Community members are active players, adding value to the lives of their CN. By engaging citizens in the challenges and opportunities afforded by death, dying and loss, relinquishing control and sharing power, hospices introduce new actors into the end-of-life arena. There is evidence that it's scalable, flexible and adaptive.

P-229 ABSTRACT WITHDRAWN

P-230 ARTIFICIAL INTELLIGENCE IN PALLIATIVE CARE: A SYSTEMATIC REVIEW TO IDENTIFY ITS SCOPE OF USE

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Background New technologies, such as artificial intelligence (AI), supported by novel ways of linking and analysing data, are transforming the way that healthcare data is analysed. AI is increasingly being used to support healthcare delivery, and examples of palliative care application are emerging. AI is an umbrella term covering a variety of intertwined sub-concepts: machine learning refers to machine algorithms automatically improving themselves through experience, and neural networking refers to a form of this mimicking the way the human brain works. Deep learning is another form of machine learning, and natural language processing may refer to a variety of AI algorithms used to understand text intended for human recipients. However, the current scope of (and potential) use of AI in palliative care delivery has not been fully explored. The aim of this project was to define the scope of use of AI methodologies in palliative care studies.

Methods A systematic review of literature was conducted in accordance with the PRISMA guidelines. Four electronic databases were searched, in addition to grey literature searches. AI was used as an umbrella term to include keyword searches for the following: machine learning, deep learning, neutral networks and natural language processing.

Results Twenty-seven relevant articles were selected. The majority of studies described people with cancer (n=10, 37%), from general palliative (n=8, 30%) and intensive care populations (n=4, 15%). Studies using natural language processing were most common (n=12, 44%), with others mainly utilising machine learning (n=10, 37%), deep learning (n=3, 11%) and neural network (n=2, 8%) methodologies. A variety of outcomes were covered, with most studies predicting survival (n=8, 30%), identifying goals of care (n=6, 22%), analysing serious illness conversations (n=2, 9%) and reporting if palliative care best practice recommendations had been followed in clinical care (n=2, 9%).

Conclusion Most palliative care AI studies report cancer, use natural language processing and machine learning methods, to predict survival and analyse goals of care. Future studies need to explore how different AI methods can support palliative care, whilst carefully assessing the risks and limitations, to ensure effective use in the management of serious illness.

P-231 THE QUALITY IMPROVEMENT METHODOLOGY USED TO CREATE DAFFODIL STANDARDS- TO IMPROVE END-OF-LIFE CARE

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Background Most palliative care is provided by GPs and wider palliative care and community services (Mitchell, Loew, Millington-Sanders, et al., 2016). The Daffodil Standards (DS) were created in order to provide a free, accessible, evidence-based support around end-of-life care (see: https://www.rcgp.org.uk/clinical-and-research/resources/a-to-z-clinical-resources/daffodil-standards/introduction.aspx). This work presents the quality improvement (QI) methodology used to establish an ongoing, national level process that helps engage practices in working to improve end-of-life care through QI and reflective practices.

Aims

- Supporting GP practices and Primary Care Networks, to provide high quality end-of-life care across their populations.
- Offering a structured approach - minimising variation in end-of-life care experienced.
- Supporting GP teams - learning and development.
- Improving equity.
- Connecting GP care within compassionate community development (see: https://www.rcgp.org.uk/clinical-and-research/resources/a-to-z-clinical-resources/daffodil-standards/the-daffodil-standards/standard-8-general-practice-being-hubs-within-compassionate-communities.aspx).

Methods The QI methodology of Diagnose, Plan and Test, Implement and Embed, Sustain and Spread (NHS England, 2019) has been employed to evidence, establish and continually improve the Daffodil Standards.

Results The process:

Diagnose

- Review of learning from policy and research for gaps.
- Review of GP QI programmes/curriculum for scale service improvements to support general practice.
- Triangulation matrix between end-of-life care 'Ambitions', I-statements, GP qualitative research and feedback.

Plan and Test

- Development of draft DS headings.
- Consultation with end-of-life care partners.
- Reviewed from 9 to 8 core DS based on feedback.
- Organisational sign-off.

Implement and Embed

- Launch February 2019.
- Connected with England end-of-life care QOF 19/20.

Sustain and Spread (including developments)

- COVID-19 learning.
- Development of Older People's Care Home Standard.
- End-of-life care GP lead review from each nation to make more devolved nation accessible.
- Refresh of the Daffodil Standards.
- RCGP end-of-life care suite of webinars 2021.
- Planned evaluation 2021/22.

Conclusions This review of processes demonstrates how QI methodologies can be used on a national level to support

clinical care and deliver improved end-of-life care in the community.

P-232 ENRICHING AND UPSKILLING HEALTH CARE PROFESSIONALS THROUGH VIRTUAL LEARNING DURING COVID-19

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Background In April 2020, the education department at a hospice recognised that the COVID-19 pandemic had highlighted the importance of enhancing the education on end-of-life care for care home and community care staff. Hence, teaching sessions aimed at health care professionals (HCP) within the hospice's catchment area were arranged.

Aim To support HCPs to build confidence in caring for patients dying in their place of care, and to avoid unnecessary hospital admissions.

Methods Community care providers and the local authority were asked to promote the training sessions that were based on several palliative care topics. These hourly sessions were delivered by a registered nurse who was experienced in delivering training in palliative care, together with assistance from the hospice's physiotherapist and head of wellbeing. All sessions were delivered virtually and were offered during the day and the evening.

Results Due to the high uptake of the initial sessions, a collaborative was subsequently formed with two other hospices and an NHS trust to support the delivery of this training. Topics included: Bereavement, Understanding Breathlessness, General Lung Health, Energy Conservation, Symptom Assessment and Management, Drug Calculations, Remote Assistance for Verification of Expected Death (VOED) by Health Care Assistants, VOED by Registered Nurses, Recognising Dying and Care of the Dying Patient. Over the course of 12 months and 128 sessions, 2,751 individuals from the UK, Canada, Australia and Singapore attended. These attendees were from a mix of 22 community care providers and acute settings. The attendees highlighted that the evening sessions were beneficial due to an increased workload during the day.

Conclusion By utilising virtual platforms, the success of this training programme exceeded the initial expectations, and the training was well attended by learners worldwide. This newly formed collaborative group will continue to deliver palliative care training collectively.