Primary care group commissioning of services: the differing priorities of general practitioners and district nurses for palliative care services

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SUMMARY
Background. General practitioners (GPs) have become more responsible for budget allocation over the years. The 1997 White Paper has signalled major changes in GPs' roles in commissioning. In general, palliative care is ranked as a high priority, and such services are therefore likely to be early candidates for commissioning.

Aim. To examine the different commissioning priorities within the primary health care team (PHCT) by ascertaining the views of GPs and district nurses (DNs) concerning their priorities for the future planning of local palliative care services and the adequacy of services as currently provided.

Method. A postal questionnaire survey was sent to 167 GP principals and 96 registered DNs in the Cambridge area to ascertain ratings of service development priority and service adequacy, for which written comments were received.

Results. Replies were received from 141 (84.4%) GPs and 86 (90%) DNs. Both professional groups agreed that the most important service developments were urgent hospice admission for symptom control or terminal care, and Marie Curie nurses. GPs gave greater priority than DNs to specialist doctor home visits and Macmillan nurses. DNs gave greater priority than GPs to Marie Curie nurses, hospital-at-home, non-cancer patients' urgent hospice admission, day care, and hospice outpatients. For each of the eight services where significant differences were found in perceptions of service adequacy, DNs rated the service to be less adequate than GPs.

Conclusion. The 1997 White Paper, The New NHS, has indicated that the various forms of GP purchasing are to be replaced by primary care groups (PCGs), in which both GPs and DNs are to be involved in commissioning decisions. For many palliative care services, DNs' views of service adequacy and priorities for future development differ significantly from their GP colleagues; resolution of these differences will need to be attained within PCGs. Both professional groups give high priority to the further development of quick-response clinical services, especially urgent hospice admission and Marie Curie nurses.

Keywords: GP commissioning; commissioning priorities; palliative care; district nurses; general practitioners.

Introduction
The prioritization of health care is an important national debate.1-2 Over recent years, despite mixed feelings,3 general practitioners (GPs) have become responsible for allocating an increasingly large proportion of the health service budget4 through fundholding,5 total purchasing,6 or GP commissioning groups.7 The 1997 White Paper8 has signalled major changes in GPs' roles in commissioning, with the phasing out of GP fundholding and the abolition of the internal market. Primary care groups (PCGs) are to be formed: typically serving around 100 000 patients, they are expected to progress up a four-stepped hierarchy of responsibility, from an advisory role in Health Authority commissioning, to the full allocation of a budget, commissioning care for their population on the basis of a public health function for their locality. (In Scotland, PCGs will have no powers to commission hospital secondary care services. In Wales, they will have no budgetary control, at least initially.) PCGs will comprise, among others, local GPs with their community nursing colleagues in a coming together of equals (White Paper, Section 5:27). For the first time, community nurses are to take on a key role in the planning and commissioning of services.

In a similar study of the public, GPs, and consultants in inner London10 also found a high priority given to palliative care; such services are thus likely to be early candidates for PCG commissioning. The primary health care team (PHCT) is central to the provision of palliative care.11-12 Most of the last year of life is spent at home,13 and, although the majority of cancer deaths occur in hospital, most terminally ill patients and their lay carers would prefer death to occur at home.15,16 There is some evidence that these preferences decline as illness progresses:15,17 GPs18,19 and DNs20 see the care of dying patients as a central part of their roles.

As part of a programme of research into palliative care in primary care, we undertook a questionnaire study of Cambridge GPs and DNs that not only focused on palliative care services, but also shed light on broader issues raised by the White Paper.

Method
A questionnaire was developed, limited to two sides of a single sheet of A4 paper, listing 11 of the main local palliative care services (Box 1). Against these services, responders were asked: 'Please indicate the priority and importance that you would like to see given to each of the following when planning future services. Given finite resources, where would you put the emphasis?' A four-point Likert scale was provided, from very important/high priority (scored as 4) to very unimportant/low priority (scored as 1). They were also asked: 'How adequately provided do you find the currently available palliative care services? Please indicate how well you feel the needs of your patients are

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British Journal of General Practice, March 1999 181
being met at present.’ A similar four-point Likert scale was provided, from very adequate (scored as 4) to very inadequate (scored as 1). Free-text comments were invited.

This questionnaire was sent to all 167 GP principals and 96 registered DNs working in the area served by the hospice in Cambridge, with one reminder to non-responders one month later. A covering letter was signed personally by the GP member of the research team.

Parametric and non-parametric statistics were conducted using SPSS for Windows Version 6.0. Chi-squared tests reported below have 1 degree of freedom and, when appropriate, use Yates’ correction unless otherwise stated.

Results
Replies were received from 141 (84.4%) GPs and 86 (90%) DNs, an overall response rate of 86.3%. The use of the Medical Directory, 21 national GP workforce data, and regional lists of approved vocational trainers, permitted comparison of some of the demographic characteristics of the 141 responding GPs with the 26 who did not respond, and the regional and national GP workforce. Compared with the non-responders, there was no significant difference (P>0.05 in all cases using chi-squared tests) by any of the parameters (sex of GP, year qualified, MRCGP, trainer approval, practice size, practice location, number of partners); responders were thus representative of local GPs. Regional and national data were available for three parameters (sex of GP, trainer status, and partnership size). Compared with the East Anglian GP workforce, responders were more likely to be female (χ² = 30.49; P<0.001), but there was no significant difference with regard to trainer status or partnership size. Compared with the national GP workforce, responders were more likely to be female (χ² = 12.59; P<0.001), trainers (χ² = 8.91; P<0.001), and to work in practices of five or more partners (χ² = 11.45; P<0.001).

Table 1 and Figures 1 and 2 summarize the responses concerning future service development priority. GPs’ and DNs’ highest priorities were cancer patients’ urgent hospice admission for symptom control or terminal care, and Marie Curie nurses. DNs and GPs also agree that the three services of lowest priority are palliative day care, and hospice outpatients. Macmillan nurses were also ranked as lowest priority for development by DNs.

Discussion
While the pattern of current services is unique to Cambridge, the different perceptions of GPs and DNs of the same set of services is of more generalizable relevance. These significantly differing views within the PHCT are of considerable importance to the developing PCGs, and may be of particular use in the planning and provision of palliative care services.

In each case, DNs rated the service to be less adequate. Content analysis22 of the free-text comments was undertaken, classifying single blocks of continuous text into the 11 categories of the questionnaire (Table 3).

The national generalizability of this study is less clear. Although our sample is representative of Cambridge GPs, and of East Anglian GPs by all parameters but sex, it differs significantly from the national GP workforce by sex, practice size, and

<table>
<thead>
<tr>
<th>Service</th>
<th>GP (95% CI)</th>
<th>DN (95% CI)</th>
<th>U-test (z)</th>
<th>Significance (P)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer patients: urgent admission</td>
<td>3.88 (3.80–3.96)</td>
<td>3.88 (3.80–3.96)</td>
<td>1.13</td>
<td>NS</td>
</tr>
<tr>
<td>for symptom control</td>
<td>3.83 (3.76–3.90)</td>
<td>3.88 (3.80–3.96)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer patients: urgent admission</td>
<td>3.74 (3.62–3.86)</td>
<td>3.74 (3.62–3.86)</td>
<td>0.65</td>
<td>NS</td>
</tr>
<tr>
<td>for terminal care</td>
<td>3.73 (3.65–3.81)</td>
<td>3.74 (3.62–3.86)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marie Curie nurses</td>
<td>3.63 (3.54–3.72)</td>
<td>3.64 (3.75–3.93)</td>
<td>3.34</td>
<td>0.0009</td>
</tr>
<tr>
<td>Medical team home visit</td>
<td>3.47 (3.35–3.59)</td>
<td>3.47 (3.35–3.59)</td>
<td>3.06</td>
<td>0.002</td>
</tr>
<tr>
<td>Macmillan nurses</td>
<td>3.42 (3.30–3.54)</td>
<td>3.42 (3.30–3.54)</td>
<td>2.86</td>
<td>0.004</td>
</tr>
<tr>
<td>Palliative day care</td>
<td>3.31 (3.22–3.40)</td>
<td>3.31 (3.18–3.44)</td>
<td>0.18</td>
<td>NS</td>
</tr>
<tr>
<td>Non-cancer patients: urgent admission</td>
<td>3.27 (3.14–3.40)</td>
<td>3.28 (3.15–3.44)</td>
<td>4.64</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>for terminal care</td>
<td>3.20 (3.07–3.33)</td>
<td>3.20 (3.07–3.33)</td>
<td>3.62</td>
<td>0.0003</td>
</tr>
<tr>
<td>Palliative day care</td>
<td>2.91 (2.79–3.03)</td>
<td>3.11 (2.95–3.27)</td>
<td>1.95</td>
<td>NS</td>
</tr>
<tr>
<td>Hospice medical outpatients</td>
<td>2.83 (2.70–2.96)</td>
<td>3.14 (3.01–3.27)</td>
<td>3.01</td>
<td>0.003</td>
</tr>
</tbody>
</table>

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The national generalizability of this study is less clear. Although our sample is representative of Cambridge GPs, and of East Anglian GPs by all parameters but sex, it differs significantly from the national GP workforce by sex, practice size, and profession group giving greater priority.

Table 1. Comparison of priority rating given to services by GPs and DNs (1 = very low priority; 4 = very high priority).
approved trainer status. GPs and DNs working in more socially deprived areas may have different perspectives on palliative care services, in part owing to different out-of-hours arrangements. Studies such as this could be usefully conducted at locality level to inform the developing PCGs as part of their process of needs assessment.

For all services, the mean priority ranking by both professional groups is at least 2.8, suggesting that all are needing development and none are regarded as dispensable.

Both GPs and DNs ranked the urgent admission of cancer patients to hospice for symptom control as the service of highest priority for future development (Table 2), as found in other stud-
This was emphasized in many of the free-text comments:

We are keen to care for our patients at home as far as possible. If we refer a patient to the hospice, it is usually a dire situation that we cannot hold out here.

The GPs and DNs both ranked the Marie Curie nursing service to be of high priority for future development, as found in other studies.\textsuperscript{18,28} Hospital at Home for Palliative Care is a non-specialist nursing service providing 24-hour nursing care at home, with the GP and DN retaining clinical responsibility. At the time of the study, this service had only been in place for 18 months, but was already viewed by DNs as a high priority for service extension and obtained the largest interprofessional difference in priority ranking. The significant interprofessional difference concerning the priority of developing these services may reflect the greater awareness of DNs regarding the nursing and night-sitting needs of patients, and the stresses and needs of their lay carers.\textsuperscript{31} Many free-text comments stressed the importance of these home-care services:

Twenty-four-hour nursing cover is needed for people to die at home: it must be available often at short notice. Sudden deterioration and decline are our worst enemies.
While Macmillan nurses are ranked by GPs as fourth in their priorities for service development, DNs rank them as significantly less in need of development. This ambivalence on the part of DNs towards Macmillan nurses is demonstrated in other work.32,33 While DNs provide the majority of community nursing care for the dying,34 patients often perceive their care as coming from other services, such as Macmillan nurses, who receive the gratitude and donations:

Many patients and carers believe that all the nursing care has been given by Macmillan nurses, in fact they have never seen one.

There may also be an ambivalence of generalist DNs to the growing number of specialist nurses in many areas of care, who may be insufficiently integrated into the PHCT,30 and who may leave them feeling deskilled.33,27 A further factor may be an unease with the evolving role of the Macmillan nurse,35 from one of psychosocial support36,38 to the educational and advisory role of the clinical nurse specialist, who may only visit the patient once or twice.33

Macmillan nurses will come and say all is well. We are aware of our own capabilities and do not need to be told, but need more support visits for the family.

Macmillan nurses may themselves feel caught between professional and public expectation of continuing support and the practical realities of high referral rates. Further research in these areas is needed.

Both GPs and DNs placed respite admission for cancer patients in the midpoint of their priority ranking. Other studies39,40 and recent national directives13 have emphasized the importance of this aspect of service provision. The role of specialist palliative care in meeting the needs of non-cancer patients is currently the subject of national debate.11,13,41 The National Service Frameworks, which will set out the patterns and levels of service to be provided, and Health Authorities’ health improvement programmes will help to ensure that PCGs bear in mind such national priorities and debates, and not solely respond to local pressures and concerns.

Past research emphasizes the complementary clinical roles of GPs and DNs in palliative care,42 and suggests that it is often the DN rather than the GP who is the key community professional most in touch with the patients’ and carers’ needs,36 and is thus most able to assess the adequacy and importance of services. The workload implications of services do not entirely explain the interprofessional differences. Indeed, the majority of GPs reporting a workload increase owing to hospital-at-home also reported that this increased workload was welcome for this special group of patients.43 The organization of Marie Curie home care involves DNs in a considerable administrative workload and both GPs and DNs in an increased clinical workload, yet both value the service highly, particularly DNs.

General practitioners and DNs gave the highest priority to the further development of services providing immediate clinical care, particularly in the final stages of illness. Such an emphasis on urgent clinical care over planned progression and education is perhaps to be expected given the nature of clinical work,44 and has been found in previous studies of needs assessment in primary care.45,46 To prevent an unduly short-term view becoming predominant in PCGs, strong partnerships with public health medicine are needed to ensure a more systematic and proactive needs assessment. This may include the need for professional education, which is a major aspect of a Macmillan nurse’s work.

As PCGs develop their roles, they will need to canvass widely when considering the mix of services to be commissioned. Surveying health professionals on their perceptions is one way of identifying their perception of need; while the survey approach may not be perfect,47 it is probably an improvement on permitting small numbers of potentially biased individuals to drive important decisions.10,19 PCGs may wish to consider adopting this methodology of canvassing concerning services that permit all parties to have an equal voice: doctors, nurses, and the public.

Over recent years, GPs have increasingly influenced service provision, and it is clear that this will continue as the primary care-led NHS develops. The inclusion of DNs in PCGs marks a significant change from the previous GP-led models. DNs’ greater contact with dying patients and their families enables them to become their advocates in a special way. This survey has given a voice to DNs and revealed their different but arguably equivalent priorities: with the development of PCGs, this voice could be regularly heard. It is not clear how the differing professional priorities will be managed within PCGs, and a consensus reached; given the tendency of doctors to expect to take the lead, and of nurses to defer to doctors, some mechanism of achieving consensus (such as a Delphi panel) may need to be developed.

The commissioning priorities of primary care, secondary care, public health, and the lay public have been shown to be different.10 Patients’ and carers’ needs may best be met when these different perceptions are identified, shared, and valued in a partnership,7,48 as commended by the White Paper. Unless innovative ways are used to promote the partnership, the old tensions and hierarchical structures of the health service are likely to dominate, hindering change.

Public participation in priority setting is essential to avoid the domination of professional priorities and remains to be clarified in the White Paper description of PCG commissioning. What is missing from this study, and from much of the literature, are the priorities of the patients themselves and their families.

References


42. Grande GE, Barclay SIG, Todd CJ. Difficulty of symptom control and general practitioners’ knowledge of patients’ symptoms. Palliat Med 1997; 11: 399-406.


