RACGP

National Rural Faculty

Palliative Care

Rural Research (April 2015)

Preliminary Results: RACGP National Rural Faculty (NRF) palliative care survey

Introduction

In a rural context palliative care patients and their families experience a range of unmet needs associated with isolation and remoteness, access to appropriate care and a lack of service integration enabling continuity of care. Palliative care requires a multidisciplinary approach, with the rural GP playing a central and increasing role in providing and coordinating this care for patients both in home and in hospital. However the current fragmentation of care and inadequate support for GPs to provide palliative care is placing significant pressure on health providers in rural and remote communities.

Findings from the RACGP's *New approaches to integrated rural training for medical practitioners (2014)* project indicated that GPs required greater support to meet the palliative care needs of rural and remote communities. Through this latest survey, undertaken in April 2015, the NRF sought to build on this research to develop a greater understanding of the specific supports required to enable rural GPs to provide palliative care services in their community across a range of service settings. These results will inform our advocacy in guiding the direction of future workforce strategies particularly in identifying service gaps and training requirements.

Aim

To determine the extent of, and demand for, GP-led palliative care services in rural and remote communities.

Method

An online survey of NRF members (practising GPs in ASGC-RA 2-5) was conducted on 20 April 2015, with a cohort of **7,433**, sourced through the RACGP National Rural Faculty (NRF) membership database[1] [2]. A targeted survey with multiple choice and free-response survey questions was sent via eblast on 20 April 2015 for a ten day period. A reminder email was sent on 27 April to maximise the survey response rate.

Results

The qualitative and quantitative results from the survey reported below forms preliminary analysis of the RACGP NRF Palliative care survey. However, the research team hopes to fully analyse the free-response survey questions to inform future policy and advocacy over the coming months.

Demographics

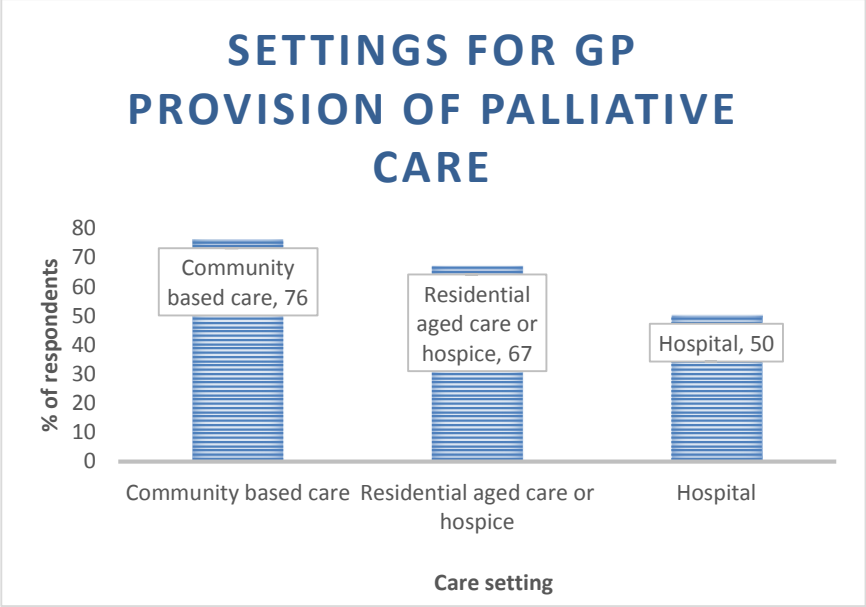
Of the **7,433**[3] NRF members invited to participate in the survey, **522** completed the entire survey (7.0% response rate). Of those, **2,849** people opened the survey (38.7%) after receiving the first email, and **2,583** (35.1%) opened the second (reminder) email. A total of **674** members viewed the survey.

[1] Membership categories: Full Time; GP Spouse/Partner; Life Members; New Fellow; Part Time;; Registrar member; Residents/Interns.
[2] Rurality factor: Those who either have a preferred address in RA 2-5 **OR** a practice or home address in RA 2-5.
[3] Delivery rate: Delivered successfully to **7,365** members (99.1%)

The age distribution was relatively well-balanced against the workforce and included under 35 (15%), 35-55 (60%) and 56+ (25%). The ASGC-RA distribution of palliative care services showed the majority of respondents were working and providing services in Inner Regional (42%) and Outer Regional (36%) locations. Participants also represented Remote Australia (13%) and Very Remote Australia (5%) a further 4% providing services in Major Cities of Australia. In terms of career stage most participants were vocationally registered (80%) with non-VR GP (6%), Registrar (13%) and Intern/Resident (0%).

Service provision across settings

Participants were asked to provide detail on the extent to which they provide palliative care services in their community across each of the key service settings: within the hospital, residential aged care or hospice care facility or within community based care. Whilst GP-led palliative care services in rural areas are provided across all settings, the majority of GPs were providing community based care (76%) or services within a residential aged care or hospice care facility (67%) with half of those surveyed reporting that they also provided services within the hospital (50%).



For those Rural GPs providing care in residential aged care or hospice care and within the hospital, the majority of visits were occasional and for patients that they were familiar with (64% and 62% respectively). Services were provided predominantly in publicly funded facilities for hospital care (58%) with a mix of public/private for residential aged care and hospice care (public 27%/private 28%).

Skill recognition

Many residential aged care, hospice and hospital facilities receive a mix of service provision from palliative care specialists and GPs as determined by local need and available resources. The recognition of palliative care skills is important in:

* Ensuring GPs have access to these facilities and can provide care to their patients;
* Clarifying the role of the GP within the multidisciplinary palliative care teams of these institutions;
* Facilitating clear referral pathways which promote continuity of care for patients moving in and out of primary and tertiary care.

Currently there are no clear accreditation or credentialing arrangements for palliative care, and a significant portion of participants reported that their palliative care skills were not recognised at a local (72%) or state level (92%).

Addressing need

Patient access to palliative care remains an issue in rural communities. In terms of unmet need 63% of participants indicated a need for more GP-led palliative care services in their (rural) community.

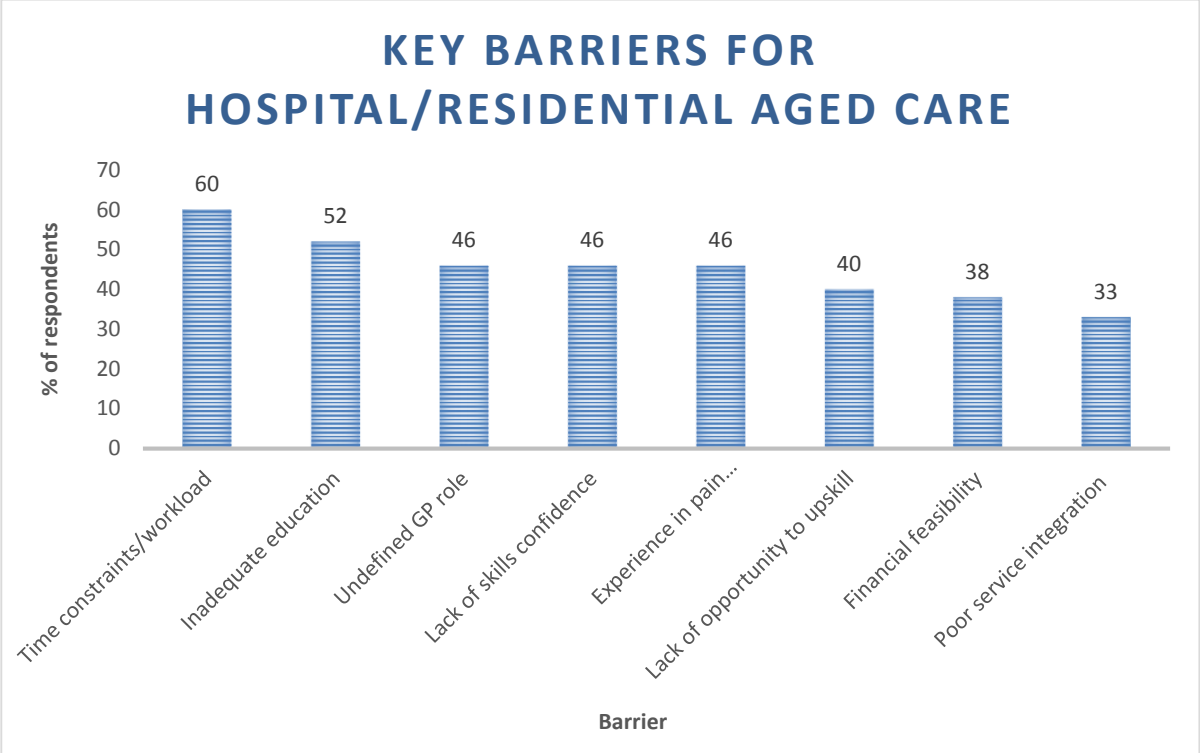
To facilitate this increase in services, GPs indicated that a number of areas need to be addressed, including:

- more training and education across entire palliative care team
- adequate funding for after-hours care, the coordination of services and team based care planning
- improvements in identification of those who would benefit from advance care health planning
- enabling admitting rights to hospitals to support continuity of care across settings
- collaboration and partnership building across primary and tertiary healthcare settings, with stronger networks and better use of clinical pathways
- recognition and credentialing for GP palliative care skills

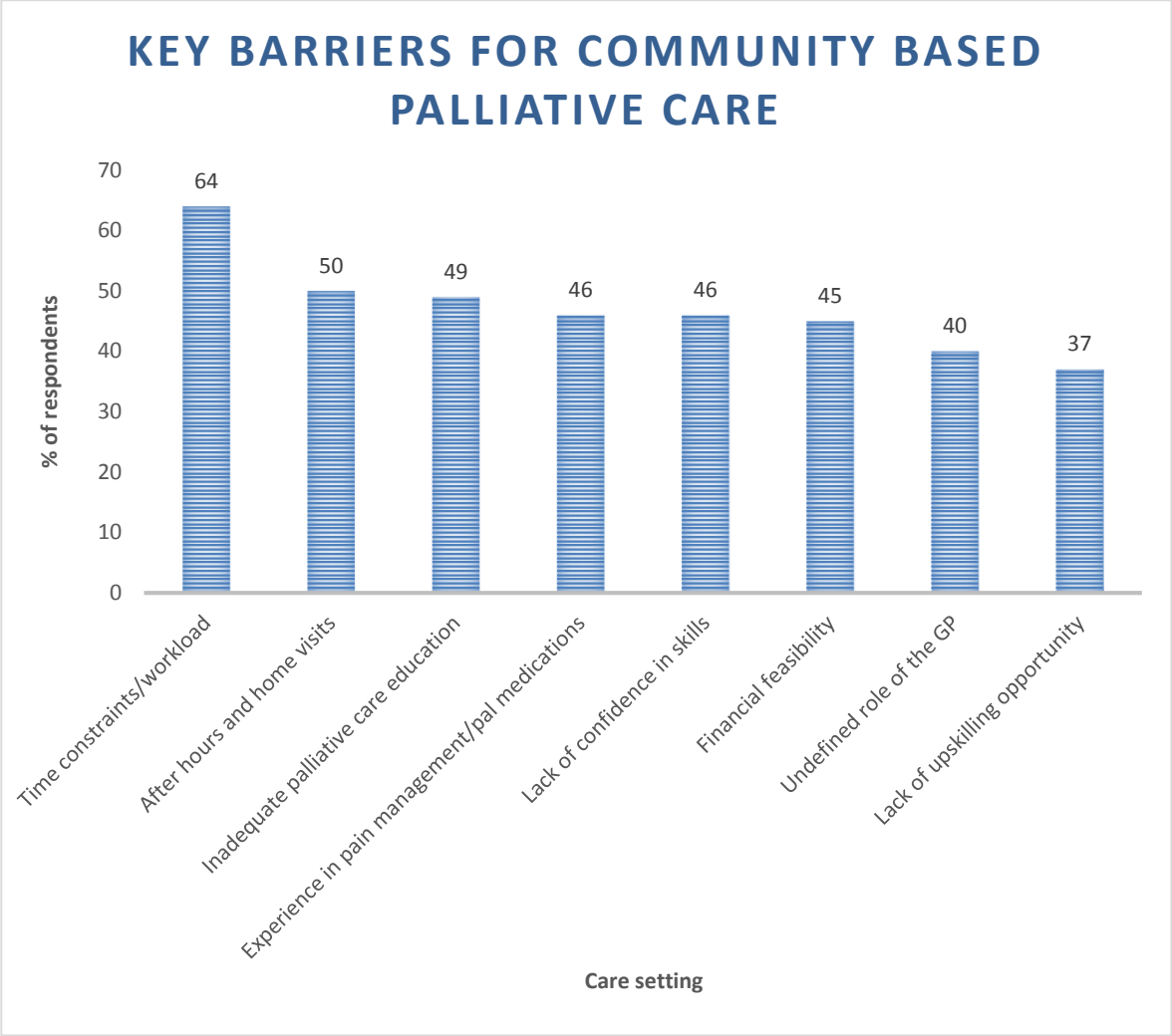
Key barriers

In order to improve the provision of palliative care in rural communities, greater understanding of the barriers impacting on GPs is needed so that any reform adequately addresses the key issues.

The key barriers for rural GPs providing care in a hospital or palliative care/residential aged care facility were time constraints and workload (60%), inadequate palliative care education (52%), undefined (GP) role (47%) followed closely by lack of skill confidence (46%).



For rural GPs providing community based palliative care the key barrier identified was time/workload (64%) which corresponds to the hospital and palliative/aged care (setting) result. However, for community based care, after hours and home visit restrictions (50%) was also identified as a key barrier followed by inadequate palliative care education (49%).



Supports for Rural GPs

Participants indicated that further support is needed to assist rural GPs in providing palliative care in their community, including more GP specific training opportunities (73%), adequate remuneration (64%) and support form palliative specialist (63%) and nursing staff.

In terms of access to training to meet patient need, rural GPs advised that whilst training was available time away from their practice (45%) restricted them. Whilst 26% stated that they had access to training 29% stated that palliative care training was not available to them.

Skills focus

The palliative care skill areas which rural GPs identified as training they would like to undertake included pain and symptom management (67%), palliative care medications (63%) and disease specific processes applicable to palliative care (60%). Many indicated that they would also undertake training in providing culturally appropriate palliative care to Aboriginal and Torres Strait Islanders patients.

In terms of skill confidence in providing end-of-life care to palliative patients 88% ranked their confidence between 5 (mid-point) and 10 (very confident) with the majority (45%) indicating a 7 or 8 score.

Confidence building end-of-life care skills training which rural GPs would like to be able to undertake included QI&CPD Category 1 activity (63%), QI&CPD Category 2 (50%) and Advanced Rural Skills Training (36%). Many participants reported both the Royal Australian College of Physicians Clinical Diploma in Palliative Medicine and The Program of Experience in the Palliative Approach (PEPA) course to be highly valuable, however the metropolitan based placements required for the PEPA course are reported to be a barrier to undertaking this training. [4]

[4] The research team notes that the PEPA course currently provides for such supports, including for the a locum and travel costs, however given these results it is clear there remains a perceived barrier to accessibility for this particular cohort.