Providing palliative care in primary care: how satisfied are GPs and district nurses with current out-of-hours arrangements?

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SUMMARY

The complex needs of palliative care patients require an informed, expert, and swift response from out-of-hours general medical services, particularly if hospital admission is to be avoided. Few general practitioners (GPs) reported routinely handing over information on their palliative care patients, particularly to GP co-operatives. District nurses and inner-city GPs were least satisfied with aspects of out-of-hours care. Most responders wanted 24-hour availability of specialist palliative care. This indicates a need to develop and evaluate out-of-hours palliative care procedures and protocols, particularly for GP co-operatives, and to improve inter-agency collaboration.

Keywords: palliative care; out-of-hours; district nurse; general practitioner.

Introduction

MOST of the last year of a palliative care patient's life is spent at home under the care of the general practitioner (GP) and district nurse (DN) and although that is where many wish to die, few do so.[1] Inadequate symptom control is an important cause of hospital admission. Out-of-hours specialist palliative care support varies in extent and availability and is generally only accessible to registered patients.[2]

The GP or DN are often the first contact for patients and carers but the shift towards GP co-operatives has reduced the time 'on call' for individual GPs; this has led to reports of a lack of continuity of care where patient information is unavailable.[3] While palliative care may comprise a small percentage (2.4%) of overall contacts, deterioration in a patient's condition may require a lengthy, urgent, and complex response.[3] DN evening and night services vary in provision and there are concerns about a lack of night services.[4]

As part of an evaluation of the Macmillan Cancer Relief GP Palliative Care Facilitator Programme we present the results of a survey of out-of-hours palliative care provision from a study of GPs and DNs in eight health authority districts. Eleven hospice services were used by responders providing combinations of day, inpatient, and community care; of these, 10 provided 24-hour advice and/or support.

Method

Semi-structured postal questionnaires were sent to 715 GP principals and 317 DNs (identified by Community Trusts) in two inner-London districts and to North West Wiltshire, Swindon, Cheltenham, Gloucester, Forest of Dean, and Cotswolds Health Authority districts. Quantitative data were analysed using SPSSpc and open-ended questions were analysed thematically.

Results

The response rate for GPs was 68.3% (488/715) and for DNs 64.4% (204/317). The mean age for both GPs and DNs was 43 years and 35.2% of GPs and 97.5% of DNs were female. Three hundred and forty-seven (71.1%) GPs used a co-operative, 95 (19.5%) used practice-based arrangements, and 25 (5.1%) used a deputising service. Most DNs (85.0% [153/204]) said they had an evening nursing service but only 85 (47.5%) reported some form of night service.

Three-quarters (304/397) of GPs said that they personally provided palliative care out of hours at least sometimes in the last weeks of life, but 93 (23.4%) indicated that they handed care over entirely to GP out-of-hours organisations. There was a greater trend for practice-based GPs (30.8% [24/78]) than GPs in co-operatives (17.0% [48/283]) in reporting routinely passing on information to their organisation ($\chi^2 = 7.315$, d.f. = 2, $P = 0.026$), although 54.7% (256/468) of all responders reported sometimes doing so.

Most GPs were satisfied with the palliative care provided by their out-of-hours organisation (Table 1), although few were very satisfied. Satisfaction was less (67.3% [72/107]) for inner-London GPs than urban and rural GPs (85.4% [316/370], $\chi^2 = 18.32$, d.f. = 2, $P<0.001$) with concerns about continuity of care. DNs reported less satisfaction with GP arrangements. Analysis of DN comments concerning out-of-hours GPs indicates dissatisfaction with the quality of some advice, a reluctance to visit, and difficulties in obtaining medication. GPs were less satisfied when caring for unknown patients, and GPs and DNs both criticised the limited availability of district night-nursing services. One hundred and fifty-two (80.0%) DNs and 205 (59.8%) GPs wanted 24-hour access to specialist palliative care teams.

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Table 1. GP and DN satisfaction with out-of-hours services.

	Very satisfied (%)	Satisfied (%)	Neutral (%)	Dissatisfied (%)	Very dissatisfied (%)	n	z	P
GP out-of-hours arrangements								
GP satisfaction	16.1 (77)	65.2 (311)	15.5 (74)	2.9 (14)	0.2 (1)	477	-3.385[a]	<0.001
DN satisfaction	17.9 (35)	45.4 (89)	24.5 (48)	10.2 (20)	2.0 (4)	196		
GP satisfaction with providing palliative care to their own patients	8.9 (33)	69.6 (257)	18.2 (67)	3.0 (11)	0.3 (1)	369	–	–
GP satisfaction with providing palliative care to unknown patients	6.5 (21)	48.1 (156)	34.9 (113)	9.9 (32)	0.6 (2)	324	-7.117[b]	<0.001
Nursing services								
Evening								
DN satisfaction	38.6 (76)	43.7 (86)	10.7 (21)	6.6 (13)	0.5 (1)	197	-2.339[a]	0.019
GP satisfaction	25.5 (109)	56.8 (243)	12.9 (55)	4.4 (19)	0.5 (2)	428		
Night								
DN satisfaction	29.9 (55)	41.3 (76)	11.4 (21)	11.4 (21)	6.0 (11)	184	-9.4[a]	0.052
GP satisfaction	18.8 (79)	46.1 (194)	23.3 (98)	10.2 (43)	1.7 (7)	421		

[a]Mann–Whitney U test, corrected for ties; [b]Wilcoxon signed ranks test.

Discussion

Our results do not represent GPs using deputising services and may not be nationally representative, but may well reflect the views of GPs and DNs in similar geographical areas.

Although generally satisfied with current arrangements, many GPs continue to provide some of their own palliative care out of hours and indicate some concerns. Our results confirm that information handover can be inadequate.[3] Satisfaction was less within inner-city areas and this is an area requiring further research.

General practice co-operatives are well placed to improve continuity in palliative care. There is limited evidence that this is happening, although guidelines published by The National Association of GP Co-operatives stipulate that such patients should receive home visits.[5] Suggested developments include protocols for GP co-operatives to ensure the adequate handover of patient information, arrangements to gain easy access to necessary drugs, training in palliative care,[6] and patient-held records. However, all of these will require evaluation and audit to ensure quality of care and this could be a role for clinical governance with primary care groups.

There is demand for more district night-nursing and specialist services and the potential remit of specialist palliative care services could be explored, together with the impact of NHS Direct. Given the extent of palliative care provided at home and the preference for death at home, it is important to ensure that these issues are speedily addressed to meet the needs and preferences of this very vulnerable group of patients.

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