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An interpretative qualitative case study of a Compassionate Cities initiative in the United Kingdom: Lessons for implementation in other settings

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Abstract

Objectives. Compassionate Cities are a novel approach to health-promotive palliative care that uses a population-based approach to promote health and encourage its citizens to act with confidence to help others during death, dying, or bereavement. This study aimed to provide a critical account of how the leaders of a Compassionate City adopted the initiative and how they experienced its development and implementation.

Methods. An interpretative qualitative case study was conducted in a newly established Compassionate City in the UK. Data was collected using in-depth interviews, documentary analysis, and non-participatory observations. Reflective thematic analysis was used to analyze the contents of the multiple resources.

Results. Five observations, 4 document analyses, and 11 interviews with members of the Compassionate City steering committee were conducted. We identified 4 themes: right model, right people, in the right place, at the right time; building a network of organizations and individuals; building sustainable community capacity to deal with grief, loss, and bereavement; and, embedding and sustaining the Compassionate City initiative. The study also found that cross-cutting factors such as leadership, visibility of work, evaluation, communication, and funding influenced and shaped the key themes when developing and implementing the Compassionate City.

Significance of results. This study provides broad insight into the key actions taken by the leaders of a Compassionate City aiming to improve the end-of-life experience of its citizens. We highlight the many challenges and complexities faced by the leaders when translating the concepts of Compassionate Cities into practice and identify key elements to consider for the successful implementation of future initiatives.

Introduction

The public health strategy for palliative care was pioneered by the World Health Organisation in the 1990s to integrate palliative care into a country's mainstream health care system (Stjernswärd et al. 2007). Going a step further, Allen Kellehear introduced the health-promotive palliative care model that united the health promotion principles outlined in the Ottawa Charter with those of palliative care (Kellehear 1999). This "new public health approach to palliative care" can be viewed as a social movement made by communities, local governments, institutions, and social or healthcare groups with the goal of enhancing the well-being and health of persons who are nearing the end of their lives (Sallnow et al. 2015).

Health-promotive palliative care enables the establishment of specific support within communities for people who are dying or have experienced loss or bereavement (Kellehear and O'Connor 2008). The principles of this approach are applied in the Compassionate Communities and Cities initiatives (Wegleitner et al. 2015). A Compassionate Community has been defined as "naturally occurring networks of support in neighbourhoods and communities, surrounding those experiencing death, dying, caregiving, loss and bereavement" (Abel et al. 2018). In contrast to Compassionate Communities that primarily focus on neighborhoods, Compassionate Cities range in size from those with populations in the tens of thousands to those with populations over one million (Transnational Forum on Integrated Community Care 2020).

They therefore use different approaches of social organization, representative of typically densely inhabited metropolitan areas, with multiple institutions and complex and interconnected social sectors (Transnational Forum on Integrated Community Care 2020). The Compassionate Cities initiative brings together city and town leaders to discuss issues and make institutional changes within their respective areas of influence (Kellehear 2020). In contrast to Compassionate Communities' "naturally occurring networks" (Abel *et al.*, 2018), Compassionate Cities use a "social ecology approach" – a top–down strategy for change that seeks to modify the social and physical surroundings in order to bring about social and behavioral change (Quintiens et al. 2022b, p. 2).

Unlike Compassionate Communities that have been well established in several high-, medium-, and low-income countries, with each initiative sharing learning from the others (Quintiens et al. 2022a), Compassionate Cities are a relatively new approach to health-promotive palliative care, with some of the first few examples being established in the UK (Public Heath Palliative Care International 2023). By investigating how a pioneering Compassionate City was established in the UK, this study aims to identify some of the key lessons that might be beneficial to other settings considering becoming a Compassionate City. In particular, we seek to provide a critical account of how the leaders of the Compassionate City adopted the initiative and their perceptions of its development and implementation.

Methods

The study employed an interpretative qualitative case study design (Andrade 2009) to make use of a variety of data sources, including in-depth interviews, documentary analysis, and observations.

Ethics

The ethics approval for the study was granted by the University of Warwick's Biomedical and Scientific Research Ethics Committee (BSREC 27/22-23). To protect participants' identities and confidentiality, it was agreed that the identity of the city would not be referred to in publications or presentations.

Study setting and population

The study was conducted in a newly established Compassionate City in the UK. The city is highly diverse with more than half of the population representing different ethnic minorities. Data collection focused on the members of the Compassionate City steering committee. Its members represent different sectors and organizations. They were involved in different workstreams according to the components of the Compassionate City Charter (Wegleitner et al. 2015). The data collection was conducted in the first 6 months of 2023.

Recruitment

SN attended monthly steering committee meetings and subgroup meetings of the Compassionate City as a non-participant observer between January and May 2023. The meetings were held both virtually (on MS Teams) and in person. The permission for observing meetings were obtained from the chairperson of the steering committee.

For in-depth interviews, a purposive sampling method was used to reach members of the steering committee using the personal links of the coordinators and the chairperson. Potential participants were contacted through email and provided with a participant information sheet, before agreeing on a time and date for an online interview. Written or verbal (participant preference) consent was taken prior to conducting interviews.

Data collection

In-depth interviews were conducted by SN using a semi-structured interview guide and were recorded through MS Teams. The interview guide sought to cover the participant's involvement with the initiative, their contribution, activities, and strategies carried out as well as any perceived challenges and proposed solutions to support and improve end-of-life experience for the citizens of the Compassionate City.

For document analysis, local government websites and web-based articles on the Compassionate City initiative that were published or produced up to June 2023 were reviewed. Documents were not cited and the text was paraphrased to maintain the anonymity of participants. A basic data extraction form was used to gather information on the development, implementation, challenges, and plans of the Compassionate City. For observations, fieldnotes were made by SN during each meeting. These recorded how the Compassionate City leaders identify issues of implementing the Compassionate City, how they seek to address problems, what type of strategies they employ, and the values expressed to guide their decision-making. No personally identifiable information or direct quotations were recorded in the notes.

Data analysis

Reflective thematic analysis (Braun et al. 2019) was used to analyze the contents of the interviews, observation notes, and documents. SN first familiarized with the transcripts by re-reading them multiple times. Second, the initial codes were generated using NVivo (Lumivero 2020). All of the study team contributed to the discussion about potential themes. The coding and generation of themes followed an abductive approach, reflecting on the existing literature, as well as the researchers' knowledge and experiences. The initial themes were re-checked for internal homogeneity and external heterogeneity, which led to some codes being combined, while others were divided. As part of this iterative process, a code book for each theme was produced, with the relationships between the tentative themes and the individual codes being re-examined before being finalized. The meeting observations and document analysis were used to further reflect upon the interview findings and explore the initial coding. Themes value was identified by their capacity to provide interpretative meaning, rather than by the frequency of occurrence.

Results

Five Compassionate City steering committee meetings were attended: 3 online and 2 in-person. Four documents were analyzed (websites and web-based articles). Seventeen members were approached for in-depth interviews leading to 11 interviews; 3 members did not respond, while another 3 declined the invitation. Two reasons for declining were offered: not spending much time on the Compassionate City project and not being involved

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Table 1. Participant's background

Organization	Number of participants
Community interest groups/Charity organizations	03
Hospice network	02
City council	02
Faith council	01
Volunteer organizations	02
Integrated care board	01
Total no. of interviews conducted	11

since its inception. The in-depth interviews lasted between 35 minutes and 62 minutes. Representatives from the hospice network, National Health Service (NHS), the city council, and voluntary and community organizations (registered charities, associations, and community groups) were among the participants (Table 1). Four themes were identified to reflect how the Compassionate City was developed and implemented: the right model, right people, in the right place at the right time; building a network of organizations and individuals; building sustainable community capacity to deal with grief, loss and bereavement; and, embedding and sustaining the Compassionate City initiative.

Right model, right people, in the right place, at the right time

We observed an uncertainty in the **model** used for the initiative. During the interviews, several participants from the community organizations did not use the term "Compassionate Cities." Instead, they often referred to the initiative as "Compassionate Communities." This slippage was also observed in the meetings. Participants did not reflect on the distinction between the 2 models directly, but several did compare their Compassionate Cities work with their roles in Compassionate Community initiatives, which we explore below.

Participants explained how the Compassionate City began with the establishment of a core team of **people** (steering committee) who were altruistic and already worked or provided services around illness, death, grief, and bereavement in the city. As the idea of developing a Compassionate City originated through the hospice network, most of the members of the core team had existing working relationships with the local hospice community. In addition, they were a group of highly accomplished individuals, leaders in their respective areas of expertise. Some participants expressed how the Compassionate City activities were similar to the activities they undertook in their current roles, making it easy to get involved. For example, a community development officer of the hospice network said,

> *"My predecessor had been on the working group of the Compassionate City Charter Group, so automatically I was led into those meetings, and it fits, you know, as part of my job description, those meetings fit perfectly well with aspects of my job role" (SM02)*

Participants from community organizations further described how they got involved in the Compassionate City to achieve better population exposure for their work. One participant from a community organization explained how she thought the Compassionate City would help her organization develop connections and reach a wider community.

> *"We felt that it would be really useful for [us] to be involved because it would be a really good way of making connections with other organisations, but also what we were hoping was that compassionate communities [sic] would do a lot of what we've been trying to do by encouraging conversations and all those kind of things. It looked like it ticked all the boxes of what our organisation was about" (SM09).*

However, involvement meant accommodating and coordinating additional activities. Some participants explained how the additional work brought by their Compassionate City role had affected their capacity to contribute, despite being committed to the initiative. A senior integration manager of the NHS said,

> *"For at least the first kind of 15 months, my project support officer was actually doing all the admin for Compassionate City, organising all the meetings, coordinating everything. It took a significant amount of resources and we ended up having to stop that just because the pressures on the team were so huge"(SM05).*

Participants explained what helped to make their region the right **place** was how the administrative structure of the city facilitated the development, as well as maintain the continued engagement of the local authority. For example,

> "*So one of the benefits of [City] is there is one City Council. And that maps to the NHS footprint. Whereas, like in [another region] where I'm doing some work, there are eight different councils within one footprint, so that's really challenging. So, in many ways the structural setup of [City] is quite neat*" (SM01).

Participants also recognized it being the right **time** to initiate a Compassionate City initiative. This was because during the initial years of the COVID-19 pandemic, the need to provide support to people dying and grieving within their community had grown. An online Compassionate City publication explained how COVID-19 had initially been a problem, delaying the progress of the Compassionate City, but later had become a catalyst for local communities to come together for support. A chief executive officer of a community organization explained,

> "*When I was doing some work around it [death and dying] pre-COVID it didn't take off because people [health, social care and community organisation leaders] really didn't want to talk about it. They didn't need to talk about it until we were hearing hundreds of deaths on television. I think then it became a priority. I don't think that would have happened sort of pre-COVID possibly. Death and dying are part of the conversation now. And that's why sort of pioneering it [Compassionate City] in [City] fitted*" (SM08).

Building a network of organizations and individuals

As observed during meetings and identified during interviews, the Compassionate City sought to represent multiple sectors spread across the city. The participants explained how individuals and organizations who shared a common interest in improving people's experiences of death, dying, and bereavement were approached and invited to join the Compassionate City network. This not only connected people with the Compassionate City movement, but also helped to connect different organizations within the network to share ideas, experiences, and resources.

Given the city's cultural diversity, it was observed through meetings and during the interviews how the Compassionate City steering committee wanted to ensure those communities were represented

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within their network. One web-based article included open invitations to any individual or organization to join the network. One such document on the city council website stated how a city-wide working committee has been formed to implement the Compassionate City Charter. The website has also included an open invitation to anyone working in official or informal networks to take part.

However, building the network had not been easy. As a member of adult social care expressed,

> *"… quite often what happens is the Council will reach out to an organisation and it's a one-way journey"* (SM11).

Participants expressed several reasons for poor engagement with those community or voluntary organizations experiencing inadequate funding, increased workload, over-stretched resources, and competing priorities. A chief executive officer from a community development organization said,

> *"But the problem is that community organisations are very under-resourced. They are burnt out after covid. And you know, dying isn't really on their agenda as a topic that they've got resources for or people or money. So, it was quite difficult getting people to come along to that"* (SM08).

One difficulty that some participants identified in developing the network was the change in power relations about engaging communities between community organizations and professional services. Those with a community organization background were often sceptical that the Compassionate City network followed in practice the ethos it exposed on paper. A member of a community interest group said,

> *"For me, the biggest frustration with Compassionate City is that it is still held by the organisations, with power. It is still the Hospice wanting to go in and host, the NHS wanting to go in and tell people how to do things. Whatever their best intentions it comes down to that and same for the City Council, any of these big organisations, it's about control and they're not very good at letting go"(SM06).*

There was also a perception that volunteer organization opinions may not be viewed as important. A member of a volunteer organization said,

> *"They [city council] are not good at just letting communities do what they know they need to do. You know, like treating them as grown-ups. You know that's my frustration. But I sometimes feel a bit of a single voice on that. It's not me that's got the voice or the power to do so"(*SM03).

However, it was recognized that these tensions could also be seen as a form of progress,

> *"Much as I find that the city council, controlling over things, at least they are interested. And they are doing something, so you can't complain too much. You know when they are finding money to progress this work so that's good"(SM06).*

Participants commonly agreed that the sustainability of the network required financial investment and that the most likely way this would be accessed is via the city council, which had already secured several sources of funding. In addition to investing in activities, these funds were used to maintain administrative support, which included financially securing a chair for the steering committee. During meetings it was observed that the chairperson provided leadership by facilitating and directing the steering committee, helping resolve differences of opinion and disputes, and ensuring everyone had a chance to speak. Participants noted how the initiative did not progress during a period when there was no chair. A commissioning manager at the city council said,

> *"I think there was a period where things kind of quieted down becoming a Compassionate City. But then there was no one leading it because there's no one paying for that leadership role"* (SM04).

The importance of personal investment in the initiative in terms of time and commitment from the members of the network was also discussed by participants. Some expressed how a lack of commitment by members resulted in poor productivity in workstreams. A member of a community organization who had a similar experience explained,

> *"I've set those meetings up and like the last meeting, there was only three of us at it, and I'm like, well, you know, we can't move forward if we're not even in a meeting together"* (SM09).

A member of a volunteer organization felt that once the Compassionate City initiative started to demonstrate a positive impact on citizens, more people would be willing to commit time and resources to the initiative. Other participants similarly talked about the importance of using different platforms to showcase work done by the Compassionate City. They expressed how employing marketing strategies will help to get support, funding, and partnerships for the Compassionate City. A board member of a community interest group stated,

> *"I think if there was more evidence of it working that would bring more people to it. If people can see that it is worth investing in and it's worth investing the time and people's time is so valuable, you know, it's not as if we're investing money, you know. We are all volunteers. We have incredibly demanding jobs. So even to invest an hour or two is a lot"* (SM07).

Building sustainable community capacity to deal with grief, loss, and bereavement

The leaders of the Compassionate City explained that for it to be successful and sustainable, it must be relevant and meet the needs of the people it served. Our observations and documentary analysis found that they used a variety of ways to identify community needs and preferences including: a baseline survey, community-led research, and focus groups to capture the desires, perceptions, understanding, and skills related to end-of-life in diverse communities. A chief executive officer from the hospice network said,

> *"We do lots of different activities, discussion arenas, we've worked with different organisations in [City] looking at the localities of where we hold those events we try and encourage different, not only different cultures and religions, also different social groups and you know, instead of just your general white middle class" (SM06).*

The Compassionate City steering committee had sought to engage "community treasures" already in place. For example, they used individuals from a particular community to approach others in the same community to build up conversations. The adult social care, at the city council with the community organizations contributed to mapping out and developing a registry of local resources to be used by the city residents. One participant from adult social care expressed the importance of this resource,

> *"If you're going to engage properly, you need to do it place-based because you need to know your assets right? And these assets that exist will be different in different areas, so you need to map it out. You need to understand who you are going to approach within different areas. You really need to go down to ward level, because no one wants to have to go to [regional] hospital if they're*

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dying and they want to die at home. But where is home? You know it's a big city"(SM11).

It was recorded in several documents that the Compassionate City involved schools, universities, hospices, prisons, homeless, neighborhoods, and businesses. A development officer of a charity organization explained about the training they conducted,

"Training is to enable people to understand what is going on in their institution, school or workplace and where to go without going to go through a service directory to find out what's happening, but also be able to hold the conversation about loss or grief" (SM01).

The Compassionate City leaders have employed different strategies for different audiences that are better suited to the needs of those particular groups. Some of the work has stemmed from reflecting upon their own experience, which enabled them to realize the importance of building capacity in some settings like workplaces. By doing so they wanted to create supportive environments for people dealing with serious illness, grief, or caregiving. A commissioning manager of the city council explained,

"…when I was going through it[bereavement], my manager had lost his dad the year before and he didn't get the support, so he was literally keen to make sure that I got what I needed and he went against policy. If I did not get that support, I would have probably left the organisation shortly after"(SM04).

In addition to conducting training and awareness, there have been considerable efforts to create spaces and opportunities for citizens to gather, share their stories, and raise awareness of death and dying. The leaders of the Compassionate City had utilized existing programs as well as created new events to meet the diverse needs of the community. A board member of a community interest group explained,

"We have community gardening clubs and community living rooms. We have coffee mornings, we have art classes, so it's about giving people those opportunities to build confidence, build networks, you know, talk about death dying and loss in any form, whether it be a pet or a divorce or a death of a loved one, it comes in lots of different forms" (SM09).

The efforts to improve community capacity to develop resilience to death, dying, and bereavement were also seen during document analysis and observations. An article on supporting the homeless and prison population in the city stated that the leaders of the Compassionate City wanted to learn what a caring community looked like for this group of people whose views are rarely heard. The article stated that the aim was to create a culture in which death, dying, and bereavement were no longer "taboo" topics, where conversations regarding end-of-life planning and grieving could be normalized, and where help was easily accessible.

Embedding and sustaining the Compassionate City initiative

Despite being at an early stage of development it was evident from the enthusiasm in the interviews and documentary evidence that the Compassionate City was gaining momentum. However, several areas of uncertainty were observed that may affect how the initiative became embedded into the community and its sustainability. These included questions about the added benefit of a Compassionate Cities approach. Even though most participants were highly involved in different activities for the Compassionate City some were not fully convinced how the initiative could affect people at the end of life. A representative from the Council of Faiths explained,

"I'm not clear what it adds cause if we were doing it anyway, we're not doing it because of Compassionate Communities [sic]. We're doing it because we're absolutely committed to the concept. But we were doing it before Compassionate Communities [sic]came along, and we will continue to do it. So, I suppose one of my challenges is, is still, I'm trying to get my head around. What's the additional benefit?"(SM10)

Using Compassionate Cities to build on what went before can contribute to the uncertainty and lack of clarity about the differences between existing groups, forms of support, services or between the Compassionate models (as described above). Similarly, another participant, a board member of a community interest group, said,

"If I'm honest, there was a sort of an assumption that these were completely new ideas to us. And I struggled a bit with that because it may be new to some, but it's not new to everybody. I've worked in this field for nearly 20 years. I was very familiar with the concept" (SM07).

Community organization participants explained that issues of poor communication could bring frustration and feelings that their existing expertise was underestimated. Through observations and interviews with participants, we noted that most members who were involved at the inception of the Compassionate City had left their roles for various reasons (retirement, changing jobs) and that new partners had joined. It was not clear to us if these changes were responsible for the frustrations and lack of clarity of value-added, but some Compassionate City committee leaders reflected on the need for better communication with new partners joining the network, so that they had a clearer understanding of the strategies employed and expected outcomes.

This need for clearer communication about the purpose of Compassionate Cities was also noted as needed when describing the initiative to groups in the community. A member of the council of faith explained how he was concerned about how Compassionate City was portrayed as potentially replacing traditional health and social care support for people at the end of life.

"Don't get me wrong, I'm completely committed to the thinking behind Compassionate Communities[sic]. I sometimes felt there was almost a criticism of professional services and that I almost felt that the way it was presented was that compassionate communities[sic] are the answer. And I just think we need to be a bit careful. I know there's a real problem with social care and healthcare and there aren't enough resources, but this is not a replacement" (SM10).

A further impediment to sustaining the development of the Compassionate City was the inability to gauge the progress and benefits of the initiative. A member of the city council stated that they did not have an evaluation plan in place from the beginning. There were individual workstream evaluations taking place, but participants explained that they faced difficulties in deciding how to assess the overall progress toward becoming a Compassionate City. A board member of a community interest group said,

"Maybe it's my failing that I'm not clear exactly where we're going. And I'm still not clear how you evaluate it in such a way that you can see what is compassionate" (SM07).

However, toward the end of data collection, participants explained how there had now been a decision to use the Death Literacy Index (DLI) (Leonard et al. 2020), a tool that has been used to evaluate compassionate communities, as an outcome measure for the city.

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Discussion

This study used observations of committee meetings, interviews with community leaders, and documentary evidence to explore experiences of how a Compassionate City was developed and implemented to identify insights that could be useful for other settings seeking to implement a similar initiative. As such, it is an important piece of work that contributes to the growing international evidence of the new public health palliative care approach – Compassionate Cities.

The Compassionate Cities literature describes how leaders from different sectors in the city should collaboratively recognize their concerns and instigate the first steps toward institutional transformation in their areas of influence (Abel et al. 2021; Kellehear 2020). Our study explored this in practice and saw how leaders with similar interests from various sectors, driven by their personal and professional end-of-life experiences, combined their efforts toward achieving a common goal. We also heard how they needed local government investment – both financially and in terms of personnel. Furthermore, participants explained how the COVID-19 pandemic helped local community groups identify a need for improved end-of-life and bereavement support networks. Finally, we found that while Compassionate Cities are conceived of as a top–down "social ecology approach" (Quintiens et al. 2022b, p. 2), leaders needed to recognize the challenges the Compassionate Cities approach brings to existing hierarchical leadership models (Fernandopulle 2021). This was particularly evident in the need to stimulate, engage, and facilitate community organizations (i.e. bottom–up), and the reflections of community leaders when their existing expertize was sidelined. At the same time, we saw how community organizations were unclear about the differences in Compassionate Cities and Communities approaches. This suggests more should be done by the city's leadership to make clear that there is a distinction between the 2 approaches and why this is important. We found how such efforts necessitate good communication. Our findings further highlight the importance of maintaining clear communication between different sector organizations. This is in line with a study by Salunke and Lal (2017), which describes how the most crucial stage in developing multisectoral convergence is to establish a robust communication process with an appropriate structure and interactions.

A significant shortcoming identified by participants was the failure to consider from the start how they would gauge and recognize "success." At the time of data collection, none of the existing Compassionate City initiatives had measured their impact on patients' and their families' well-being or evaluated the effects of the initiatives on local health systems. This is not to say that such a consideration is easily accommodated, as public health interventions and health promotion interventions are commonly complex (Jackson et al. 2004) and generally difficult to measure (Gugglberger 2018). The objectives to the usual intervention questions, "Does it work?" or "What additional benefit does it bring?," may not be easily operationalized and could take many years to materialize. The participants later identified running the DLI survey, to assess how the initiative has improved community members' knowledge, understanding and practice in dealing with death and dying (Leonard et al. 2020). Although it is important to monitor changes to attitudes, culture, and community behavior around dying and bereavement, we believe Compassionate City leaders need to also consider the effects of the initiative on "upstream" factors that affect end-of-life care, such as organizational growth and systems (Aro et al. 2005; Jackson et al. 2004).

A Compassionate City model seeks to connect and involve all key dying and end-of-life stakeholders in the region (Kellehear 2012). However, we noted a lack of primary care involvement, which we suggest is problematic as primary healthcare providers are known to provide a significant proportion of palliative and end-of-life care for individuals in the community (Mitchell et al. 2022). General practitioners (GPs) are in an excellent position to engage in public health palliative and end-of-life care initiatives (Couchman et al. 2024; Royal College of General Practitioners 2024). As primary care is a vital component of universal healthcare, we feel future Compassionate City initiatives should seek to engage such a crucial stakeholder.

The availability of funding was another important factor that we found had indirectly or directly affected the initiation, networking, capacity building, and sustainability of the Compassionate City initiative. Participants described how having adequate funding had a positive impact on moving things forward, such as appointing a chairperson, conducting awareness programs and conducting training that was not happening otherwise. This is a commonly seen scenario in behavior change interventions targeting individuals or communities where long-lasting effects were only seen when continuous financing and resources were available (Swerissen and Crisp 2004). It is crucial to recognize that without proper funding, even the most well-intentioned initiatives are likely to fall short. Therefore, future projects must prioritize the development of comprehensive and sustainable funding mechanisms.

Strengths and limitations of the study

The study draws upon multiple sources of evidence to provide an in-depth understanding of a Compassionate City initiative. Although it only included a relatively limited number of interviews, this included most of the committee members (11 of 17) and we were also able to observe in 5 committee meetings individuals who declined to be interviewed.

The lead researcher (SN) was a non-UK visiting public health scholar and it was important to consider how her ethno-cultural "outsider" status could be drawn upon as part of a reflexive interpretative analysis (Madden 2017). As part of developing her positionality, SN regularly met with the co-researchers to discuss her thoughts and reflections on the "field" of Compassionate Cities (ibid: 37). We used these meetings to strengthen our analysis by providing a multidisciplinary approach to interpretation, drawing on a research team that also included a professor in primary care, a sociologist of health and illness with specific interests in palliative and end-of-life care, and an academic GP with a special interest in primary and community palliative care. Throughout the research process, the team maintained an open and reflexive stance to competing ideas from the study participants. The team recognized the value of reflection and interpretation in research, aiming to better comprehend its context and strengthen the trustworthiness of the findings (Sheard 2022). We are therefore confident that our interpretations are based on in-depth and robust data collection.

Conclusion

The findings of this study will be useful for those who are interested in developing future Compassionate City initiatives as we provide crucial insight into how leaders adopted the initiative and how their experiences of its initiation and implementation affected their understanding of its success. This study found multiple views

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from the leaders on its initiation and implementation, and how the initiative has tried to influence the behaviors of its citizens when dealing with death, dying or bereavement. Even though the activities for improving community capacity and building networks were supported by all organizations involved, the responsibility for success remained rooted in the city council and hospice network. The need to include primary care was also noted, as they are a key service providing public health palliative and end-of-life care. Since leaders leaving the initiative cannot be avoided, clear communication practices should be established to ensure new and existing team members remain informed during periods of personnel change to help prevent confusion and misunderstanding.

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