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General practitioners' and district nurses' views of hospital at home for palliative care

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Abstract: Cambridge Hospital at Home (CH@H) provides 24-h nursing in a patient's own home to patients requiring terminal and palliative respite care. To investigate views of the service, we surveyed all GPs and district nurses (DNs) in the catchment area of the scheme. Of those who responded 85% were DNs and 65% were GPs.

The majority of DNs (93%) and GPs (57%) had patients referred to CH@H, whereas 90% of DNs and 42% GPs had patients admitted. The most commonly reported reason for non-referral was lack of availability of places (GPs 62%; DNs 63%). Ninety per cent DNs and 84% GPs rated continuation of the scheme as important. The most important reported benefits were 24-h care (GPs 84%; DNs 82%) and help in keeping patients at home (GPs 69%; DNs 83%). Seventy-four DNs also considered help in arranging discharge to be important. Almost half GPs and DNs considered CH@H worse than other NHS services in terms of availability and limits on the duration of care. Whilst 65% of DNs thought CH@H had reduced workload, 77% GPs reported it had made no difference or had increased it. Most indicated that CH@H made a difference in allowing patients to die at home (GPs 60%; DNs 68%).

The CH@H scheme is viewed as beneficial for patients requiring palliative care at home, although GPs and DNs expressed realistic reservations about specific aspects of the scheme. With the emergence of Primary Care Trusts, NHS commissioning of hospice at home services will more firmly rest with primary care practitioners, who on balance clearly prize them. *Palliative Medicine* 2002; **16**

Key words: district nurses; general practitioners; hospital at home; palliative care; professional views; questionnaire survey

Introduction

Whilst more than half of terminally ill patients express a preference to remain at home until death,[1–3] only 21% of deaths in England and Wales occur at home.[4] Death at home is preferred by most of the general public[5] and primary care professionals alike.[6] Informal carers are more likely to state that the place of death was right if the patient died at home.[7] In response to these discrepancies, there has been considerable increase in UK palliative home care provision. Cambridge Hospital at Home for palliative care (CH@H) is one such service development. CH@H was set up with the explicit aim of improving terminal care and is available to any diagnostic group during the last 2 weeks of life, but provides respite care for cancer, HIV/AIDS and MND. CH@H provides hands-on nursing care, but is not a specialist service: GPs and district nurses (DNs) maintain clinical responsibility. At the time of the study, the CH@H team comprised a co-ordinator, six qualified nurses, two auxiliaries, with agency nurses used as required.

There has been little published about the impact of such services. We studied the Cambridge service using a variety of techniques.[8,9] Patients allocated

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Table 1 Response rates for CH@H evaluation questionnaire

	District nurses *n* (%)	General practitioners *n* (%)
Questionnaire completed	61 (85)	136 (65)
Respondent 'away'/maternity	6 (8)	6 (3)
No experience and unable to give an opinion on CH@H	1 (1)	4 (2)
No response	4 (6)	65 (31)
Total *n*	72	211

to CH@H were no more likely to die at home than patients receiving standard care, although those patients actually admitted to CH@H were significantly more likely to die at home. There was no clear evidence that CH@C increased likelihood of remaining at home during the last 2 weeks of life, but the service was associated with fewer GP out-of-hours visits and better quality home care.[8,9] Here we report a postal survey of professionals' views of the service, after it had been running for $2^1/_2$ years.

Methods

We surveyed the total population of GPs and DNs in Cambridge Health District, all of whose patients were potential users of CH@H: (DNs, N=72; GP principals, N=211). The survey was developed from semi-structured interviews conducted with health professionals and managers at the inception of CH@H and covered topics including referral and non-referral to CH@H, benefits of CH@H, access to and quality of care provided in comparison to other services. A covering letter and freepost return envelope were enclosed with the questionnaire. A reminder was sent after a month to non-responders. Two tailed parametric and non-parametric statistics are used, α=0.05; where appropriate Yates' correction is used.

Results

Completed questionnaires were returned by 85% DNs and 65% GPs (Table 1).

Significantly more [55/59 (93%)] DNs than GPs [76/133 (57%)] reported[1] that they had a patient referred to CH@H (χ^2=22.9, df=1, P<0.0001). However, 10 (8%) GPs were 'unsure', possibly because they may not personally have referred the patient. Likewise, 54/60 (90%) DNs and 55/132 (42%) GPs responded that they had a patient admitted to CH@H (χ^2=37.32, df=1, P<0.0001). Twelve (9%) GPs were unsure. Thus, as might be expected DNs are more likely to have experience of CH@H than GPs.

Respondents were asked whether they had a patient suitable for CH@H, for whom a choice was made not to refer. 30/61 (49%) DNs and 39/131 (30%) GPs indicated that they had had a suitable patient, who was not referred (χ^2=5.99, df=1, P=0.014).

The number of individual patients considered is unclear, as respondents may have provided ratings on the basis of one or several patients, or conversely the same patient may have been considered by several health professionals. The most common reason for non-referral was perceived lack of availability of CH@H places (Table 2). Respondents also rated the benefits of CH@H and how important they felt it was that CH@H continued to be available (Figure 1). Clearly, DNs and GPs felt that CH@H was an important resource.

More than 89% of GPs and DNs thought that CH@H was important or very important because of its provision of 24-h care, support for patients, and for family, because it provided another source of nursing care, and helped keep patients at home, as well as enabling discharge home. Only 'enabling discharge home' was rated as more important by DNs than by GPs (Z=2.05, P<0.05). DNs were significantly more likely than GPs to feel that availability of nursing care would be affected by the withdrawal of CH@H (Z=1.96, P<0.05).

Although in general, attitudes to CH@H were positive both GPs and DNs considered CH@H worse than other services in terms of availability, limits on duration and delays in getting care underway. GPs

[1]For brevity we write `reported', but readers are reminded that respondents indicated responses on prepared response sets.

Table 2 Reasons for not referring an eligible patient to CH@H*

	District nurses (*n*=30) *n* (%)	GP s (*n*=39) *n* (%)
Other support was sufficient	11 (37)	18 (46)
Patient or carer was reluctant to accept additional help	9 (30)	4 (10)
Circumstances changed too rapidly	13 (43)	12 (31)
Lack of availability of places	19 (63)	24 (62)
Problems with randomisation at referral	19 (63)	8 (21)
Other	3 (10)	4 (10)

Note respondents could tick more than one category.

were significantly more likely than DNs to be unsure about how CH@H compared with other services (all items P<0.05).

Amongst those who had a patient in CH@H 35/54 (65%) DNs reported a decrease in workload, 22/53 (42%) GPs reported no effect and 19 (36%) that it had increased workload (Z=3.37, P<0.0001). On the other hand, both professional groups indicated that the organisation of care had been made easier [42 GPs (80%), 37 DNs (68%)].

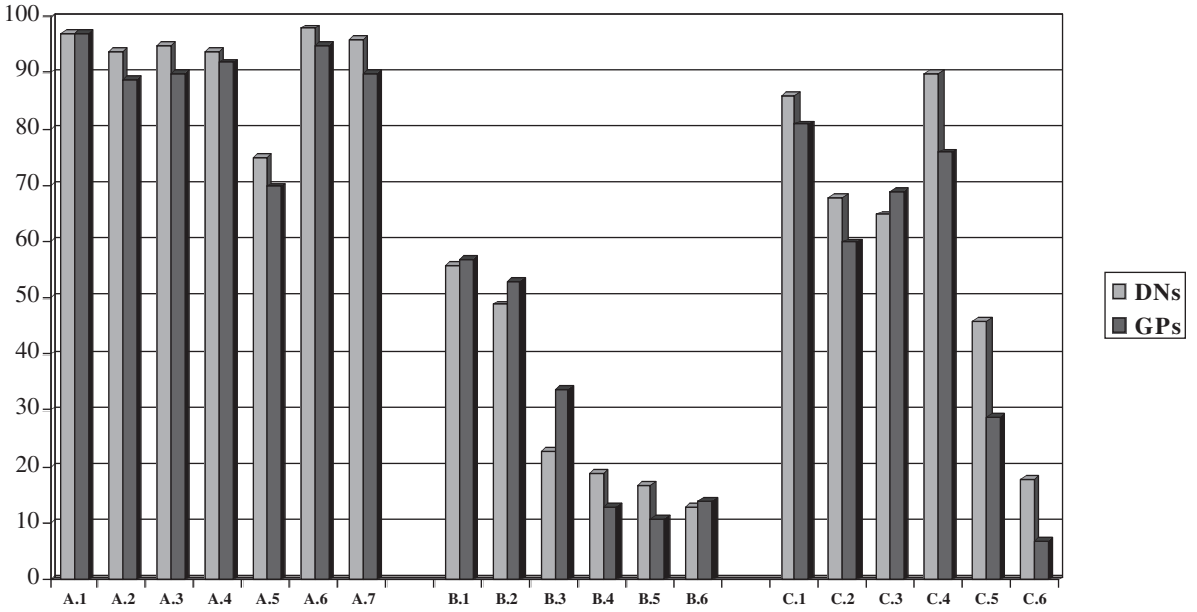

Figure 1 A: Importance of specific aspects of CH@H service: percentage of GPs and district nurses who rate aspect of service as important or very important. B: Issues related to CH@H care: percentage of GPs and district nurses who rate CH@H as worse than alternative care options. C: General views about CH@H: percentage of GPs and district nurses who agree or strongly agree with statements about CH@H. A.1: Provision of up to 24-h care in the home. A.2: Patient support from someone who understands the problems faced by the terminally ill. A.3: Availability of another source of nursing care. A.4: Support for the family as well as the patient. A.5: Support for myself from someone with palliative care experience. A.6: Help towards keeping patients at home. A.7: Help towards enabling discharge home. B.1: Availability limited to a few patients at any given time. B.2: Limits to the duration of care. B.3: Delays in getting care underway. B.4: Increases health professionals' problems of co-ordinating care from many different sources. B.5: Lack of continuity of care in the home. B.6: Access to care co-ordinator difficult. C.1: The benefits of CH@H outweigh the disadvantages. C.2: CH@H has made a difference over and above other services in allowing my patients to die at home. C.3: If CH@H for palliative care were to stop, it would make care for my patients worse. C.4: It is important to have a set team of CH@H nurses providing CH@H care rather than bank nurses. C.5: CH@H has helped increase my job satisfaction. C.6: Palliative care funding could be better spent by discontinuing CH@H and increasing the funding to other community services

Summary and discussion

Questionnaire response rates were good for both professional groups, thus findings are likely to be representative. Nearly 1/3 GPs and 1/2 DNs reported that they had had patients whom they considered suitable for CH@H, whom had not been referred. Most GPs and DNs wanted CH@H to continue to be available. Key benefits were 'provision of 24-h nursing care in the home' and 'help towards keeping patients at home'. Difficulties reported were that availability was limited to a few patients at any one time, there was limited duration of care and delays in starting care problems that can be fixed by the organisation. However, in all other ways CH@H was seen as better than standard care.

Some responses may be specific to the way the service was organized, for example, restricting admissions to patients during the last two weeks of life has a specific effect and a service with different admissions criteria would give rise to different views. Earlier findings are very much in line with those of the present study and according to nurses and GPs hospice at home type services provide real benefits to patient care.[10,11] Whilst perhaps not all their beliefs are reflected in reality, what is clear is that the views of nurses and GPs are remarkably consistent in their essentially positive views of home care. They clearly recognized issues that were considered problematic within the service (e.g., availability and duration of care) but which are perennial problem for health service management; priority setting and resource allocation in a system with finite resources. With the emergence of Primary Care Trusts (PCTs), decisions regarding commissioning of such services will rest more firmly than before with primary care practitioners.[11] Thus, it is likely that hospice at home type services will become more common, which makes it imperative that we ensure that they function as (cost) effectively as possible and fulfil the objectives set out for them.

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