The Macmillan Unit is situated at Christchurch Hospital, and is part of the specialist palliative care service at The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust. The service offers specialist palliative care to patients with any advanced, progressive, incurable illness with difficult symptoms or problems. The Macmillan Unit is an NHS Unit; the NHS funds core services but a significant proportion of the funding comes from Macmillan Caring Locally, thanks to the generosity of the local community.

The specialist palliative care service is made up of an inpatient unit (a ward at the Macmillan Unit) with 16 beds and a dedicated team of inpatient nurses, a team of specialist palliative care community nurses who visit patients at home and in nursing or residential care, a team of doctors, a day centre at the Macmillan Unit which offers some complementary therapies, a team of physiotherapists and occupational therapists, a family support team, and a hospital palliative care team which sees patients in the Royal Bournemouth Hospital. The specialist palliative care team works closely with the Royal Bournemouth Hospital and Poole General Hospital, with GP services, and with community based generalist palliative care teams in some areas.

Patients are admitted to the Macmillan Unit for treatment of complex or difficult to manage symptoms, or to receive care when they are approaching the end of their life. It is not a long stay unit. Many patients are discharged from the Macmillan Unit ward with ongoing support from the specialist palliative care service, either to their own home, or to nursing or residential care, once their symptoms have been controlled.

Patients can be referred by their GP, or hospital consultant. Referrals are taken from doctors, nurses or other health and social care professionals; self-referrals from patients are also accepted. Patients will be offered an initial assessment, which is carried out either by a specialist palliative care community nurse, or by a doctor, or jointly – by a senior nurse and doctor together, usually at an outpatient appointment or on a domiciliary visit at home. Follow up is usually by a specialist palliative care community nurse who liaises with the rest of the specialist palliative care team. Patients who no longer need the support of the specialist palliative care service are discharged to their primary care team or their hospital team. Patients can be referred back to the service as and when appropriate, for instance if their condition deteriorates.