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Evaluating provision of psychological assessment and support in palliative care: A national survey of hospices in England

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Objective: Psychological distress is common in palliative care patients. The 2004 National Institute of Healthcare and Excellence (NICE) guidance for supportive and palliative care for adults with cancer, which remains contemporary, recognised that access to psychological support was inconsistent and often inadequate. Their 4-tier model requires multidisciplinary psychological assessment at key points. Implicit is the need for improved training and support for staff and equity in service provision. This survey was designed to determine the levels of self-reported competence amongst healthcare staff in the psychological assessment and screening of patients in adult hospices in England and their awareness of the NICE guidelines.

Methods: A short anonymised online questionnaire was sent to 164 hospices to determine perceptions of healthcare professionals (HCPs) on their own competence in screening and assessment of distress, provision of therapies and levels of training and supervision.

Results: Responses were received from 140 HCPs in approximately thirty-eight hospices. Key findings included self-reported needs for training and supervision. Over a quarter of nurses (28.8%) and AHPs (27.8%) had no level 2 training, and only half of nurses, AHPs and physicians were aware of the NICE guidelines. Access to level 3 specialist psychological services was lacking and some HCPs felt unable to screen and assess patients for referral to specialist services.

Conclusions: Consistent, standardised training in assessment of psychological needs is required to ensuring delivery of high-quality care for psychological needs. Areas for future development identified include essential communication skills and high-quality supervision for those delivering psychotherapeutic interventions.

Keywords: Palliative care, Palliative therapy, Psychotherapy training, Psychological distress, Psychological screening, Clinical supervision

Introduction

Psychological distress has been defined as a ‘unique, discomforting, emotional state experienced by an individual in response to a specific stressor or demand that results in harm, either temporary, or permanent, to the person’.¹ It has also been described in terms of suffering, hopelessness, and existential or spiritual crisis, which has negative effect on the quality of life.^{2,3}

Psychological distress is common for patients with advanced disease^{4,5} and a frequent reason for referral for specialist palliative care support. Several studies have suggested that patients in palliative care settings may benefit from early psychological intervention,

which has been shown to reduce distress and enhance quality of life.^{6,7} Psychological distress is multifactorial, and can affect relationships between patients, family members and carers.^{8–10} It can be a barrier to effective management of symptoms such as fatigue, pain and breathlessness,¹⁰ and might be detrimental to health-related behaviours, leading to an exacerbation of mental health issues.^{11,12}

In 2004, the National Institute of Healthcare and Excellence (NICE) published guidance for improving supportive and palliative care for adults with cancer, stating that there was inconsistent and often inadequate support available to cancer patients and caregivers living with the psychological and physical burden of the disease.¹³ This guidance is still contemporary, and has been strengthened in recent years with additional

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guidance on end-of-life care¹⁴ and the publication of a quality standard.¹⁵ Recommendations included better co-ordination of care and communication between multidisciplinary teams and other stakeholders, service user involvement, improvements in communication and access to appropriate, adequate and timely information.

In the 2004 NICE guidance, a 4-tier model of professional psychological assessment and support was introduced (Fig. 1).¹³ In this approach, a systematic psychological assessment occurs at key points, with a multidisciplinary approach. Implicit in these recommendations is the need for improved training and supervision in psychological assessment and support for health and social care staff, and equity in the provision of psychological assessment and support services. Shortly after these recommendations, a survey highlighted that 45% of hospices in the UK and Republic of Ireland had limited access to professional psychological support.¹⁶ Nearly a decade later, a study found that many patients were not receiving specialist palliative approaches to their care, even though both their physical and psychological needs were significant.¹⁷ At level 4, clinical psychologists are essential to provide care to patients experiencing complex psychological needs and undertake a wide range of tasks, including direct work with and consultation, teaching and training, group supervision and debriefing.¹⁸

In the 2019 NICE guidance on end-of-life care there was an attempt to address these issues by publishing service provision guidelines for end-of-life care highlighting the need for health and social care practitioners to have psychological assessment skills, provide psychological support and make referrals.¹⁴ A survey conducted just after this guidance on end-of-life care, examined the provision of psychological support available to adults in UK-wide hospice care.¹⁹ This sought to identify the types of support provided and the organisation of this support. This showed that even though provision had improved over the previous decade, there were gaps in psychological support and in some cases, patients had no access to support in tiers 3 and 4.

Chapman, et al.¹¹ conducted a qualitative analysis of effective symptom management in palliative care from the viewpoint of multidisciplinary professionals working in specialist palliative care. This work highlighted that staff felt that provision of psychological support for patients continues to be lacking, even though they were aware of its importance in symptom management.

In recognition of the ongoing requirement for more consistent provision of high-quality psychological support for palliative care patients, we designed our survey to provide an insight into perceived

competencies, clinical supervision, and unmet training needs at individual HCP level. Information on specific therapies and who had received specific training and clinical supervision for delivering them was also collected.

The results of our study will provide an important update on progress since both the 2004 NICE recommendations and the recent surveys of psychological provision conducted by McInnerney et al.¹⁹, Russell and Fountain¹⁸, and Price et al.¹⁶. An understanding of existing competencies could guide enhancement of existing provision and act as a comparator for future surveys of this type.

Study aims

The purpose of this study was twofold:

1. To describe the levels of individual, health care professionals' self-reported competence in screening and assessment of psychological needs of patients in adult hospices in England.
2. To evaluate the level of training and supervision in psychotherapeutic approaches delivered by health care professionals in hospices in England.

Method

Study design

An online questionnaire for hospice-based health care professionals (HCPs) in England was developed and distributed to ask about their experience of current practice. Hospice multidisciplinary teams include doctors, clinical psychologists, nurses, social workers, allied health professionals (AHPs) and counsellors. We aimed to identify areas of good practice and identify gaps in service provision and training. Data was collected on the availability of different psychological approaches and who delivered them. We asked how competent staff felt at assessing and supporting patients with psychological distress and what their training and supervision needs were.

Procedures

A short (< 10 min), anonymised online questionnaire, developed on the Online Surveys© platform (onlinesurveys.ac.uk, Jisc), was piloted in collaboration with hospice staff and medical students. The survey link was sent by email to 164 hospices registered with Hospice UK (a national charity for hospice and end-of-life care) across England between February to April 2020 (Supplementary information 1); this represented most English hospices. It was directed to a clinical lead nurse or medical doctor/consultant with a request to cascade the survey link amongst all levels of HCPs, including consultants, physicians, clinical psychologists, psychotherapists, allied health professionals (AHPs), social workers, complementary therapists, and other health professionals at all levels. Survey

| Level | Group | Assessment | Intervention |
|-------|--|---|---|
| 1 | All health & social care professionals | Recognition of psychological needs | Effective information giving, compassionate communication and general psychological support |
| 2 | Health & social care professionals with additional expertise | Screening for psychological distress | Psychological techniques such as problem solving |
| 3 | Trained and accredited professionals | Assessed for psychological distress and diagnosis of some psychopathology | Counselling and specific psychological intervention such as anxiety management, solution-focused therapy, delivered according to explicit theoretical framework |
| 4 | Mental health specialists | Diagnosis of psychopathology | Specialist psychological and psychiatric intervention such as psychotherapy, including cognitive behavioural therapy (CBT) |

Figure 1 NICE model of professional psychological assessment and support¹²

questions about competence in screening, assessment, referrals to psychological therapy and training in communication and psychological skills Level 2 were informed by the NICE guidance, questions about training and supervision in psychological approaches were informed by the survey conducted by Russell and Fountain.¹⁸ The questionnaire was designed to route the questions on training needs appropriately according to the level of training the HCPs had already received, i.e., those with ‘adequate’ and ‘some’ training in each area were asked ‘do you need more training’ and those with no training in that area were asked ‘do you need training’. The survey specifically sought information at an individual level rather than a hospice level and from health professionals working in a variety of roles. The only identifier was an optional postcode area. To preserve anonymity, personal details, such as sex, age and length of time qualified were not collected. Three fortnightly reminders were issued by email.

Ethics approval was obtained from the University of Leeds School of Medicine Research Ethics

Committee (MREC19-027). A participant information sheet and consent form were included with the questionnaire.

Results

One hundred and forty responses were returned. We estimated that thirty-eight hospices were represented based on the 133 postcode districts provided. Seven postcodes were missing. It was not possible to estimate the return rate as we were unaware how many individuals received the survey. An analysis of responses by profession is shown in [Table 1](#): ‘Characteristics of participants and access to psychological therapy in their respective hospice’.

Health care professionals’ self-reported competence

Most level 3 services were provided within the hospice environment by clinical psychologists or other specialist level 3 practitioners but 18.6% of respondents did not have access to any level 3 specialist services.

Limits on the availability of level 3 services were listed and these included:

Table 1 Characteristics of participants and access to psychological therapy in their respective hospice

| Characteristics | Frequency <i>n</i> (%) <i>n</i> =140 | |
|--|--|---|
| Participant job role (group) | Clinical nurse specialist (Nurse) | 31 (22.1) |
| | General nurse (Nurse) | 28 (20.0) |
| | Palliative care consultant (Physician) | 17 (12.1) |
| | Counsellor/psychotherapist | 14 (10.0) |
| | Specialty doctor (Physician) | 12 (8.6) |
| | Support assistant (Other) | 8 (5.7) |
| | Occupational therapist (Allied health professional: AHP) | 6 (4.3) |
| | Physiotherapist (Allied health professional: AHP) | 6 (4.3) |
| | Social worker (Allied health professional: AHP) | 6 (4.3) |
| | Clinical psychologist | 4 (2.9) |
| | Clinical manager/leader (Other) | 4 (2.9) |
| | Pharmacist (Other) | 2 (1.4) |
| | Complementary therapist (Other) | 2 (1.4) |
| | Availability of Level 3 services | Access to level 3 specialist service 114/140 (81.4) No access to any level 3 service 26/140 (18.6) |
| *Availability of Clinical Psychologist | Hospice access to Clinical psychologist (<i>n</i> =114) | |
| | Yes | 69/114 (60.5) |
| | Limited | 17/114 (14.9) |
| | No access | 28/114 (24.6) |
| | Clinical psychologist: Provider (<i>n</i> =86) | |
| | Hospice | 27/86 (31.4) |
| | NHS | 41/86 (47.7) |
| | Both Hospice & NHS | 5/86 (5.8) |
| | Other | 1/86 (1.1) |
| | Don't know | 12/86 (14) |
| | Clinical psychologist: Activities undertaken | |
| | Staff training and teaching | 44/78* (56.4) |
| | Consultation | 55/78* (70.6) |
| | Supervision | 34/78* (43.6) |
| Staff support | 44/78* (70.6) | |
| *Hospice access to specialist counsellor/other Level 3 | Access specialist counsellor/other Level 3 practitioner (<i>n</i> =114) | |
| | Yes | 76/114 (66.6) |
| | Limited | 8/114 (7.0) |
| | No access | 9/114 (7.9) |
| | Don't know | 21/114 (18.4) |
| | Specialist counsellor/other Level 3: Provider (<i>n</i> =84) | |
| | Hospice | 68/84 (81.0) |
| | NHS | 3/84 (3.6) |
| | Both Hospice & NHS | 3/84 (3.6) |
| | Other | 3/84 (3.6) |
| | Don't know | 7/84 (8.3) |
| | Specialist counsellor/other Level 3: Activities undertaken | |
| | Staff training and teaching | 71/84 (85.0) |
| | Consultation | 70/84 (83.3) |
| Supervision | 58/84 (69.0) | |
| Staff support | 68/84 (81.0) | |

*Percentages calculated as those responding yes out of those applicable (i.e., discounting no responses) (Denominators are shown).

- Availability of service.
- Long waiting lists.
- Patient type: limited availability for non-cancer, community patients.
- Hospital referrals only (i.e., outside of hospice).
- Requirement for a medical referral to a local mental health unit outside the hospice.
- Client type: e.g., counsellors' focus is on bereaved relatives.

Self-reported assessment competencies of HCPs in terms of whether assessment or screening was carried out, and how many patients were referred to another professional are summarised in [Table 2](#).

Over 25% of the respondents (36/140) said that they did not screen or assess patients for psychological problems, of these around 50% (17/36) were aware of the NICE referral criteria.

Self-reported competency in the development of trusting relationships, provision of information at an appropriate level, confidentiality of discussions and recognition of the needs of family and carers are shown in [Table 3](#). Clinical psychologists and psychotherapists were not included in this table as these are professionally required competencies. All respondents felt competent in building trusting relationships and working in an open, engaging and non-judgmental manner and most were aware of stigma and discrimination issues

Table 2 Assessment competencies of the sample

| Assessment competency | Clinical Psychologist n=4 n (%) | *Psycho-therapist n=14 n (%) | Nurse n=59 n (%) | AHP n=18 n (%) | Physician n=29 n (%) | †Other n=16 n (%) | Total responses n=140 n (%) |
|--|---------------------------------------|------------------------------------|------------------------|----------------------|----------------------------|-------------------------|-----------------------------------|
| 1.1 Recognise but not screen or assess | | | 18 (30.5) | 8 (44.4) | 1 (3.4) | 9 (56.3) | 36 (25.7) |
| a. Aware of the referral criteria for psychological services and am able to refer on to an appropriate service | | | 9 (15.2) | 6 (33.3) | | 2 (12.5) | 17 (12.1) |
| b. Not aware of the referral criteria there is someone in the hospice who will make a referral for me | | | 4 (6.8) | 2 (11.1) | 1 (3.4) | 4 (25.0) | 11 (7.9) |
| c. Not aware of referral criteria | | | 3 (5.1) | | | 2 (12.5) | 5 (3.6) |
| d. Other (No criteria, missing data) | | | 2 (3.4) | | | 1 (6.3) | 3 (2.1) |
| 1.2 Screen for referral to another professional | | 1 (7.1) | 31 (52.5) | 9 (50) | 18 (62.1) | 6 (37.5) | 65 (46.4) |
| 1.3 + 1.4 Conduct a full assessment of psychological distress or psychopathology | 4 (100) | 13 (92.9) | 10 (16.9) | 1 (5.6) | 10 (34.5) | 1 (6.3) | 39 (27.9) |

*Psychotherapist group includes a range of therapist types – e.g., person-centred, psychodynamic – that hold a professional qualification (Graduate, Advanced Diploma, Masters). Professional accreditation status is not known (e.g., BACP, NCP, NCS, BABCP).

†Other – 8 Support assistants, 4 clinical leaders, 2 pharmacists, 2 complementary therapists.

including the need for dignity and confidentiality. However, approximately two-thirds of nurses and AHPs, and 43.8% of others did not feel competent at either providing information at an appropriate level, and in explaining the psychological problem or being able to provide information on the range of treatments available.

Level of training and supervision in psychotherapeutic approaches

We asked participants about their need for communication skills training. A high proportion of nurses and AHPs identified a need for further training in communication skills (24% of nurses, 33% of AHPs), and advanced communication skills (48% of nurses, 45% of AHPs). Whilst most physicians reported adequate training in communication skills (83%) and advanced communication

skills (72%), there was still a need identified for further training in advanced skills in this group (21%).

Participants were also asked whether they received sufficient training and clinical supervision for level 2 psychological skills (Fig. 2) and where they saw a need for further training (Fig. 3).

The overall percentages of HCPs with ‘adequate’ or ‘some’ training in each therapeutic approach is shown in Fig. 4a. As anticipated, both clinical psychologists and psychotherapists had received training in most approaches (as part of their professional training), but other HCPs scored much lower on many, notably dignity therapy, life story work, cognitive behavioural therapy (CBT) and acceptance and commitment therapy (ACT).

Participants were asked to indicate where they felt they had a training need in each psychotherapeutic

Table 3 Self-reported competency levels¹³

| Competency | Nurse n (%) n=59 | AHP n (%) n=18 | Physician n (%) n=29 | Other n (%) n=16 | Total responses n (%) n=122 |
|---|------------------------|----------------------|----------------------------|------------------------|-----------------------------------|
| Building a trusting relationship and working in an open, engaging and non-judgmental manner | 59 (100.0) | 18 (100.0) | 29 (100.0) | 16 (100.0) | 122 (100.0) |
| Providing information at an appropriate level of understanding – explaining the psychological problem and range of treatments available | 39 (66.1) | 12 (66.7) | 27 (93.1) | 7 (43.8) | 85 (69.7) |
| Being aware that stigma and discrimination can be associated with the psychological problem and how this may affect the patient | 56 (94.9) | 17 (94.4) | 29 (100.0) | 15 (93.8) | 117 (95.9) |
| Ensuring that discussions take place in a setting where confidentiality, privacy and dignity are respected | 59 (100.0) | 18 (100.0) | 29 (100.0) | 15 (93.8) | 121 (99.2) |
| Offering carers an assessment of their caring, physical and mental health needs if necessary | 42 (71.2) | 17 (94.4) | 24 (82.8) | 10 (62.5) | 93 (76.2) |
| Providing information about local patient, family or carer support groups and voluntary organisations | 41 (69.5) | 13 (72.2) | 21 (72.4) | 9 (56.3) | 84 (68.9) |

Note: Clinical psychologists and psychotherapists were not included in this table as they are already trained in these competencies.

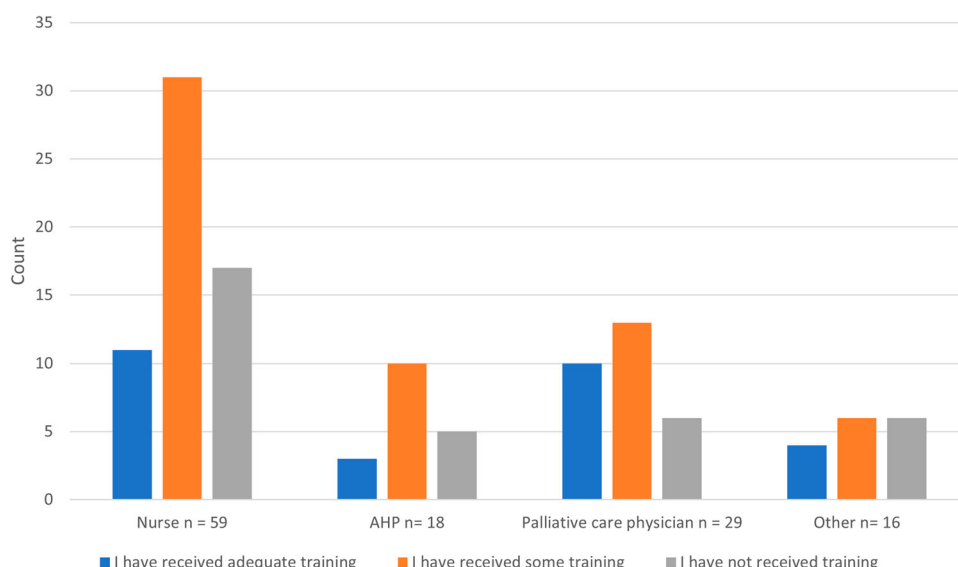


Figure 2 Level 2 psychology skills training received

approach (Fig. 4b). More than half of psychotherapists indicated a training need for systemic therapy (57.1%) and CFT (57.1%). More than 40% of AHPs and 50% of nurses indicated a training need in most approaches (nurses: MBSR 66.1%, CFT 56%, ACT 50.9%, CBT 66.1% and DT 61%; AHPs: MBSR 50%, CFT 66.7%, ACT 72.2%, CBT 44.4% and DT 61%). Mindfulness was indicated as a training need amongst HCPs including 44.8% of palliative care physicians and 43.8% of the other HCP group.

Where training had been received, participants were asked to indicate where they felt they had sufficient supervision in each approach (Fig. 5). It was notable that some HCPs received inadequate supervision for therapeutic approaches in which they had some training. Examples of this include some commonly used approaches such as acceptance and commitment therapy where both psychotherapists and physicians

appear not to receive sufficient supervision, and cognitive behavioural therapy, where only 70% of psychotherapists had sufficient supervision but the other HCPs did not. Life story work, which is a reparative process to help patients reflect and make sense of their lives²⁰ required more supervision for nurses, clinical psychologists, and physicians.

Overall, Figs. 4b and 5 indicate that AHPs and nurses had the most unmet training needs and lack of supervision was most noticeably reported by AHPs. Lack of training and clinical supervision was identified as ‘a barrier to providing access to timely and appropriate psychological support’.¹⁹

Discussion

The aims of our survey were to describe competence in screening and assessment of psychological needs of patients and secondly to evaluate the level of

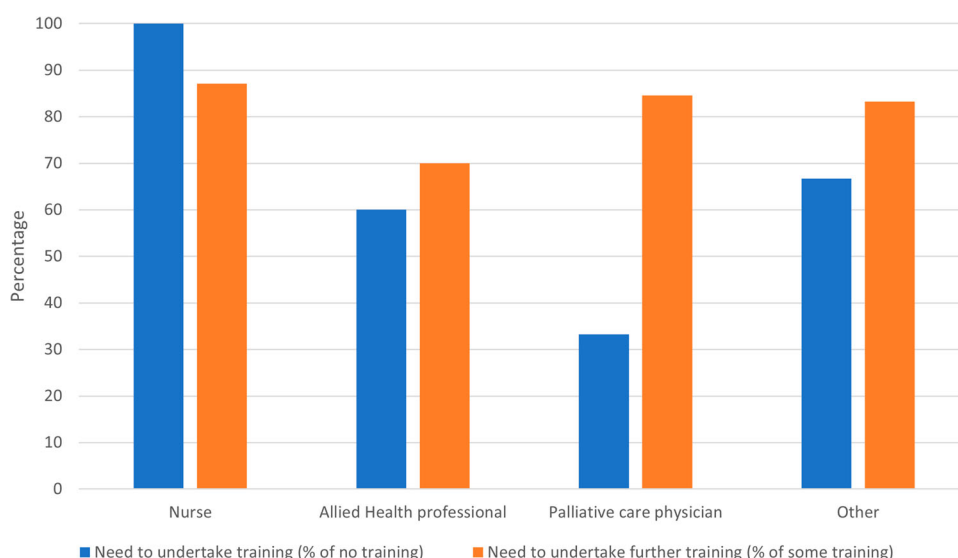


Figure 3 Level 2 psychology skills training needs



Figure 4 (a) Percentage of HCPs with some or adequate training. (b) Percentage of HCPs who indicated a training need for each approach

training and supervision in psychotherapeutic approaches delivered by HCPs in English hospices. The results of the survey provided evidence that many hospice healthcare professionals perceive that their training and supervision in provision of psychological support is inadequate. Some healthcare professionals felt unable to screen and assess patients for referral to specialist services and access to these services was limited. We revealed that approximately half of nurses, AHPs and physicians in our survey felt they could recognise and screen for psychological distress for referral to another specialist; however, a considerable proportion (25.7%) said they would neither screen nor assess patients for it. Psychological distress can be a barrier to effective management of other symptoms such as pain, breathlessness and fatigue,¹¹ therefore recognizing and

addressing it is an essential part of holistic palliative care.

This situation has changed little since the Price, et al., survey in 2006¹⁶ where 41.2% of hospices had access to a clinical psychologist and 10.2% had access to a psychotherapist. In our survey, it was therefore encouraging to note that over a third of physicians would conduct a full psychological assessment, which suggests a higher level of training in psychology skills amongst palliative care physicians.

Our study is aligned with earlier work highlighting (18) psychological support was felt to be good at levels 1 and 2 but decreased significantly at levels 3 and 4.

A national 3-day advanced communication skills training programme called ‘Connected’ was developed for HCPs working in cancer and palliative care, but on evaluation it was found that the ‘one

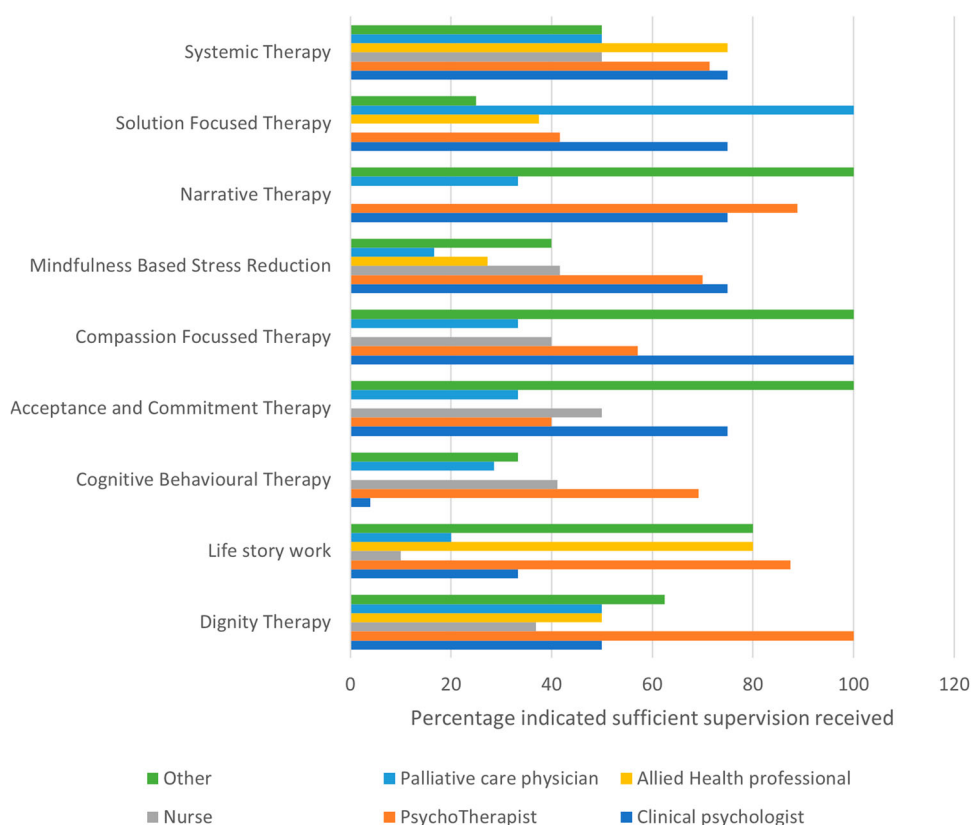


Figure 5 Sufficient supervision received where respondent is trained

size fits all’ method of delivery was not well received across different professions.²¹ However, in our survey, a quarter of nurses and a third of AHPs recognised that they had a need for further communication skills training at both a basic and advanced level, and almost half of nurses and AHPs and some physicians also felt that they needed further training. Notably, some of the groups had not received any advanced training at all. Given the importance of advanced communication skills on a daily basis, this needs to be addressed.^{22,23}

For HCPs, other than psychologists and psychotherapists, training in psychological therapies was variable, even though CBT and mindfulness have been shown to be effective in reducing distress in patients with advanced disease and could be delivered with adequate training and supervision.^{24–27} Fifty per cent of AHPs surveyed had some CBT training and over 44% had some solutions focused therapy (SFT) training. Training in some therapies is not as easily accessible (e.g., ACT, CFT and narrative therapy), even though there is a growing evidence-base for therapies such as ACT in cancer.²⁸ In England, hospices are often run as small, autonomous organisations and this might contribute to a lack of consistency in staff training, competencies and skills. Our findings present an opportunity for training and supervision to be reviewed and standardised.

Nurses and AHPs felt that they had significant unmet training needs. More than half of our sample of AHPs identified a need for training in all therapy areas except for narrative and systemic therapies.

Within the 2022 Health and Care Act, Integrated Care Boards (ICBs) who are responsible for planning budgets and provision of NHS services within a geographical region, have a legal responsibility to provide palliative care services. Within this responsibility:

There must be sufficient workforce in place across all settings, with the knowledge to deliver the care required. Regard should be given to supporting general clinicians to build knowledge, skills and confidence to deliver high quality, personalised PEOLC [palliative and end of life care], supported by specialist palliative care clinicians and services where appropriate.²⁹

This ambition was clearly set out in 2021 in a report by the national palliative and end-of-life care partnership.³⁰ However, the ability of the hospice sector to provide the requisite workforce is hindered by limited funding from the government, with an expectation that two thirds of income is raised from charitable sources, which limits their ability to employ appropriately trained staff.³¹

Non-pharmaceutical interventions such as mindfulness, cognitive behavioural therapy (CBT), relaxation techniques and music or art therapy which are used within palliative care settings to manage psychological distress^{32–35} are also affected by a lack of funding, limited staff capacity and training.^{19,36,37}

Given the current funding situation, retaining skills and competences remains a challenge. Competence, (alongside autonomy and belonging) has been described as one of the three core needs of doctors which are required to ensure wellbeing and motivation and work and reduce workplace stress.³⁸ Health Professionals in our survey, other than clinical psychologists and psychotherapists, said that they were not receiving enough supervision, which may be problematic, especially if using therapeutic approaches that they did not feel competent in delivering. A feeling of lack of competence may contribute to increased stress and psychological ‘burnout’; an important issue in palliative care staff^{39–41} that may impact upon the ability to provide compassionate and effective care. For specialist level 3 practitioners within the hospice environment, who have a key role in providing a service, training and supervision, the lack of support is indicative of a serious gap in high-level psychological input and training/supervision of HCPs, issues which were identified many years ago and that persist today.⁴²

Study limitations

Our survey was opened on 17th February 2020, just before the first COVID-19 pandemic lockdown in the UK. Cuts in healthcare spending and charitable funding⁴³ during and since the pandemic have undoubtedly affected the provision of psychology services further^{44,45} and our interpretation may therefore not fully represent the current picture of psychological assessment and services.

The survey was limited to hospices based in England. Also, we did not include other care providers such as inpatient hospital teams and community care such as the NHS ‘Hospice at Home’ service,⁴⁶ or charities offering care at home.⁴⁷

Conclusions

Our study highlights a perceived lack of training and competence amongst health professionals in surveyed hospices in England, with low levels of support and supervision especially in some key areas such as counselling and communication skills. There was also a significant gap in the ability to recognise psychological distress and know who to refer patients to for further treatment. These findings implied that some health professionals were acting outside their own competencies. Other key findings included the relatively high

number of health professionals who did not screen or assess patients for psychological distress and the number who were unaware of the NICE guidance and referral criteria. We suggest that each service should set referral criteria based on their capacity, including the training and supervision available. Validated screening and assessment tools should be used as routine.

Implicit in our findings is the need to address the standardisation of training and competencies across the hospice network to ensure that all staff are working to the relevant guidance. Ideally, HCPs should have advanced communication and level 2 psychology skills to ensure that they can recognise distress and screen either for further psychological assessment or refer on to another professional. They need to have access to appropriate training and supervision with continuing professional development, which will require national policy changes for end-of-life care.

Implications for research, policy and practice

In our survey, we identified a need for universal communication skills training. Further research on the implementation and efficacy of this training would inform future policy and practice. Implementation of this would require funding and provision of study leave for nurses and AHPs to address their reported training gaps.

Secondly, this survey only examined the provision of psychological support in adult hospice services for patients and families; how this compares with the situation in palliative care for children and young adults also merits investigation.

Our survey focused only on healthcare professionals working in hospices. Volunteers are also an important part of the palliative care workforce and future studies should investigate their role in psychological support to evaluate the training and support they receive and need.

Finally, it would also be valuable to conduct further research to obtain views of patients directly to give us a deeper understanding of their satisfaction with the care they receive for their psychological needs in the context of limited provision.

Disclaimer statements

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Supplemental data

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