Received: 28 September 2023 | Revised: 10 November 2023 | Accepted: 27 November 2023

DOI: 10.1002/pon.6267

WILEY

ORIGINAL ARTICLE

Barriers and facilitators to national guideline implementation for palliative cancer care in a Danish cross-sectoral healthcare setting: A qualitative study of healthcare professionals' experiences

Dina Melanie Sørensen[1,2] | Susanne Oksbjerg Dalton[1,2,3,4] | Cecilie Lindström Egholm[5,6] | Pernille Bidstrup[7,8] | John Brandt Brodersen[9,10,11] | Elizabeth Rosted[2,12]

[1]Danish Research Center for Equality in Cancer (COMPAS), Zealand University Hospital, Næstved, Denmark

[2]Department of Clinical Oncology and Palliative Care, Zealand University Hospital, Næstved, Denmark

[3]Cancer Survivorship, Danish Cancer Institute, Copenhagen, Denmark

[4]Institute of Clinical Medicine, Faculty of Health, Copenhagen University, Copenhagen, Denmark

[5]REHPA, Danish Knowledge Centre for Rehabilitation and Palliative Care, Odense University Hospital, Nyborg, Denmark

[6]Department of Clinical Research, University of Southern Denmark, Odense, Denmark

[7]Psychological Aspects of Cancer, Cancer Survivorship, Danish Cancer Institute, Copenhagen, Denmark

[8]Institute of Psychology, University of Copenhagen, Copenhagen, Denmark

[9]The Centre of General Practice, Department of Public Health, University of Copenhagen, Kobenhavn, Denmark

[10]Research Unit for General Practice, Region Zealand, Denmark

[11]Research Unit for General Practice, Department of Community Medicine, Faculty of Health Sciences, UiT Arctic University of Norway, Tromsø, Norway

[12]Department of Regional Health Research, University of Southern Denmark, Odense, Denmark

Correspondence
Dina Melanie Sørensen.
Email: dise@regionsjaelland.dk

Funding information
Danish Cancer Society, Grant/Award Number: grant number R290-A16876; Novo Nordisk Foundation, Grant/Award Number: grant number NNF22OC0077502

Abstract

Objective: Patients with incurable cancer should receive general palliative care according to their needs, as provided through collaboration between hospital departments, municipalities, and general practices and as outlined in national guidelines. However, the implementation of general palliative care in Denmark has been inadequate. This study aimed to investigate the healthcare professionals' (HCPs') perceptions on barriers to and facilitators of the implementation of the Danish National Guideline (NG) for general palliative care.

Methods: This descriptive, qualitative study was guided by the Consolidated Framework for Implementation Research (CFIR). Qualitative focus group and individual interviews were conducted with 23 HCPs. The interview guide, coding, analysis, and reporting of findings were developed within the CFIR framework.

Results: The main barriers to implementing NG were as follows: lack of knowledge about the NG, lack of an implementation plan, and insufficient communication and collaboration across sectors. Important facilitators were as follows: HCP motivation to meet palliative care needs, HCPs with special functions taking responsibility for incorporating NG into local guidelines, and the role of district nurses specialised in palliative care as opinion leaders providing security and continuity for the HCPs working in palliative care.

Conclusions: To address the needs of patients with incurable cancer, greater efforts are required on implementing general palliative care. Although HCPs in our setting were motivated to improve NG implementation, financial resources and strategies are necessary to ensure sufficient knowledge uptake and accommodate identified barriers in order to translate the NG into practice.

KEYWORDS
barriers, cancer, CFIR, cross-sectoral collaboration, facilitators, implementation, national guidelines, oncology, palliative care, qualitative methods

1 | BACKGROUND

Patients with incurable cancer may experience several physical, psychological, social, and spiritual symptoms that may severely affect their quality of life[1]; the most common of which are pain, appetite loss and fatigue.[2] Palliative care aims to alleviate these symptoms and improve patients' quality of life.[3] A Danish national guideline (NG) for rehabilitation and palliative care in patients with cancer[4] was introduced in 2012 and updated in 2018, which follows the World Health Organization (WHO) recommendations stating that patients with a life-threatening illness or serious health-related issues must be offered palliative care.[5] Furthermore, the Danish NG on palliative care aligns with the European Association for Palliative Care (EAPC)'s definition of task and responsibilities. It highlighted that general palliative care should address palliative care needs that may be provided by healthcare professionals (HCPs) frequently involved with, but not solely providing palliative care; conversely, specialised palliative care should address the complex needs that may be met only by specialised palliative care professionals.[6]

The Danish NG on palliative care recommends systematic needs assessment, planning and initiation of services based on patient needs, collaboration across healthcare sectors and between general and specialised palliative care providers such as the hospital department, municipalities, and patients' general practitioners (GPs), implementation, and follow-up[4] (Appendix). The lack of collaboration, coordination, and communication between sectors and within individual sectors has repeatedly been identified as a barrier to palliative care.[7,8] A Norwegian study identified three main barriers experienced by district nurses and GPs.[9] The first was the lack of an initial interdisciplinary meeting to ensure coordination of palliative care. The second barrier was related to 'passing the baton', indicating insufficient coordination across the healthcare system. The final barrier was a lack of collaboration and competency within primary HCPs.[9] Research on the barriers to implementing NGs in palliative cancer care remains limited. Ruojas-Concha et al. investigated these barriers in Denmark and reported that guidelines for the management of physical symptoms were more successfully implemented than for depression in specialized palliative care.[10] Other studies identified HCPs' lack of knowledge about NG and/or their attitudes toward palliative care as barriers to implementation.[11–13] In contrast, a study from Singapore successfully developed and implemented a similar NG, including quality measures which brought about a positive change in the culture of palliative care.[14] The previously identified barriers and facilitators toward implementing general palliative care may be relevant within the Danish healthcare system. However, other aspects may also affect the successful implementation of the NG in the Danish setting.

In 2019, the National Audit Office in Denmark identified an absence of systematic needs assessment for patients with incurable diseases. They warned that patients with complex needs are at risk of delayed or no referral to specialised palliative care,[15] thus leading to an incomplete implementation of the NG. Therefore, this study aimed to map barriers and facilitators to the implementation of the NG in general palliative care for patients with incurable cancer, with a specific focus on collaboration, communication, and coordination within the municipality, general practice, and hospitals.

2 | METHODS

2.1 | Design

This descriptive study used semi-structured interviews, guided by the Consolidated Framework for Implementation Research (CFIR).[16]

2.2 | Study setting

All Danish residents have free and direct access to healthcare, including cancer treatments. The study was conducted in the

Department of Clinical Oncology and Palliative Care at Zealand University Hospital, and in two municipalities and general practices in Region Zealand, Denmark, in the fall of 2021. Region Zealand is one of the five health regions in Denmark; the Department of Oncology provides all out- and inpatient treatments free of charge. Seventeen municipalities in the region are responsible for the basic care of cancer patients whether at home or in nursing homes and provide general palliative care and rehabilitation as well as social and employment services.

2.3 | Study participants and recruitment

We invited five municipalities; only two had the resources to participate. One contact person from each participating municipality was informed of the study; the participants were then recruited. All GPs in the participating municipalities were informed of the study via email. Recruitment was conducted by the chairpersons of the local GP clusters. From the Department of Oncology, the participating HCPs volunteered after a presentation of the project at staff meetings.

2.4 | Theoretical framework, data collection, and analyses

The theoretical framework guiding the study was the CFIR framework.[16] It was applied when developing the interview guide, coding, analyses, and reporting.[16] The CFIR consists of five domains associated with effective implementation, and thus enables a systematic assessment when identifying barriers and facilitators.[16] The five domains refer to the participants in the study (individual characteristics), the intervention (NG) to be implemented (innovation characteristics), the contexts (outer and inner settings), and the process of implementation (process).[16] The interview guide was developed to address themes regarding NG, general palliative cancer care, factors influencing collaboration across healthcare sectors and at individual workplaces, and the HCPs' views on NG implementation.

Data were collected by the first author (DMS) using semi-structured individual and focus group interviews, which were conducted between 14 October and 18 November 2021. The interviews were audio-recorded, transcribed verbatim, and coded deductively based on CFIR domains and associated constructs using NVivo^{R} 1.6.1 (Lumivero). Three authors (DMS, ER, and CLE) were engaged in the coding process to discuss the findings and solve any ambiguity in coding.[17]

2.5 | Ethics

All participants provided written informed consent. The study was registered in Region Zealand to process and store personal data for research (REG-072-2021).

3 | RESULTS

Twenty-three HCPs participated in 16 interviews (Table 1). Table 2 describes the domains in the CFIR framework as well as identified barriers to the implementation of NG, including the lack of knowledge about NG and insufficient collaboration. Conversely, the patients' perceived needs and district nurses specialised in palliative care (DNSPC) were facilitators.

3.1 | Characteristics of individuals

While all HCPs voiced a high degree of commitment to palliative cancer care, they had little or no knowledge of the NG.

> 'Well, I have not read it in detail, but when you say it exists, well yes, I know it exists, but I do not use it' (Healthcare assessor)

Those familiar with NG were primarily HCPs with specific palliative care functions. The GPs knew of the NG, but one GP expressed that engagement in implementing guidelines is based on the individual GP's interest and that even the GP's own perception of death may impact the provision of palliative care. Despite having

TABLE 1 Overview of participants and interview forms.

	Individual interview	Focus group interview
Municipality I		
One district nurse specialised in palliative care	+	
One nurse manager	+	
Three district nurses		+
One healthcare coordinator	+	
Municipality II		
One district nurse specialised in palliative care	+	
One nurse manager	+	
Three district nurses		+
Two healthcare assessors		+
General practice		
Three general practitioners	+	
Hospital department		
One clinical nurse specialist	+	
One nurse manager	+	
Three nurses		+
Two oncologists	+	

TABLE 2 Domains of the Consolidated Framework for Implementation, its relation to the study, and the identified barriers and facilitators.

Domain	Description related to present study	Barriers	Facilitators
Characteristics of individuals	The HCPs' involvement in general palliative care; their knowledge and beliefs about the NG; and the phase the HCP is in as he/she progresses toward sustained use of the NG.	• Little or no knowledge about the NG (M, GP, H) • Own perception of death (GP)	• HCPs with special functions are familiar with the NG (M) • Engagement of HCP and management in palliative care (M) • Motivation and competencies to employ changes (M) • HCPs see the purpose of the intervention (M, H)
Intervention characteristics	The HCPs' perceptions of the characteristics of the NG, its perceived complexity, and the relative advantages of implementation.	• NG is extensive and a time-burden (GP) • Uncertainty about incorporating the NG into local guidelines (H)	• HCPs welcome a common language (GP, M) • HCP with special functions incorporate the NG into local guidelines (M) • Shorter form of the NG (GP)
Inner setting	The context where the NG is being implemented (hospital/municipality/GP), including factors influencing the implementation of the NG; structural characteristics and degree of specialization, networking, and internal communication.	• Different healthcare units in the municipalities have different views on palliative needs (M)	• District nurse specialised in palliative care ensures safety of other HCPs (M, GP) • District nurse specialised in palliative care has a key function (M,GP) • Multi-disciplinary meetings (M) • Good communication among district nurses (M) • GPs working closely together entails high degree of collaboration (GP)
Outer setting	External context. The extent needs and resources of the palliative cancer patients are known and prioritised; and networking with external organisations.	• Poor network across sectors (M,GP,H) • Poor communication and coordination across sectors (M,GP) • Lack of knowledge about GPs' need for information (H) • Complicated relationships between patient and GP/oncologist (M,H)	• Accommodating patients' needs is a high priority (M,GP,H) • District nurses and district nurses specialised in palliative care are the link between the patient and healthcare sectors (M,GP) • Good relations promote collaboration (M)
Process	Activities and strategies that might influence the implementation of the NG: engagement of HCPs and presence of opinion leaders.	• No structured plan for implementation of the NG into clinical practice (M,GP, H) • Select parts of the NG and use it individually for each patient (GP) • No formal leader (H)	• HCP with special functions incorporate the NG into local guidelines (M) • District nurses specialised in palliative care function as opinion leaders (M) • Knowledge leads to informal leadership of district nurses specialised in palliative care (M) • Managers' opinions and attitudes influence HCPs in a positive way (H) • Works individually without formal leaders (GP)

Abbreviations: GP, general practitioner; H, hospital; HCP, healthcare professionals; M, municipalities; NG, national guidelines.

sparse knowledge about the NG, HCPs from the municipalities welcomed an increased focus on implementation and described themselves and their organisations as having the competencies and motivation to make changes. District nurses expressed engagement in future implementation efforts and perceived their managers to have the same degree of commitment. In the Department of Oncology, almost all HCPs felt that they could manage any meaningful changes brought on by the future implementation of the NG.

3.2 | Intervention characteristics

The DNSPC perceived NG as advantageous over the usual practice; it provides a common language and reduces uncertainty about patient care, thus motivating them to incorporate NG into local guidelines. Likewise, some GPs welcomed NG; they saw opportunities for the use of a common language, leading to optimised coordination and division of responsibilities across sectors for the benefit of vulnerable patients.

> Well, I think it will be good to have a better plan for those patients who do not contact the healthcare system by themselves (GP)

On the contrary, one GP perceived NG to be too lengthy and expressed concerns that this would lead to low commitment to implementation. Thus, the GP preferred a shorter version. Since none of the HCPs in the Department of Oncology had been introduced to the NG except for the nurse manager, they did not have any experiences with or comments to it.

3.3 | Inner setting

Both participating municipalities prioritised the employment of a full-time DNSPC, which district nurses and GPs perceived as contributory to a high level of professionalism in general palliative care by providing security and continuity for HCPs. The DNSPC was considered to play a facilitating role in the implementation of NG based on her key function in a complex municipal setting.

> It is nice that our municipality has prioritised a DNSPC, we have a lot of supervision, because we feel confident with her. I think it works very well (District nurse)

To coordinate palliative care, HCPs from municipalities prioritised internal collaboration in a structured manner. One municipality held multidisciplinary meetings once a week with the DNSPC, whereas the DNSPC in the other municipality met regularly with patients and HCPs at the municipal health center.

Although communication between district nurses were described as well-functioning, they experienced challenges when coordinating with other municipal healthcare or social work units. A municipal manager mentioned that this may be a barrier to the implementation of NG; palliative patients are only a minor proportion of all patients served by the municipality. Moreover, compatibility with other workflows in varying units may clash.

The GPs participating in this study all worked closely with other GPs. They felt that they had a well-functioning network to ensure all patients had access to palliative care, thus facilitating future NG implementation.

3.4 | Outer setting

HCPs' perception of patient needs was a central facilitator for implementation. In an effort to meet patient needs, district nurses and DNSPC experienced a facilitating function by coordinating and communicating with the patients and their relatives, the attending GP, and the hospital.

> I have a very good collaboration with the DNSPC, she often handles a lot of things on her own, but sometimes we go together to visit the patient and relatives at home, and then we listen to their needs and set up a plan based on that (GP)

A lack of networking and communication across sectors was described as a major barrier to NG implementation. The GPs expressed a wish for more frequent contact with the hospital regarding palliative patients with cancer, which was substantiated by an oncologist who expressed a lack of knowledge about the GPs' need for information.

A challenging relationship between patient and GP or oncologist was highlighted by several HCPs as a prominent issue because HCPs from other sectors then have to step in and provide palliative care. A district nurse expressed that her work stagnated if relations between patient and GP or oncologist were dysfunctional. Professional relations were perceived as both a barrier and a facilitator in the implementation of NG underlining that well-functioning relations promote collaboration.

3.5 | Process

The findings indicated the overall lack of a structured plan for implementing NG across sectors. The interviews reflected individual HCPs doing their best to fulfill the NG recommendations. For instance, HCPs from municipalities who were aware of the NG incorporated recommendations in the local guidelines.

> Based on my function I know all the recommendations, and I can see now, that after I became a full-time DNSPC I have time to keep up to date with the recommendations from the health authorities. I make guidelines based on the recommendations, and I am quite aware of using the same words as the authorities because it makes it more recognisable (DNSPC)

The resources and knowledge of the DNSPC provided informal leadership to transform NG into a daily practice valued by their colleagues. Therefore, they were perceived as opinion leaders.

The GPs were very engaged in palliative care, worked individually, and were not influenced by other GPs' attitudes toward NG implementation. Despite their knowledge, they did not work in a structured manner to implement the NG. One GP stated that he selected only parts of the NG and used them individually for each patient.

The process of implementing NG in the Department of Oncology was unclear. None of the HCPs could account for the implementation plan. The facilitating factors were clear in theory: having a clear opinion, involvement, and collaboration with key stakeholders, and having a positive attitude that may influence other HCPs; these were observed to promote an implementation process according to a nurse manager.

4 | DISCUSSION

This study examined HCPs' perceptions of barriers and facilitators to the implementation of NG for general palliative cancer care across healthcare sectors. Importantly, their knowledge about NG was very sparse; little effort was made to implement NG 4 years after the updated version was launched. The findings indicated that the implementation efforts were based on fragmented initiatives by individuals. The interviews focused on barriers in the practice delivery of cross-sectoral general palliative care rather than the NG implementation. Thus, the findings reflect the HCPs' thoughts and ideas about how to improve palliation trajectories. Furthermore, HCPs were enthusiastic about fulfilling the patients' perceived needs and providing optimal general palliative cancer care across sectors, which may be a key facilitator for future implementation.

These findings underpin our assumption that Danish NG for general palliative care was not sufficiently implemented, which underscores the importance of focusing on a contextual enquiry into its determinants, as stated by Davis and Beidas.[18] We identified the barriers and facilitators for multiple CFIR levels. The complex interaction of barriers at different levels may have affected the implementation process of NG,[16] although facilitating contextual characteristics must also be seen as elements to build on in relation to a more explicit implementation of NG.

A prominent barrier was the lack of knowledge about NG; similarly, Kalies et al. reported that 46% of staff lacked knowledge concerning recommendations in palliative care based on an NG launched in 2015 in Germany.[11] Barriers and facilitators concerning communication, coordination, and collaboration in general palliative cancer care were highlighted in most of the interviews; poor networking and a lack of information exchange across sectors hindered optimal implementation. In an overview of systematic reviews investigating barriers and facilitators in implementing clinical practice guidelines in primary care, Wang et al. found that limited healthcare networks and poor interprofessional communication pathways were often mentioned as barriers.[19] Concurrent with our findings, this signifies that efforts must be invested in improving communication and collaboration across sectors when implementing NGs.

A prominent facilitator of NG implementation was that all HCPs shared the common goal of fulfilling patient needs. The DNSPC and district nurses emphasised their overview and ability to coordinate and collaborate internally and across sectors to fulfill patient needs as key to the implementation of NG. Van Riet Paap et al. investigated barriers and facilitators to improving the organisation of palliative care in five European countries; they identified HCPs' skills and attitudes as facilitators for improving the quality of palliative care.[20] Similarly, in our study, district nurses' skills and positive attitudes were considered essential in securing the continuity of care across sectors and promoting the implementation of NG. However, Albizu-Rivera et al. found that a negative attitude toward palliative care was perceived as a barrier to providing palliative care services, in an investigation of 21 member institutions of the National Comprehensive Cancer Network in the US.[12] Similarly, Sommerbakk et al. identified a negative attitude toward implementing changes in palliative care as a barrier.[21]

To translate NGs into clinical practice, relevant implementation strategies must be selected and provided; for example, by utilising different methods or techniques to enhance the adoption, implementation, and sustainability of the different actions included in the NG.[22] An implementation strategy in our setting could involve district nurses as local opinion leaders who could discuss with their collaborators about how to translate NG actions into their local setting. Evidence for applying this strategy is mixed and is underlined in a synthesis of systematic review findings by Prior et al.[23] Moreover, Grimshaw et al. showed that the more specialised the group, the more opinion leaders may be a useful strategy for implementation.[24] Pereira et al. pointed out that NG developers are not responsible for implementation and must delegate responsibility[25]; however, implementation may still require multifaceted strategies as a basis for effective use at the local and national level[23] Concurrently, Lind et al. found that more tailored implementation strategies were preferable.[13] Furthermore, according to recommendations from WHO,[5] the Danish NG contains a proposal for how to implement the guidelines, thereby endorsing that the palliative care delivery must be included in the collaboration agreements between municipalities and regions which represent the primary and secondary healthcare sectors in Denmark. In the Danish setting, it may be questioned whether sufficient resources were provided and distributed at all levels as needed in the implementation process. As the NG for some HCPs was perceived as extensive, a suggestion could be to develop a digital app containing all the palliative care guidelines, thus making it easier to find the needed information to promote a better implementation of the NG.

Our findings illustrate that even though HCPs were highly engaged in providing palliative cancer care, their implementation strategies were insufficient. A Canadian study showed that by surveying key stakeholders to understand their attitudes toward the collaboration and implementation of national palliative care policies, they could develop recommendations to support targeted engagement strategies.[26] Therefore, the present analysis of barriers and facilitators may contribute to the process of choosing strategies to optimise NG implementation.

4.1 | Study limitations

During the interviews, we did not ask participants to define the palliative patient with cancer. No HCPs mentioned their own description or definition of the patients. In retrospect, having explored how the participants specified patients with cancer in need for general palliation might have strengthened or widened our identification of the barriers to NG implementation. The relatively small geographical distribution of the participating municipalities GPs and one oncological department in one region of Denmark might have limited the generalisability of our results; other municipalities, GPs, and regional oncological centers may be organised differently.

The primary healthcare system in Denmark is characterised by staff shortages which, despite financial compensation for participation in the study, may have lowered the recruitment of municipalities and GPs. We also did not include the perspectives of healthcare decision makers who are also stakeholders in NG implementation. The participating HCPs volunteered and expressed special interest in palliative care. This may be considered both a strength and a limitation, as the participants were highly engaged but their perspectives may not have reflected the perspectives of HCPs with less interest in palliative care. Due to a general lack of knowledge about NG, the interviews turned out to be more about HCPs' thoughts and ideas about barriers and facilitators than their actual experiences in relation to NG implementation.

4.2 | Clinical implications

This study included all three settings responsible for the delivery of palliative care in Denmark and provided valuable knowledge about HCP experiences with the care process, which may inform and tailor the future implementation of NGs for palliative care across healthcare sectors. This study may also inspire healthcare authorities and HCPs to analyze barriers and facilitators at the national and local levels prior to engaging in other national implementation projects. The CFIR seems like a suitable framework in relation to investigating barriers and facilitators in multi-settings at multiple levels. Taken together with other research, our findings indicate a need for development of evidence-based implementation strategies internationally, that is, in the EAPC, to support implementation of complex organisational healthcare like palliative care.

5 | CONCLUSION

The study confirmed that the implementation of NG in cross-sectoral palliative cancer care remained insufficient and highlighted that HCP knowledge about NG in general was sparse or even non-existent in the Danish healthcare setting. Although our findings show that HCPs across sectors were highly committed to providing general palliative cancer care, individual HCPs across and within the healthcare sector could not undertake the task of implementing NG by themselves. This illustrates that further work is needed to ensure the complete implementation of NG, which requires financial resources and strategies with concrete actions for translating each of the NG elements into practice.

ACKNOWLEDGEMENTS

The authors would like to thank the healthcare professionals for participating in the interviews and sharing important insights. This study was supported by grants from the Danish Cancer Society (grant number R290-A16876) and the Novo Nordisk Foundation (grant number NNF22OC0077502).

CONFLICT OF INTEREST STATEMENT

The authors declare no conflicts of interests.

DATA AVAILABILITY STATEMENT

Data may be accessed upon reasonable request to the corresponding author.

ORCID

Dina Melanie Sørensen https://orcid.org/0000-0002-6014-9355
Susanne Oksbjerg Dalton https://orcid.org/0000-0002-5485-2730
Cecilie Lindström Egholm https://orcid.org/0000-0002-3527-0268
Pernille Bidstrup https://orcid.org/0000-0002-9704-6800
John Brandt Brodersen https://orcid.org/0000-0001-9369-3376
Elizabeth Rosted https://orcid.org/0000-0002-1186-650X

REFERENCES

1. Vogt J, Beyer F, Sistermanns J, et al. Symptom burden and palliative care needs of patients with incurable cancer at diagnosis and during the disease course. *Oncologist*. 2021;26(6):e1058-e1065. https://doi.org/10.1002/onco.13751
2. Hansen MB, Ross L, Petersen MA, Groenvold M. Age, cancer site and gender associations with symptoms and problems in specialised palliative care: a large, nationwide, register-based study. *BMJ Support Palliat Care*. 2022;12(e2):e201-e210.
3. Howie L, Peppercorn J. Early palliative care in cancer treatment: rationale, evidence and clinical implications. *Ther Adv Med Oncol*. 2013;5(6):318-323. https://doi.org/10.1177/1758834013500375
4. Sst.dk. Pathway for Rehabilitation and Palliative Care in Cancer [Forløbsprogram for Rehabilitering Og Palliation I Forbindelse Med Kraeft] [Internet]. 2018. [cited 2022 Jan 11]. www.sst.dk
5. World Health Organization. Quality Health Services and Palliative Care: Practical Approaches and Resources to Support Policy, Strategy and Practice; 2021:59.
6. Payne S, Harding A, Williams T, Ling J, Ostgathe C. Revised recommendations on standards and norms for palliative care in Europe from the European Association for Palliative Care (EAPC): a Delphi study. *Palliat Med*. 2022;36(4):680-697. https://doi.org/10.1177/02692163221074547
7. Bennardi M, Diviani N, Stüssi G, et al. A qualitative exploration of interactional and organizational determinants of collaboration in cancer palliative care settings: family members', health care professionals' and key informants' perspectives. *PLoS One*. 2021(10):16.
8. Lundereng ED, Dihle A, Steindal SA. Nurses' experiences and perspectives on collaborative discharge planning when patients receiving palliative care for cancer are discharged home from hospitals. *J Clin Nurs*. 2020;29(17–18):3382-3391. https://doi.org/10.1111/jocn.15371
9. Danielsen BV, Sand AM, Rosland JH, Førland O. Experiences and challenges of home care nurses and general practitioners in home-based palliative care - a qualitative study. *BMC Palliat Care*. 2018;17(1):1-13. https://doi.org/10.1186/s12904-018-0350-0
10. Rojas-Concha L, Hansen MB, Adsersen M, Petersen MA, Groenvold M. Implementation of clinical guidelines in specialized palliative care—results from a national improvement project: a national register-based study. *Palliat Med*. 2023;37(5):749-759. https://doi.org/10.1177/02692163231155977
11. Kalies H, Schöttmer R, Simon ST, Voltz R, Crispin A, Bausewein C. Barriers for the implementation of guidelines in palliative care—results from a national survey of professionals. *Support Care Cancer*.

2018;26(6):1943-1952. https://doi.org/10.1007/s00520-017-4030-z
12. Albizu-Rivera A, Portman DG, Thirlwell S, Codada SN, Donovan KA. Implementation of NCCN palliative care guidelines by member institutions. *Support Care Cancer*. 2016;24(2):929-932. https://doi.org/10.1007/s00520-015-2862-y
13. Lind S, Wallin L, Brytting T, Fürst CJ, Sandberg J. Implementation of national palliative care guidelines in Swedish acute care hospitals: a qualitative content analysis of stakeholders' perceptions. *Health Pol*. 2017;121(11):1194-1201. https://doi.org/10.1016/j.healthpol.2017.09.011
14. Lo TJ, Neo PSH, Peh TY, et al. Improving quality of palliative care through implementation of national guidelines for palliative care. *J Palliat Med*. 2019;22(11):1439-1444. https://doi.org/10.1089/jpm.2018.0345
15. Rigsrevisionen dk. Report on Access to Specialized Palliation [Beretning Om Adgangen Til Specialiseret Palliation] [Internet]; 2020:37. [cited 2022 Apr 4]. https://rigsrevisionen.dk/Media/637830383760074804/SR1819.pdf
16. Damschroder LJ, Aron DC, Keith RE, Kirsh SR, Alexander JA, Lowery JC. Fostering implementation of health services research findings into practice: a consolidated framework for advancing implementation science. *Implement Sci*. 2009;4(1):1-15. https://doi.org/10.1186/1748-5908-4-50
17. Elo S, Kyngäs H. The qualitative content analysis process. *J Adv Nurs*. 2008;62(1):107-115. https://doi.org/10.1111/j.1365-2648.2007.04569.x
18. Davis M, Beidas RS. Refining contextual inquiry to maximize generalizability and accelerate the implementation process. *Implement Res Pract*. 2021;2:26. https://doi.org/10.1177/26334895219949 41
19. Wang T, Tan JYB, Liu XL, Zhao I. Barriers and enablers to implementing clinical practice guidelines in primary care: an overview of systematic reviews. *BMJ Open*. 2023;13(1):1-19. https://doi.org/10.1136/bmjopen-2022-062158
20. Van Riet Paap J, Vernooij-Dassen M, Brouwer F, et al. Improving the organization of palliative care: identification of barriers and facilitators in five European countries. *Implement Sci*. 2014;9(1):130. https://doi.org/10.1186/s13012-014-0130-z
21. Sommerbakk R, Haugen DF, Tjora A, Kaasa S, Hjermstad MJ. Barriers to and facilitators for implementing quality improvements in palliative care - results from a qualitative interview study in Norway. *BMC Palliat Care*. 2016;15(1):1-17. https://doi.org/10.1186/s12904-016-0132-5
22. Proctor EK, Powell BJ, McMillen JC. Implementation strategies: recommendations for specifying and reporting. *Implement Sci*. 2013;8(1):1-11. https://doi.org/10.1186/1748-5908-8-139
23. Prior M, Guerin M, Grimmer-Somers K. The effectiveness of clinical guideline implementation strategies - a synthesis of systematic review findings. *J Eval Clin Pract*. 2008;14(5):888-897. https://doi.org/10.1111/j.1365-2753.2008.01014.x
24. Grimshaw JM, Eccles MP, Greener J, et al. Is the involvement of opinion leaders in the implementation of research findings a feasible strategy? *Implement Sci*. 2006;1(1):1-12. https://doi.org/10.1186/1748-5908-1-3
25. Pereira VC, Silva SN, Carvalho VKS, Zanghelini F, Barreto JOM. Strategies for the implementation of clinical practice guidelines in public health: an overview of systematic reviews. *Heal Res Pol Syst*. 2022;20(1):1-21. https://doi.org/10.1186/s12961-022-00815-4
26. Xiao J, Brenneis C, Fassbender K. Stakeholder perspectives towards implementing the national framework on palliative care in Canada. *Health Po*. 2022;126(6):576-583. https://doi.org/10.1016/j.healthpol.2022.01.011

SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

How to cite this article: Sørensen DM, Dalton SO, Egholm CL, Bidstrup P, Brodersen JB, Rosted E. Barriers and facilitators to national guideline implementation for palliative cancer care in a Danish cross-sectoral healthcare setting: a qualitative study of healthcare professionals' experiences. *Psychooncology*. 2024;e6267. https://doi.org/10.1002/pon.6267