Bridging the gap – Supporting our patients across the primary / secondary care divide

BY JANET POOLEY

Providing the best care for patients is surely a fundamental goal for all healthcare professionals. When waiting-times are long and getting longer, clinics are full, colleagues are off with stress-related illness and patients are complaining, is it possible to still provide the 'best' care to patients? At what point does this fundamental goal become impossible, an unachievable goal, or something that requires rationing, a goal achievable for just some patients?

The Royal College of Ophthalmologists commissioned 'The Way Forward' in response to the growing demand for ophthalmology services, a demand that is struggling to be met by the present workforce [1]. The documents illustrate some models of excellent care that are being provided around the country and highlight some of the changes that have been tried and that have been less successful. Clearly, fundamental changes need to be made; in the next 25 years those over 65 years are set to increase by 50%, and the number of people in the UK over 90 years of age is likely to triple. With older patients being the highest users of ophthalmology services, action is required to ensure that patients receive the care that they have rightly come to expect.

Accessing ophthalmology services

Traditionally, the gatekeeper role of the GP has been fundamental to how the NHS in the UK functions. This role has, for many years, been an effective way of appropriating patient care across the hospital sector. However, GP services are under huge pressure [2] and whilst UK GP workforce numbers have increased in the last five years, a heavier workload and an increasing complexity and intensity of work have led to a feeling of crisis.

In eyecare, it is optometrists who refer many of the patients. Whilst traditionally this has been via the patient's GP, this function has long been simply an administrative role for general practice [3]. Optometry referrals are finally being directed straight to the hospital eye service in many parts of the UK [4]. Indeed, in some of the home nations, the GP is no longer seeing patients with ophthalmic problems at all, triaging them directly to optometry for appropriate assessment.

Concerns about direct referral from optometry have often focused on the lack of the patient's medical records. Where general health and systemic medication details are required, various solutions have been developed, including: access to patient's out-of-hours summary records, patient held records and automated e-requests to GPs for the required information.

Seventy-five percent of optometry referrals in Scotland are now electronic and Northern Ireland has an on-line system in place to make e-referrals in many areas. With secure network connections, the advantages of an electronic referral are clear and allow not only swift referral and rapid triage, but also the potential for photographs and test results to be attached. It cannot be acceptable for such assessment material not to be easily available to ophthalmology when making decisions about appointment allocation. Indeed, even if the decision is made to repeat assessments at the patient's first appointment, historical data supports decision-making about on-going care.

NHSmail is also widely used to send patient information securely. It is approved by the Department of Health for sharing patient identifiable and sensitive information. Optometry practices, like the other contractor services, are also approved to use NHSmail. NHS Grampian in the north of Scotland has been using NHSmail for many years, especially for consultant advice. Such support has enabled community optometrists to manage many more patients within the community with confidence [5]. Requiring close working relationships to establish such a system was vital and credit must be given to colleagues who worked hard over many years to put pathways and procedures in place. The result is a very impressive eyecare network, enabling patients to be cared for locally, and treatments started without delay, whilst only those most in need are referred to the hospital.

Making appropriate referrals

If the optometrist is acting as the gatekeeper, these professionals have a duty to refer only patients that require hospital care. Many patients with non-sight threatening conditions can safely and effectively be cared for within the community. Where appropriate, it is important that optometrists also have open conversations with their patients about when referral is required. This could well be when considering the right time to refer for cataract surgery, for example. Informed conversations at the outset and the requirement to act in the patient's best interests are important to support the best possible patient centred care [6,7].

Good evidence-based guidance is also fundamental to supporting appropriate referral and community patient management. In Scotland, for example, the Glaucoma Referral and Safe Discharge guidance was developed [8]. The guidance supports optometrists in assessing their patients for glaucoma and allows them to confidently retain patients within the community for continued follow-up.

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Referral feedback

Eyecare professionals need more than ever before to work together to care for patients. Referral feedback is vital to the ongoing care of the patient and it is this type of communication that is so important [9]. Regardless of who takes on the management of the patient, or what the outcome of the referral, patients will go back to their optometrist for their routine eye test at some time in the future. Knowing the outcome of the referral allows the optometrist to support the ongoing care, e.g. ensuring drug compliance, making appropriate spectacle prescribing decisions and preventing unnecessary re-referral. It can also help the optometrist to answer questions that the patient may have about their eye conditions. Questions that they forgot to ask at the hospital.

Patient consent to permit the referring optometrist to receive feedback is clearly important. The patient will already have previously consented to the optometrist making the initial referral; optometrists, as with other healthcare professionals, are required to gain patient consent to make any referral, even to the patient's GP. Most patients expect their optometrists, like their GP, to have heard back about the outcome of any referral.

Referral feedback has wider implications than just for the care of an individual patient. It is possibly the best CPD any community optometrist can receive. Consider working in an environment where your referrals are consistently incorrect but you are unaware that there is a problem. How can you ever improve? Consistent feedback would allow optometrists to continually monitor their own performance and allow them to make improved referral decisions in the future.

Improving the quality of referrals

False positive referrals overburden the system and increase waiting times for patients with real need. This may be obvious to those working in secondary care, but is not widely understood in optometry. Community optometrists often work alone and lack the professional support of their peers to develop their decision-making skills. Unlike in a hospital setting where a colleague will be in the clinic next door for a quick chat, the optometrist is often isolated. Optometrists who are consistently over-referring are putting patients at risk and require additional training and support. Such 1:1 support for practitioners is available in Scotland if identified, but elsewhere in the UK this support is patchy.

The profession has been slow to recognise career development with flat career structures and no regulatory drive to develop beyond the competence of a newly qualified practitioner. Indeed, a requirement only to maintain and not develop competence is all that is required by the regulator. If optometry is going to be there to support ophthalmology, the CPD which many do undertake should be acknowledged and encouraged, not least to drive safe professional practice.

If patient numbers within the hospital eye service are not to become overwhelming, decisions need to be made to rapidly discharge patients who should not have been referred in in the first place. A drive to improve the referrals will help, but only patients who require a hospital service should remain within the hospital setting.

The future

Whilst fundamental change is inevitably required across the service, there are things that all practitioners can do immediately to deliver a better-quality of service. Making small changes can often have much bigger implications than might be imagined. Colleagues working effectively across primary and secondary care sectors will support patients; it's what patients expect and something that we all have a duty to deliver.

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