(Maclean, Kelly, Geddes et al., 2017. Nurs Ed Today. 48: 90; Coleman & McLaughlin, 2019. Br J Nurs. 28: 1300). Following the COVID-19 pandemic online simulation was adopted at Birmingham City University (Warren, et al., 2021, Nursing Times. 117: 34) and developed for the Palliative and End of Life Care module as part of the Post Qualifying programme.

Evidence shows us that people with learning disabilities experience extensive health inequalities which impacts on mortality (Heslop et al., 2013; NIHR, 2020). In addition, the quality of palliative care received by this group can contribute to poorer outcomes that are often avoidable (Hospice UK, 2021). Using suitable methods of communication to impart information in a format that allows for deeper understanding opens potential for greater quality of life and expectancy (Heslop et al., 2013; NIHR 2020).

Aim To practice the skill of 'Breaking Bad News' to people with learning disabilities, by using actors in simulated patient scenarios.

Methods On MS Teams in small groups, with a facilitator, to engage all learners in an interactive, authentic and safe experience with an actor. Varied scenarios were used to demonstrate breaking bad news to a person with learning disabilities.

Results Reflective evaluative feedback from students demonstrate a deeper confidence in breaking bad news. This included a perceived lessening of anxiety when involved in discussing Breaking Bad News in practice generally after being involved with simulation. Confirmation of online simulation as a valuable practical skills-based learning experience.

Conclusion This is now embedded in the Post Qualifying Introduction to Palliative and End of Life Care module and is applicable to a wider workforce approach including practitioners both generalist and those working within Learning Disabilities and End of Life Care. This is a focus of co-author doctorate studies.

P-87 | **HOW DO WE CREATE CULTURALLY SAFE PALLIATIVE AND END OF LIFE CARE IN THE UK?**

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Background COVID-19 has resulted in greater attention on health inequities associated with culture and ethnicity in palliative and end of life care. Patients from minority ethnic groups are less likely to access palliative care services or rate the quality of their care as excellent. Understanding why this is the case remains limited. In trying to address health inequities, concepts like cultural competence, cultural humility and cultural congruence have been used to frame approaches. Within the UK context, these terms have been used to develop particular outcomes, for example, staff training courses on unconscious bias, as opposed to an ongoing reflective process. Cultural safety on the other hand is where healthcare providers, at both systemic and individual levels, use reflective practice to identify differences in experience between themselves and their patients, their families and caregivers and recognise how these differences may influence power in the patient-professional relationship (Curtis et al; 2019. Int J Equity Health.18: 1). Cultural safety is used more extensively in countries such as New Zealand and Australia. We aim to explore the current conceptualisation of cultural safety, within palliative and end of life care in the UK, as well as barriers and facilitators to its implementation; to understand what cultural safety means and how culturally safe practice can be applied across palliative care settings in the UK.

Methods A systematic review has been designed using the PRISMA-P framework. The data will be extracted, analysed by five reviewers, and assessed for the strength of evidence given.

Results These will be presented using an appropriate framework.

Discussion Given the significant discrepancies between the provision of palliative care for different ethnic minority backgrounds, we need to understand what good palliative care looks like. Patient – professional relationships, as well as 'competence' are key considerations which is why cultural safety is an important starting point. This systematic review will critically examine this in the UK context specifically.

P-88 | **EXPLORING THE EXPERIENCES OF BLACK, ASIAN AND OTHER ETHNIC MINORITY HOSPICE SERVICE USERS**

Sarah Maan, Leena Patel, Corinna Midgley. *Saint Francis Hospice, Romford, UK*

Background National work identifies risk of poorer access to palliative care services for people from ethnic minorities. Locally we identified that our referral rates did not reflect the palliative health needs of our most ethnically diverse borough. Qualitative work was deemed essential to interpret this finding.

Aims To better understand the experiences of Black, Asian and other ethnic minority users of our hospice services and to identify ways to ensure that our services are inclusive for the local population.

Methods Research ethics approval for semi-structured telephone interviews was granted. Patient information leaflets detailing our aims and the option to opt out were sent to individuals who met the inclusion criteria (18 years and over, identify as Black, Asian or other ethnic minority and accessed hospice services between September 2020-2021). On telephone contact, consent was obtained and capacity was checked. The interviews were recorded. The interview comprised nine questions, which were designed with support from the research ethics committee and from our in-house research interest group. Thematic analysis, performed by two researchers, independently, identified patterns and codes within the interview transcripts. Results were then reviewed together to finalise themes.

Results 177 referrals reviewed; 53 potential participants contacted. Eight interviews completed, two by proxy. Reasons for not interviewing included: not consenting, unable to contact, death, current admission, and incorrect coding.

Identified themes
1. '*I didn't know*' - unfamiliarity with the service.
2. '*I have been listened to, I have been understood*'.
3. '*They give me courage*' – feeling informed and empowered.

Conclusion We learnt that most people were unfamiliar with the hospice until they had been referred. Overall, experiences were described as positive with individuals feeling listened to, supported and empowered. There was emphasis on the hospice needing to focus on promotion and collaboration,

particularly with other health care providers, to reach Black, Asian and other ethnic minority communities.

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What we knew People of African and Caribbean descent are less likely to access palliative and end of life care. It is unclear why they are so poorly served by our services and how COVID-19 has exacerbated this.

What we wanted to know We sought bereaved relatives', health and social care professionals' and community workers' views on experiences of and barriers to palliative and end of life care and suggestions for improvement.

Methods Public recruitment was utilised. Over 150 diverse organisations throughout the UK were contacted. Qualitative semi-structured interviews were conducted with a diverse sample of 26 bereaved relatives and 13 professionals.

Findings There were three key themes:

1. Representation, encompassing discrimination and racism.
2. Personalisation, including culture and the impact of COVID-19.
3. Awareness and Access, including support before and after death and communication and involvement in decision-making.

Participants recommend services should

Represent

- Identify and acknowledge racism and discrimination in palliative care provision.
- Ensure better representation of African and Caribbean communities within services and in public facing material.

Personalise

Adapt services to ensure they are culturally and religiously competent:

- Recognise diversity in cultural and religious needs.
- Challenge racial and cultural stereotypes.
- Enable equitable remote engagement.

Ensure awareness and education

- Better integrate services within communities by working with faith/community leaders.
- Raise awareness of the value of palliative care services in all communities.
- Provide training/education for professionals to build confidence and competence.

Conclusion Palliative care was perceived as inadequate during the pandemic. Inequities in care provision were exacerbated, to the detriment of people of African and Caribbean descent who were disproportionately and uniquely effected. Palliative care services and local communities could and should learn from each other, to enhance equitable access to appropriate care for all. Significant investment in services and communities may be required.

Emma Powell, Tricia Evans, Dee McKinnon. Compton Care, Wolverhampton, UK

Introduction Compton Care's Clinical Services Strategy identified the need to engage with patients and families from Ethnic Minority communities to address health inequalities. This project is being delivered in partnership with Royal Wolverhampton Trust (RWT), to improve support to patients with complex and incurable conditions from Ethnic Minority communities.

Aim This project aims to provide a key link for patients/families to help navigate the health system and access care and support.

Methods Funding was secured from NHS Charities Together. Funding is being used to provide further reach and extend Compton's palliative care services into a larger population of Wolverhampton's community, helping to address some of the inequalities of care experienced by people from ethnically diverse backgrounds (Szczepura, 2005. Postgraduate Medical Journal. 81: 141). An Ethnic Minority Support Worker was employed in March 2022, taking referrals from Royal Wolverhampton Trust Community Nurses and Compton teams. Evaluation is via a patient/family member completed electronic form and asks for self-rating how they feel their needs were met in areas including information delivery and access to services.

Results The support worker has signposted to external services, referred to Compton services, facilitated family discussions, given emotional support and practical help (e.g., finances, accessing social care). At present 21 individuals have received support. By identifying and contacting patients early in their diagnosis, we maximise the amount of support which can be offered. Creation of an electronic system has supported the rapid identification of potential patients and family members. This has run for 7 days and already 10 patients have been flagged and will be onboarded to the service. None of these individuals were aware that Compton could assist them with their needs.

Discussion The project has recently started and is already having an impact. Further collection of broader activity data and completion of case studies during the remainder of the project will contribute to a fuller picture.

Sally Watson. Lindsey Lodge Hospice, Scunthorpe, UK

Conversations about spirituality, culture and faith may generate anxiety in health and social care professionals, due to a lack of knowledge or cultural understanding (Choudry, Latif & Warburton, 2018. Clin Med. 18: 23). The local population comprises a significantly lower representation of both ethnic minority groups and religious groups than the national average despite a doubling of ethnic minority populations over the last decade (Office for National Statistics, 2019). Locally, a new end of life strategy has been implemented with the aim of