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Health professionals' experience of implementing and delivering a 'Community Care' programme in metropolitan Melbourne: a qualitative reflexive thematic analysis

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ABSTRACT

Objectives To explore the experiences of health professionals involved in delivering a multidisciplinary Community Care programme that provides a transitional care coordination service for patients visiting a tertiary hospital service in Melbourne, Australia.

Design Reflexive thematic analysis was used to identify themes from descriptions of delivering the programme, including its perceived strengths and challenges.

Participants 12 healthcare professionals from four disciplines working in the Community Care programme were interviewed.

Results Four themes were identified: (1) 'increasingly complex', depicts the experience of delivering care to patients with increasingly complex health needs; (2) 'plugging unexpected gaps', describes meeting patient's healthcare needs; (3) 'disconnected', explains system-based issues which made participants feel disconnected from the wider health service; (4) 'a misunderstood programme', illustrates that a poor understanding of the programme within the health service is a barrier to patient enrolment which may have been exacerbated by a service name change.

Conclusions The healthcare professionals involved in this study described the experience of providing care to patients as challenging, but felt they made a positive difference. By unravelling the patients' health problems in context of their surroundings, they were able to recognise the increasingly complex patients' health needs. The disconnection they faced to integrate within the wider healthcare system made their role at times difficult. This disconnection was partly contributed to by the fact that they felt the programme was misunderstood.

STRENGTHS AND LIMITATIONS OF THIS STUDY

⇒ This study used Braun and Clarke's reflexive thematic analysis which allows a theoretically flexible approach. This is a strength of this study, as it enabled the researchers to best represent the experiences reported by the participants.
⇒ The inductive approach to data coding and theme development allowed rich insight into the participant's experience of implementing and delivering a Community Care programme.
⇒ A limitation of this study is that 12 of 60 eligible participants in the programme were interviewed, and the convenience sampling method may not have allowed all experiences to be captured and reported on.

INTRODUCTION

As demand for healthcare continues to increase within Australia and globally, health services are increasingly being asked to do more with less, while patient complexity continues to increase.[1] Factors driving this demand and increasing patient complexity include an ageing population with an accompanying increase in the prevalence of multimorbidity, resulting in an increased need for holistic interdisciplinary care.[1 2] In response, health services are seeking to better support patient groups who are frequent users of healthcare resources such as people residing in residential aged care facilities and those with chronic conditions.[3] These patient groups often require a nuanced and collaborative multidisciplinary approach to their care.

Multidisciplinary care in the form of a Hospital Admission Risk Programme (HARP) aims to identify and support at-risk patients to prevent avoidable hospital admissions. Similar multidisciplinary programmes that provide care in the community for patients at risk of re-presentation to emergency department (ED) and hospital are Post-Acute Care (PAC) and Residential-In-Reach (RIR) services. PAC provides short-term care following discharge from hospital or presentation to the ED[4] and RIR provides assessment, triage, care, and support to patients living in residential aged

care as well as support and education to staff caring for these patients.[5] The commonality between case management and multidisciplinary care team approaches like HARP, PAC and RIR is they are transitional care coordination programmes designed to assist patients as they journey through a fragmented healthcare system.[6] Transitional care programmes lie at the intersection between hospital-based care and primary and community-based services. Patients are often enrolled in these transitional care programmes just before or during discharge from hospital and they can act as a post-discharge service.[7]

Transitional care programmes provide short-term care to at-risk or vulnerable patient cohorts with the aim of 'promoting recovery, restoring independence, and providing the interface between acute care services and home'.[8] Transitional care programmes have been found to improve patient outcomes in reducing rates of readmission to hospital and reducing presentations to ED.[9] This is coupled with increased patient satisfaction with communication and home-based care being appreciated by patients.[10] However, when evaluating the clinician experience of providing care to patients in transitional care programmes, there are issues at the interface with the acute care setting. Issues may include inadequate discharge notifications,[11] difficulty in linking patients into transitional care programmes and patients failing to see the importance of preventative care.[12] A transitional care coordination programme which operates from Peninsula Health, Victoria, Australia, known as Community Care, is a programme that sees the amalgamation of PAC, RIR and HARP services,[13] as can be seen in figure 1.

The Community Care programme was formed in 2015, providing a multidisciplinary team approach to outreach care coordination. Outreach care coordination is where health and medical staff provide care to the patient in the community rather than the hospital. Outreach care coordination provides the coordination of services patients require to meet their health needs and is not necessarily just concerned with discharge planning. The Community Care programme provides services including medical consultancy, nursing or allied health interventions to support patients who have used hospital care frequently and/or are at high risk of presenting to hospital. Patients are referred into the programme by clinicians in the acute sector as a method of assisting discharge, as well as from aged care facility staff. Direct referrals from general practitioners and paramedics seeing patients with unmet needs in the community are also received and the programme takes referral requests from patients directly as well as from their formal or informal carers. It is timely to review the effectiveness of the Community Care programme given programme objectives and literature suggesting multidisciplinary care teams increase patient satisfaction and improve health service provision.[14] An important step in this evaluation includes taking the learning from the development and delivery of the programme to help inform future programmes seeking to provide transitional care coordination. An important part of this review was the experience of health professionals involved in the Community Care programme. The aim of this qualitative study was to describe the experience and perspectives of health professionals involved in the Community Care programme, investigating the delivery of the programme and exploring its strengths and challenges.

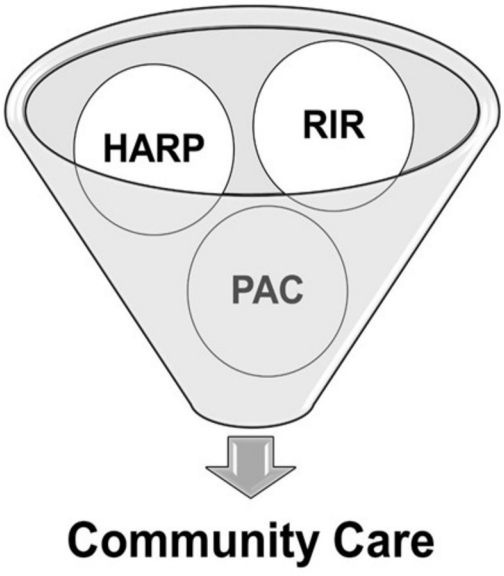

Figure 1 Amalgamation of existing community programmes to Community Care. HARP, Hospital Admission Risk Programme; PAC, Post-Acute Care; RIR, Residential-In-Reach.

METHODS

Design

Braun and Clarke's approach to reflexive thematic analysis[15] underpinned the framework for the study due to its adaptable components and theoretical flexibility which was deemed to best enable the exploration of the phenomenon of interest. Reflexive thematic analysis is a qualitative approach that seeks to identify patterns across data that look to understand and represent people's experiences, perceptions and understanding of a phenomenon.[15]

The reflexive thematic analysis framework was appropriate for our study design due to the authors' relativist/contextualist position. An inductive approach to data analysis was conducted and while this is often misinterpreted to mean this is an atheoretical approach, this is not the case. Detailed participant accounts of the delivery of the Community Care programme allowed the opportunity to identify experiences, strengths and weaknesses in regard to the delivery of the programme.

Patient and public involvement

No patients involved.

Setting

This research was undertaken at Peninsula Health, a health service in metropolitan Melbourne, Victoria,

Australia. Peninsula Health has one of the largest catchment areas in metropolitan Melbourne and serves a population of approximately 400 000 people.[16] This health service was selected due to the interest from the service in having its programme evaluated from a holistic perspective, In 2017, the Community Care programme supported 3620 patients.

Study participants

Sixty (60) health workers working in the Community Care programme were eligible to participate. No limit to time was placed on employment within the health service or programme as an exclusion criterion.

Recruitment process

Participants were recruited via a 'whole of programme' email. All participants provided informed and written consent prior to booking a mutually acceptable interview time. Interviews were conducted either face to face or via a security-encrypted teleconference. Video conferencing is an emerging acceptable practice for conducting qualitative interviews.[17]

Participant selection

Convenience sampling, supplemented with a snowballing technique, was used to recruit participants. Participants were recruited until enough data were collected to enable the research team to 'answer the question' in a way considered to be a diverse representation of the health professionals' experience.[18] At the end of recruitment, there were 12 participants who responded and met the eligibility criteria. No participants were lost to follow-up after recruitment.

Data collection

Semistructured interviews were used to collect the experiences of the healthcare professionals by two researchers (BS or HS). Data collection occurred during November 2019–July 2020. The interviews followed an interview guide consisting of nine open-ended questions (see table 1).

Questions were developed by the research team and edited as needed to best allow participants to tell their experiences and highlight the strengths and weaknesses of working in the programme. After two interviews, authors reviewed the interview audio and transcripts and adjusted the question guide to assist in consistently obtaining rich interview data. The face-to-face interviews were recorded via a digital audio recorder and only the audio files of the teleconferencing interviews were recorded and saved. Face-to-face interviews were conducted in the participants' workplace in a private office. All audio files were transcribed by NVivo transcription services,[19] and all transcripts were checked for accuracy and amended where needed to ensure transcripts reflected the interview audio verbatim. Field notes were written using a preset template and these were used as a point of reflection on central ideas brought up or new insights gained from each interview. After 10 interviews, the authors (BS and HS) felt that there was significant repetition of ideas and themes from participants and sufficiently rich responses to the research questions had been obtained. The final two interviews were continued as the authors had already organised times for the participants and it also increased representation from as many health disciplines in the programme as possible.

Analysis

Data analytical strategies

Braun and Clarke's approach to thematic analysis was used as a framework within our reflexive thematic analysis methodology.[15] One author (BS) undertook the data analysis which was conducted using NVivo V.12 software.[15 20] Data analysis used an inductive approach to coding and theme development using the approach recommended by Braun and Clarke.[15] The two interviewing authors (BS and HS) met frequently throughout

Table 1 Questions for semistructured interviews

Question 1	How have you been involved in the Community Care programme?
Question 2	Think back over all the years that you've participated and tell us what have you come to understand what the purpose of the Community Care programme is?
Question 3	Did this change throughout your time of being involved in the programme? If so, how?
Question 4	Think back over the past 2 years (or however long you have been involved) in the Community Care programme. What went particularly well? This can be about things such as rostering, workload, patient outcomes, nature of the work undertaken, etc.
Question 5	What needs improvement? And what in your opinion do you think the advantages of the programme are?
Question 6	What are some of the stressors you faced while working for the Community Care programme?
Question 7	Suppose that you were in charge and could only make one single change that would make the programme better. What would you do?
Question 8	Do you think the programme helped to achieve better health outcomes for patients? If so/not, why do you think this way?
Question 9	Is there anything else you would like to add about the Community Care programme that you feel we haven't yet spoken about?

data analysis ensuring coherence in the coding and together constructed preliminary themes. All authors met during step 5 and beyond to ensure the definition and scope of the themes answered the research questions and were plausible and coherent. This study used the Consolidated criteria for Reporting Qualitative research checklist to report methods, data analysis and results[21] (see online supplemental appendix 1).

RESULTS

Twelve (12) participants were interviewed in this research. Disciplines represented were medicine (2 of 12), social work (1 of 12), occupational therapy (4 of 12) and nursing (5 of 12). The years of experience in their designated profession varied from 3 to 40 years. Time of experience involved in the Community Care programme or its predecessor programmes ranged from 6 months to 14 years. All participants were actively working in the programme at the time of interview, with most in a full-time capacity. All participants were assigned pseudonyms to protect identity. Each participant was interviewed once only with interview length ranging from 35 to 73 min, and a mean interview time of 59 min.

Four overall themes were produced from the data-rich interviews. The themes were (1) 'increasingly complex', (2) 'plugging the gaps', (3) 'disconnected' and (4) 'a misunderstood programme'.

Theme 1: 'increasingly complex'

This theme describes the participants' experience of delivering care for the patients enrolled into the Community Care programme. Participants reported that their role in the programme was to provide holistic care to patients and assist them in navigating the healthcare system to achieve greater health and independence in the community. Participants described that they pull apart the patient's health issues and that these issues span across the biopsychosocial continuum. Participants consistently stated that the patients they cared for had progressively complex health needs:

> … the complexity of people that we are seeing this year has been far more than we've ever seen or imagined. People just seem to just have so much more going on now whether that's because we're identifying it better or because people are becoming more complex just because of life and what's happening in the world, I don't know. But the clients that we see are in some really tough situations. (India)

In turn, this complexity increased stress and workload for the participants. As the health needs of patients were not always obvious, participants needed to spend time, and be experts in communication and health assessment, to really identify all the patient's needs:

> … And I find with our clients, and I found this myself, that they are so complex, and things just sort of unravel as you start working with them. You may start uncovering elder abuse, you start uncovering this and that. Some clinicians do stay involved for quite a while and sort of see how the client [care needs] just unravels. (Rhiannon)

As patient complexity was identified, participants subsequently realised just how difficult their patients' lives had become after unravelling their issues. Participants described that their patients were often a victim of circumstance and a product of the societal, social and economic environment they were situated in. These difficult circumstances often contributed to patients not engaging in the care being offered and provided. This was described by a participant, who explained that while they were trying to foster health independence, there was significant tension between what the patient wanted from care and what the participant felt the patient needed. Attempting to bridge the gap between the health challenges found and intervening into a patient's life was at times a challenge:

> They can be a volatile group and they don't want to link in [with the Community Care program] some of them, they don't want to be told what to do… It's really difficult to make changes when you're a drug and alcohol victim. It's really difficult to make changes if you've got serious cognition [impairment] and you think people were going to interfere with your life and lock you up. (Maria)

Theme 2: 'plugging unexpected gaps'

This theme captures the participants' experience of assisting patients to journey through the healthcare system from care in the hospital to health independence in the community. Participants felt the programme was essential to providing patient-centred care within the health service, in particular for the most vulnerable patients. Participants, both experienced and inexperienced in the role, regularly commented that they felt the Community Care programme's central purpose had shifted, to plug unexpected gaps in the patient healthcare journey. Participants described issues in hospital discharge planning, with success commonly dependent on a patient's own ability to independently navigate the healthcare system and be their own advocate. The approach that many patients required, in order to navigate discharge planning and rehabilitation back to their 'normal' level of function, required time, compassion and advocacy. This contrasts strongly against the often rushed, and at times non-patient-centred, discharge process that was imposed on hospital staff to increase hospital bed availability. The rushed approach to hospital discharge was leaving gaps in the patient discharge process that the participants found they were having to address. A participant highlighted the difference in approach by reflecting on their time working in the hospital setting and comparing that with working in the community setting:

> And that was the main thing. It was like you walk in the [hospital ward] door and straight away it's like, right we need 10 patients discharged because there's so many people waiting in ED. And it's just like "get them out". And I would not, unless I had the time to really build rapport with people, it would just be me going into them going "Okay what do you need for me to get you out of hospital?" And people [patients] do say it. You know, "I feel like I'm being rushed. I still don't feel well enough to go home". But then you have got people coming from above and it's like, "You need to go; we need the bed. We need to go". So that's, yeah, that's one big difference…when you actually have time to sit down with people and talk them through what's happened and the results and these are your follow ups, medications you're taking. This is how it's impacting you. You are able to build that rapport and that trust a bit more. (Lisa)

Participants noticed that they were often providing services they expected to be completed by other healthcare providers either during hospital admission or in the community. One participant highlighted this by discussing their amazement that patients did not know about basic services that would help them function in their daily lives:

> But it really does make a difference because they don't know about financial services out there. They don't know about the mental health services out there and we connect them to them. And from a clinical perspective, I can give them something so simple, like a shower stool, and they'd never seen one before, even if they were in hospital. They say, "I didn't know about that, no one showed me that". I am like, how is that possible? (Sarah)

This concept was further explored by participants describing how they regularly supported patients to apply for insurance schemes, something they felt was within the scope of practice of primary care providers and not within the remit of the Community Care programme. Participants commented that they found they were undertaking tasks for patients not only outside the remit of the programme's role but also on the boundaries of what would be considered their disciplines' scope of practice. Rhiannon, a participant, highlighted this by explaining that they felt the need to go above and beyond what would be expected care just to ensure their patients were set up for success and not failure:

> They've never been told about services that they could access or no one, nor their GP, never brought up NDIS [National Disability Insurance Scheme]. So, we do a lot of NDIS applications now as well. If they come on our program and they are eligible for NDIS, we'll support them and do the applications. But yeah, they always said "oh my GP put that in the too hard basket. No one wanted to help me do the report or the documents". So we do definitely go above and beyond… just to make sure that they are safe. (Rhiannon)

Theme 3: 'disconnected'

This theme describes the apparent disconnect between the acute and Community Care services within the health service. Participants stated that there was frustration in delivering their role due to this disconnect. A participant, India, expressed that they occasionally felt they were operating counter to other hospital departments. They felt this directly hindered both patient enrolment into the programme and the participants' ability to undertake meaningful work:

> There's always been the acute sector and then there's always been community and never the two shall meet. But I think that really needs to change where, you know, instead of us being the discharge plan, maybe we're involved in the discharge plan so that our intervention can start at that point rather than when they're at home. (India)

A contributing factor to the disconnect between Community Care and the wider health service was reinforced through separated electronic medical records. Different parts of the health service used different electronic medical record platforms leading to inefficiencies in referrals and an inability to access medical records from different areas. Participants noted that in-hospital staff were unaware they also had access to the detailed primary care and social health information collected and collated by the Community Care programme. While these records were available, they were inadvertently out of sight:

> [Its] really annoying [we have] two different platforms. So, we've got [system A] for our notes and the hospital uses [system B] and we don't read each other's notes. So, I know when I was working in the hospital I never looked at [system A], I'm guilty. So now if I'm seeing someone over there [in the acute hospital] I'll write notes in both. (Frankie)

Participants noted this was frustrating, as simply reading the patient's notes from Community Care had the potential to decrease length of stay through care management, and in some cases may have avoided an admission in the first place. Some participants stated that as a way to circumnavigate this problem and ensure their notes and management plans were seen, they duplicated their notes across both electronic medical systems, but this increased their administrative workload:

> So sometimes even though we've got a really comprehensive assessment of what is happening for that client in the community, it's useless if it's not being read… but we're really hopeful and working towards having all of us on [system B]. If it's something really important and we know that [system A] won't be looked at. But again, that's duplication for us having to write in [system A] and then having to write it in

[system B]. So, we're hopeful that the organisation can support some of that change. (Emma)

Another factor that contributed to the sense of being disconnected was the geographical location of the Community Care programme. The Community Care programme operated in a building that was separate to the main hospital. While it was still located within the health service grounds, participants felt that this geographical separation further disconnected them from the rest of the health service:

> We're missing people potentially because the acute system lives in their bubble over there. And we live over here. And you wouldn't believe how little they know about each other, which is why we're trying to extend ourselves and to making friends with them. But there's many other reasons we're not capturing them [patients]. People don't know who we are or what we do. (Sarah)

Theme 4: 'a misunderstood programme'

This theme describes the components that have led to the Community Care programme being either misunderstood or not well known by both internal and external stakeholders. A general misunderstanding of the programme's role and availability may have also led to external stakeholders not using the programme for their patients, reducing the programme's impact. For those who were aware of the programme, the current structure lacks clear criteria for patient enrolment meaning that patients that would not be suitable for the programmes were being referred. There was then the possibility of rejection of the referral due to it not fitting the programme's scope. If rejections were repeated with a lack of consistency, health professionals referring to the Community Care programme were less inclined to refer again in the future as it would be a waste of their time. A participant reflected on their time in a previous role trying to get patients referred into the Community Care programme:

> I mean, a couple of times you would send a referral and your referral will get rejected and then another time you will get accepted and then you get rejected and you just kind of had no idea what was happening. And I guess it was not good communication, in that there is not a clear [enrolment] criteria. (Lisa)

Participants also described that despite attempts at promotion of the programme's purpose, there was still a lack of knowledge of the role the Community Care programme holds within the health service:

> So, I think if it was more known in the community, even in the hospital, we are becoming a better-known program. But people in the hospital still don't know what we do and [that] we're available. So that's probably the difficulties with that kind of transition to other services. (India)

Participants also spoke of the programme name change in 2015, reporting that it compounded the lack of understanding about the programme. The usage of more traditional names such as HARP was still being practised to explain the programme and its goals. Although the amalgamation of many programmes into the umbrella term of Community Care was done to simplify the community health programmes within the health service, it may be too broad, reducing understanding:

> I think that we had a name change a while ago. We were HARP. And I think a lot more people knew what HARP was… I think HARP was a nation state wide program, isn't it? I go to conferences and stuff like that with people from all over the state. If I said hi, I'm [Fran] I'm a specialist in Community Care, they go what? But if I go I'm [Fran] I'm a specialist in HARP, they go oh right OK because they all know HARP… I find myself now having to say Community Care/HARP… So, I wonder whether the name change actually has been quite difficult. (Fran)

To overcome the perceived misunderstanding and lack of knowledge, participants described that they were focusing on rebuilding relationships within the health service. Participants felt that relationship building helped to increase promotion and understanding of the Community Care programme's role in the health service. One participant explained their experience in liaising with ward staff and felt liaising had fostered relationship building. This led to increased understanding of the programme and resulted in patients who would benefit from the programme's care successfully being enrolled:

> We have been trying to address that by having our HIP [Health independence Program] liaison workers. We've also been meeting up with our acute colleagues. So, our nurses will meet up with the nurse unit managers within the hospital, and I will meet up with the allied health unit managers. And look, that has helped in that now they (acute hospital staff) will ring us directly and say, oh, is this patient good for you? And, you know, it really does come down to that basic thing of building relationships. (Jill)

DISCUSSION

Our reflexive thematic analysis of the health professionals' experience of delivering an amalgamated Community Care programme was categorised into four themes. The first theme, 'increasingly complex', highlighted that the patients enrolled into the programme were an increasingly complex patient group with multiple health needs. Participants perceived that the complexity of patients has increased over time. It is unclear if this increased complexity was driven by participants' better identification of underlying health needs, that is, staff were better at identifying complexity, and therefore recognised this more readily. With the identification of patient health

needs, there was noted tension between what the participants felt the patient needed to achieve better health and what patients chose to engage in. This disconnect between provider and patient engagement in health management plans has been described in the literature to be driven by a lack of patient knowledge, particularly related to post-hospital discharge needs, but it is also likely multifaceted.[22 23] Despite the best efforts of caregivers, patients may choose to not follow discharge care plans.[24 25] There is evidence that the integration of multidisciplinary teams in discharge planning reduces hospital use and improves mental health and quality of life for patients.[26–28] The Community Care programme endeavoured to employ these principles; however, discharge care plans were not always followed. This reinforces the need for patient engagement in care decisions,[29] and highlights that support is essential to enable this transition from care within the hospital to care in the community.

The Community Care programme model of care gave participants the time required to allow the patients' health issues to be fully realised. This opposes an often rushed and chaotic discharge process faced by health professionals caring for patients within the hospital.[30] Participants described that they felt they were 'plugging unexpected gaps' a patient may experience, as they navigate the healthcare system. Our findings showed participants believed that inadequate or rushed discharge planning was a potential contributor to a patient's inability to navigate the transition between hospital care and care in the community. As an outreach care coordination service, the Community Care programme assists with discharge planning and transitional care but is not expected to be the place where the discharge plan is made. A lack of discharge planning has previously been described as a key contributor to poorer patient outcomes, with patients who received adequate discharge planning found to have a decreased risk of both readmission and death compared with those who did not.[31] While participants felt that they were plugging unexpected gaps in the patient's discharge journey, this may actually be explained due to a mismatch between what the Community Care programme participants felt that hospital-based staff should provide to patients on discharge versus what actually occurs. A qualitative study examining nursing clinical decision-making during the discharge process found that nurses perceived activities associated with 'identifying and procuring equipment or service providers as disruptive and burdensome' to their role.[32]

The 'disconnected' theme raised some current areas for further development in achieving cross-service and interprofessional integration. This theme discussed the disconnect between the Community Care programme and the acute hospital sector that has developed over time. The disconnect between the acute hospital sector and community care services is not a unique finding to this study, and has previously been linked to adverse events, medication errors, increased patient anxiety and dissatisfaction with care.[33–35] Disconnection between services is further exacerbated by miscommunication, with insufficient system integration playing a key role in miscommunication.[36] This was evidenced in our results through multiple separate information technology systems being used across the service. The infrastructure supporting handover, discharge planning or care plans needs to work seamlessly between hospital, community, and primary care services for safe and effective patient-focused care.[37]

Finally, the shift of the programme to be named 'Community Care' in 2015 from the more traditional programme names such as HARP, PAC and RIR was found to have potentially contributed to the programme being misunderstood. The name 'Community Care' may be too broad or vague compared with what has previously been used or may even be confused with other public community-based services in Australia, such as Community Health or Home and Community Care.[38] The latter services are well established within Australia with state and federal funding but have a different remit to the Community Care programme. The results from this study also found there was an absence of clear patient enrolment criteria and associated education about the programme. This appears to have contributed to a misunderstanding of the purpose of the programme by other services. This phenomenon has also been previously observed, particularly when there is a poor understanding by health professionals of what a service is able to provide for patients.[39 40] Overcoming this with clear patient enrolment criteria, which currently do not exist, may be beneficial in overcoming this challenge of being a misunderstood programme.

There are limitations to the results within this study. First, we relied on a convenience sample of participants and as such not all eligible participants were enrolled in the study. Therefore, there is a risk that the results are not truly reflective of all experiences within the Community Care programme. However, the representation across many disciplines working within the multidisciplinary programme was achieved. This study being a reflexive thematic analysis of perceptions and experiences means that the results are context specific to the health service that this study was undertaken in, being a metropolitan area of Melbourne, Victoria, Australia. The transferability of our results may be limited to similar or identical contexts. Using an inductive approach to data analysis means that there is variability in the interpretation of the experiences reported and the themes which were developed. However, the robust nature of data familiarisation and the challenging and reviewing of codes and themes generated, by all authors, ensured that results gave a balanced insight into the experiences of the participants involved. Further qualitative research should look to explore the experiences of those services referring patients into the programme. This would complement the results from this study and provide a further perspective on understanding the interface of community and hospital care.

CONCLUSION

Providing holistic care for patients at risk of increased healthcare resource utilisation challenges traditional models of care. The healthcare professionals involved in this study described the experience of providing care to these population groups as challenging but felt they made a positive difference to patients' lives. By unravelling the patients' health problems in context of their surroundings, they were able to recognise the patients' health needs which were becoming increasingly complex. While the participants found their work rewarding, the disconnection they faced to integrate within the healthcare system and with external services made their role at times difficult. The lack of integration within the wider health service may have contributed to the programme being misunderstood. The importance of promotion of what the Community Care programme provides and criteria for patient enrolment is something to consider in order to achieve seamless integration with the wider healthcare system.

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Contributors BS conceived the study. BS, HS, K-AB, CW and JM equally designed the study and the questions. BS and HS undertook the data collection and data analysis. CW, K-AB, JM and NA equally interpreted the data. BS drafted the manuscript and circulated to authors for contribution. BS, HS, K-AB, CW, NA and JM edited drafts and approved the current manuscript for publication. BS is the author responsible for the overall content as the guarantor.

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Patient consent for publication Not required.

Ethics approval This study involves human participants and ethical approval was granted by the Human Research Ethics Committee (HREC) of Peninsula Health service (HREC/AM/56828/PH-2020-214196(v1)) and Monash University (MUHREC 27998). Participants gave informed consent to participate in the study before taking part.

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