

P-10 BRINGING END OF LIFE CARE EDUCATION TO A COUNTY

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Background Two years ago, when the pandemic lockdown began, our county's health, social and spiritual care teams realised there was no centralised hub for vital end of life care information and education. As a consequence information was stored on various organisational websites, but this proved to be an unsatisfactory solution, confusing to both staff and service users.

Aim A new 'End of Life Care Education' team was formed in partnership between our Clinical Commissioning Group and the NHS; the team's goal was to bring parity of content and access to end of life care education and resources to both staff and the public countywide.

Process and outcomes We have developed a network across organisations, bringing together palliative care experts from the NHS, social services, the three hospices within our county and various care and faith organisations. Through this we have established and agreed our end of life care education strategy as a network, in alignment with both the Health Education England End of Life Care Education Framework (2017) and NICE Quality Standards 13 (2021) and 144 (2017).

We have centralised an online palliative care information hub (Somerset End of Life Care and Bereavement Support - <https://somerset.eolcare.uk>) and developed a new cross-organisational open access website platform for staff and public use. We have developed a learning management system and are promoting our website to the public via a library digital accessibility project with occupational therapy students.

We intend to evaluate our work to demonstrate improvement system wide, via a series of thematically analysed interviews with staff which explores their knowledge and skills in end of life care against the Health Education England End of Life Care Core Skills Education and Training Framework (2017).

Summary We hope our presentation will demonstrate both a record of our achievements so far and also provide inspiration, structure and suggestions to other organisations and counties wishing to standardise their resources and education.

P-11 THE CO-DESIGN AND EVALUATION OF A STANDARDISED MODEL FOR DELIVERING COMMUNITY SPECIALIST PALLIATIVE CARE MULTI-DISCIPLINARY CARE TEAM MEETING ACROSS FOUR INTEGRATED SPECIALIST PALLIATIVE CARE TEAMS

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Research has repeatedly identified the negative impact that poor coordination and collaboration of health and social care can have on patient outcomes. Both national and international policy makers have advocated an inter-professional collaboration approach to improve quality and patient safety, recognising that patients with complex needs require increased

collaboration between health and social care professionals to improve the provision of effective care.

The St Barnabas Multidisciplinary process was co-designed and tested by two multidisciplinary teams, through a series of Plan Do Study Act cycles, based on the principles of the Specialist Level Palliative Care Commissioning Guidance. Logic Modelling was applied to describe intended outcomes and inform evaluation methodology. This rapid quality improvement process was then applied across all services and the co-design group was widened to include other community practitioner stakeholders.

This Specialist Palliative Care Multidisciplinary Team (SpMDT) continues to be refined, yet has a clearly defined purpose and process. Through the co-design process and delivery of SpMDT we have facilitated a culture of learning and improvement and our practice reflects Raine, et al., (2014). *Health Services and Delivery Research*. 2:37).

Patient outcomes achieved

- Consistent access to high quality SpMDT review and care planning within 7 days of first assessment for all new patients.
- Increased access to SpMDT review and personalised care planning for patients irrespective of diagnosis.
- Access to SpMDT review and care planning for patients with complex needs who are managed by other community practitioners.

Staff outcomes

- Improved confidence in knowledge of skills within the SpMDT.
- Development of specialist palliative care skills and knowledge.
- Improved inter-professional collaboration and learning for the benefit of the health and wellbeing of patients.

System outcomes

- Improved integration between generalist and specialist palliative care service.
- Equitable service delivery.
- Improved communication between wider MDT stakeholders.
- Identification of gaps in resource to inform future and strategic service developments.

P-12 HOW TO GET URGENT END OF LIFE MEDICATIONS TO PATIENTS IN THE MIDDLE OF A PANDEMIC

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Background Access to urgent end of life medications out of hours can be difficult at times (Ogi, Campling, Birtwistle, et al., 2021. *BMJ Support Palliat Care*.), so how could we work together to ensure vulnerable patients in the middle of a global pandemic get what they need when they need it most? How could hospices support patients and families if the worst should happen, and other community services were overstretched?

Aims To provide consistent 24-hour, 7 day a week access to palliative medicines and advice for patients and professionals alike (National Institute for Health and Care Excellence. [NG163]. 2020). To have plans in place to support carer administration of medicines (Poolman et al., 2020. *CARer-*