

Evaluating a specialist palliative care service in a community setting

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Abstract

Background/Aims In the Norfolk and Waveney Integrated Care System, a community organisation and a hospice have collaborated to develop an innovative specialist palliative care service in a community hospital. The aim of this service evaluation was to review the specialist palliative care service 2 years after implementation began across the integrated care system.

Methods A multi-method approach was used to evaluate this service. Data were collected from pre-existing datasets on referrals, discharge and service use and described using descriptive statistics to assess how the service was used during the evaluation period (1 April 2019–31 March 2021). Qualitative data were collected via semi-structured interviews with 25 patients, carers, staff and other stakeholders. Interview transcripts were analysed using thematic analysis.

Results During the 2-year evaluation period, the service recorded 1800 referrals, 189 admissions to specialist beds and 19712 telephone calls to the 24-hour advice line. Thematic analysis of interview transcripts identified four themes: impact of the specialist palliative care beds, implementation of changes to practice, communication and coordination, and challenges related to providing the service. Overall, patients and carers had very positive views of the quality of care they received. Staff also identified benefits, including access to training and improved morale. Challenges included the limited number of beds and difficulties balancing the care needs of palliative care patients with other patients in the inpatient ward.

Conclusions The specialist palliative care service promoted collaborative working, leading to enhanced knowledge and skills for staff supporting patients with specialist palliative care needs. The service was well-used and patients and their carers were generally very satisfied with the care they received.

Key words: Hospice care; Palliative care; Palliative nursing; Palliative supportive care

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Introduction

Every year in England and Wales, over 500 000 people die; three-quarters of these deaths do not come suddenly (Hunter and Orlovic, 2018). The National Institute for Health and Care Excellence (2021) have stated that adults with advanced life-threatening illnesses and their families should receive good end-of-life care. These guidelines indicate that proper management of care should be effective and collaborative, incorporating multidisciplinary working within and between generalist and specialist teams, whether the person is at home, in hospital or elsewhere.

In the UK, most hospices rely on charity funding and are limited in terms of the number of beds available and the number of patients they can provide care for at any one time. Meanwhile, community-based care is typically funded by the NHS. Therefore, the National Palliative Care and End of Life Partnership (2021) has produced a new framework describing six national ambitions for end-of-life care. These include providing individualised and fair access to care, maximising comfort and wellbeing, and delivering coordinated care that all staff and communities are prepared to provide. To realise these ambitions, new ways of delivering services are being sought (Department of Health and Social Care, 2022a).

To meet the National Palliative Care and End of Life Partnership (2021) goals, a new specialist palliative care service was created in the Great Yarmouth and Waveney region. In

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this area, there was previously no hospice provision for patients with specialist palliative care needs. Two local organisations (a community interest company and a county-based hospice) used a collaborative approach to develop an innovative specialist palliative care service within a community hospital, ensuring that it was integrated both vertically and horizontally across pathways and organisations. The team based the new service on the framework designed by the National Palliative Care and End of Life Partnership (2021). The two organisations worked together to co-produce a model to meet these requirements by enhancing end-of-life care skills and standards across the local system, designed in line with National Institute for Health and Care Excellence (2021) guidance.

By using a partnership approach, the specialist palliative care model aimed to offer coordinated and comprehensive palliative care to patients, their families and carers. The model was designed to complement the well-established community NHS services available in this area, which provide support from nurses and allied healthcare professionals both in patients' homes and in community hospital settings. The newly established specialist palliative care service provided community care, as well as six specialist palliative care beds on an inpatient unit, where patients were cared for by generalist staff with support from the specialist palliative care team from a hospice. This type of service would usually be delivered in a hospice setting, but as there was no hospice available in the region, these six beds were placed alongside rehabilitation beds in a community hospital ward.

The community hospital ward also provided general end-of-life care, with the new specialist palliative care model aiming to provide a 'step-up' and 'step-down' service, whereby patients who needed more complex specialist palliative care management could be stepped up from generalist to specialist palliative end-of-life beds and vice versa. This decision to provide the specialist palliative care beds in the community hospital was agreed with the local commissioners as a more financially attractive and innovative alternative to existing specialist palliative care services in the region.

The delivery objectives of the specialist palliative care service included National Palliative and End of Life Care Partnership's (2021) six ambitions for end-of-life care:

1. Develop a coordinated and comprehensive palliative care service for patients, carers and families
2. Establish six specialist palliative care beds within a community hospital, for which generalist staff provide care for patients with the support of a specialist palliative care team provided by a local hospice
3. Ensure effective delivery of specialist palliative care, including upskilling staff to use robust coordination systems for record sharing and apply the gold standards framework
4. Establish a 24-hour support and advice line (OneCall) for staff and patients in Great Yarmouth and Waveney
5. Adopt specific screening tools, assessments and outcome measures to support patient care
6. Establish a 'compassionate neighbourhood', based around the four primary care home localities in Great Yarmouth and Waveney, to improve the experience of people with life-limiting illness, loss or grief by mobilising assets and resources that already exist in the community level, such as bereavement and psychological support provided by third sector organisations.

The collaborative and co-productive nature of the specialist palliative care service represents a new method of service delivery. Therefore, evaluation of the service is essential to review this new approach, understand patients' and carers' perceptions, explore the adaptation and upskilling required of individual staff members and consider feedback from other stakeholders. This service evaluation was commissioned by the community organisation that co-produced the service and conducted 2 years after it was implemented. The evaluation was underpinned by the aforementioned delivery objectives of the service. The main goals of the evaluation were:

- To undertake semi-structured interviews to a) assess patients' and carers' perceptions of the quality of the service, b) retrospectively explore the adaptation and upskilling required of individual staff members to deliver the service and c) seek feedback from other stakeholders, such as senior staff who commissioned the evaluation, to gain a comprehensive overview of how well the specialist palliative care service is working

- Use quantitative data to explore and describe referral patterns and service use throughout the evaluation period.

Methods

A multi-method evaluation approach was used, including analysis of existing quantitative datasets collected over a 2-year period and a descriptive phenomenological approach to describe qualitative data regarding the lived experience of individuals, collected using semi-structured interviews (Ingham-Broomfield, 2015; Christensen et al, 2017). A multi-method approach was used so that the researchers could draw on the strengths of qualitative and quantitative approaches to explore the quality of the service in detail (Shorten and Smith, 2017).

Data collection

Quantitative data

Existing datasets that had been collected by the local hospice from 1 April 2019 (when the service was implemented) to 31 March 2021 were used to explore and describe referral patterns and use of the service. Available data included the number of referrals made to the service (including the source of and reason for the referral), the number of patients discharged from the service, use of the six specialist palliative care beds and use of the 24-hour helpline.

Qualitative data

Participants were recruited for the semi-structured interviews via purposive sampling. This method was chosen because participants had particular characteristics that enabled detailed exploration of the central themes being considered (Bryman, 2015). Potential participants were informed about the study via posters, telephone calls and email by members of the community and specialist palliative care teams. If they were interested in participating, individuals then contacted the research team via telephone or email.

Any individual aged 18 years or over who was receiving or had received care for the specialist palliative care team was eligible to participate. Relatives or carers of these individuals, and staff who had been involved in the design, management or delivery of the specialist palliative care service, were also all eligible for inclusion. There were no exclusion criteria.

Semi-structured interviews were used, as they have some flexibility in allowing the researcher to phrase or order the questions depending on the participant and the situation (Bryman, 2015). The schedule of questions (shown in [Appendix 1a–c](#)) was based on the six objectives of the service. The interviews were conducted either via a virtual platform or in person, depending on the participant's preference. Participants included patients, carers, staff from the inpatient unit, staff from the local acute hospital, community service staff and some of the commissioning team who support the specialist palliative care team to either deliver or monitor the service. The interviews were recorded and notes were taken for comparison with the transcripts. Each interview took approximately 30 minutes. Transcripts were sent to participants for member checking and amendments were made as requested.

Data analysis

Quantitative data were classified, sorted and grouped to allow descriptive analysis, enabling inferences to be drawn about patterns of referral and use of specific elements of the service. Data are presented as frequency distributions, percentages and ranges as appropriate.

The qualitative data were analysed using thematic analysis based on descriptive phenomenology, as outlined by Sundler et al (2019). The analysis began by reading the text with an open mind to become familiar with the data. The next step involved searching for, marking and describing any meaningful data. The data were then organised to achieve further familiarity; from this step, patterns were recognised, then themes emerged. When conducting the analysis, the authors aimed to describe the meanings and compare differences and similarities, so that the themes described participants' lived experiences in their actual context. The interview transcripts were annotated by each researcher independently. Prominent and unifying themes were identified. The team also systematically examined

differences between the proposed themes, which were resolved by consensus. Finally, the themes were named and described in a meaningful way.

Ethical considerations

The researchers upheld the domains of the research governance framework (Department of Health and Social Care, 2020) by always ensuring that the dignity and wellbeing of participants were maintained, providing appropriate information about the study and adhering to appropriate health and safety regulations. Data protection regulations were always adhered to. Ethical approval for the study was granted by the research ethics committee at the University of Suffolk (approval code: RETH20/073), which was commissioned by the service to complete the evaluation. The aims of the study were explained to participants before the interviews began and written consent was obtained.

Results

Between 1 April 2019 and 31 March 2021, 1800 referrals were made to the specialist palliative care service. This excluded any referrals to other services, such as wellbeing and bereavement. Of the 1800 referrals, 47% ($n=847$) were for female patients and 53% ($n=953$) were for male patients. The most common reason for referral was complex symptom control, as shown in **Table 1**. Complex end-of-life issues refers to an acute exacerbation of clinical symptoms. Complex psychosocial family issues refers to challenging family or carer dynamics which may impact psychosocially on either the patient or their family/carer, and effect the delivery of care at the end of life. Rehabilitation issues refers to issues that occur during palliative rehabilitation.

The source of referrals to the service are shown in **Table 2**—the highest percentage of referrals (28.2%) came from nurse specialists based in an acute hospital setting, followed by GPs (23.2%). Of the 1800 referrals, only 29 were made internally. The average time between initial date of the referral and discharge was 64 days, although this ranged from 1 day up to 721 days. Reasons for discharge from the service are shown in **Table 3**.

During the 2-year evaluation period, there were 189 admissions to the specialist palliative care beds in the community hospital, with 156 different patients. The mean length of stay was 15 days, but this ranged from 1–71 days.

A total of 19 712 telephone calls to the OneCall 24-hour advice line were recorded. The highest proportion of these calls were from carers or relatives (46%), followed by patients (22%) (**Table 4**). **Figure 1** displays the number of calls to the OneCall 24-hour helpline per month. The number of calls increased significantly from the first to second year, showing an increase in engagement.

A total of 25 individuals participated in the semi-structured interviews, of whom eight were patients (four men, four women). All patients were diagnosed with cancer, with specific diagnoses including prostate cancer ($n=2$), breast cancer ($n=2$), colorectal cancer ($n=2$), sarcoma ($n=1$) and pancreatic cancer ($n=1$). The mean age of patient participants was 68.6 years (range: 51–88 years). Two carers also participated: one was a 40-year-old woman, who was the daughter of a patient with breast cancer, while the other was a 60-year-old man, who was the husband of a patient with pancreatic cancer. Other participants

Table 1. Reasons for referral to the specialist palliative care service ($n=1800$)

Reason for referral	<i>n</i> (%)
Complex end-of-life issues	48 (2.7)
Complex psychosocial/family	198 (11.0)
Complex symptom control	1305 (72.5)
Rehabilitation (palliative)	245 (13.6)
Not given	4 (0.2)

Table 2. Source of referrals to the specialist palliative care service (n=1800)

Source	n (%)
Allied health professional	137 (7.6)
Children's hospice	1 (0.1)
Community nursing team	10 (0.6)
Complex discharge nurse	1 (0.1)
Consultant	211 (11.7)
Continuing healthcare service	2 (0.1)
GP	417 (23.2)
Internal referral	29 (1.6)
Nurse-led assessment	3 (0.2)
Nurse specialist (community)	127 (7.1)
Nurse specialist (acute hospital)	508 (28.2)
Nursing home team leader or manager	4 (0.2)
Palliative care team (hospital)	235 (13.1)
Patient/family self-referral	111 (6.2)
Social worker	4 (0.2)

Table 3. Reason for discharge from the specialist palliative care service (n=1800)

Reason	n (%)
Admitted to hospital	3 (0.2)
Admitted elsewhere	2 (0.1)
Data cleansing (removal of duplicate records)	2 (0.1)
Death	1147 (63.7)
Declined treatment	13 (0.7)
Inappropriate referral	44 (2.4)
Transferred to hospice service	6 (0.3)
Treatment completed	449 (24.9)
Moved out of area	22 (1.2)
No contact from patient	22 (1.2)
Patient too unwell to transfer	1 (0.1)
Not given	89 (4.9)

included eight community service providers, four specialist palliative care service staff and three other stakeholders (senior staff from the community organisation that commissioned the evaluation).

Following analysis of the qualitative data, the following overall themes emerged:

- Impact of specialist palliative care beds
- Implementation of changes to practice
- Communication and coordination
- Challenges related to providing the service.

Table 4. Sources of calls made to the 24-hour helpline (n=19712)

Caller	n (%)
Carer or relative of service user	9115 (46.2)
Patient	4387 (22.3)
Other professional providing related services*	4211 (21.4)
Healthcare professional working outside of the organisation	1463 (7.4)
GP	287 (1.5)
Healthcare professional working within the organisation	191 (1.0)
Generalist healthcare professional with enquiry unrelated to specific patient receiving specialist palliative care	58 (0.3)

*Eg occupational therapists, social workers, care home staff or paramedics

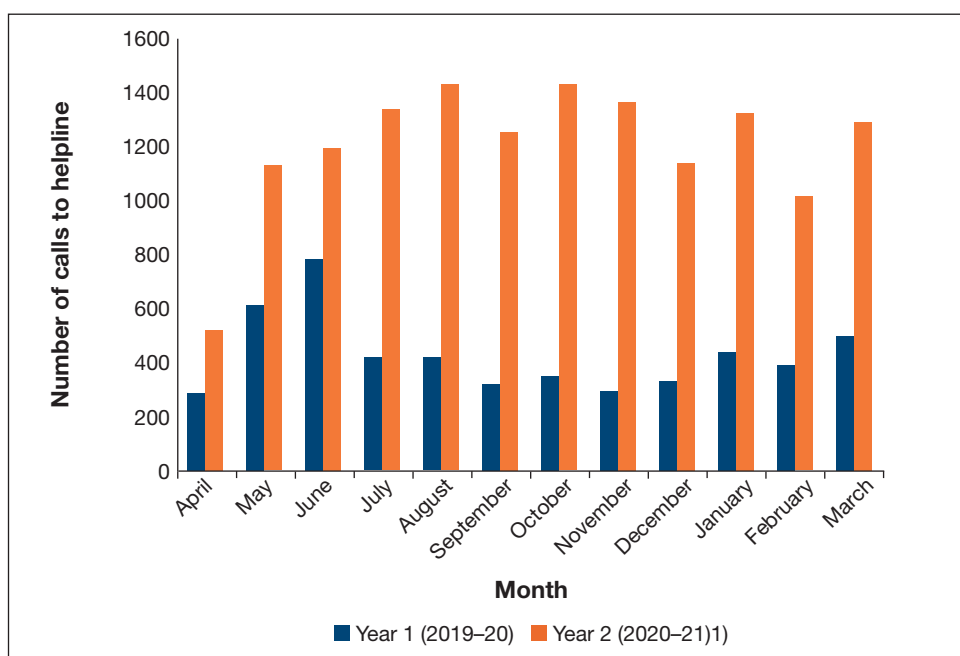


Figure 1. Number of calls to the OneCall helpline per month in year 1 and year 2 of the service.

Impact of specialist palliative care beds

Delivery of care

Several participants noted that having the specialist palliative care beds and team led to a better understanding of how this type of care can facilitate a more holistic approach and provide broader and more in-depth medical support. Patient participants commented on how effective and caring the staff at the inpatient unit were.

‘It has made a great difference; the staff have learned so much from them. They share their knowledge [and] protocols and you can see how that makes a difference to patient care.’ (Stakeholder 2).

Participants also liked that the specialist palliative care team dealt with patient discharges, as this freed up the nurses’ time for patient care:

‘It is much better as it frees up our time to enable us to do other things with the patients that are already with us.’ (Community service provider 1).

Ward environment

The service providers and specialist palliative care team noted that having the specialist beds in the inpatient unit had a positive impact on the ward environment. Participants felt that the specialist palliative care team fit in well, created a more positive environment for patients, provided support to other staff and boosted both staff and patient morale. However, some participants also noted that having the specialist palliative care beds made the ward busier because of the increased number of carers and other visitors. The patients and carers interviewed felt that the ward environment was positive, perceiving it as different to other treatment they had experienced in an acute setting.

‘The environment can be heavy, as we have a lot of very young and ill patients that can create their own issues as well, yes they get busy and stressed at times but there is normally a lot of good humour.’ (Community service provider 3).

Patients

Participants indicated that the presence of specialist palliative care nurses, doctors and consultants improved the delivery of care, which resulted in more positive patient feedback. The impact of having the specialist palliative care beds on the ward in a community hospital was appreciated by the patients and carers. One patient participant stated:

‘The care I am getting is very good and I am very grateful for it. I could not wish for a better service. Everyone is helping me as much as they can. I have had bad days and I have had good days and I cannot beat this service.’ (Service user 1).

Implementation of changes to practice

Participants reported that the introduction of the specialist palliative care beds led to several changes being implemented, notably that the service providers became more patient focused. Staff participants also stated that they received more training, and that more meetings were implemented to improve collaborative working:

‘We had some training days that were given by hospice staff which were really helpful I found they talked us through different medication and also... all the different paperwork they had and what we could bring into the hospital which may help us and we could adapt to our ward which was very handy.’ (Community service provider 5).

However, another staff participant suggested more educational training was needed for healthcare support workers:

‘We get support from the ward manager and the matron but we have no training from the specialist palliative care team. I think if we did, we could support each other better because we do get quite a lot of young people which is quite hard and there may be different things we may be able to do for the patients if we knew more.’ (Community service provider 4).

Communication and coordination

Coordination

Several participants reflected on how coordinated they found the service. This included how well they felt the specialist palliative care team fitted in and supported the other service providers, as well as how effective they found the teamwork to be.

The patients and carers interviewed all felt that the care they received was very well coordinated:

‘Everything was in place, everything was done very efficiently. We did not have to wait for anything. Everything kicked in very efficiently, it was just very good really.’ (Service user 10).

Suggestions for improvement

Some participants suggested that the coordination of care and communication could be improved, especially with the community nursing teams. Staff participants who worked in the generalist community team indicated that they would like the specialist palliative care team members to be more visible and to attend community staff team meetings. Meanwhile, staff participants from the inpatient ward suggested that there needed to be better communication about visiting times for relatives and specialist palliative care team ward rounds, as these can affect patients' mealtimes. Some participants reported that they did not receive information about who the special palliative care team would be seeing and at what time. However, overall feedback was positive:

'I found mainly it has been very good, there were times when it could be better, but the specialist palliative care team are very much wanting us to be involved and they ask us what we think as well as just telling us what they want done.' (Community service provider 5).

Communicating with the wider community

Some participants stated that communication with the wider team or community was effective and that all parts of the team worked well together. This was perceived as being, in part, a result of regular team meetings:

'We have a daily huddle where complex palliative patients are discussed with the district nursing teams. The palliative care team are part of the huddle so that is good in general I think we work well together.' (Community service provider 1).

Competency of staff

Almost all participants stated that they found the staff highly confident and competent. It was noted that the specialist palliative care team were very helpful and knowledgeable and willingly shared their knowledge. Patient and carers interviewed felt that the specialist palliative care team were confident and often tried different things to improve their symptom management:

'I have had care from a lot of different medical teams and I say for what I see of this team, they are extremely efficient, confident and competent in their attitude and the care that they have given me so far is brilliant. Just cannot fault them.' (Service user 8).

Challenges with providing the service

Impact of COVID-19

Participants regularly mentioned the impact that COVID-19 had on the delivery of care for patients in the specialist palliative care beds. Challenges included not being able to give the patients as much attention as they would like, as limited staffing meant they had to less time to devote to all patients, as they needed to also give attention to patients undergoing rehabilitation. Training and supervision also stopped during the early stages of the pandemic, and reduced face-to-face contact meant that other staff struggled to communicate with the specialist palliative care team:

'Supervision for me has gone out the window because of COVID-19 but it is something I need to look at again.' (Specialist palliative care service staff member 2).

Travel requirements

Several service providers and patients noted that one of the challenges was that the hospital was quite far away from patients' homes, which led to difficulties with attending the service or visiting relatives. This made some patients feel apprehensive about staying at the hospital. However, some patients did not see this as a major barrier, with one stating:

‘It can be a bit of a struggle for my wife to get here to see me because there is no public transport, [but] we are both so happy with the care I am getting here we are very happy to put up with this one inconvenience.’ (Service user 7).

Lack of beds

Some service providers reported that they found the specialist palliative care beds were often unavailable because of their limited number. Staff participants also noted that the step-down service was not being used very often:

‘We do not use [the step-down service] a lot, it is often due to the bed capacity either they are full or we are full, so often we just give them advice on the patients in the non-specialist palliative care beds.’ (Specialist palliative care service staff member 1).

Difficulties combining specialist palliative care and rehabilitation services on one ward

Some participants reported finding it difficult to deliver high-quality care to both the patients under the specialist palliative care service and those receiving rehabilitation at the same time, as they require different types of care. Some staff participants felt that they did not have the time and resources to give the specialist palliative care service patients as much attention as they would like:

‘I think sometimes it is difficult as they take up a lot more time because they need more of our time than our rehabilitation patients.’ (Community service provider 7).

Discussion

The National Institute for Health and Care Excellence (2021) guidelines state that end-of-life care should involve effective and collaborative multidisciplinary working within and between generalist and specialist teams. The specialist palliative care service implemented in Great Yarmouth and Waveney used a novel model of care; there is no other UK service with specialist palliative care beds based in a community hospital, and the service was co-produced by two organisations within an integrated care system.

Retrospective analysis of the quantitative data collected over a 2-year period following implementation of the model demonstrated that the specialist palliative care service was needed and used effectively. Referral patterns were consistent throughout the evaluation period, with 1800 received in total and the main reason for referral being for support with complex symptom control management. Over two-thirds of the referrals (64.5%) came from an acute hospital setting, which suggests that acute care staff were able to embrace this community-based care model. Other referrals came from community staff and GPs (23.2%).

A key element of the specialist palliative care service was the allocation of six specialist beds in a community hospital inpatient ward. The collaboration between the specialist palliative care and general hospital staff to care for patients in these beds shows the benefits of closer working between organisations. As highlighted in the Department of Health and Social Care’s (2022b) white paper, integrated care systems are expected to improve patient flow and care. The beds were well used during the evaluation period, with almost 190 admissions from acute and community settings.

The specialist palliative care service also established a 24-hour telephone advice line. This service recorded a total of 19 712 telephone calls during the 2-year evaluation period. Nearly half (46.2%) of these calls were from carers or relatives of patients undergoing palliative care, but a substantial proportion of calls were also from healthcare staff from various roles and specialisms. This indicates that having a constantly available source of advice and support is useful in palliative care services. This is aligned with previous research, which has shown that telephone advice and support services can facilitate considerable improvements to symptom management patient satisfaction, while reducing unnecessary hospital admissions (Plummer and Allan, 2011).

The qualitative analysis showed that participant perceptions of the specialist palliative care service were largely positive, particularly in terms of the coordination and quality of

care delivered. Participants indicated that the specialist palliative care team had a positive impact on the ward environment and helped with the upskilling of staff. The value of a multidisciplinary, holistic approach to care delivery was recognised by all participants, with interviews highlighting the positive impact of the service on both the physical and psychological aspects of care, which enhanced the quality of care. The positive impact of collaborative multidisciplinary special palliative care has been supported by previous research. For example, Kamal et al (2013) suggested that effective palliative care should be collaborative and coordinated, with an interdisciplinary team, in order to deliver improved patient care, reduced rates of hospital readmission and lower health costs.

Participants noted the importance of having the specialist palliative care team on site, as this facilitated upskilling among the generalist ward staff. This supports previous research by Ho et al (2020), which found that specialist palliative care services led to increased general palliative care skills in small teams, as well as several other benefits, such as enhanced workflow and care delivery. Specialist palliative care services were also found to improve teamworking (Ho et al, 2020). In the present study, generalist staff reported gaining knowledge and understanding of the services provided by the wider specialist palliative care team. For example, some generalist staff felt they had a better understanding of the different medications and specialist palliative care protocols, which allowed them to provide better support to patients. In general, ward staff stated that they found the specialist palliative care staff highly confident, competent, helpful and knowledgeable. Having the specialist palliative care team working in the community hospital setting was perceived as creating a more positive environment for patients receiving end-of-life care because of the additional support that specialist staff can provide.

Despite the benefits reported, the interviews also highlighted some challenges. Some of these were caused by the COVID-19 pandemic, which led to a reduction in supervision and discontinuation of regular training for community staff, which may have impacted the care received by some patients (Pastrana et al, 2021). Furthermore, some participants suggested that the geographical location of the specialist palliative care service was problematic, as it was far from their homes and there was a lack of public transport to the hospital. However, the patients interviewed suggested that the quality of care they received was worth this inconvenience.

Additionally, some community staff suggested that admitting patients to the specialist palliative care beds could be challenging, as they were often all occupied. This meant that the step-up/step-down service could not be used, as there were not enough specialist palliative care beds to move patients into. Nevertheless, although there were only six inpatient beds, community staff had direct access to the specialist palliative care team if they need specialist support or advice for patients, and the service was designed to allow ongoing communication between the teams about individual patients' needs to ensure that they receive optimal care regardless of where they are located.

Another challenge highlighted by generalist staff working in the inpatient unit related to delivering care to both to patients under the specialist palliative care service and patients undergoing rehabilitation in the same ward. Some generalist staff participants reported that this could impact on the quality of care they delivered, as they had less time to support all patients because of the complexity of care required by the patients receiving special palliative care. However, participants also suggested that, as they became more familiar with patients' treatment regimens, their confidence and competence increased, which they believed would help to resolve this challenge.

Participants reported that there was sometimes confusion around the timing of ward rounds by the specialist palliative care team, although they found that this improved as the teams developed stronger professional relationships. This highlights the importance of good teamworking for communication and coordination of patient care.

Limitations

Quantitative data were collected retrospectively, so the research team had no input in the possible variables being collected or measured. It would have been preferable to collect data prospectively so that the full impact of the service could be compared to previous

models of care. It would also have been beneficial to explore the impact of the development of the specialist palliative care service on patient flow across the system, and whether this process affected the admission of specialist palliative care patients to acute organisations.

The qualitative component of this study had a relatively small sample size. It would be beneficial for future research to gather feedback from a wider group of participants, such as primary care staff. This could be achieved by carrying out focus groups, or developing a questionnaire for wider dissemination on the impact of the service. However, these measures were not possible in the present study because of time constraints. It should also be considered that the thematic analysis of the interview transcripts may have introduced an element of bias.

Conclusions

Overall, this evaluation indicates that the implementation of the specialist palliative care service in Great Yarmouth and Waveney has been beneficial to patients, carers and staff. Quantitative data demonstrated high levels of engagement with all aspects of the specialist palliative care service, while qualitative data showed how staff from both specialist palliative care and generalist teams have worked collaboratively together. Participants highlighted the training provided by the specialist palliative care to the generalist team, noting how this has enhanced their knowledge and skills in supporting patients with specialist palliative care needs. Some challenges with the service were reported, mainly relating to communication with community nursing teams and balancing care on the ward between specialist palliative care patients and rehabilitation patients. However, the coordination and communication of the service was described positively by most participants. Patients and carers reported that they received high-quality care and valued having easy access to members of the team when needed.

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Conflicts of interest

This evaluation was conducted independently by a local university. It was funded by East Coast Community Healthcare community interest company, who commissioned the specialist palliative care service. Although some of the community staff participated in the interviews, they had no input in the design of the study or analysis of the results.

Declaration of funding

This evaluation was commissioned and funded by the East Coast Community Healthcare community interest company, which also commissioned the specialist palliative care service. The funding for this article's open access license was provided by the University of Suffolk.

Data availability statement

The data that support the findings of this study are available from the corresponding author on reasonable request.

Key points

- An innovative specialist palliative care service developed across an integrated care system within a community hospital with six specialist palliative care beds improved the quality of care for patients
- Generalist staff working on the inpatient were upskilled to support the delivery of the specialist palliative care service
- Patients and carers suggested the quality of care they received was excellent.

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Appendices

Appendix 1a. Schedule of questions for semi-structured interviews with patients and carers

1. How did you access the specialist palliative care service?
2. How do you feel that you are/were being treated?
3. How does the specialist palliative care service maximise comfort and wellbeing for you?
4. From your experience, how coordinated have you found the palliative care support provided to you?
5. From your experience, how competent and confident have you found staff in the delivery of the specialist palliative care service?
6. Any further comments.

Appendix 1b. Schedule of questions for semi-structured interviews with specialist palliative care team, ward and community staff

1. How has having the specialist palliative care beds based within a community hospital impacted the delivery of care that you provide?
2. What changes have you had to make in your practice to support the specialist palliative care service?
3. How coordinated have you found the palliative care delivery across services?
4. How competent and confident have you found staff in the delivery of the specialist palliative care service?
5. How do you interface with the wider team in the delivery of end-of-life care?
6. What support have you received to ensure that you are delivering the expected service commissioned by the clinical commissioning group?
7. How effective have you found the community provision to assist in the care of specialised palliative care patients?
8. What feedback have you received from patients/carers/relatives about the specialist palliative care service?
9. Any further comments.

Appendix 1c. Schedule of questions for semi-structured interviews with stakeholders

1. How has having the specialist palliative care beds based within a community hospital impacted the delivery of care that you commissioned?
2. How coordinated have you found the specialised palliative care delivery across services?
3. How competent and confident have you found staff in the delivery of the specialist palliative care service?
4. How do you interface with the wider team in the delivery of end-of-life care?
5. How effective have you found the community provision to assist in the care of specialised palliative care patients?
6. What feedback have you received from patients/carers/relatives about the specialist palliative care service?
7. Any further comments.