

Factors supporting good partnership working between generalist and specialist palliative care services:

a systematic review

Abstract

Background

The care that most people receive at the end of their lives is provided not by specialist palliative care professionals but by generalists such as GPs, district nurses and others who have not undertaken specialist training in palliative care. A key focus of recent UK policy is improving partnership working across the spectrum of palliative care provision. However there is little evidence to suggest factors which support collaborative working between specialist and generalist palliative care providers

Aim

To explore factors that support partnership working between specialist and generalist palliative care providers.

Design

Systematic review.

Method

A systematic review of studies relating to partnership working between specialist and generalist palliative care providers was undertaken. Six electronic databases were searched for papers published up until January 2011.

Results

Of the 159 articles initially identified, 22 papers met the criteria for inclusion. Factors supporting good partnership working included: good communication between providers; clear definition of roles and responsibilities; opportunities for shared learning and education; appropriate and timely access to specialist palliative care services; and coordinated care.

Conclusion

Multiple examples exist of good partnership working between specialist and generalist providers; however, there is little consistency regarding how models of collaborative working are developed, and which models are most effective. Little is known about the direct impact of collaborative working on patient outcomes. Further research is required to gain the direct perspectives of health professionals and patients regarding collaborative working in palliative care, and to develop appropriate and cost-effective models for partnership working.

Keywords

collaborative working; generalist palliative care; partnership working; specialist palliative care.

INTRODUCTION

The need to increase the numbers of health professionals involved in palliative and end-of-life care has become a priority of palliative care policies across the developed world. Ageing nations and expanding populations mean annual numbers of deaths are predicted to rise by as much as 17 per cent over coming years.¹ In the UK, the recent palliative care funding review has estimated that, currently, up to 457 000 people need access to a palliative care, but around 92 000 people are not being reached.² In the UK in 2009, there were 507 specialist palliative care inpatient services, whose remit is to care for patients who require continuous or high levels of support;³ however, the care that most people receive at the end of their lives is provided not by specialists but by generalists, such as GPs, district nurses, nursing home staff, hospital staff, and others who have not undertaken specialist palliative care training.⁴

Generalist palliative care provision has seen limited research attention to date. There is no consensus regarding the definition of the term 'generalist' in the context of palliative care,⁴ and people have reported differing understandings of the purpose and scope of generalist palliative care;^{5,6} in spite of this, international health policy has sought to place the generalist at the heart of palliative care provision.^{7,8} In the UK, recent policy has highlighted the importance of training and education for generalist providers if they are to provide

effective palliative care.⁹ However, difficulties incorporating palliative care into a generalist workload have been reported, as has defining the role of palliative care outside the specialist setting.^{10,11} A recent study by Gott *et al* reported significant challenges in generalist working in England and New Zealand. Difficulties with defining the nature and limits of generalist palliative care, as well as negotiating partnership working were reported; these reveal a significant gap between palliative care provision as enshrined in policy and the reality reported by frontline staff.⁶

A key focus of UK policy is improving communication, partnership working, and multidisciplinary involvement across the spectrum of palliative care provision.⁹ Although good communication and improved partnership working between specialist and generalist providers have been identified as facilitators for optimum palliative care provision,¹² there is little evidence to suggest which factors support these working relationships. In addition, partnerships have costs in terms of negotiating, developing and maintaining working relationships, and translating these into successful outcomes.¹³

The current economic climate makes significant expansion of palliative care services unlikely, yet policymakers have highlighted a commitment to ensuring high-quality palliative care for all.^{7,9} As such, identifying factors that support effective partnership working between generalist and

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How this fits in

A key focus of UK policy is improving partnership working across the spectrum of palliative care provision. This systematic review identifies factors supporting partnership working between specialist and generalist palliative care providers, and provides clinicians with examples of successful partnership working models. Further research is required to generate a better understanding of partnership working, and to identify and evaluate appropriate outcome measures.

specialist providers of palliative care is not only timely, but also crucial for improving patient care. This study aimed to carry out a systematic review of factors supporting good partnership working between generalist and specialist palliative care providers.

METHOD

Design

A systematic review was undertaken to explore factors supporting good partnership working between generalist and specialist providers of palliative care. The review synthesised evidence from a variety of sources and included quantitative, qualitative, and grey literature,¹⁴ and was undertaken in the following stages:

- Development of a search strategy and inclusion criteria;
- Assessment of relevance; and
- Data extraction and synthesis, using a descriptive thematic model.

Search strategy and inclusion criteria

The aim of the search was to identify a

comprehensive list of literature that met predefined inclusion criteria. An initial scoping search was undertaken to identify and evaluate search terms. Medical Subject Headings and keywords were identified, and relevant databases selected and searched using the search terms highlighted in Box 1. The databases MEDLINE, Embase, CINAHL, Cochrane, PsychINFO, and Web of Science were searched for literature published until January 2011. Grey literature searches were conducted in the above databases and using internet search engines. Relevant references from bibliographies and citations were followed up.

To comply with the inclusion criteria, studies had to:

- relate to factors affecting collaborative or partnership working between generalist and specialist providers of care;
- relate to palliative or end-of-life care in adults;
- be empirical; and
- be written in English (resource restrictions prevented the translation of non-English-language papers).

For the purposes of this review 'specialist' providers were defined as health and allied health professionals with specialist or accredited training in palliative care delivery, and 'generalist' providers as health professionals with no specialist or accredited training in palliative care. These definitions are in line with *The End of Life Care Strategy for England*.⁷

Assessment of relevance

The search resulted in 159 papers being identified. Study selection was conducted in a systematic sifting process over three stages: title, abstract, and full text (Figure 1). Full texts were extracted for 68 papers, each of which was independently reviewed by two researchers; 46 papers were rejected. Where there was disagreement between reviewers, consensus was reached through discussion. In total, 22 papers satisfying the inclusion criteria were identified,^{5,15-35} these are detailed in Table 1.

Data extraction and synthesis

As it was anticipated that a range of papers using different methodologies would be obtained, the review was conducted using a descriptive thematic method for systematically reviewing and synthesising research from different paradigms. Thematic analysis offers advantages,

Box 1. Search terms

End-of-life terms

Terminally ill; end of life; end-of-life; last year of life; palliative; hospice; terminal care; terminal patient; supportive care

Specialist care provider terms

Palliative service; palliative care service; (palliative and (expert or specialist)); palliative care team; palliative medicine; palliative care consultant; palliative doctor; palliative care nurse; Macmillan nurse; Marie Curie nurse

Generalist provider terms

Primary care physician; family doctor; general practitioner; GP; Community Health Nursing/or Public Health Nursing; district nurse; community matron; community nurse; Homes for the Aged/or aged residential care/or Nursing Homes; care home; residential home; nursing home

Partnership and collaboration terms

Partnership working; collaboration or cooperative behaviour; collaborative working; communication; shared working; joint working; shared care; inter-agency collaboration; extended team.

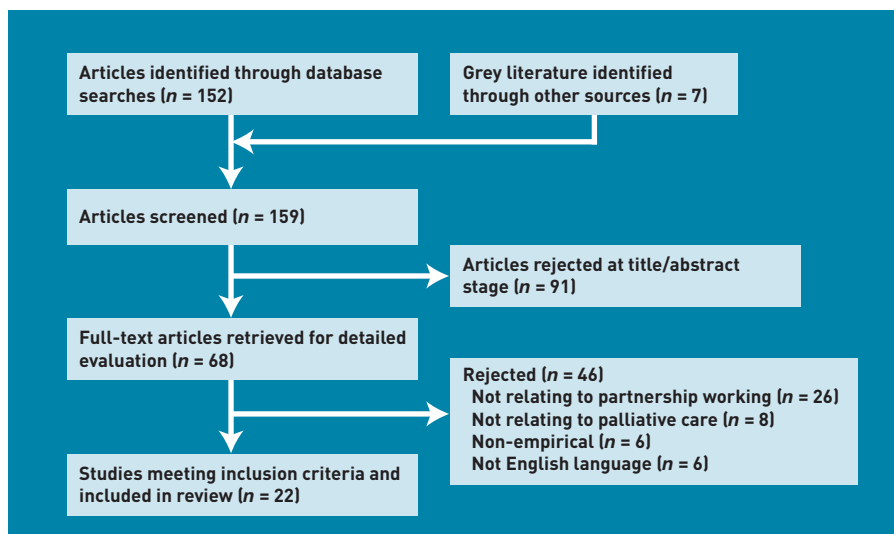


Figure 1. PRISMA diagram of included literature.

including allowing clear identification of prominent themes, and providing organised and structured ways of dealing with the literature.³⁶ The thematic approach was data driven; major or recurrent themes relating to partnership or collaborative working were identified in the literature and the findings of the primary studies were summarised under these headings. Within each theme, both supporting and conflicting data were reported, if available. No attempts were made to quantitatively summarise and synthesise study quality, due to the recognised methodological problems with this approach when combining qualitative and quantitative evidence.^{36,37} These include heterogeneity of study purpose and study design, and lack of numerical data in qualitative studies.

RESULTS

The 22 papers included in the review represented an international perspective; 13 papers were from the UK, seven from Australia, one from New Zealand, and one from Canada (Table 1). Eleven papers were concerned with exploring factors involved in, or attitudes to, partnership working.^{5,15,17,20,21,24,28,31,33–35} six were descriptions of the development or implementation of partnership working models.^{16,18,19,22,25,30} and five were evaluations of partnership working models.^{23,26,27,29,32} Eleven of the papers used qualitative methods;^{5,15,17,20,21,24,28,30,31,33,34} seven used quantitative methods;^{19,22,23,25,27,29,35} three used mixed methods;^{18,26,32} and one used a case-study approach.¹⁶

Some methodological weaknesses exist in the studies reviewed, so some caution must be exercised when attempting to draw any firm conclusions. Only one of the studies

was a randomised controlled trial and most evidence was derived from sources that do not enable generalisability. Analysis of the data led to the emergence of five key factors that could enhance partnership working between specialist and generalist palliative care providers:

- Good communication between providers;
- Opportunities for education;
- Clear definition of roles and responsibilities;
- Access to specialist palliative care; and
- Coordinated and continuous support.

Good communication between providers

Communication between specialist and generalist providers was a feature of many of the included studies. The evidence suggests that existing communication strategies are not necessarily appropriate, timely, or relevant. Good communication between teams was a key feature of the successful implementation of collaborative working models.^{17,19} Examples of good communication strategies that were reported included heart failure nurses being invited to attend community palliative care multidisciplinary team meetings,¹⁸ liaison links being established between care home staff and a local hospice,²² and case conferences being held between GPs and specialist palliative care providers.²⁷

Poor communication was cited as a factor that prevented generalist staff from becoming more involved in palliative care.^{24,31} Encouraging dialogue between specialities was identified as an important future priority.²¹ Identified barriers to effective communication included a lack of processes for communication,³⁵ and issues establishing networks. Good communication networks are often the result of personal liaison rather than systematic processes.³³

Opportunities for education

Education and training were identified as important facilitators of collaborative working, with the many of studies identifying education for generalists as a particular priority.^{19,23,24–26,28} Examples of successful education models for generalists included study days for care home staff,²² practice-based education and decision support for GPs,²⁵ and educational inductions for palliative care partnership models involving GPs and practice nurses.²⁶ One study reported shared learning practices involving both specialists and generalists: as part of

Table 1. Papers included in the review

Study	Aims	Participants	Setting	Study design/ method	Relevant findings
Aitken (2006) District nurses' triggers for referral of patients to the Macmillan nurse ¹⁵	This study aimed to explore the triggers that motivate district nurses to refer patients to the Macmillan nurse in order to reveal whether influences other than 'patient need' determine referrals	District nurses (n = 8)	Primary care locality in the UK	Qualitative semi-structured interviews	Three themes emerged: knowledge and skills; interprofessional issues; perception of Macmillan. Reasons for referral to Macmillan services were often cited as the extra knowledge and skills of staff in physical and psychosocial symptom control, and family issues. Referral paths to Macmillan differed greatly and there were gaps in district nurses' knowledge of the Macmillan role. Patient perceptions could also affect referral to Macmillan. The study concluded that there is a need to educate health professionals and patients about the role of the Macmillan nurse, as well as a pressing need to develop referral criteria for the Macmillan service.
Alsop (2010) Collaborative working in end-of-life care: developing a guide for health and social care professionals ¹⁶	Review of a project to develop collaborative working between palliative care nurse specialists and community matrons for patients with a non-cancer diagnosis	Community matrons and hospice staff	UK hospice	Non-empirical: project review. Focus groups of community matrons and hospice nurse specialists met to develop models of collaborative working	Two care pathways were developed: one for 'palliative care' and one for 'urgent care'. One of the key functions of the pathways is to facilitate partnership working by providing clarity around concepts and principles, as well as roles, responsibilities, and decision making. These pathways were subsequently developed into a guide for use by health or social care professionals, to facilitate best practice in end-of-life care, and have been adopted by two primary care trusts.
Blackford, Street (2001) The role of the palliative care nurse consultant in promoting continuity of end-of-life care ¹⁷	To explore the experiences and strategies used by palliative care nurses to communicate with GPs	Specialist palliative care nurses (n = 11) and other nurses working in specialist palliative care services (n = 11)	Specialist palliative care services, hospitals, district nursing services in Melbourne, Australia	Qualitative — focus groups and semi-structured interviews	Some issues identified related to defining roles and responsibilities of different nurses providing specialist palliative care. Difficulties were reported with communication at acute/community interface; specialist palliative care nurses could help improve this and promote continuity of care. Professional territorialism can undermine care as there is no agreed consensus on roles and responsibilities. The success of communication strategies, for example written documentation and regular meetings, were dependent on specialist palliative care nurse provision of accurate and timely information. It would be beneficial if the role diversity that exists in the palliative care nurse consultant position could be addressed to provide consistency between services and appropriate resource support.
Daley <i>et al</i> (2006) Heart failure and palliative care services working in partnership: report of a new model of care ¹⁸	To describe the evolution of joint working between heart failure and specialist palliative care services	491 heart failure (HF) patients	HF services and specialist palliative care services in Bradford, UK	Service description incorporating descriptive service data and qualitative data from patients	Shared learning was undertaken between HF nurses, specialist palliative care staff, and primary care staff. HF nurses took on a role as key worker for patients' holistic care providing care where possible or coordinating other services. Collaboration over patient care generally took the form of advisory care or direct care. Hospice-based HF support groups were also set up to provide total care for patients with HF. Collaborative services did not lead to excess burden on specialist palliative care or increased use of hospice beds. Patients/carers were positive about the support group and found it helpful.
Davidson <i>et al</i> (2004) Integrated collaborative palliative care in heart failure: the St. George Heart Failure Service experience 1999–2002 ¹⁹	To describe the development of a model of an integrated, consultative, palliative care approach within a comprehensive HF community-focused disease management programme	—	Teaching hospital in Sydney, Australia	Description of model development and evaluation	Model for integrated palliative care in HF management was developed following literature review, casenote review of patients with HF, and consultation with stakeholders. A template for a systematic care plan was developed for the integrated care of patients with HF who were dying in hospital; a key recommendation was to equip and empower generalist palliative care clinicians with specialist palliative care knowledge through education and training. An important facilitator to the model was communication between teams. Model implementation resulted in more home deaths, fewer referrals to specialist palliative care, and a probable decrease in presentations at accident and emergency.

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Table 1 continued. Papers included in the review

Study	Aims	Participants	Setting	Study design/ method	Relevant findings
Ewing <i>et al</i> (2009) Delivering palliative care in an acute hospital setting: views of referrers and specialist providers ⁵	The aim of the study was to describe referrer (specialist palliative care service user) and provider (specialist palliative care service staff) perspectives on delivery of specialist palliative care in hospital	Junior doctors (<i>n</i> = 5), consultants (<i>n</i> = 13), clinical nurse specialists (<i>n</i> = 6, interviews), medical staff (<i>n</i> = 6), nursing staff (<i>n</i> = 5, focus groups)	Acute hospital trust in England	Qualitative interviews and focus groups	Large areas of agreement between referrers and providers on what hospital specialist palliative care teams should be providing for patients, that is, expertise in managing difficult symptoms and complex psychosocial problems. Access to specialist palliative care was also important, including visibility on the wards, informal routes of access to advice, and a timely response by specialists. Discordance in views of providing palliative care was identified; in particular, whether specialists should be providing generalist palliative care (such as basic psychological support) neglected by ward teams. Some issues with speed of implementation of specialist advice by generalists was also identified.
Field (1998) Special not different: general practitioners' accounts of their care of dying people ²⁰	To explore GPs' experiences of caring for dying people, and their attitudes towards such work	GPs (<i>n</i> = 25)	GPs who had graduated from University of Leicester 10 years previously	Qualitative unstructured interviews	Use of specialist palliative care led to tensions as GPs felt they knew most about social circumstances and patients' general requirements, but would nevertheless lose control of patient care. Some hospices were not willing to involve GPs and district nurses as full-time partners, and were only willing to deliver care on their own terms. Specialist palliative care can have detrimental consequences for GPs by deskilling them. (Note: this paper is fairly old and its relevance was questioned.)
Harratty <i>et al</i> (2002) Doctors' perceptions of palliative care for heart failure: focus group study ²¹	To identify doctors' perceptions of the need for palliative care for heart failure and barriers to change	GPs (<i>n</i> = 36) and consultants in cardiology, geriatrics, palliative care, and general medicine	Northwest England	Qualitative focus groups	Uncoordinated care and unplanned services reported as barriers to good palliative care in HF. Poor coordination between teams led to poor continuity of care; the concept of a key worker was suggested as a solution. Cardiologists accused of failing to recognise palliative care needs. GPs questioned the need for specialist palliative care as they felt able to manage patients who were dying and didn't want them to be 'sloven'. A need for discussion and links between specialties was acknowledged, as was a clarification of roles.
Heals (2008) Development and implementation of a palliative care link-nurse programme in care homes ²²	To explore the development and implementation by a hospice education department of a palliative care link nurse programme in care homes with nursing	Questionnaires (<i>n</i> = 16) completed by link nurses and nursing home staff	Hospice in Southwest England	Service development evaluation	Findings included: the importance of contact and liaison with the hospice; the value of specialist nurses working in the community; and the support received from the hospice's 24-hour advice line. Networking was considered to be an integral part of the programme. Study days were found to be valuable, with increased knowledge and skills for nursing home staff. Changes in documentation and care planning were recognised as an important consequence of the programme. The link nurse was seen as a resource to cascade information, although there was a lack of knowledge and reluctance to change practice in some generalist palliative care staff.
Lloyd-Williams, Rashid (2003) An analysis of calls to an out-of-hours palliative care advice line ²³	To analyse the calls to a palliative care out-of-hours service during its first year	Analysis of phone calls (<i>n</i> = 98)	Hospice in Liverpool, England	Descriptive analysis of phone calls	GPs, community nurses, and junior hospital doctors called the service most frequently. Most calls related to pain control and conversion of drugs. Many callers were unaware of the existence of 24 hour on-call pharmacy service. Communication between professionals caring for patients was poor; many callers reported not knowing enough about the patient. The study supports continuing need for palliative care education in the community.
Low <i>et al</i> (2001) Specialist community palliative care services — a survey of GPs' experience in Eastern Sydney ²⁴	A pilot survey in to assess GPs' experience with a palliative care support service and to explore whether there were any barriers that might prevent needs being met effectively	GPs (<i>n</i> = 51)	GP practices in a locality provided by a palliative care service in Sydney, Australia	Qualitative questionnaire	Factors preventing GPs becoming more involved in palliative care included: poor training; poor communication and liaison with specialist palliative care services; difficulty accessing the service (especially out of hours); and utility of advice given. However, most GPs found the service accessible, giving useful advice with good communication.
Marshall <i>et al</i> (2008) Enhancing family physician capacity to deliver quality palliative home care: an end-of-life, shared-care model ²⁵	To describe a shared-care model to enhance family physician capacity to deliver palliative home care through collaboration with interprofessional palliative care specialists	Family physicians (<i>n</i> = 21) and community nurses (<i>n</i> = 6)	Family health care teams (<i>n</i> = 3) in Niagara West region of Ontario, Canada	Description of new model of care	The shared-care model components included: an enhanced palliative care team available to community teams; improved access and new referral criteria; coordinated continuous care; and education and decision support. The shared-care model resulted in a 40% increase in referrals and increased patient death in place of preference. Family doctors/nurses reported that access to round-the-clock consultations and practice-based education were the most important aspects of the model; they also felt patients benefited from the model.

... continued.

Table 1 continued. Papers included in the review

Study	Aims	Participants	Setting	Study design/ method	Relevant findings
McKinlay, McBain (2007) Evaluation of the Palliative Care Partnership: a New Zealand solution to the provision of integrated palliative care ²⁶	To evaluate a model of integrated palliative care — the Palliative Care Partnership (PCP)	Stakeholders (n = 63)	MidCentral Mixed Health Board, New Zealand	A mixed-method approach including in-depth, semi-structured interviews with a purposeful sample of stakeholders and analysis of routinely collected data	PCP comprised generalist palliative care (provided by GPs/practice nurses) and specialist palliative care (provided by nurse palliative care coordinators and hospice staff). A staff induction and education session is a prerequisite to joining PCP; stakeholders reported favourably on the model of care, clinicians reported increased confidence and satisfaction. Small numbers of patients are refused entry to the PCP (inc. aged). PCP supports GPs to provide early sustainable palliative care, generalist palliative care practitioners felt well-supported by advice from hospice staff. Educational content was seen as valuable.
Mitchell <i>et al</i> (2008) Do case conferences between GPs and specialist palliative care services improve quality of life? ²⁷	To explore whether case conferences between GPs and specialist palliative care services improve patients' quality of life	Patients receiving palliative care (n = 159; intervention, n = 79; control, n = 80)	Sites (n = 3, inner urban, outer urban and a regional general hospital) in Queensland, Australia	Multicentred randomised controlled trial	Global quality of life was not influenced by the intervention. Some improvement in carer burden was seen. The case conference group showed better maintenance of some physical and mental health measures of quality of life in the 35 days before death. Case conferences may improve clinical relationships and care plans at referral, which are not implemented until severe symptoms develop.
O'Connor, Lee-Steere (2006) GPs' attitudes to palliative care: a Western Australian rural perspective ²⁸	What are GPs' attitudes to palliative care in a rural centre of Western Australia? What factors contribute to GPs' attitudes to palliative care? What are the perceived barriers to the provision of palliative care?	GPs (n = 10)	Rural Western Australia	Qualitative in-depth interviews	GPs believed continuity of care was important when delivering palliative care in a rural setting. Working in a multidisciplinary team was seen as highly beneficial; GPs lead palliative care teams, but nurses may provide more care. GPs were thankful to have a specialist palliative care service but were wary of palliative care becoming a specialist-only service. Overemphasis on specialist palliative care services was identified as a barrier to rural GPs' participation in palliative care. GPs had mixed attitudes to more education and training. A telephone service for specialist palliative care advice was viewed positively.
Plummer, Hearnshaw (2006) Reviewing a new model for delivering short-term specialist palliative care at home ²⁹	To evaluate a new community palliative care nursing service at the end of its first year	Health professionals (n = 27) who completed questionnaires	Specialist palliative care unit attached to a hospital in Middlesex, England	Service evaluation: audit examining service activity and questionnaire for health professionals using the service	Evaluation of a new community outreach service, developed in response to problems experienced with discharge from inpatient care. The service comprised specialist palliative care nurses providing short-term, post-discharge care (approx. 72 hours), with medical support. Issues raised prior to implementation included: concerns about deskilling district nurses; duplicating services; raised expectation; withdrawing after 72 hours. Evaluation showed high numbers of referrals led to non-involvement — 49% of patients were enabled to stay at home following care. Health professionals reported the benefits of the service as: support for patients in crisis; facilitating preferred place of care; flexible and quick response; out-of-hours care; support for community team.
Pooler <i>et al</i> (2007) Caring for patients dying at home from heart failure: a new way of working ³⁰	To describe the development of a collaborative working model between HF nurse and Macmillan nurses, to facilitate specialist palliative care for HF patients	—	HF and specialist palliative care services in Northwest England	Description of service development	Barriers to changing practice were identified and included: lack of clinical knowledge in each other's clinical practice; specialist palliative care services being concerned about being overrun; concerns among other health professionals about non-cancer referrals to specialist palliative care. A collaborative working model was developed and involved a Macmillan nurse, HF nurses, and patients being visited at home by district nurses. The service helped address patient understanding of HF, sense of isolation, financial worries, management of physical symptoms.

... continued.

Table 1 continued. Papers included in the review

Study	Aims	Participants	Setting	Study design/ method	Relevant findings
Shipman <i>et al</i> (2002) How and why do GPs use specialist palliative care services? ²¹	To explore GP use of and attitudes to specialist palliative care	GPs (<i>n</i> = 63)	Inner-city, urban, and rural health districts in England	Qualitative interview study	GPs used specialist palliative care services for advice, information, and being updated, as well as patient referral, symptom control, and respite care. GPs fell into four categories: seldom using specialist palliative care; using specialist palliative care as a resource; working with specialist palliative care as an extended team; and handing over responsibility to the specialist palliative care team. These ways of working could change, depending on context, patient need, etc. Barriers to working with specialist palliative care included: communication differences; disagreement over medication; separation of responsibility; and lack of decision making. GPs reported changes in the amount of palliative care they were able to provide now compared to historically, due to time restraints.
Shipman <i>et al</i> (2003) Building bridges in palliative care: evaluating a GP facilitator programme ²²	To evaluate the impact of a Macmillan GP facilitator programme on: palliative care on knowledge, attitudes, and confidence in symptom control of GPs; communication with patients and out-of-hours practice	GPs (<i>n</i> = 449)	GPs in England	Mixed-method evaluation, comprising before/after trial and in-depth interviews	Compared with controls, facilitator GPs were more likely to use local palliative care guidelines. They were less likely to discuss diagnosis, but were more satisfied with out-of-hours services. Facilitators perceived well in qualitative element, building bridges between specialist palliative care and generalist palliative care, and providing an extra perspective to traditional specialist palliative care nurses. This programme led to an increased positive attitude among GPs towards specialist palliative care.
Street, Blackford (2001) Communication issues for the interdisciplinary community palliative care team ²³	To examine communication patterns between nurses and GPs providing palliative care	Palliative care nurses (<i>n</i> = 40)	Community, hospice and hospital, Australia	Qualitative interviews and focus groups	Issues that impeded effective communication included networking issues — effective networking was rarely the result of systematic processes but via specialist palliative care nurses personally liaising and providing coordination. Transmission of information was patchy. There was little consensus on case management, and who had coordinating responsibility for patients; territorialism was sometimes an issue. Multiple service providers meant there was insufficient time for GPs and specialist palliative care nurses to ensure continuity of care, and tracking patients through the system (e.g. being informed about admissions) could be difficult. Lack of standardised documentation between services could also be a problem. Various strategies were identified to improve communication and continuity of care.
Walshe <i>et al</i> (2008) Judgements about fellow professionals and the management of patients receiving palliative care in primary care: a qualitative study ²⁴	To explore the influences on referrals within general and specialist community palliative care services	Health professionals (<i>n</i> = 47), including GPs, district nurses, and specialist palliative care professionals.	Three primary care trusts in northwest England	Qualitative interviews	GP involvement in palliative care and responsiveness varied, and was influenced by professional boundaries. Professionals recognised that their relationships with, and perceptions of, each other influenced how they worked together and made referrals. Nurses reported having to negotiate relationships; power may be an issue. Some mutual criticism of workload management practices, e.g. that of district nurses. Negative comments were made about each others' expertise. Specialist palliative care could be seen as providing an elite service; there was a 'them and us' mentality and GPs could be reluctant to refer. Strategies (e.g. game playing) had been developed to 'get round' difficult colleagues or where relationships had broken down.
Woodhouse (2009) Exploration of interaction and shared care arrangements of generalist community nurses and external nursing teams in a rural health setting ²⁵	To determine the understanding of nurses within a shared-care model, as well as the degree of interaction evident in their practice in the shared-care nursing environment in a rural care setting	Nurses from generalist community health team (<i>n</i> = 6), specialist palliative care team, and aged care team	Primary care in a rural health setting, Australia	Descriptive questionnaire study	Four recurring themes were identified: care plans seemed to be developed in isolation from other teams; case coordination was seen as necessary but not always achieved; knowledge of the role of other teams was varied; a variety of communication strategies described. An enduring theme was a lack of processes for communication and difficulty in achieving feedback.

the evolution of joint working between heart failure and specialist palliative care staff, heart failure nurses attended formal education events organised by specialist palliative care services and vice versa, which was successful in facilitating shared learning.¹⁸

Increased education was not seen as necessary in all studies: O'Connor and Lee-Steere reported that some rural GPs did not see the lack of training in palliative care as a problem.²⁸

Clear definition of roles and responsibilities

A need for clarification regarding the roles and responsibilities of specialist and generalist providers was identified as a priority. Misunderstandings regarding roles and responsibilities were found to have a negative impact on: effective partnership working; the degree of interaction between specialist and generalist colleagues; and the readiness of professionals to engage in partnership working.^{15,17,20,21,35,30} In a national consultation on generalist palliative care provision, separation of responsibility was identified as a significant barrier to collaborative working.³¹ Alsop identified that any model for collaborative working should also clarify definitions and terminologies to reflect the roles and responsibilities of different specialist and generalist services.¹⁶ Professional territorialism — an unspoken demarcation between health professionals, regarding who coordinates and provides patient care — was also identified as a barrier to effective partnership working.^{17,33} Professional territorialism may result in difficulties negotiating relationships, power issues,³⁴ and concerns about deskilling generalist staff.^{20,29}

Access to specialist palliative care

Appropriate and timely access to specialist palliative care services was seen as crucial to effective partnership working and was shown to support generalists in providing sustainable care.^{5,26} Regular contact and liaison with a hospice,²² a flexible service from specialist palliative care providers,²⁹ and visibility of specialist palliative care services in hospital⁵ were all reported as enhancing the capacity of generalists to deliver effective palliative care. Generalists identified good out-of-hours care and access to round-the-clock support from specialist palliative care services as being key aspects of successful partnership working.^{22,24,25,28} Specialist palliative care telephone consultation services for generalists were viewed positively in a

number of studies exploring models of palliative care collaboration in the community.^{18,22,28} Difficulty accessing specialist palliative care services was identified as a factor preventing GPs from becoming more involved in palliative care.²⁴

Coordinated and continuous support

Coordinated patient care and continuous support were identified as important outcomes of successful partnership working. Achieving coordinated care and continuous support for patients was seen as challenging, and different models were proposed for ensuring continuity of care.³² In one study, heart failure nurses took on the role as coordinating key workers for their patients with heart failure. The model was evaluated as both cost effective and sustainable.¹⁸ A study by Blackford and Street found that palliative care nurse consultants played an important role in facilitating continuity of care across healthcare services.¹⁷ A lack of consensus about who has coordinating responsibility for patients,³³ the development of care plans in isolation from other teams,³⁵ and poor coordination between teams²¹ were all found to impede continuity of care and effective coordination of care.

DISCUSSION

The studies described in this article provide a range of examples of good partnership working between specialist and generalist palliative care providers. The evidence suggests that successful collaborative working models can have several positive outcomes. These include positive impacts on patients such as more patients dying in their place of preference,^{19,29} and improved patient education and better symptom management.³⁰ Successful collaborative working models have been shown to be cost effective, and do not lead to excess burden on specialist palliative care services.¹⁸ Enhanced partnership working also has significant positive impacts for health professionals, including empowering generalists, supporting staff in decision making, and increasing positive attitudes among generalists to specialist palliative care provision.³² These findings are in line with other research that highlights a range of positive outcomes of multidisciplinary working in other areas of healthcare delivery.³⁸

Strengths and limitations

This review addresses a gap in the evidence by identifying a range of factors supporting partnership working between generalist and

specialist palliative care providers. Comprehensive electronic search, retrieval, and review strategies were used. However, this study's searches are subject to some limitations, as principally English language databases were used and, due to time and resource limitations, hand-searches of journals were not completed and experts in the field were not contacted directly. As such, some studies may have been missed.

Comparison with existing literature

Evidence from this review suggests that a significant barrier to good partnership working is a lack of clear definition regarding the roles and responsibilities of both generalist and specialist providers. A lack of clearly defined terminology has been well recognised as an issue in the palliative care literature,^{11,39,40} and a lack of consensus regarding definitions has been described as a fundamental problem in the field.³⁹ Although there is a growing recognition that palliative care provision needs to be integrated into the practice of generalists,⁹ clearly defined roles have yet to be agreed. Roles, responsibilities, and definitions require clarification to minimise the separation of responsibility and to improve decision making in palliative care collaborative working models.

Education and training were highlighted as important facilitators of successful partnership working. However, the majority of studies in this review focused on educational opportunities for generalists; findings regarding efficacy and acceptability were mixed. Evidence has suggested that education alone may be insufficient to effect culture change among health professionals,⁴¹ so initiatives that more effectively moderate attitudes and behaviour should be explored. Opportunities for education involving shared learning may be more effective in engaging health professionals and facilitating learning.¹⁸ Further research should seek to explore models of shared learning more formally to facilitate education across disciplines.

Contact and liaison with specialist palliative care services, and timely access to them, are important features of successful partnership working. Good communication is a key component of improved access to specialist palliative care. Models of partnership working, therefore, need to develop strategies to enhance communication between different groups and facilitate formalised routes of access between specialists and generalists. The evidence suggests that communication may, more often, result from personal liaison rather than formal

processes;³³ successful routes of communication should be examined for common features to generate evidence that can facilitate formal communication and enhance access to specialist palliative care.

Achieving coordinated and continuous support for patients at the end of life is an important outcome of successful partnership working. Patients have reported continuity of care and an individualised approach as some of the most important features of good palliative care⁴² but continuity of care can be difficult to achieve when many agencies are involved in providing an individual package of care.⁴³ Studies involving GP facilitators, key workers, and link nurses have met with mixed success, and barriers to achieving continuity of care include the difficulty that exists in liaising between different services and accessing specialist palliative care. Further research is needed to explore ways in which continuity of care can be successfully achieved and to ascertain patient outcomes as a result of coordinated care between specialists and generalists.

Implications for practice

The evidence suggests that, although there are a range of strategies for enhancing collaborative working between specialists and generalists, these are often the result of informal interactions rather than systematic processes. Although 11 of the included studies described the development or evaluation of a formal model of collaborative working, those models varied widely in their aims, processes, and intended outcomes.^{16,18,19,22,23,25–27,29,30,32} There is little consistency in the way models are developed and their success evaluated.

There is a clear need to undertake empirical research to generate a deeper understanding of factors mediating partnership working in palliative care. In addition, research should explore the direct effects of partnership working on patient outcomes and experience, and should seek to identify further appropriate outcome measures for formally evaluating models of partnership working. Outcome measures may include those reported by patients or carers, as well as perceived staff competency in communication and coordinated care delivery. Finally, research should aim to identify the most cost-effective methods of partnership working models and integrated care packages, in order to stimulate service provision across disciplines and improve patient outcomes.²

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