GP Association of Geelong[1]: Improving GPs knowledge and skills in palliative care

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The Palliative Care Program at the GP Association of Geelong commenced in 1995 as part of the Association's Cancer Program. Since the early days of the Division, palliative care and cancer have been regarded as priority areas and, although specific funding has not been available, the Division ensured that the program has been supported. The program has two GP advisors.

The main aims of the program are to:

- improve general practitioners' knowledge of palliative care
- improve the management of palliative care in the general practice setting
- provide support to general practitioners who work in this area
- improve links between general practitioners, consultants and palliative care services

Strategies and achievements

There have been a variety of strategies used to achieve these aims and the program has evolved over a number of years based on the needs of the stakeholders.

Involvement in Oncology Supervised Clinical Attachment Program.

Since 1995 GPs have had the opportunity to attend clinics under the supervision of a consultant. These clinical attachment programs are available in the palliative care setting. More than 80 GPs (approximately 40 per cent) have participated in rotations of GPs through the Andrew Love Cancer Centre, the Grace McKellar Centre and community visits. They have also participated in multidisciplinary meetings including meetings with allied health workers.

Small Group Learning for Palliative roster GPs.

A dedicated group of nine GPs are involved in the after hours palliative care roster for weekend cover for palliative care patients (both inpatients and community). These GPs together with palliative care consultants and Palliative care project officer appointed under the Strengthening Palliative Care project attend monthly breakfast meetings. Topics discussed are determined by the group and include guest speakers, case discussion, planning of the annual palliative care seminar and discussion of relevant issues.

Practice visits with Palliative Care Consultant and Community Palliative Nurse.

This provides an opportunity for GPs to meet with the palliative care team face to face. The team attends the GP's practice at lunch time for an informal meeting. A needs assessment prior to the meeting determines the content of the meeting. 178 GPs (almost 90 per cent) have participated in these meetings although some GPs have been visited more than once due to change of staff and demand. Initially these meetings were conducted with groups of practices. More recently, due to workforce difficulties the team now meets with individual practices mainly due to workforce issues.

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[1] Material in this section is based on material provided by Janine Fargher, Cancer Program, GP Association Geelong, Forum presentation by Dr Deb Harley and interviews with Dr Michael Homeward, Dr Deb Harley, Janine Fargher, Alison King (formerly Clinical Coordinator, Community Palliative Care, Newcomb Community Health Centre) & Mark Arnold, Nurse Unit Manager, Barwon Health Service: Grace McKellar

Annual Palliative Seminar.

The palliative care small group organises an annual seminar which includes GPs, palliative care consultants, nurses and other allied health professionals. Past topics include prostate cancer, Gynae-Oncology, Sexuality & Cancer, Respiratory Failure and Cardiac Failure. The seminar was first held in 2001 and 80 GPs participated in 2005.

Educational column in Newsletter

One of the local palliative consultants, wrote an educational column in the Division's newsletter which is distributed to all members of the GP Association of Geelong.

GPs are invited to participate in the Palliative Care ward round at Grace McKellar Centre. GPs are welcome to attend the weekly palliative care ward round and team meetings as advertised in the monthly GP newsletter. This has recently been formalised in the new policy for palliative care area service teams GP care planning process. The area service case manager is identified as the person responsible for notifying the GP when their patients are to be discussed at the team meeting and for providing feedback if the GP is unable to attend.

Continuing Professional Development Activities.

Palliative Care topics are included in the Continuing Professional Development calendar although the number of events per annum is low

Future possibilities

The Palliative Care Interest Group is working on the development of a template for Care Plan for Medical Director specifically for the Geelong region. The goal is to minimise the administrative demands of producing a care plan and to ensure that all members of the palliative care team share a common language in care planning. The team also plans to promote and support GP participation in more case conferences, to provide more opportunities for multidisciplinary professional development activities and to provide more administrative time for evaluation, planning and liaison with other agencies.

Meeting the preconditions

The Geelong program provides illustration of a program that successfully meets the six pre-conditions for successful collaboration as identified in the Harris model [2] . The program demonstrates a mutual recognition of the **need** to work together.

Although they have not received a specific program grant the Division has created the **opportunity** for cooperation in palliative care (a) through building on the clinical attachment program for oncology and (b) through seeking funding support from the Division's core grant and through sponsorship of the various components of the program.

The program strengthens the **capacity** for partnership by developing GP knowledge and skills through the clinical attachment program, through the practice meetings with agendas based on individual need, through the annual palliative care seminar as well as the occasional activity in the annual Continuing Professional Development (CPD) program and through the Consultant's educational column in the Division's newsletter. The position of area service case manager ensures system support for GP participation and so strengthens the capacity for GP participation as a team member in palliative care. The current focus on care planning and case conferencing is now strengthening capacity through improvement of support systems for GP participation in palliative care.

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[2] E.Harris. M.Wise, P.Hawe. P.Finlay and.Nutbeam (1995) on *Working Together: intersectoral action for health*, , Commonwealth of Australiat

A very strong emphasis in the Geelong program has been on the building of the **relationship** between GPs and palliative care services. This relationship is developed at two levels: the special interest group with lead GPs and palliative care specialists and nurses, and at the individual level (a) through the clinical attachment program and (b) through the face-to-face lunch time meetings in the GP's practice. At the special interest level the relationship is reinforced with a very high level of commitment on both parts: the palliative care consultant and nurse commitment to practice visits and the GP commitment to covering after-hours and weekend rosters for the inpatient unit.

The high participation rate in the Geelong program suggests that members have a high awareness of the program, although it is not as clear, in the language of the Harris framework, that 'the **plans** were transparent to all and the program was regularly evaluated'. As the Program is not tied to a grant it has not undergone the same evaluation processes as have taken place in Mornington Peninsula, although the future plans show a commitment to more time for evaluation and planning.

Finally, the continuation of the palliative care interest group with clearly defined plans for further development illustrates the commitment to **sustain** outcomes gained through the program.

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