Improving Communication Between GPs and ‘Out of Hours’ Teams in Terminally Ill Patients

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Senior Registrar Presentation
Project Idea – Palliative Care

- Time spent between General Practice (Claremont Surgery) and the Thames Valley Hospice.
- Time spent with Rosemary Martin – Palliative Care lead in the PCT (Community palliative care).
- Project with the East Berkshire Out of Hours team – improving communication.
Aims and Objectives

- To become efficient at symptom control – controlled drugs, adjuvant treatments.
- Knowledge of local resources.
- Treating terminal patients from an holistic approach.
- Improve communication therefore benefiting the patient and the PCT.
- Develop team working and change management skills.
Hospice Component

- Dr Robert Shaw – Medical Director.
- 2 days a week
- In-patient care – symptom control, holistic approach.
- Day-patients – transfusions, pamidronate.
- Alternative therapies
- Multi-disciplinary meetings
- GPwSI role at Wexham Park Hospital.
‘Improving communication between GP’s and ‘Out of Hours’ teams in terminally ill patients.’

- Sandy Davis – Clinical Governance lead.
- Pilot project – based in Wokingham.
- Use skills from the hospice to determine which aspects are most important.
GP Component

- Claremont Surgery, Maidenhead.
- 2 days.
- Routine surgeries and ‘urgent’ clinics.
- Palliative care meetings – new QOF area.
- Practice management.
- Chronic disease management – QOF lead.
Rationale

- Personal eg OOH experience, training.
- Shipman – controlled drugs.

- National Level
  - At home unlikely to receive OOH care from Dr they know. Therefore good communication essential.
  - Cancer care – National Service Framework.
  - NHS Cancer Plan.
  - NICE Guideline 2004
NICE Guideline

- Each Multidisciplinary team or service should implement processes to ensure effective inter-professional communication with teams and between them and other service providers with whom the patient has contact. Methods should be developed to promote continuity of care.
White Paper 2006 – Community Care

(Only 20% achieve wish of dying at home)

BJGP 2006 – qualitative study. Lack of knowledge and time constraints leads to hospital admissions.

Local Level:

- Palliative care PCT priority.
- Pilot scheme with OOH
Personal Implications

- Knowledge of symptom control, alternative therapies and local resources.
- More confidence in using controlled drugs.
- More knowledge Practice Management.
- Chronic disease management.
- Enhance team-working and leadership skills.
- Future – dip pall med, GPwSI
Implications for PCT

- Improve communication.
- Less hospital admissions.
- Money saved.
- More patient/family satisfaction.
- Better use of local resources eg hospice day unit.
- Future role working with PCT on palliative care issues.
Implications for NHS

- Meets White Paper targets of reducing hospital admissions.
- Save money.
- This money could be used towards other areas in the NHS.
- NICE, NHS Cancer plan, NSF
- Ageing population – future implication.
- Assisted suicide – good palliative care.
- Public confidence – Shipman.
“In this world nothing can be said to be certain, except death and taxes”

Benjamin Franklin 1706-90
(letter to Jean Baptiste Le Roy, 1979)