O-9 CREATING EQUITY OF COMMUNITY PALLIATIVE CARE IN MANCHESTER IN A PANDEMIC. DOES THE 'MIDHURST MODEL' OF CARE WORK?

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Manchester is among the most socially deprived areas in the UK leading to increased comorbidities, hospital attendances, admissions and deaths.[1] Deaths will increase to the levels seen in the pandemic by 2040[2 3] with 75–90% benefitting from palliative care[4 5] and many more home deaths expected.[6] In 2015, North Manchester successfully piloted the 'Midhurst Model' of community palliative care.[7 8] In 2018 this was extended citywide with extra funding from Macmillan, co-produced with service users.[9]

Method A service evaluation using qualitative and quantitative data in order to see if the model was successful and met the original aims and objectives.

Results Aims and objectives were mainly achieved. Patients, carers and community staff valued the regular support, 7-day service, single point of access and rapid access to support by appropriate staff. Patients/carers felt supported, respected and listened to, with less need to call other services. GPs and external staff rated the care highly. More time is needed to embed the service for district nurses. A reduction in bed days and preventable admissions was shown, with 90% of admissions deemed appropriate. More patients on the caseload were able to die at home with 89% achieving their preferred place of death. Timely identification of patients, discharge from hospital and advance care planning was promoted. Numbers on the caseloads and contacts increased exponentially. Remote reviews helped protect vulnerable patients. Work with 'hard to reach' (e.g. homeless) groups was undertaken. Patients were given bisphosphonates at home for malignant hypercalcaemia. Gaps identified were spiritual and level three psychological support and over representation of cancer and 'white British' patients on caseloads.

Conclusion The model of care worked well despite the effects of the pandemic. Financial savings are likely. Investment in community care is required going forwards.

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O-10 PALLIATIVE MEDICINE SPECIALIST TRAINING: DESIGNING AND IMPLEMENTING AN ONCOLOGY PLACEMENT FIT FOR THE FUTURE

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Background Palliative Medicine trainees in Yorkshire and the Humber undertake a largely observational Oncology rotation. A successful pilot of proactive early palliative care (PC) input was conducted in an Acute Oncology Assessment Unit (OAU) leading to the initiation of a PC in-reach service, provided by PC registrars, with the aims of improving patient care and learning (including curriculum fulfilment) for trainees.

Aims

1. Determine educational learning opportunities afforded by the pilot
2. Assess impact of the in-reach service on trainees
3. Consider if this model could fit the development of the new Internal and Palliative Medicine curriculum

Methods PC registrars provided input on the OAU, initially through a pilot period, then in an established in-reach service. Appropriate patients were identified by Oncology staff and PC registrars. PC intervention consisted of a face-to-face review or verbal advice. The learning opportunities were documented and service provision was mapped to the draft Palliative Medicine Curriculum 2022 'capabilities in practice' (CiPs).

Results

- Pilot: 41 referrals: 32 face-to-face reviews; 9 advice
- In-reach service: 44 additional referrals: 28 face-to-face reviews; 16 advice
- Diverse disease– and treatment-related presentations
- Referrals for symptom control, ACP/information needs, psychological support and liaison with community and hospital palliative care teams
- The clinical experiences and competencies developed can be mapped to generic and specialty specific (including Internal Medicine) CiPs.
- All PC registrars felt it improved the Oncology rotation; increasing exposure to relevant acute medical and oncological presentations.