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

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. 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. 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; 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. 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, and people have reported differing understandings of the purpose and scope of generalist palliative care; in spite of this, international health policy has sought to place the generalist at the heart of palliative care provision. In the UK, recent policy has highlighted the importance of training and education for generalist providers if they are to provide effective palliative care. However, difficulties incorporating palliative care into a generalist workload have been reported, as has defining the role of palliative care outside the specialist setting. 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.

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

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. As such, identifying factors that support effective partnership working between generalist and
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, 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.

**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, 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,
including allowing clear identification of prominent themes, and providing organised and structured ways of dealing with the literature. 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. 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, and were descriptions of the development or implementation of partnership working models, and five were evaluations of partnership working models. Eleven of the papers used qualitative methods, and seven used quantitative methods; three used mixed methods, and one used a case-study approach. 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. Examples of good communication strategies that were reported included heart failure nurses being invited to attend community palliative care multidisciplinary team meetings, liaison links being established between care home staff and a local hospice, and case conferences being held between GPs and specialist palliative care providers. Poor communication was cited as a factor that prevented generalist staff from becoming more involved in palliative care. Encouraging dialogue between specialties was identified as an important future priority. Identified barriers to effective communication included a lack of processes for communication, and issues establishing networks. Good communication networks are often the result of personal liaison rather than systematic processes.

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. Examples of successful education models for generalists included study days for care home staff, practice-based education and decision support for GPs, and educational inductions for palliative care partnership models involving GPs and practice nurses. One study reported shared learning practices involving both specialists and generalists: as part of

Figure 1. PRISMA diagram of included literature.
### Table 1. Papers included in the review

<table>
<thead>
<tr>
<th>Study</th>
<th>Aims</th>
<th>Participants</th>
<th>Setting</th>
<th>Study design/method</th>
<th>Relevant findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aitken (2006)</td>
<td>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</td>
<td>District nurses (n = 8)</td>
<td>Primary care locality in the UK</td>
<td>Qualitative semi-structured interviews</td>
<td>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.</td>
</tr>
<tr>
<td>Alsop (2010)</td>
<td>Review of a project to develop collaborative working between palliative care nurse specialists and community matrons for patients with a non-cancer diagnosis</td>
<td>Community matrons and hospice staff</td>
<td>UK hospice</td>
<td>Non-empirical: project review. Focus groups of community matrons and hospice nurse specialists met to develop models of collaborative working</td>
<td>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 and social care professionals, to facilitate best practice in end-of-life care, and have been adopted by two primary care trusts.</td>
</tr>
<tr>
<td>Street (2001)</td>
<td>To explore the experiences and strategies used by palliative care nurses to communicate with GPs</td>
<td>Specialist palliative care nurses (n = 11) and other nurses working in specialist palliative care services (n = 11)</td>
<td>Specialist palliative care services, hospitals, district nursing services in Melbourne, Australia</td>
<td>Qualitative — focus groups and semi-structured interviews</td>
<td>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.</td>
</tr>
<tr>
<td>Daly et al. (2006)</td>
<td>To describe the evolution of joint working between heart failure and specialist palliative care services</td>
<td>491 heart failure (HF) patients</td>
<td>HF services and specialist palliative care services in Bradford, UK</td>
<td>Service description incorporating descriptive service data and qualitative data from patients</td>
<td>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. Patient/carers were positive about the support group and found it helpful.</td>
</tr>
<tr>
<td>Davidson et al. (2004)</td>
<td>To describe the development of a model of an integrated, consultative, palliative care approach within a comprehensive HF community-focused disease management programme</td>
<td>—</td>
<td>Teaching hospital in Sydney, Australia</td>
<td>Description of model development and evaluation</td>
<td>Model for integrated palliative care in HF management was developed following literature review, case note 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.</td>
</tr>
</tbody>
</table>

...continued...
<table>
<thead>
<tr>
<th>Study</th>
<th>Aims</th>
<th>Participants</th>
<th>Setting</th>
<th>Study design/method</th>
<th>Relevant findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ewing et al. (2009)</td>
<td>Delivering palliative care in an acute hospital setting: views of referers and specialist providers</td>
<td>The aim of the study was to describe referer (specialist palliative care service user) and provider (specialist palliative care service staff) perspectives on delivery of specialist palliative care in hospital.</td>
<td>Junior doctors (n = 5), consultants (n = 13), clinical nurse specialists (n = 6, interviews), medical staff (n = 6), nursing staff (n = 5, focus groups)</td>
<td>Acute hospital trust in England</td>
<td>Qualitative interviews and focus groups</td>
</tr>
<tr>
<td>Field (1998)</td>
<td>Special practitioners' accounts of their care of dying people</td>
<td>To explore GP's experiences of caring for dying people, and their attitudes towards such work</td>
<td>GP's (n = 25)</td>
<td>GP's who had graduated from University of Leicester 10 years previously</td>
<td>Qualitative unstructured interviews</td>
</tr>
<tr>
<td>Hanratty et al. (2002)</td>
<td>Doctors' perceptions of palliative care for heart failure: focus group study</td>
<td>To identify doctors' perceptions of the need for palliative care for heart failure and barriers to change</td>
<td>GP's (n = 36) and consultants in cardiology, geriatrics, palliative care, and general medicine</td>
<td>Northwest England</td>
<td>Qualitative focus groups</td>
</tr>
<tr>
<td>Heals (2008)</td>
<td>Development and implementation of a palliative care link nurse programme in care homes</td>
<td>To explore the development and implementation by a hospice education department of a palliative care link nurse programme in care homes.</td>
<td>Questionnaires (n = 16) completed by link nurses and nursing home staff</td>
<td>Hospice in South West England</td>
<td>Service development evaluation</td>
</tr>
<tr>
<td>Lloyd-Williams, Rashid (2009)</td>
<td>An analysis of calls to an out-of-hours palliative care advice line</td>
<td>To analyse the calls to a palliative care out-of-hours service during its first year</td>
<td>Analysis of phone calls (n = 98)</td>
<td>Hospice in Liverpool, England</td>
<td>Descriptive analysis of phone calls</td>
</tr>
<tr>
<td>Low et al. (2011)</td>
<td>Specialist community palliative care services—a survey of GPs' experience in Eastern Sydney</td>
<td>A pilot survey in to assess GP's experience with a palliative care service and to explore whether there were any barriers that might prevent needs being met effectively</td>
<td>GP's (n = 51)</td>
<td>GP practices in a locality provided by a palliative care service in Sydney, Australia</td>
<td>Qualitative questionnaire</td>
</tr>
</tbody>
</table>
| Marshall et al. (2008) | Enhancing family physician capacity to deliver quality palliative home care: an end-of-life, shared-care model | To describe a shared-care model to enhance family physician capacity to deliver palliative home care through collaboration with interdisciplinary palliative care specialists | Family physicians (n = 21) and community nurses (n = 6) | Family health care teams (n = 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**

<table>
<thead>
<tr>
<th>Study</th>
<th>Aims</th>
<th>Participants</th>
<th>Setting</th>
<th>Study design/ method</th>
<th>Relevant findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>McKinlay, McBain (2007) Evaluation of the Palliative Care Partnership: a New Zealand solution to the provision of integrated palliative care</td>
<td>To evaluate a model of integrated palliative care — the Palliative Care Partnership (PCP)</td>
<td>Stakeholders (n = 63)</td>
<td>MidCentral Mixed Health Board, New Zealand</td>
<td>Amixed-method approach including n-depth, semi-structured interviews with a purposeful sample of stakeholders and analysis of routinely collected data</td>
<td>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.</td>
</tr>
<tr>
<td>Mitchell et al (2008) Do case conferences between GPs and specialist palliative care services improve patients' quality of life?</td>
<td>To explore whether case conferences between GPs and specialist palliative care services improve patients' quality of life</td>
<td>Patients receiving palliative care (n = 159; intervention, n = 79; control, n = 80)</td>
<td>Sites [n = 3, inner urban and a regional general hospital] in Queensland, Australia</td>
<td>Multicentred randomised controlled trial</td>
<td>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.</td>
</tr>
<tr>
<td>O'Connor, Lee-Steele (2006) GPs' attitudes to palliative care: a Western Australian rural perspective</td>
<td>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?</td>
<td>GPs (n = 10)</td>
<td>Rural Western Australia</td>
<td>Qualitative in-depth interviews</td>
<td>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.</td>
</tr>
<tr>
<td>Plummer, Hamshaw (2006) Reviewing a new model for delivering short-term specialist palliative care at home</td>
<td>To evaluate a new community palliative care nursing service at the end of its first year</td>
<td>Health professionals (n = 27) who completed questionnaires</td>
<td>Specialist palliative care unit attached to a hospital in Middlesex, England</td>
<td>Service evaluation: audit examining service activity and questionnaire for health professionals using the service</td>
<td>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.</td>
</tr>
<tr>
<td>Pooler et al (2007) Caring for patients dying at home from heart failure: a new way of working</td>
<td>To describe the development of a collaborative working model between HF nurse and Macmillan nurses, to facilitate specialist palliative care for HF patients</td>
<td>—</td>
<td>HF and specialist palliative care services in Northwest England</td>
<td>Description of service development</td>
<td>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.</td>
</tr>
</tbody>
</table>

... continued.
Table 1 continued. Papers included in the review

<table>
<thead>
<tr>
<th>Study</th>
<th>Aims</th>
<th>Participants</th>
<th>Setting</th>
<th>Study design/ method</th>
<th>Relevan findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shipman et al (2002)</td>
<td>To explore GP use of specialist palliative care services in England</td>
<td>GP practices (n = 38)</td>
<td>Inner-city, urban, and rural health districts in England</td>
<td>Qualitative interview study</td>
<td>GPs used specialist palliative care services for advice, information, and referral. GPs fell into four usage categories: using specialist palliative care in a specialist palliative care team; using specialist palliative care in a primary care team; using specialist palliative care in a multi-disciplinary team; and using specialist palliative care in a primary care setting.</td>
</tr>
<tr>
<td>Shipman et al (2003)</td>
<td>To evaluate the impact of a facilitator programme on the use of specialist palliative care in general practice in England</td>
<td>GP practices (n = 420)</td>
<td>Mixed-method study</td>
<td>Community, hospice, and hospital care nurses participated. The facilitator programme included guidelines and a facilitator programme to evaluate a GP's knowledge, attitudes, and in-depth interviews with specialist palliative care and generalist palliative care nurses. This programme led to an increased positive attitude among GPs towards specialist palliative care.</td>
<td></td>
</tr>
<tr>
<td>Street &amp; Blackford (2001)</td>
<td>To examine communication patterns between nurses and GPs in palliative care practice</td>
<td>Community, hospice, and hospital care nurses (n = 40)</td>
<td>Mixed-method study</td>
<td>Community, hospice, and hospital care nurses participated. 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 interdisciplinary patchy. There was little consensus on the management of patients and out-of-hours practice. Sample size 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 was being information about continuation of care and tracking patients through the system. Various strategies were identified to improve communication and continuity of care.</td>
<td></td>
</tr>
<tr>
<td>Walshe et al (2008)</td>
<td>To explore the influences on referrals within general and specialist palliative care services</td>
<td>Three primary care nurses and a district nurse in northwest England (n = 4)</td>
<td>Qualitative interviews</td>
<td>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 their work. Some mutual criticism of work load management practices, e.g. that of district nurses, was made. Specialist palliative care could be seen as providing an elite service, and GPs could be reluctant to refer. Strategies (e.g. game playing) had been developed to 'get around' difficult colleagues or where relationships had broken down.</td>
<td></td>
</tr>
<tr>
<td>Woodhouse (2009)</td>
<td>To determine the understanding of nurses within a shared-care environment model, as well as the degree of interaction evident in their practice in the shared-care setting</td>
<td>Nurses from a generalist community health team in an elderly health care setting</td>
<td>Exploratory study</td>
<td>Nurse education and communication strategies in a shared-care setting were discussed. An enduring factor was the lack of processes for communication and difficulty in achieving feedback.</td>
<td></td>
</tr>
</tbody>
</table>
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.29 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.5,24 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.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.33 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,21 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.22 These findings are in line with other research that highlights a range of positive outcomes of multidisciplinary working in other areas of healthcare delivery.18

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 literature11,29–40 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 involving shared learning may be more effective in engaging health professionals,51 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.15 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, these 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.52
REFERENCES


