Direct referral to Ophthalmology, Improving the Urology Patient Pathway and more…

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In the beginning…

The pressures on primary care in the UK are well documented, with an increase in patient contacts of 66% in the decade from 2003/4 to 2013/14 (BMA, 2015). The recent General Practice Forward View, aiming to reduce GP workload and improve patient care, highlighted the need to avoid inappropriate secondary care workload shift and ensure GPs are involved in the activities that require their expertise (GPFV, 2016).

The aim of the project was to look at an area where the GP potentially had unnecessary involvement in a patient pathway and look at ways to change this, implementing these changes if possible. In this case, referral of patients to ophthalmology from the optometrist, via the GP and then onwards to the ophthalmologist was seen as not improving patient care and increasing GP workload. The intended outcome was that referrals would be sent directly from the optometrist to the ophthalmologist.

Data was collected regarding the number of ophthalmology referrals made, those which were seen by the optometrist requesting referral and the time taken in practice to make the referral. The possibility of changing the process was then discussed with the head of the clinical commissioning group and ophthalmologists. Sadly there was not agreement about direct referral, despite the benefits shown, meaning it was not possible to achieve the aim of direct referral.

Outcome:

Whilst a change to direct referral was not possible, some of the GP time was able to be reduced by a process in practice to allow onward referral with a standard letter for those optometrist referrals received.

Next Steps…

Discussion with the local Clinical Commissioning Group as to areas that I may be able to focus upon, revealed a concern regarding the Urology Patient Pathway. Data was collected in the practice, of all urological referrals over a one month period, looking at the timings of referrals, the number of letters received and investigations during the patient journey. Contact was made with the hospital urology team and informal patient and colleague discussion held. Using the displayed driver diagram, further data to collect and analyse was discussed.

Outcome

Despite initial enthusiasm for on going collaboration, my hospital colleagues completely disengaged from further contact and the project stalled. Using the audit data in practice we were able to identify a possible concern with 'urgent' referral letters and agree a change to avoid missed patient results.

What went wrong?

1. The Experience:

I attempted to identify an area of practice that could be improved to better the patient experience for those involved in the process and those who would benefit from the increased GP availability. I had difficulty in finding supportive input to make a change.

2. Reflection, how did I feel?

Frustrated! I identified processes that colleagues and patients found to be poor, yet could not gain support to make a change.

Disappointed. I could see areas that a real difference could be made, but also could see others who felt 'too busy' to get involved.

3. Evaluation

What was good? Despite limited progress, both of my abortive quality improvement projects still resulted in change and positive actions, both in the change in the practice ophthalmology referral process with a rapid onward letter and in identifiying a potential for missing results in the practice regarding urology and other important test results

What was bad? The lack of progress and disappointing struggle to gain input and momentum with colleagues.

4. Conclusions

Driving change is vital to improve patient care, but as a individual without a clear mandate of buy in within a local group, it can be difficult to drive change.

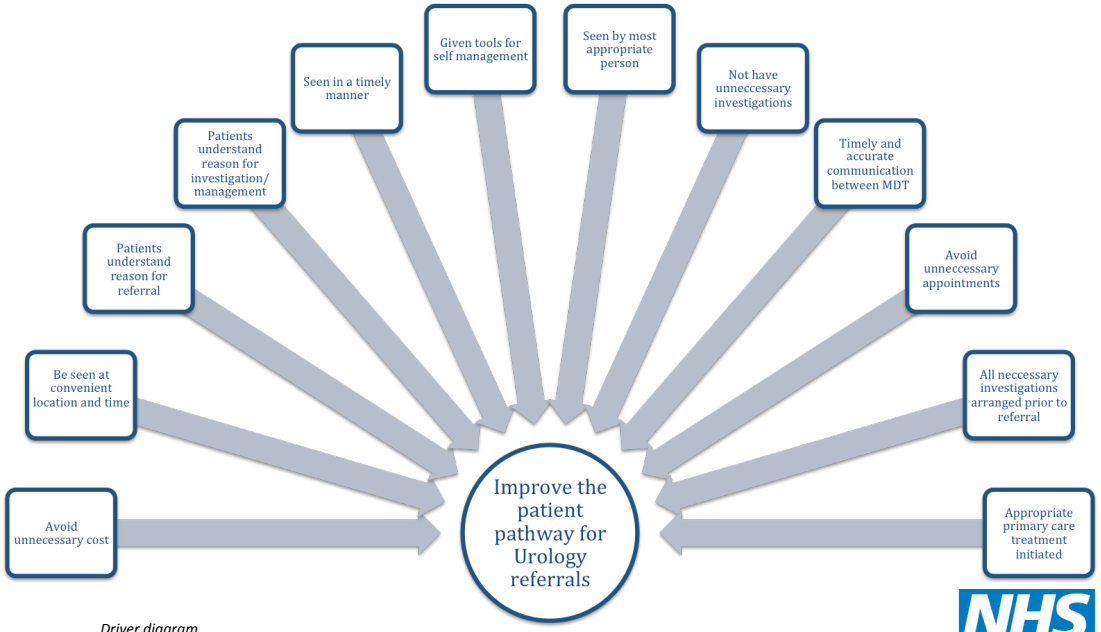
The pressure of time and targets can limit innovation.

5. The Future, what next?

I am keen to continue improving quality of patient care.

Start small – ideas and small changes may lead to bigger changes

Learn – I have learnt significantly about the challenges of quality improvement and driving change.



Driver diagram

NHS

Health Education England