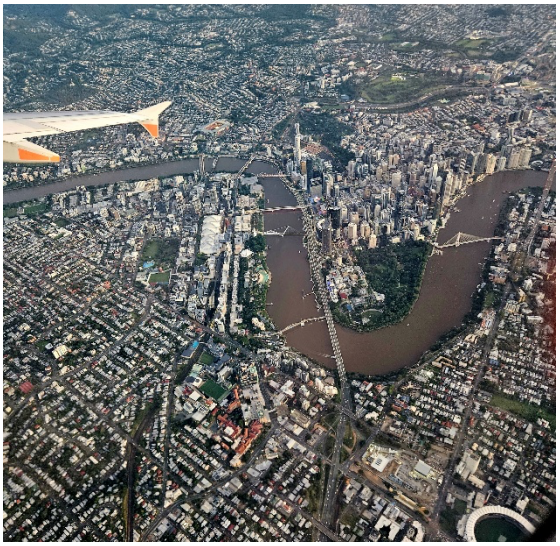
Expanding Specialist Palliative Care Access: Telehealth Solutions for Rural Communities

Gerard Leddy MSc MCSP

Care from here… **to here**



Contents

Copyright © 2025 by Gerard Leddy. "The moral right of the author has been asserted. The views and opinions expressed in this report and its content are those of the author and not of the Churchill Fellowship or its partners, which have no responsibility or liability for any part of the report."

Acknowledgments

This project and opportunity for learning would not have been possible if it was not for the support and flexibility offered to me from my team mates and colleagues in the Southern Health & social Care Trust. I offer my sincere thanks to all of the Community Specialist Palliative Care Team, keeping on top of all work while I was away.

Thank you to Elaine Mulligan, Head of Service for Specialist Primary Care, for being available to support the team whenever required in my absence.

I would like to thank all the professionals within the SPaRTa service in Queensland, for being so welcoming and taking the time to meet with me.

A special mention of thanks goes to Dr Graham Grove, who not only spent the time meeting with me, but helped draft the itinerary and make the connections required to maximise the learning outcomes from my time in Queensland. Connections were made with and support provided by the named contacts in each locality in Queensland who were: Dr. Graham Grove (Gold Coast), Dr Arron Veltre (Sunshine Coast), Dr Claus Bader (Townsville), Dr Ofra Fried (Townsville), Jess Pinkerton (Cairns), Dr Sophie Lam (Cairns) and Dr Travis Moran (Cairns). Thank you all and to each of the wonderful team members who took time out to speak with me during my journey.

Executive Summary

With more people opting for their care to remain in the community and dying at home being the preferred option for an increasing number of the population, there is a need to ensure ongoing access to specialist palliative care in the community. As caseloads increase, and more complex cases appear, the increasing demand needs to be met at a time when there are no additional resources available.

Following a visit to Queensland, and in particular the Specialist Palliative Care access to Rural areas via Telehealth (SPaRTa) service, I observed at close hand the benefits of supporting service delivery with telehealth. Taking this learning on board, the Southern Health and Social Care Trust (SHSCT) aims to pilot a hybrid model of specialist palliative care delivery. To help with the implementation of this much focus was placed on regular, good communication and developing relationships, which will be replicated within this pilot.

Introduction

The World Health Organisation (2020) defines palliative care as an approach, aiming to improve the quality of life of patients and families who are facing problems associated with a life-threatening illness. When delivered early, palliative care, which aims to prevent or decrease suffering from physical, psychological, social and spiritual problems, can have significant benefits for people in relation to symptom burden and quality of life according to Zimmermann et al. (2014). Gomes et al (2013) also noted it to help reduce carer stress.

Luta et al. (2021) suggests that improved access to palliative care has economic value in its potential to improve patient outcomes and lowering overall health costs. It is therefore apparent that palliative care support must remain accessible and unnecessary barriers identified as early as possible so potential solutions can be considered.

From the end of 2021 until the end of 2024, the Southern Health & Social Care Trust's (SHSCT) Community Specialist Palliative Care Team (CSPCT) saw an increase of more than 33% in referrals. The SHSCT CSPCT is a multidisciplinary team, consisting of 0.6 Whole Time Equivalent (WTE) Consultant, 1.0 WTE Pharmacist, 6.8 WTE Palliative Care Nurse Specialists, 2.4 WTE Palliative Care Nurses, 2.0 WTE Dietitians, 1.0 WTE Occupational Therapist, 1.4 WTE Physiotherapist, 1.0 WTE Social Worker, 1.0 WTE Speech & Language Therapist and 1.0 WTE admin support.

Although there is a wide-ranging scope of professionals within the CSPCT, an essential service according to DHSSPSNI (2010), aiming to support patients and other teams with the provision of holistic Specialist Palliative Care intervention, in addition to the benefits noted above, the overall small number of WTE staff finds it increasingly difficult to manage the growing number of referrals, with increasing complexities, at a time of no additional funding or resources. Other ways of working are therefore needing consideration, especially to reach areas of more rurality, that are further away from the two trust acute hospitals (Craigavon Area Hospital and Daisy Hill Hospital).

An example of the distance that may be required to be covered on any given day could be 162 miles (261km). The estimated time to drive this distance without traffic, according to Google Maps, is 3.5 hours. This would equate to 47% of the team's Palliative Medicine Consultant's day driving, being in her car without the clinical contact required and administrative follow-up that is generated from visits. Valuable, clinical time can be lost travelling to further away, more rural areas, however a specific focus is also needed to ensure care is not missed here, with Dismore et al. (2025) noting that living in a rural or remote area is associated with poorer end-of-life care.

Remote services in context

Telehealth has been widely used in healthcare for some time now. Klecun-Dabrowska (2003) outlined that Telehealth is an umbrella term for health services delivered remotely, over various telecommunication networks. According to Kidd et al. (2010) in a review of the literature investigating the use of telehealth in Palliative Care settings across the UK, it is used

by a range of health professionals including specialist palliative care, hospices, nursing homes, hospitals, primary care as well as directly with patients and carers. The most common uses of telehealth appear to be out-of-hours telephone support, advice services for palliative care patients, carers and health professionals, videoconferencing for case discussions, consultations and assessments, as well as for training and education.

According to Snoswell et al. (2024) Telehealth can extend the reach of specialist palliative care services outside of hospital-based services, ensuring patients can access specialist services closer to home. This approach was implemented within Queensland, Australia with the development of their SPaRTa (Specialist Palliative Care access via to Rural areas via Telehealth) project. It has been noted that only three years ago, there were many patients living in rural areas of Queensland, that had no access to specialist palliative care support, therefore had no option to consider dying at home.

This meant them having to leave their communities and preferred place of care. Increasing access to and utilising more telehealth has helped change this and increase the potential to have a larger reach with Specialist Palliative Care provision that was not possible before due to resources available.

Due to the growing demand on the SHSCT CSPCT with the increased referrals noted above, there is a need to ensure ongoing access while increasing capacity to deliver Specialist Palliative Care supports without losing the needed clinical time through *unnecessary* time spent travelling.

So, what to do…

The Queensland Health Department established the Statewide Specialist Palliative Rural Telehealth (SPaRTa) service in 2020. Bringing together the combined services of four major hospital and health services, providing telepalliative care to patients living in Queensland. Primary objectives at this time included providing high quality, equitable specialist palliative services and end of life supports. SPaRTa provides many benefits to patients, but also supports local clinicians through increasing palliative care knowledge and skills. Snoswell et al. (2024) noted that SPaRTa and an approach with telehealth, reduced the number of hospital admissions, as well as increased the number of individuals who were dying at home through more timely access to specialist advice and support.

Therefore, a visit to Queensland and the SPaRTa service ensued, capturing further information, feedback and analysis first hand. This visit occurred between 23rd April 2025 and 20th May 2025. During this time, 10 hospitals/team sites were visited, with 17 consultations observed, through a mixture of telehealth (12) and face-to-face (5), as well as having conversations/discussions with 52 professionals to gain as much insight into the success of SPaRTa to date, while also capturing any areas of further learning or development that may be required. The combination of telehealth versus face-to-face consultations allowed for styles or variations in outcomes to be looked at. (Overview of hospital/sites and professionals met with can be seen in Appendix 1.)

In addition to the meetings/discussions noted above, there was the opportunity to attend the two day, SPaRTa planning event, held within Cairns. This brought together professionals working from the SPaRTa hubs across Queensland along with professionals working in the rural areas as well as senior managers, planners and commissioners. This enabled the opportunity to have further conversations around SPaRTa as well as seeing presentations on its development, use and future direction.

From start to finish the feedback from both professionals at the telehealth end and service users at the rural/receiving side is very positive, with all noting the benefits to this and the access to specialist support in these areas which wasn't there before. There have been many points of learning to help with the implementation or success in replicating/mirroring this service within the SHSCT Specialist Palliative Care area.

What I learned

Telehealth was observed being used from main hubs in four areas along the east coast of Queensland; Gold Coast, Sunshine Coast, Townsville and Cairns. Specialist palliative care support and advice is provided, with no time spent on travel to places as far away as 1150km. This was observed with support to Doomadgee from the Townsville team as an example.

A major benefit of SPaRTa, was having the support required to ensure completion of a full assessment and relationship building, through having a nurse/specialist nurse in the patient's home. This helps with the virtual support as well as completing physical parts of the assessment and relaying information to both the professional at the telehealth end, or the patient/family. This really helped with the sharing of important information, while also helping with the patient/families understanding.

The benefits from this really became apparent when difficulties in communication were observed during the Townsville visit, and issues getting the required information across was seen, when there wasn't the same support in some patients' homes or place of care. In one instance, the doctor within the rural area appeared to have a different idea/understanding than the specialist doctor supporting which led to a breakdown in communication. It was noted in a lot of the rural areas further north in Queensland, supported by the Townsville and Cairns teams there isn't the same rural nurse community supports that were observed in Gold Coast & Sunshine Coast, which professionals then noted leaves the consultations much more difficult.

By having a nurse already known to the patient or that they are comfortable with, helped the patients and families remain at ease throughout consultations. It was also reassuring for the professional working via Telehealth to know there was a professional remaining in the home to help with understanding of how complex/difficult information is understood and processed.

Saving time through decreasing unnecessary travel, not only means more contacts can be made, but hopefully free up time for further education provision as well, which currently is

not happening or remains sparse compared to previous provision when caseloads where smaller within the SHSCT CSPCT.

Communicate, Communicate, Communicate…

Whether it was a meeting with a team member, the observations of a consultation, a multidisciplinary meeting or learning from the planning event, communication kept coming up as being at the centre of all that has worked well. Regular meetings between all teams were seen and accepted by all taking part. During the telehealth consultations, communication was paramount. Professionals involved took time to speak clearly, ensure they were understood and listened tentatively when being spoken too. Pauses were used and conversations were never rushed.

Although telehealth was being used and not face-to-face home visits, communication was not an issue and remained a constant focus throughout, using mixtures of verbal and non-verbal cues. With iPads/cameras being strategically placed, whole environments could be seen and body language was noted. There was even review of lesions and screen shot pictures taken to look at and examine changes.

Through good and regular communication, it was clear relationships have flourished. This again came up in many conversations. With having several providers involved in a patient's care, for example Community Nursing, Allied Health Professionals, Blue Care Rural & Remote staff, SPaRTa team, Royal Flying Doctors and a GP (plus or minus professionals in other areas), the importance of professionals having relationships and respecting each other was very clear. Good relationships were helping ensure the patients got what they needed, with decreased risk of unnecessary repetition or things being missed.

In addition to the relationships between the professionals, at the centre of every case is the relationship between the patient and the professionals involved. This helps with accepting information and management plans that have been agreed together. Understandably, creating a relationship with a patient 1,500km away, that you have never met is going to have its own difficulties, but the relationship between the professional in the home and the patient helped to overcome this and instil confidence through opening the lines of communication with the professional at the other end of the telehealth consultation.

Limitations to the use of Telehealth

New staff without the relationships noted above may have an impact on communication between professionals using or supporting each other with the use of telehealth or even with the patients they are working with. This will need to be taken into consideration, as it has been observed there is an element of fluidity within the NHS staff pool. According to Department of Health (2024) there was a 9.3% joining rate in staff, as well as a 7.7% leaving rate across Health Care in NI. This will have a combined changeover of 17% in staff, not taking in to consideration people moving internally between posts. With this fluid change in staff, there

will need to be regular education and emphasis on the importance of building relationships and good communication throughout to balance this out.

The professional offering advice via telehealth will not be able to complete the physical component of the assessment. However, this issue can be resolved by involving another professional in the patient's home. Effective communication and a strong rapport between these professionals will minimize potential challenges.

In cases where no professional is present, telehealth can experience initial delays. Nonetheless, having a supporting professional in the home should alleviate these concerns and help with the delivery of care.

An instance was observed where the professional at the patient's end wasn't on the same page as the doctor providing the recommendations via telehealth. This led to a delay in the recommendations being implemented with the consultation being amended to prevent any further breakdown in communication. This further reiterated the benefits of good communication and relationships.

What next?

The aim is to trial a two-tiered hybrid approach to specialist palliative care, with telehealth being used alongside face-to-face visits to maximise the use of resources, help get supports at the right level and maximise the number of people that can be seen, including people in areas of more rurality without becoming solely a telehealth service. Face-to-face appointments will not be replaced completely.

They remain a vital type of intervention for particular situations which is acknowledged in Dismore et al's (2025) review of exploring patient and carer's experience of using video consultations, noting that video consultations were beneficial, enabling reliable and convenient access to specialist palliative care when living remotely, however they must be offered as an option rather than a replacement of in-person visits if required or preferred. The SHSCT CSPCT will therefore pilot a hybrid model of care to support professionals within the core teams, e.g. District Nurses/GPs when delivering palliative care, as well as helping patients to remain in their own homes, if this is their preferred place of care.

The provision of 1 x iPad per District Nursing team, to be used to facilitate urgent telehealth consultations with the CSPCT, will hopefully increase timely access to acutely deteriorating patients with complex needs, while also increasing the capacity within the CSPCT, who are close to moving to a waiting list for the first time. With the intended, increased collaboration between core teams and specialist palliative care teams there is the hope for improved outcomes and learning. Bradley et al. (2025) note, this collaborative approach allows opportunities for specialist palliative care professionals to share knowledge, learning and skills which in-turn helps professionals feel more confident and skilled in providing the care needed.

Each of the CSPCT will also have access to an iPad which can then be used to facilitate pre-arranged appointments with the CSPCT consultant during her working hours in pre-blocked

slots, again increasing timely access and potential for increased capacity to support patients with a greater complexity. With the potential for increased capacity, there is not only the opportunity to see a growing number of patients but also provide further education to other services around palliative care, which as noted earlier was one of the expected duties of these posts.

To monitor the effectiveness of this we can review the number of contacts, average length of time patients are waiting for an assessment (compared to previous three months) and a combination of patient/trust staff feedback on satisfaction. A questionnaire has been designed to capture staff satisfaction on current job role, pre and post pilot (see appendix two), which will help with evaluating the effectiveness of utilising a hybrid model on staff satisfaction as well as capacity within the team.

To decrease the impact of the limitations noted above and take forward the learning, there will be an emphasis on and encouragement to continue with communication training, have regular communication with all professionals involved in a patients care and ensure relationships are maintained. This is reinforced by Bradley et al. (2025) in their review of evidence investigating integrated palliative care and oncology outcomes, outlining that effective communication and useful collaboration between teams is required for the best outcomes.

Conclusion

The SHSCT CSPCT is going to pilot a hybrid model of Specialist Palliative Care support through maintaining face-to-face contact but supplementing with virtual/telehealth support when appropriate. This will be when advice can be provided via telehealth and supported through the physical assessment from another colleague in the patient's home to help with clinical decisions, as well as the facilitation of the virtual call. As noted above, this aims to help with timely access, decreased time spent on travel and increasing capacity to see the growing number of patients, as well as providing more educational support to other teams. Virtual consultations will only be used if the patient consents to same.

To utilise the learning from observations in Queensland, there is consideration being given to remove any barriers around technology by utilising MS Teams in the first instance, ensure a professional is in the homes to help facilitate the virtual/telehealth consultation, and place a strong emphasis on the importance of good communication and relationships.

The pilot will run for a total of six months and a follow up report on the outcomes will be provided.

References

Bradley et al. (2025) Integrated palliative care and oncology: a realist synthesis. *BMC Medicine,* 23; 272

Department of Health (2024), Northern Ireland Health and Social Care Workforce Census March 2024.

DHSSPS (2010), Living Matters, Dying Matters

Dismore et al. (2025) Remote and rural communities face inequalities in access to specialist palliative care, could telemedicine enhance care? A qualitative study of patient, carer and healthcare professionals' experiences of video consultation. *Palliative Care and Social Practice;* **19**; pp. 1-9

Gomes et al. (2013) Effectiveness and cost-effectiveness of home palliative care services for adults with advanced illness and their caregivers. *Cochrane database Systematic Reviews*; **6**.

Kidd et al. (2010), Telehealth in palliative care in the UK: a review of the evidence. *Journal of Telemedicine and Telecare*

Klecun-Dabrowska, E. (2003) Telehealth in the UK: A critical perspective. *Electronic Journal of Business Research Methods*; **2** (1) pp. 37-46

Luta et al. (2021) Evidence on the economic value of end of life and palliative care interventions; a narrative review of reviews. *BMC Palliative Care*; **20**(1); 89.

Snoswell et al. (2024) A cost-consequence analysis of the Queensland specialist palliative rural telehealth (SPaRTa) service

World Health Organisation (2020), Palliative Care: fact sheets. https://www.who.int/news-room/fact-sheets/detail/palliative-care Cited 16/07/2024

Zimmermann et al. (2014) Early palliative care for patients with advanced cancer: A cluster-randomised controlled trial. *Lancet*

Appendix 1

Hospitals/Sites visited & Breakdown of team members

Gold Coast

Gold Coast University Hospital, I Hospital Blvd, Southport, QLD

Robina Hospital, 2 Bayberry Lane, Robina, QLD

Dalby Hospital (Darling Downs), Hospital Road, Dalby, QLD

Dalby Palliative Care Office, New Street, Dalby, QLD

Professionals met with:

- Consultants x 2
- Doctors x 3
- Nurses x 5
- Pharmacists x 2
- Social Workers x 3
- Occupational Therapists x 1
- Bereavement Coordinator/support x 1
- Admin support x 2

Sunshine Coast

Nambour General Hospital, Hospital Road, Nambour, QLD

Professionals met with:

- Consultant x 1
- Nurse x 1
- Social Worker x 1
- Bereavement Coordinator/support x 1
- Admin support x 1

Townsville

Townsville Palliative Care Unit, Townsville University Hospital, 100 Angus Smith Dr, Douglas, QLD

Professionals met with:

- Consultants x 2
- Doctor x 1
- Nurses x 5
- Occupational Therapist x 2
- Physiotherapist x 1
- Social Worker x 1
- Bereavement Coordinator/support x 1

Cairns

SPaRTa Team Office, Care Coordination Service Centre, 162 Draper Street, Portsmith, QLD

Cairns Hospital, 165 Esplanade, Cairns North, QLD

Gordonvale Hospital, 1-11 Highleigh Rd, Gordonvale, QLD

Blue Care R&R Nursing Team, Mossman Community Care, 27 Mill St, Mossman, QLD

Professionals met with:

- Consultants x 3
- Doctors x 2
- Nurses x 4
- Occupational Therapist x 2
- Social Worker x 1
- Bereavement Coordinator/support x 1
- Support Worker x 1
- Admin support x 1

Appendix 2

Job satisfaction & Capacity Questionnaire

1. How satisfied are you with your current role?

   Completely dissatisfied 1 2 3 4 5 Completely satisfied

2. Do you feel you have any capacity to see additional clinical referrals?

   Yes Maybe Definitely not

3. Do you feel you have capacity to provide education to other professional groups?

   Yes Maybe Definitely not

4. Are you happy to consider alternative ways of working?

   Yes Maybe Definitely not

5. If you could change 1 thing within the team what would it be?

   _____

   _____

   _____

   _____

Professional Group (please underline/highlight)

a. Consultant/Nursing/Pharmacy
b. AHP/Social work/Admin