triaging framework that is to be used by all Northern Region Diabetic Retinal Screening providers to ensure that during times when demand exceeds capacity or/and during COVID-19 lockdown that patients at the highest risk of developing or progressing diabetic eye disease are seen in a timely manner.

These are guidelines and clinical discretion should be used for any patients of concern. If a screening group consistently finds the guidelines difficult to adhere to for whatever reason, please report back to the governance group.

Triaging framework for new and follow up patients

New patients should be triaged as a higher priority to recall patients. However, clinical judgement discretion should be used for any patients of concern and the Clinical Lead can use their clinical discretion to adjust priorities.

Triaging new referrals

Ethnicity	Latest HbA1c recording in mmol/mol (last 15 months)				
	95+	85-94	75-84	65-74	<=64
Māori and Pacific	1	1	1	2	2
Indian and Other Asian	1	1	2	2	3
Other	1	2	2	3	4

Priority 1 | Priority 2 | Priority 3 | Priority 4

Immediate screen:

Regardless of ethnicity or HbA1c the following new referrals should be screened immediately

- Pregnant
- Serious systemic manifestations of Diabetes eg lower limb ulcer/amputation, renal impairment/or their Diabetologist requests urgent screening.

Proposed timeframes for new referrals (as per the Ministry of Health guidelines)

Priority one: should be seen within two weeks
Priority two: should be seen within six weeks
Priority three: should be seen within three months
Priority four: should be seen within four months

Triaging recalls [1]

Based on analysis of risk factors for disease progression using local data (60,000 screening images) (reference to be provided)

Immediate screen: No delay in recall ie screen on time

- Pregnant
- Serious systemic manifestations of diabetes eg lower limb ulcer/amputation, renal impairment/or their Diabetologist requests urgent screening
- Those who are lost to follow up and identified as a priority one

Priority one (P1) (2 or more of): Could be deferred by up to 2 months

- Māori or Pacific Island ethnicity
- Type 2 diabetes on insulin, or type 1 diabetes > duration 10 years
- HbA1c >90 mmol/mol
- R3 or M3 at last screen.

Priority 2 (P2): (2 or more of): Could be deferred up to 6 months

- Māori or Pacific Island ethnicity
- Type 1 diabetes, or Type 2 Diabetes on oral tablets
- Duration of diabetes 5-10 years
- HbA1C between 65-90 mmol/mol
- R grade ≤R2 and M grade ≤M2 at last grade.

Priority 3 (P3) (all of the following): Could be deferred by up to 9 months

- Type 2 diabetes not on insulin (diet controlled or on oral tablets)
- Duration of diabetes <5 years
- HbA1C ≤64 mmol/mol
- R0 or M0 at last grade

When can patients be seen when we are at the different COVID alert levels

The Community Diabetic Retinal Screening will follow the Hospital Response Framework and not the national lockdown levels. However, the following caveat applies:

1. If capacity[2] becomes an issue Providers will book patients based on priority ie only see priority one new patients and high risk recalls and all immediate screen patients

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[1] The criteria used to allocate priority for recall is aspirational. If your centre is not able to generate recall lists with all of these criteria, it is encouraged that the recall lists/decisions are based on as many of these criteria as possible.

[2] Capacity issues include, but are not limited to: capacity issue at location, inability to social distance (1meter social distancing within wait rooms), inability to perform required cleaning, staffing issues (being redeployed or having to step down for other reasons) or loss of screening locations.

Hospital alert level	New patients that can be seen	Follow up patients that can be seen
COVID-19 Hospital Readiness GREEN ALERT	all patients	
COVID-19 Hospital Initial Impact YELLOW ALERT	immediate patients, P1, P2 and P3	immediate patients, P1 and P2
COVID-19 Hospital Moderate Impact ORANGE ALERT	immediate patients, P1	immediate screen patients, P1
COVID-19 Hospital Severe Impact RED ALERT[3]	Screen immediate screen patients and P1 deemed urgent by clinicians[4]	Screen immediate screen patients and high risk deemed urgent by clinicians[2]

National Hospital Framework V4 12082

Messaging to patient this needs to be clear allowing patients to make an informed decision about whether they wish to be seen or not. If a patient self selects to not be seen their priority must not reduced. They should then be offered an appointment as the national and hospital alert levels drop but the patient should also be reassured that they can contact the service when they feel ready/safe to be seen.

Review of patients on waitlist

It is expected that waitlists are reviewed as part of normal booking process. However, a formal review of waitlists should happen every 3months to identify if any patients have been waiting longer than 1.5 times their due date or a maximum of three and a half years since last review. If this is the case then the patient's priority should be moved up a level; ie if a patient was due to be seen in 6months after 9months if they have not been seen their priority levels moves up.
During waitlist reviews the Screening Co-ordinator and Lead Ophthalmologist should review the reasons for the increased waiting times and a plan developed to address this. At the same time the Programme Manager/Funder and the Regional Retinal Screening Clinical Governance notified.

As part of business as usual the Screening Co-ordinator/ Lead Ophthalmologist will bring the services waitlist times to the quarterly Regional Retinal Screening Clinical Governance meeting for review/discussion.

3 At Red Alert, staff may be deployed for other duties and screening may be shut. Therefore, it may be appropriate to treat a few patients in the respective ophthalmology departments.
[4] At hospital level red capacity issues and patient self-selection will most likely determine which of the highest need population is seen

Review of framework period

It is expected that this framework will be reviewed again in March 2021. However, if providers are adjusting the framework on a regular basis due to clinical risk/clinical judgement etc then this review will be brought forward.

Priscilla Philip (ADHB)

From: Aaron Puckey (ADHB)
Sent: Friday, 25 September 2020 14:10
To: Shailender Malgari (ADHB); Warren Oxenham (ADHB); Ole Schmiedel (ADHB)
Cc: Naama Ine (ADHB)
Subject: RE: Northern Region Diabetic Retinal Screening Clinical Governance meeting

Hi All
Attached is the full Retinal Waitlist as of this morning – we have **15%** overdue currently and are booking July patients at the moment
I'll add this now into the SCRUM Pack to review regularly
Any queries let me know

Regards
Aaron


Retinal Screening Follow Up Wa...

P.S Thanks Shailender for help this morning isolating this list

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From: Aaron Puckey (ADHB)
Sent: Thursday, 24 September 2020 10:04 a.m.
To: Shailender Malgari (ADHB); Warren Oxenham (ADHB); Ole Schmiedel (ADHB)
Subject: RE: Northern Region Diabetic Retinal Screening Clinical Governance meeting

HI Shailender

<< File: retinal waiting list.xlsx >>
<< File: Diabetes SCRUM Pack Sep 2020.ppt >>
I've attached the Retinal Waiting list as it is this morning and the SCRUM Pack from earlier this month
I've ranked the Retinal Waitlist from the longest waiting patient

Can't extract the recall list out of HCC ... there are 36 overdue on this currently

Let me know if you need anything else

Regards
Aaron

From: Shailender Malgari (ADHB)
Sent: Thursday, 24 September 2020 9:26 a.m.
To: Warren Oxenham (ADHB); Ole Schmiedel (ADHB)
Cc: Aaron Puckey (ADHB)
Subject: RE: Northern Region Diabetic Retinal Screening Clinical Governance meeting

Hi Warren,

Aaron would be able to extract the data but just looking at the patients from the waitlist there are roughly about 200 NP's that are overdue by 45 days and Follow ups by 3 months.

Aaron,
Can you please advise how do I get the data from the HCC pls?

Thanks,
Shailender

From: Warren Oxenham (ADHB)
Sent: Thursday, 24 September 2020 9:10 a.m.
To: Ole Schmiedel (ADHB)
Cc: Shailender Malgari (ADHB); Aaron Puckey (ADHB)
Subject: RE: Northern Region Diabetic Retinal Screening Clinical Governance meeting

Shallender

Do we have the numbers on this as of Today?

On 13th May there were 317 New patients waiting to be screened - also did we have the breakdown of waiting times of 4 months ? and do we have this as of today

Followups on the 13th of may 2,484 follow-up overdue – How many follow ups in total ?

Also from the below table I assume we are saying we will see the overdue Priority 1 patients in 3 weeks , the priority 2 patients in 6 weeks ...

3/12	6/12	12/12	18/12	24/12
Priority 1	Priority 2	Priority 3	Priority 4	Priority 5
N=small	N=224	N=354	N=177	N=1729
<3 weeks	<6 weeks	<3 months	<4 months	<6 months

Do we have the total follow-ups for each of these buckets so we can work out the % Overdue

Also Aaron /Ole does retinal screening follow ESPI2 rules

Warren Oxenham
Operations Manager – Specialist Outpatient Services
Community and Long Term Conditions Directorate
[redacted]
Auckland District Health Board
Level 4 | Building 4| Greenlane

From: Ole Schmiedel (ADHB)
Sent: Thursday, 24 September 2020 8:49 AM
To: Warren Oxenham (ADHB) [redacted]
Cc: Shailender Malgari (ADHB) [redacted]; Aaron Puckey (ADHB) [redacted]
Subject: FW: Northern Region Diabetic Retinal Screening Clinical Governance meeting

Hi

Attached/embedded the latest data I have – from Ros.

Shailender, can you please have a look at wait list for retinal screening, for new and f/u. Aaron are you able to help please?

Many thanks
Ole

Nga Mihi | Kind regards
Ole Schmiedel MRCP MD FRACP
Physician and Endocrinologist | Service Clinical Director | Dept. of Diabetes
[redacted]
Auckland District Health Board | Level 1 Building 4 GCC, Private Bag 92189, Greenlane, Auckland NZ

<< OLE Object: Picture (Device Independent Bitmap) >>

From: Ros Moffatt (ADHB)
Sent: Tuesday, 01 September 2020 3:45 p.m.
To: Eirean Gamble (WDHB); David Squirrell (ADHB); 'Edward Pattinson'; 'Carol Ennis [redacted]; 'Tracy Walters [redacted]; Carol Barker (WDHB); Lorraine Bailey (WDHB); Helen Liley (CMDHB); Stephanie Emma (CMDHB); Barbara Miller (NDHB); Tracy Molloy (AE); Tahira Malik (ADHB); 'Aroha Hudson [redacted]; Ole Schmiedel (ADHB); Sarah Welch (ADHB); Brandon Orr-Walker (CMDHB); David Dalziel (NDHB); Samantha Titchener (ADHB); Tim Wood (WDHB); Lis Cowling (WDHB); Janice Kirkpatrick (WDHB); Simon Young (Medicine) (WDHB)
Cc: 'SARAH WELCH'; 'Dene Coleman'
Subject: RE: Northern Region Diabetic Retinal Screening Clinical Governance meeting

Hi All,

One more from me, << File: Covid Response - Retinal Screening Auckland Diabetes Centre .docx >>

Ros Moffatt

Retinal Screening Co-ordinator Optometrist, Auckland Diabetes Centre

[redacted]**Auckland District Health Board** | Level 1 | Building 4 | Greenlane Clinical Centre

<< OLE Object: Picture (Device Independent Bitmap) >>

From: Eirean Gamble (WDHB)
Sent: Tuesday, 01 September 2020 9:38 a.m.
To: David Squirrell (ADHB); 'Edward Pattinson'; 'Carol Ennis [redacted] 'Tracy Walters [redacted] Carol Barker (WDHB); Lorraine Bailey (WDHB); Helen Liley (CMDHB); Stephanie Emma (CMDHB); Barbara Miller (NDHB); Tracy Molloy (AE); Tahira Malik (ADHB); 'Aroha Hudson [redacted] Ole Schmiedel (ADHB); Sarah Welch (ADHB); Brandon Orr-Walker (CMDHB); David Dalziel (NDHB); Samantha Titchener (ADHB); Tim Wood (WDHB); Lis Cowling (WDHB); Janice Kirkpatrick (WDHB); Ros Moffatt (ADHB); Simon Young (Medicine) (WDHB)
Cc: 'SARAH WELCH'; 'Dene Coleman'
Subject: RE: Northern Region Diabetic Retinal Screening Clinical Governance meeting

Hi all

One more document

<< File: COVID impact on DRS.pptx >>

Cheers

Eirean

PLEASE NOTE: I am only working part time and my current hours are Tuesday 0800 to 1600, if your request is urgent and outside these hours please contact Lis Cowling, [redacted]

Eirean Gamble I Programme Manager, Primary Care I Planning Funding & Outcomes I Auckland & Waitematā District Health Boards
Level 1, 17 Shea Terrace, Private Bag 93-503, Takapuna
[redacted]

<< OLE Object: Picture (Device Independent Bitmap) >>

From: Eirean Gamble (WDHB)
Sent: Tuesday, 1 September 2020 9:28 a.m.
To: David Squirrell (ADHB); Edward Pattinson; Carol Ennis [redacted] Tracy Walters [redacted] Carol Barker (WDHB); Lorraine Bailey (WDHB); Helen Liley (CMDHB); Stephanie Emma (CMDHB); Barbara Miller (NDHB); Tracy Molloy (AE); Tahira Malik (ADHB); Aroha Hudson [redacted] Ole Schmiedel (ADHB); Sarah Welch (ADHB); Brandon Orr-Walker (CMDHB); David Dalziel (NDHB); Samantha Titchener (ADHB); Tim Wood (WDHB); Lis Cowling (WDHB); Janice Kirkpatrick (WDHB); Ros Moffatt (ADHB); Simon Young (Medicine) (WDHB)
Cc: SARAH WELCH; 'Dene Coleman'
Subject: RE: Northern Region Diabetic Retinal Screening Clinical Governance meeting

<< File: COVID response.xlsx >> << File: 2 September Agenda NRDRSCG.docx >>

Hello everyone

Please find attached the final agenda for tomorrows meeting and the response from some of our providers on the impact COVID has had, this will be discussed further at tomorrows meeting

Cheers

Eirean

PLEASE NOTE: I am only working part time and my current hours are Tuesday 0800 to 1600, if your request is urgent and outside these hours please contact Lis Cowling, [redacted]

Eirean Gamble I Programme Manager, Primary Care I Planning Funding & Outcomes I Auckland & Waitematā District Health Boards
Level 1, 17 Shea Terrace, Private Bag 93-503, Takapuna
[redacted]

<< OLE Object: Picture (Device Independent Bitmap) >>

-----Original Appointment-----
From: Eirean Gamble (WDHB)
Sent: Tuesday, 11 August 2020 1:45 p.m.
To: Eirean Gamble (WDHB); David Squirrell (ADHB); Edward Pattinson; Carol Enni[redacted]; Tracy Walters [redacted] arol Barker (WDHB); Lorraine Bailey (WDHB); Brian Millen (WDHB); Helen Liley (CMDHB); Stephanie Emma (CMDHB); Barbara Miller (NDHB); Tracy Molloy (AE); Tahira Malik (ADHB); Craig Murray; Aroha Hudson [redacted] Ole Schmiedel (ADHB); Sarah Welch (ADHB); Brandon Orr-Walker (CMDHB); David Dalziel (NDHB); Samantha Titchener (ADHB); Tim Wood (WDHB); Lis Cowling (WDHB); Janice Kirkpatrick (WDHB); Ros Moffatt (ADHB); Simon Young (Medicine) (WDHB)
Cc: SARAH WELCH; 'Dene Coleman'
Subject: Northern Region Diabetic Retinal Screening Clinical Governance meeting
When: Wednesday, 2 September 2020 8:00 a.m.-9:00 a.m. (UTC+12:00) Auckland, Wellington.
Where: [redacted]

Hello everyone

I am sorry this meeting is an hour not 30min

Cheers
E

Hello everyone

It appears that the 2 September option seems to suit the majority of people for this meeting.

Please note this will be a meeting held via zoom and I have not booked a room for this meeting.

At the moment the agenda items for this meeting are:

1. Quality check on retinal screening data match patient lists – this will be a verbal briefing by Carol Barker

2. Opportunity for providers to share any learnings or processes they have developed to safely manage demand from the COVID lock down. These learnings can also help providers think about how to manage any future demand from the retinal screening data match project.

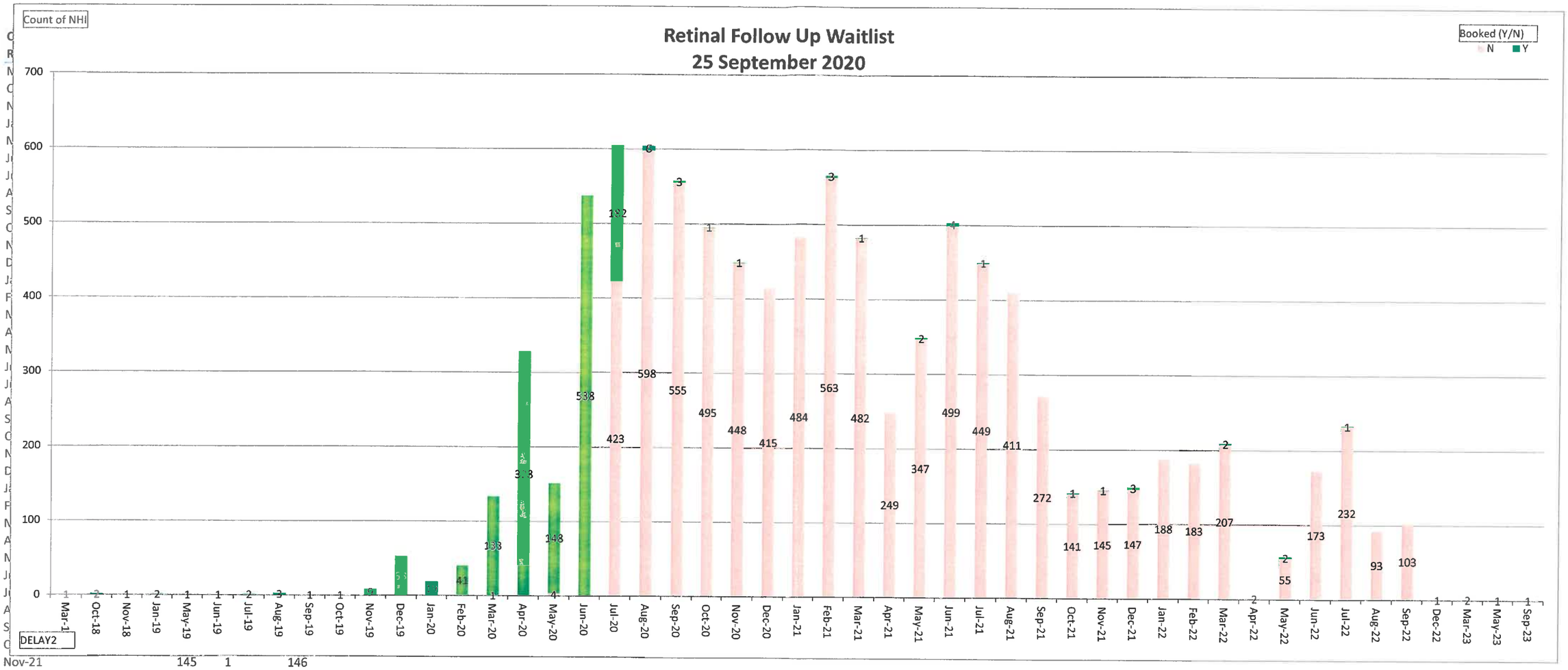
3. OptoMize update (pending)

If there are any other agenda items you would like to add please let me know and I will add it to agenda. I will circulate a final agenda one week prior to this meeting.

Cheers
Eirean

Count of NHI	Column Labels		
Row Labels	Y	N	Grand Total
Mar-18		1	1
Oct-18	2		2
Nov-18	1		1
Jan-19	2		2
May-19	1		1
Jun-19	1		1
Jul-19	2		2
Aug-19	3		3
Sep-19	1		1
Oct-19	1		1
Nov-19	9		9
Dec-19	53		53
Jan-20	19		19
Feb-20	41		41
Mar-20	133	1	134
Apr-20	328		328
May-20	148	4	152
Jun-20	538		538
Jul-20	182	423	605
Aug-20	6	598	604
Sep-20	3	555	558
Oct-20	1	495	496
Nov-20	1	448	449
Dec-20		415	415
Jan-21		484	484
Feb-21	3	563	566
Mar-21	1	482	483
Apr-21		249	249
May-21	2	347	349
Jun-21	4	499	503
Jul-21	1	449	450
Aug-21		411	411
Sep-21		272	272
Oct-21	1	141	142
Nov-21	1	145	146
Dec-21	3	147	150
Jan-22		188	188
Feb-22		183	183
Mar-22	2	207	209
Apr-22		2	2
May-22	2	55	57
Jun-22		173	173
Jul-22	1	232	233
Aug-22		93	93
Sep-22		103	103
Dec-22		1	1

Mar-23		2	2
May-23		1	1
Sep-23		1	1
Grand Total	**1497**	**8370**	**9867**



Nov-21	145	1	146
Dec-21	147	3	150
Jan-22	188		188
Feb-22	183		183
Mar-22	207	2	209
Apr-22	2		2
May-22	55	2	57
Jun-22	173		173
Jul-22	232	1	233
Aug-22	93		93
Sep-22	103		103
Dec-22	1		1
Mar-23	2		2
May-23	1		1
Sep-23	1		1
Grand Total	**8370**	**1497**	**9867**

Priscilla Philip (ADHB)

From: Eirean Gamble (WDHB)
Sent: Monday, 07 September 2020 09:43
To: David Squirrell (ADHB); Edward Pattinson; Carol Ennis (Carol@aucklandpho.co.nz); Tracy Walters (tracy.walters@tehaoranga.co.nz); Carol Barker (WDHB); Lorraine Bailey (WDHB); Brian Millen (WDHB); Helen Liley (CMDHB); Stephanie Emma (CMDHB); Barbara Miller (NDHB); Tracy Molloy (AE); Tahira Malik (ADHB); Craig Murray; Aroha Hudson (arohah@healthwest.co.nz); Ole Schmiedel (ADHB); Sarah Welch (ADHB); Brandon Orr-Walker (CMDHB); David Dalziel (NDHB); Samantha Titchener (ADHB); Tim Wood (WDHB); Lis Cowling (WDHB); Janice Kirkpatrick (WDHB); Ros Moffatt (ADHB); Simon Young (Medicine) (WDHB)
Cc: SARAH WELCH; 'Dene Coleman'
Subject: RE: Northern Region Diabetic Retinal Screening Clinical Governance meeting

Hello everyone

Please find attached the draft meeting minutes from Wednesday 2 September meeting.

Please note the "COVID" working group will be meeting on Thursday 10 September from 8-10am via zoom. If you would like to be part of this group please email me ASAP and I will forward the meeting invite to you

02 Sept RSCGF minutes draft.d...

Cheers
Eirean

PLEASE NOTE: I am only working part time and my current hours are Tuesday 0800 to 1600, if your request is urgent and outside these hours please contact Lis Cowling, [redacted]

Eirean Gamble I Programme Manager, Primary Care I Planning Funding & Outcomes I Auckland & Waitematā District Health Boards
Level 1, 17 Shea Terrace, Private Bag 93-503, Takapuna
[redacted]

Waitemata District Health Board
Best Care for Everyone

-----Original Appointment-----
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Sent: Tuesday, 11 August 2020 1:45 p.m.
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(WDHB); Janice Kirkpatrick (WDHB); Ros Moffatt (ADHB); Simon Young (Medicine) (WDHB)
Cc: SARAH WELCH; 'Dene Coleman'
Subject: Northern Region Diabetic Retinal Screening Clinical Governance meeting
When: Wednesday, 2 September 2020 8:00 a.m.-9:00 a.m. (UTC+12:00) Auckland, Wellington.
Where: https://waitematadhb.zoom.us/j/91290426015

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3. OptoMize update (pending)

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Cheers
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Priscilla Philip (ADHB)

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Sent: Tuesday, 01 September 2020 09:28
To: David Squirrell (ADHB); Edward Pattinson; Carol Ennis [redacted]; Tracy Walters [redacted] Carol Barker (WDHB); Lorraine Bailey (WDHB); Helen Liley (CMDHB); Stephanie Emma (CMDHB); Barbara Miller (NDHB); Tracy Molloy (AE); Tahira Malik (ADHB); Aroha Hudson [redacted] Ole Schmiedel (ADHB); Sarah Welch (ADHB); Brandon Orr-Walker (CMDHB); David Dalziel (NDHB); Samantha Titchener (ADHB); Tim Wood (WDHB); Lis Cowling (WDHB); Janice Kirkpatrick (WDHB); Ros Moffatt (ADHB); Simon Young (Medicine) (WDHB)
Cc: SARAH WELCH; 'Dene Coleman'
Subject: RE: Northern Region Diabetic Retinal Screening Clinical Governance meeting

COVID response.xlsx 2 September Agenda NRDRS...

Hello everyone

Please find attached the final agenda for tomorrows meeting and the response from some of our providers on the impact COVID has had, this will be discussed further at tomorrows meeting

Cheers

Eirean

PLEASE NOTE: I am only working part time and my current hours are Tuesday 0800 to 1600, if your request is urgent and outside these hours please contact Lis Cowling, [redacted]

Eirean Gamble I Programme Manager, Primary Care I Planning Funding & Outcomes I Auckland & Waitematā District Health Boards
Level 1, 17 Shea Terrace, Private Bag 93-503, Takapuna
[redacted]

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Cheers
Eirean

Initial lockdown

1. During the initial lock down when did you restart screening patients and how was this different from BAU

2. When did you return to BAU screening

3. As a result of the initial lockdown what impact has this had on your weight lists?

4. Have you been able to screen all those people reschedule as a result of the initial lockdown

5. What prioritisation framework did you use to rebook patients post the initial lockdown

6. Do you have a plan to manage your waitlists

7. Are there any changes in practices that you have implemented as a result of the initial lockdown

August lockdown

1. When do you plan to start seeing patients again after this current lockdown, or if you are seeing patients when did this start and how is this different from BAU?

2. What prioritisation framework do you plan to use to rebook patients after this lockdown

3. What impact does this lockdown have on your waitlists

Overall, how are you managing your demand during COVID?

HealthWEST

We restarted 30 June 2020 as staff had been off on ACC due to workplace injuries. Appointment times were extended from 10mins to 20mins to allow for use of PPE, screening patients and cleaning everything down in between.

26-Jun-20

Waiting lists were longer as we had to rebook all the patients that were cancelled while in lockdown.

Yes

Prioritised pregnant women, those that had previously been cancelled and had to be rebooked, HBA1C > 65 and those that have been on the waitng list longest

We have been screenign 5 days

We are ringing more to book appointments rather than relying on letters

31 August 2020 20 minute appointments

As above

As above

We are doing the best we can. A lot of time has been spent cancelling and rescheduling appointments.

Auckland Eye

2ND June , spaced patients to 20 minute appts rather than 10mins. Advised unwell patients to stay home and not attend appointment, reschedule when better.

On the 2 June

No impact – We managed to have patients rebooked within time frame of appointment needed

Yes

Appointments to booked within 6 weeks of when original appointment was

Yes, When we cancelled we rebooked patients appointment again for 6 weeks time. So patients would not miss out on their appointment, also asked optoms to create more clinics and appointments to clear all patients not seen during lockdown

We have been in contact with patients as soon as we know we have to cancel appts, during each lockdown our DRS services phone line was available all day not just the 2.5 hours we usually operate and we have made ability to use optomize offsite with access to the phone during this time which was not previously set up.

We have also needed to allocate additional resources to moving of appointments, answering patient queries and have had a large increase in calls due to this.

1 September, advise patients if unwell, awaiting covid 19 test results, been in contact with someone who is unwell. Stay home and advise us to rebook. Space appt times out as much as possible

same as lockdown 1- Patients have been rebooked when the initial appointment was cancelled to be seen first week after level 3. All patient that were in the level 3 period have been rebooked

No impact we will be arranging more clinics and appointments as previous lockdown with optoms who screen our patients.

Northern Region Diabetes Retinal Screening Clinical Governance

Agenda

Date: Wednesday, 2 September 2020

Time: 0800 to 0900

Venue: zoom: [redacted]

Members: David Squirrell (chair), Edward Pattinson, Carol Ennis, Tracy Walters, Carol Barker, Lorraine Bailey, Brian Millen, Helen Liley, Stephanie Emma, Barbara Miller, Tracy Molloy, Tahira Malik, Aroha Hudson, Simon Young, Ole Schmiedel, Sarah Welch, Brandon Orr-Walker, Samantha Titchener Sarah Welch, Dene Coleman

David Dalziel (NDHB) [redacted] is not able to attend meetings but gets copies of agenda/minutes and all other communication

In attendance: Eirean Gamble, Tim Wood, Lis Cowling

Apologies: Carol Ennis

Time	Item	By
0800	Welcome, introductions, and apologies	Ole
0805	Minutes from December meeting NRDRSCGF 11 Dec 19 Minutes Final.docx Action points:	Ole

Action	By	Outcome
Retinal screening data match draft monitoring and reporting framework	Carol to redraft framework based on group's guidance.	Deferred to October meeting
Retinal screening coding and clinical terminology update	Request re HL7 format to be forwarded to Optomize upgrade team (see Action point in Other Business below)	? Eirean working to see if this was completed
Eligibility for screening in WDHB	Emi to collect eligibility criteria from international guidelines, the Primary	Completed

Northern Region Diabetes Retinal Screening Clinical Governance Agenda

		Care Handbook, and HealthPathways. DSLA to review the relationship between a diagnosis for type 2 diabetes and the eligibility criteria for diabetes retinal screening, with a view to improving alignment between the two .		
	A letter from the Chair to be sent to the Optomize upgrade project sponsor, outlining the Northern Region Diabetes Retinal Screening Clinical Governance Group's requests and concerns.	David	The Chair raised concerns directly in a meeting with the Optomize upgrade sponsor.	
0820	Update on OptoMize			Tim
0835	Quality check on retinal screening data match patient lists			Stephanie
0845	Opportunity for providers to share any learnings or processes they have developed to safely manage demand from the COVID lock down. These learnings can also help providers think about how to manage any future demand from the retinal screening data match project.			Providers/Ole/David
0855	Other business			
Next meeting: 7 October 2020 0800 to 0900				

Future Agenda items:

Retinal screening data match draft monitoring and reporting framework

- Carol B

Update Terms of Reference – Eirean (aim for the October or December meeting)

Workplan – Eirean (aim for the October or December meeting)

Northern Region Diabetes Retinal Screening Clinical Governance

Agenda

REGISTER OF INTERESTS

DSLA Member	Organisaton represented	Role in organisation	Nature of conflict	Last Updated
Aroha Hudson	HealthWEST	CEO		
Barbara Miller	Northland DHB	Service Manager, ED, Breast & Retinal Screening, Mauri Ora Breast Clinic	Nil	14/08/19
Brandon Orr-Walker	Counties Manukau DHB	Clinical Director - Diabetes		
Brian Millen	Waitematā DHB	General Manager - Diabetes		
Carol Barker	Waitematā DHB	Public Health Physician	Nil	30/10/19
Carol Ennis	Auckland PHO	Lead nurse		
Craig Murray	Comprehensive Care PHO (retinal screening provider)	General Manager		
David Dalziel	Northland DHB	Clinical Director Ophthalmology, Ophthalmologist in	Shareholder & Director Kensington Hospital Ltd Shareholder & Director Dr David Dalziel Ltd – trading as Eye Centre Primecare Director	25/10/19

Northern Region Diabetes Retinal Screening Clinical Governance Agenda

		charge of Diabetic Retinal Screening Member of the following Northland DHB groups – Information Services Governance Group (ISGG), Information Services PCG (priority setting group), Northland Clinical Governance Forum, Medical Executive Leadership Team (MELT), Capital Expenditure Prioritisation Group	Save Sight Society Ophthalmologist in charge of Diabetic Retinal Screening for Southland	
David Squirrell (chair)	Auckland DHB	Ophthalmologist	Director of a company which is developing AI to grade diabetic retinopathy	14/08/19
Helen Liley	Counties Manukau DHB			
Jennie Montague	Auckland DHB	General Manager - Diabetes		

Northern Region Diabetes Retinal Screening Clinical Governance

Agenda

Ole Schmiedel	Auckland DHB	Clinical Director - Diabetes		
Lorraine Bailey	Waitematā DHB	Programme Manager		
Edward Pattinson	NHC			
Sarah Welch	Auckland DHB	Clinical Director - Ophthalmology		
Simon Young,	Waitematā DHB	Clinical Director - Diabetes	Nil	29/10/19
Stephanie Emma	Counties Manukau DHB	Retinal Screening Service Lead	Nil	12/08/19
Tahira Malik	Auckland DHB	Ophthalmologist	Nil	29/10/19
Tracey Molloy	Auckland Eye			
Tracy Walters				