

DEEP END SUMMARY 15

Palliative care in the deep end

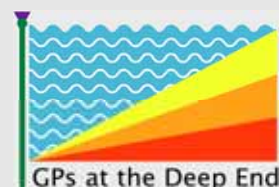
15 practitioners, from general practice, community nursing and specialist palliative care met on Tuesday 22 February 2011 in the Academic Unit of General Practice and Primary Care at the University of Glasgow for a roundtable discussion and review of the challenges of delivering palliative care in severely deprived areas.

- The essential key to delivering effective palliative care in the community is the trust established between district nurses and general practitioners, who know each other well, understand each other's roles and can contact each other quickly as the need arises.
- Neither the GP, nor the district nurse on her own, are "enough". GPs feel that district nurses are central to palliative care and fear the loss of attached district nurses more than any other staff.
- The work of palliative care in the community is increasing, but staff are not being replaced as they leave or retire, putting greater pressure on the remaining staff. No new district nurses have been trained in the last year.
- The group considered that all GPs should be active in palliative care, meeting patient and family expectations, and sharing the work of palliative care within the practice. A "GP who doesn't visit" was considered by district nurses to be a huge obstacle to providing high quality care ("Like having our hands tied behind our back").
- Effective joint working needs an "open door policy" whereby district nurses can always access the relevant GP when necessary.
- The over-riding problem for GPs is pressure of work and lack of time so that it may sometimes be impossible to visit a patient at home.
- It is reassuring for patients to know and see that the district nurse and GP are communicating with each other. The sooner the team is involved the better, establishing initial contact and relationships before urgent needs take over. "Reassurance" is less effective without a prior relationship.
- The trust and confidence of patients and their families in the palliative care team arises from successive positive experiences of teamwork in action.
- Palliative care for non-malignant conditions is much harder to arrange than palliative care for cancer, where the starting point and agenda are more easily understood and addressed.
- The group anticipate an increase in the need for palliative care for non-malignant conditions, especially as deaths increase from alcoholic liver disease.
- Hospices tend to have substantial expertise and resources, especially for palliative care of cancer, and a key issue is how these could be better deployed in supporting community care.
- Specialist nurses are valued, but can de-skill existing teams and interfere with their relationships with patients. Building up good relationships between general practice and outreach staff takes time.
- Families in very deprived areas are less demanding, often not knowing what is available (including financial help). They also have fewer skills in accessing professionals and may also have fewer resources, such as reliable telephones and cars.
- There is a culture of expecting the patient's "own GP" to visit.

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- At the end of palliative care, the patient's home can be "like Piccadilly Circus" as a result of the number of professionals visiting to provide specific components of care. In general, the smaller the number of professionals involved in providing continuity of care the better.
- Social work was not represented at the meeting, despite invitations. It was noted that social work has no sub-speciality expertise in palliative care.
- It was said that community carers and their managers "don't understand what district nurses do" in assessing clinical aspects of care, and tend to withdraw as the end of life draws near. It was felt that community carers could be a very important part of the caring team, but that district nurses are best placed to lead the team.
- Current GP contractual arrangements supporting palliative care include "essential services", a Designated Enhanced Service (DES) and part of the Quality and Outcomes Framework.
- Minimum elements of care are inclusion on a register (so that care can be planned and reviewed), minuted regular multi-professional meetings and the availability and passage of relevant information for use out of hours.
- The DES is considered "too much a data collection exercise" and sometimes out of touch with the needs of the service at ground level, where flexibility and discretion are part of the art of tailoring care to individual needs.
- GPs described how it was sometimes "better not to put some patients on the palliative care list", because of the bureaucratic implications.
- The previous Gold Standard Framework had involved 80% of practices, without reward or incentives, but had been "torpedoed" by the DES.

"General Practitioners at the Deep End" work in 100 general practices, serving the most socio-economically deprived populations in Scotland. The activities of the group are supported by the Royal College of General Practitioners (Scotland), the Scottish Government Health Department, the Glasgow Centre for Population Health, and the Academic Unit of General Practice & Primary Care at the University of Glasgow.



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Full report available at <http://www.gla.ac.uk/departments/generalpracticeprimarycare/deepend>