# Options Analysis

## Diabetic Eye Screening in the South West

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# Document management

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| 1.0 | 14/12/17 | Initial Draft |
| 1.1 | 10/01/18 | Various amendments to format and updated data |
| 1.2 | 20/03/18 | Inclusion of Gloucestershire |
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# Contents

1 Background....4
2 Overview of current provision....4
3 Performance....6
4 Current and future issues....7
5 Options for future service configuration....9
6 Summary....15

# 1 Background

The NHS Diabetic Eye Screening Programme (DESP) aims to reduce the risk of sight loss among people with diabetes by the early detection and treatment, if needed, of sight-threatening retinopathy. Screening is delivered locally in line with national quality standards and protocols. Each local programme co-ordinates screening for its population and organises invitation letters, screening clinics, result letters and referrals to hospital eye services. Local screening programmes inform GPs when people are invited for screening and of their patients' screening results.

There are more than 2.5 million people with diabetes identified by GP practices in England. Using figures from a study in Scotland, it is estimated that in England every year 4,200 people are at risk of blindness caused by diabetic retinopathy and there are 1,280 new cases of blindness caused by diabetic retinopathy. It is estimated that screening could save more than 400 people per year from sight loss in England.

In England in 2016-17:

- 2,734,000 individuals were offered screening for diabetic retinopathy and
- 2,248,000 individuals received screening, an uptake of 82%

These numbers are increasing each year with estimates suggesting that the number of people with diabetes will increase to 3.7 million by 2020 and 4.2 million by 2030.

# 2 Overview of current provision

Locally there are 8 programmes which cover the South West region of which 7 are in scope for this procurement these are as follows:

- Bristol and Weston Diabetic Eye Screening Programme: Bristol Community Health CIC
- Cornwall Diabetic Eye Screening Programme: Royal Cornwall Hospital NHS Trust
- North and East Devon Diabetic Eye Screening Programme: Royal Devon and Exeter NHS Foundation Trust
- Plymouth Diabetic Eye Screening Programme: Emis Care ltd
- Somerset Diabetic Eye Screening Programme: Somerset Partnership NHS Foundation Trust
- South Devon NHS Diabetic Eye Screening Programme: Torbay & South Devon NHS Foundation Trust
- Gloucestershire Diabetic Eye Screening Programme: Gloucestershire Hospitals NHS Foundation Trust

The 8th programme, which is not in scope as it has only very recently been procured covers the geography of Bath and North East Somerset, Swindon and Wiltshire. This programme is delivered by Emis Care Ltd.

All DESP programmes are currently commissioned by the NHS England Public Health Commissioning Team for the respective area. Changes to the historical NHS England South West and South Central geographies are underway but following discussion this

will not impact on the procurement. Representatives from both teams will be fully engaged in the procurement planning & scoring process.

Each of the programmes are summarised below.

Table 1:

| | Eligible population (31/03/17) | Uptake (Q4 16/17) | Annual contract value (17/18) | Cost per head of population | Cost per screen |
|---|---|---|---|---|---|
| Somerset Partnership | 33,000 | 90.9% | £692,508 | £20.99 | £23.09 |
| Bristol Community Health | 48,000 | 78.1% | £1,033,270 | £21.53 | £27.56 |
| Cornwall | 31,000 | 78.8% | £807,544 | £26.05 | £33.06 |
| Torbay (South Devon) | 17,000 | 87.1% | £471,611 | £27.74 | £31.85 |
| Royal Devon and Exeter (North East Devon) | 33,000 | 87.5% | £977,045 | £29.61 | £33.84 |
| Plymouth | 19,000 | 79.6% | £585,000 | £30.79 | £38.68 |
| Gloucestershire | 35,500 | 77.8% | £920,510 | £25.92 | £33.32 |

Of the seven programmes five are delivered predominantly through GP practices (Bristol, Cornwall, North East Devon, South Devon and Gloucestershire) with the remaining two using predominantly an optician or a combined optician / community hospital model. With pressures upon Primary Care facilities however all services across the South West are increasingly utilising community hospital facilities.

The programmes vary in size quite considerably with the Bristol programme for instance having a database which is more than double the size of the Plymouth programme and nearly two thirds larger than South Devon. There is also large variation in the cost per patient registered and per patient screened suggesting inequity in terms of the how programmes were historically funded although it should be noted that programmes have differing geographies and overheads and it is acknowledged that core operating costs still have to be met despite the population size meaning small programmes may appear to cost more. These factors however do not fully explain the variance in cost per head and cost per screen where the Somerset programme appears to cost the least and the Plymouth programme the most.

# 3 Performance

The purpose of nationally set key performance indicators is to define consistent performance measures for all screening programmes, so that performance can be understood, assessed and compared.

For diabetic eye screening the key performance indicators and quality standards for 2017/18 are summarised at http://diabeticeye.screening.nhs.uk/kpi and described below:

- DE1: Uptake of screening. Acceptable level: ≥ 75.0%; Achievable level: ≥ 85.0%
- DE2: Results issued within 3 weeks of routine screening, digital surveillance or slit lamp biomicroscopy. Acceptable level: ≥ 70.0%; Achievable level: ≥ 95.0%
- DE3: Timely consultation for R3 screen positive result (attending consultation within six weeks of attending screening event). Acceptable level: ≥ 80.0%

These KPI thresholds, in particular for DE1, were increased from those agreed in 16-17 to which the which the data below refers. DE1 being 70% acceptable and 80% achievable and DE3 was consultation from referral in 4 weeks 80% acceptable and in 2 weeks 95% achievable.

All providers in the south-west achieved above the "acceptable" threshold for DE1 & DE2 performance indicators in 2016/17 with most close to or equal to "achievable" performance levels. However there is significant variance across programmes particularly evident in KPI DES 1 (Diabetic eye – uptake of digital screening encounter) with between 77.8% and 90.9% being achieved and in KPI 3 (Diabetic Eye – Timely consultation for a screen positive result) where performance varies between 72.7% and 84.9%. When performance is considered against England and South of England the picture is mixed (Table 2).

Table 2: 2016/17 Annual performance against DES Key performance indicators

| | DE1 | DE2 | DE3 |
|---|---|---|---|
| England | **82.2** | **96.5** | **75.4** |
| South | **81.7** | **92.1** | **74.7** |
| Bristol and Weston Diabetic Eye Screening Programme | **78.1** | **94.6** | **83.1** |
| Cornwall Diabetic Eye Screening Programme | **78.8** | **99.8** | **84.9** |
| South Devon NHS Diabetic Eye Screening Programme | **87.1** | **95.2** | **89.2** |
| North and East Devon Diabetic Eye Screening Programme | **87.5** | **99.9** | **84.8** |
| Plymouth Diabetic Eye Screening Programme | **79.6** | **96.9** | **77.4** |
| Somerset Diabetic Eye Screening Programme | **90.9** | **99.6** | **72.7** |
| Gloucestershire Diabetic Eye Screening Programme | **77.8** | **99.7** | **84.0** |

In considering this data it should be noted that:

- Somerset data includes a small amount of data from the Mendip area. Up until Jan 31st 2017 this population was screened by the Royal United Hospital Bath and uptake lower than in the Somerset programme.
- DE3 performance in 2016-17 was more an indication of Hospital Eye Service performance and capacity than screening programme and can be impacted by small numbers.

# 4 Current and future issues

**Demand**
Work undertaken by the Yorkshire and Humber Public Health Observatory in estimating the number people with diabetes allows us to estimate the likely increase across the South West over the coming years. Across the local authorities within the South West more than 30,000 additional people are expected to have diabetes by 2020 and in the region of a further 50,000 by 2030. Not all of these people will be diagnosed and identified by GP practices and it is therefore difficult to extrapolate exactly how many extra patients will appear on each programme's diabetic registers. Despite these caveats the table below developed by local Public Health England colleagues in 2017 illustrates how the local programmes register might increase up until 2020 if the estimates prove correct.

Table 3: Anticipated eligible population increase by programme based on 16/17 actuals

| | Actual | Year | | | Average % Increase |
|---|---|---|---|---|---|
| **Programme** | **16/17** | **17/18** | **18/19** | **19/20** | |
| **Bristol** | 41008 | 44772 | 45766 | 46781 | 2.2% |
| **Cornwall** | 27921 | 30147 | 30731 | 31326 | 1.9% |
| **North and East Devon** | 29753 | 32233 | 32884 | 33549 | 2.0% |
| **Plymouth** | 16666 | 17822 | 18124 | 18430 | 1.7% |
| **Somerset** | 25684 | 27929 | 28520 | 29124 | 2.1% |
| **South Devon** | 15144 | 16345 | 16660 | 16981 | 1.9% |
| **Total** | 179425 | 194387 | 198323 | 202340 | 2.0% |

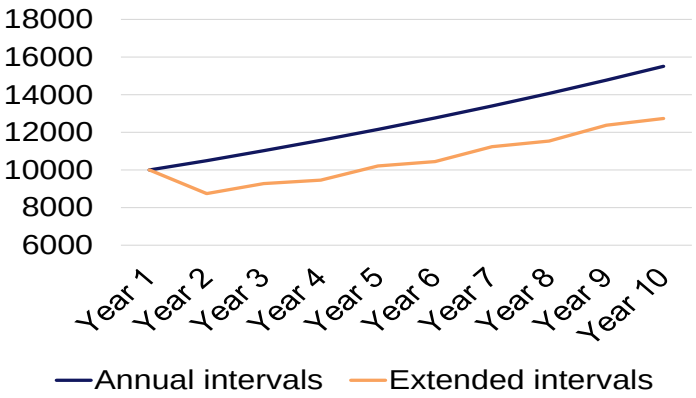
Figures for Gloucestershire are awaited but not anticipated to be significantly different. The eligible population in 16/17 being 35,265.

Overall we would expect to see an increase of around 2.0% if the national estimates prove correct although local providers are currently reporting up to 6% increase in demand for screening. The increase may however in part relate to data validation issues and differences in how proactively the eligible population is identified. Population wise, there will be slight variation across the programmes owing to a number of factors including ethnicity and deprivation.

**National changes**
Growing numbers of people being diagnosed with diabetes presents potential capacity issues for DESP programmes however; this may in part be addressed in the short term by proposed national changes to screening frequency. Evidence has identified that annual screening is not required and not cost effective for all thus some stable patients going forwards will only be seen every two years. New software requirements are to be imminently specified by NHS England which will support the schedule changes. This software is necessary before any change to the pathway occurs and is likely to be implemented in stages.

It is anticipated that reducing the frequency of screens could initially reduce activity by 25-30% in the first years however, as the number of people with diabetes increases the activity gap will steadily reduce. The initial reduction may pose sustainability risks for programmes with smaller populations.

Graph 1: Impact of reducing frequency of screens over 10 years




| Assumptions | |
|---|---|
| 10 000 | Patients screened in year 1 |
| 35% | Eligible for extended interval screening (move to 2 yearly screening following 2 x R0M0 grades) |
| 5% | Increase in screening per year (population growth) |

**Engagement with Primary Care**

Owing to competing priorities and often building capacity, the engagement with and support from individual GP Practices for this programme varies both within local programmes and across the wider geography. Specific diabetic eye screening indicators have been removed from the GP contract thus the approach to DESP now varies especially with regard list validation - some practices taking a very proactive approach others less frequent.

**Engagement with Hospital Eye services**

Robust processes and engagement with Hospitals Eye Services is a critical factor for the DESP programme to ensure patients receive a smooth and seamless pathway of care. The effectiveness of this pathway varies across the geography often due to practitioners being unable to access different IT systems thus alignment to STP / CCG/ Accountable care system planning for Hospital Eye Services is of key consideration within this procurement.

**Clinical Leadership**

Whilst now not an issue locally, on occasions in the past there have been difficulties recruiting and retaining clinical leads for the programme.

**EU Procurement Regulations**

In 2015 changes to the European Union procurement regulations were introduced which altered the way public bodies could offer contracts to their Providers. Acute trusts, that had once been awarded contracts on a rolling basis, were no longer to be guaranteed these contracts should other interested parties wish to compete for them. In addition the 2017 Standing Financial Instructions changed the discretionary ability of Commissioners to award contracts on a one year rolling basis and to provide surety of business for Trusts, contracts were to be awarded on at least a two year basis.

**Large scale Innovation**

Providers currently only have a two year contract which makes it difficult for them to plan and implement large scale service improvements. Longer term contracts would offer greater security for the providers and would eliminate the need for extensive contract negotiations every two years. Economies of scale from larger delivery footprints, single instances of DESP IT platforms, fewer providers to performance manage, service continuity for patients and other stakeholders may be achieved.

# 5 Options for future service configuration

The table below identifies a range of options to be considered when considering the procurement of the Diabetic Eye Screening Programme. Those shaded out are considered to be discountable owing to the reasons given.

| Option | Description | Advantages | Disadvantages |
|---|---|---|---|
| 1 | **Do nothing** | Owing to advice from the procurement team on legal responsibilities, the requirement for NHS England to treat providers equitably and not roll over contracts plus the fact the Plymouth contract ends in March 2019 without the option of extension this option should be discounted | |
| 2 | **New NHS England South West South management geography only** – BNSSG / Gloucestershire procured separately to rest of the old South West. | Dorset and BSW have recently been procured and BNSSG and Gloucestershire would be left stranded. South West (North) recommendation is to include BNSSG and Gloucestershire in South West South procurement process to achieve economies of scale in the procurement process and management. | |
| 3 | **One single procurement lot encompassing the full BNSSSG, DCIOS and Gloucestershire geography** | Owing to the scale of the geography, eligible population size ( >200,000), changes to the NHS England commissioning footprints, the ability to effectively communicate with multiple accountable care systems / STPs / CCGs as well as individual Hospital Eye Services and GP practices this option is felt unviable and potentially pose too many risks to the effectiveness of the programme. | |
| 4 | **Existing geographical responsibilities**<br><br>7 lots - BNSSG, Somerset, Devon, Torbay, Plymouth, Cornwall, Gloucestershire | • Negates any uncertainty for staff around future geography<br>• Maintains existing stakeholder relationships and processes. | • Does not address identified issues within services i.e. sustainability and resilience risks for small programmes due to changes to screening frequency and impact of sickness on small team sizes,<br>• Risks continuation of geographical variances<br>• Does not consider the impact of changes to screening incidence.<br>• Multiple contracts to manage.<br>• Small programmes within large Trusts are at risk of being less visible than larger high profile services. |

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| | | | • Considerable disruption & capacity requirements with minimal gain. |
| 5 | **Historical geographical planning footprints**<br><br>4 lots – BNSSG, Somerset, Peninsula, Gloucestershire | • Opportunity to scale up provision in peninsula for continuity, achieve economies of scale & quality but could maintain requirement within contract for there to be distinct locality approach based on CCG / LA footprints<br>• Opportunity to address performance, provide a fairer distribution of funds relative to programme size, address growing diabetic population & programme changes and sustainability.<br>• Programmes will be compliant with the national specification and common pathway.<br>• Reduced number of programmes to manage and inspect enabling greater focus on driving quality and consistency.<br>• Larger workforce numbers within individual providers enabling greater resilience and priority.<br>• Reduced number of clinical leads required across geography.<br>• Good alignment to STP footprints – Devon & Cornwall already looking at some work together.<br>• Negates boundary issues/ confusion for ongoing treatment in hospital eye services<br>• Continuity of approach, processes and development across the geography | • Uncertainty for staff regarding where services may be based<br>• Programme in peninsula risks lack of local focus unless specified in contract<br>• Peninsula programme would have c90,000 eligible population – nearly double BNSSG & 3 times larger than Somerset. Risk this creates ongoing differences and could be too large to be efficient.<br>• More complicated mobilisation requiring considerable oversight and capacity.<br>• Risks around ability of large programmes to respond effectively over large geographical footprints would require close oversight |
| 6 | **STP model**<br><br>5 lots - BNSSG, Devon, Cornwall, Somerset, Gloucestershire | • Enables full alignment with new planning footprints and opportunities to streamline eye & diabetic care pathways<br>• Opportunity to scale up provision in Devon for continuity, economies of scale & quality but could maintain requirement for there to be distinct locality approach | • Uncertainty for staff regarding where services may be based in Devon<br>• Does not address potential boundary issues with Cornwall patients / Plymouth Hospital Eye Services<br>• Does not fully exploit potential efficiencies of scale & consistent processes achievable in larger programmes. |

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| | | • Opportunity to address performance, provide a fairer distribution of funds relative to programme size, address growing diabetic population & programme changes plus sustainability.<br>• Programmes will be compliant with the national specification and common pathway.<br>• Reduced number of programmes to manage enabling greater focus on driving quality.<br>• Greater alignment of programme size – Devon would be largest with c65,000.<br>• Larger combined workforce in Devon enabling greater resilience and priority.<br>• Reduced number of clinical leads required in Devon /Torbay<br>• Continuity of approach, processes and development across the geography | |
| 7 | **CCG based model**<br><br>8 lots - Bristol, South Glouc, Nth Somerset, Somerset, New Devon, South Devon & Torbay, Cornwall & IOS, Gloucestershire | • Enables full alignment with CCG planning footprints and opportunities to streamline eye & diabetic care pathways at a local level<br>• Distinct & visible locality approach<br>• Programmes will be compliant with the national specification and common pathway.<br>• Consistent expectations driving quality & performance.<br>• Reduces uncertainty for staff about geographies apart from in Plymouth / Exeter | • Multiple programmes to manage and inspect<br>• Increases identified resilience and sustainability issues within services by there being more “small” programmes with potential populations less than 15,000<br>• Would split existing single service in BNSSG so may not be appropriate or a backward step for this geography.<br>• Considerable disruption and capacity requirements for minimal gain<br>• Risks continuation of geographical variances<br>• Does not release economies of scale<br>• Increases risk of geographical variances through there being more programmes |

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| 8 | **Local Authority based**<br><br>10 lots - Bristol, South Glouc, Nth Somerset, Somerset, Devon, Plymouth, Torbay, Cornwall, IOS, Gloucestershire | • Enables full alignment with LA Public Health planning footprints<br>• Distinct & visible locality approach<br>• Programmes will be compliant with the national specification and common pathway.<br>• Consistent expectations driving quality & performance.<br>• Reduces uncertainty for staff about geographies | • Multiple programmes to manage and inspect<br>• Increases identified resilience and sustainability issues within services by there being more "small" programmes with potential populations less than 15,000<br>• Would split existing single service in BNSSG so may not be appropriate or considered a significant backward step for this geography.<br>• Considerable disruption and capacity requirements for minimal gain<br>• Risks continuation of geographical variances<br>• Does not release economies of scale<br>• Increases risk of geographical variances through there being more programmes |
| 9 | **South West (North) / South West Peninsula Model**<br><br>2 lots – BNSSGG and Peninsula/Somerset | • Opportunity to scale up provision in peninsula for continuity, economies of scale & quality but could maintain requirement within contract for there to be distinct locality approach based on CCG / LA footprints<br>• Opportunity to address performance provide a fairer distribution of funds relative to programme size, address growing diabetic population & programme changes and sustainability.<br>• Programmes will be compliant with the national specification and common pathway.<br>• Reduced number of programmes to manage enabling greater focus on driving quality.<br>• Larger workforce numbers within individual providers potentially enabling greater resilience<br>• Reduced number of clinical leads required across geography. Negates boundary issues/ confusion for ongoing treatment in hospital eye services<br>• Continuity of approach, processes and development across the geography | • Uncertainty for staff regarding where services may be based<br>• Programmes risks lack of local focus and adversely impacts upon local stakeholder relationships / communication unless specified in contract<br>• SW Peninsula programme would have c115,000 eligible population – nearly three times larger than BNSSG. Risk this creates ongoing differences and is so large it's unwieldy.<br>• More complicated mobilisation requiring considerable oversight and capacity. |

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| 10 | **Hospital patient flow model**<br><br>5 lots - BNSSG, Somerset, Cornwall & Plymouth, Devon & Torbay, Gloucestershire | • Follows where the majority of patients access Hospital eye care services thus negates the majority of potential boundary issues (i.e. some Somerset patients may still access Bath services).<br>• Opportunity to scale up for continuity, economies of scale & quality but could maintain requirement within contract for there to be distinct locality approach based on CCG / LA footprints<br>• Greater equity in programme size with all but Somerset having an eligible population c45,000.<br>• Opportunity to address performance, provide a fairer distribution of funds relative to programme size, and address growing diabetic population, changes to programme and sustainability.<br>• Programmes will be compliant with the national specification and common pathway.<br>• Reduced number of programmes to manage enabling greater focus on driving quality.<br>• Larger workforce numbers within individual providers potentially enabling greater resilience.<br>• Reduced number of clinical leads required across geography. | • Does not fully exploit potential efficiencies of scale & consistent processes achievable in larger programmes.<br>• Does not match STP or New Devon planning footprints which could create confusion / differences across boundaries<br>• Uncertainty for staff regarding bases |
| 11 | **Mixed Model 1 –** 2 lots – BNSSGG/Somerset and Peninsula. | • Opportunity to scale up provision for continuity, economies of scale & quality but could maintain requirement within contract for there to be distinct locality approach based on CCG / LA footprints<br>• Opportunity to address variance in performance, provide a fairer distribution of funds relative to programme size, address growing diabetic population, programme changes and sustainability.<br>• Programmes will be compliant with the national specification and common pathway.<br>• Reduced number of programmes to manage enabling greater focus on driving quality. | • Uncertainty for staff regarding where services may be based<br>• Programmes risks lack of local focus and adversely impacts upon local stakeholder relationships / communication unless specified in contract<br>• Risk this creates too large, unwieldy programmes.<br>• More complicated mobilisation requiring considerable oversight and capacity. |

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| | | • Larger workforce numbers within individual providers potentially enabling greater resilience<br>• Reduced number of clinical leads required across geography.<br>• Negates boundary issues/ confusion for ongoing treatment in hospital eye services<br>• Continuity of approach, processes and development across the geography | |
| 12 | **Mixed Model 2 –** 3 lots – Gloucestershire, Peninsula, BNSSG/ Somerset | • As per option 11 above with exception that Gloucestershire remains a standalone geography. | • As per option 11 above |
| 13 | **Plymouth only** | Procurement guidance and legislation requires us to be fair and transparent treating all providers in a consistent manner. | |
| 14 | **Small Programmes only** (Plymouth / Torbay) | Procurement guidance and legislation requires us to be fair and transparent treating all providers in a consistent manner. | |

As we have done in other recent procurements and should this be appropriate to the delivery of the programme, we have the opportunity to procure a larger contract covering a wide geographical area but within this, via the terms and conditions, require the provider to deliver services and reporting by distinct specified geographical footprints i.e CCGs or STPs. This potentially enables greater continuity of approach & economies of scale to be realised whilst retaining a local relationship and approach in specified geographies but needs careful consideration to ensure it meets the needs of the programme and patient pathway.

# 6 Summary

The NHS Diabetic Eye Screening Programme (NDESP) is a preventative national programme which aims to reduce the risk of sight loss among people with diabetes by the early detection and treatment, if needed, of sight-threatening retinopathy. Screening is delivered locally in line with national quality standards and protocols. Owing to the way local services have historically developed, considerable variances are evident in tariff, models of delivery and eligible population sizes. With existing contracts all coming to an end on March 31st 2019, changes to procurement legislation and changes to the national DESP programme there is a need for NHS England to procure local services. A range of options exist for future service configuration which require consultation.