

Impact This first-ever Designer-in-Residence model is expected to impact both research and practice. Through documenting the principles and processes of the research and offering an auto-ethnographic account of conducting design research in the sensitive context of palliative and end of life care, we expect to inform and impact research in this area. We also expect to impact practice, through enabling better capture and communication of hospice care on a complex systems level, through the current and future systems maps created as outputs of the project.

33 'A POST CODE LOTTERY': EXPERIENCES OF HEALTHCARE PROFESSIONALS PROVIDING PALLIATIVE CARE OUT-OF-HOURS ACROSS THE UK

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Introduction Patients and their families receiving palliative care in the community rely on 'out-of-hours' services over 70% of the time. Although distressing symptoms, or new problems may arise at any time., out-of-hours service availability and provision across the UK varies widely.

Aims To understand current service provision and availability of out-of-hours care across the UK for patients and families receiving specialist palliative care.

Methods Semi-structured qualitative interviews with healthcare professionals across the UK providing out-of-hours community palliative care. Transcripts were analysed thematically to explore and identify models and components of out-of-hours care.

Results 28 interviews were conducted with 39 participants, including: GPs, community nursing teams, and palliative care medical consultants and specialist nurses. Four overarching models of out-of-hours care were identified, based on levels of integration and balance between generalist and specialist care out-of-hours, and type of care available (hands-on care/advisory care). These showed large service variation from a uni-disciplinary single service by out-of-hours GPs to multidisciplinary via a dedicated 24/7 telephone line staffed by specialist palliative care nurses supported by integrated community and specialist palliative care services, providing hands-on clinical and advisory care.

Conclusions The study identified community out-of-hours palliative care as highly varied from sole reliance on GPs to provision by integrated multidisciplinary specialist and generalist teams. Sampling across providers, disciplines, and geography, identified four overarching models of out-of-hours care and key components, including level of integration between services and variability of care provision.

Impact The study identifies the inequity and 'post-code lottery' for patients and families requiring palliative care out-of-hours. The findings inform the strategic planning and provision of palliative care services by commissioners and service providers

34 PRIMARY CARE AND HOSPICE ENGAGEMENT WITH PATIENTS TO THINK, TALK OR ACT ON CURRENT OR FUTURE END OF LIFE NEEDS: THE THINK, TALK, ACT (TTA) PILOT

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Introduction Referral of patients to hospice care happens late.¹ Earlier referral leads to better outcomes at the end of life,² Patients with frailty are shown to be at greater risk of mortality, hospital admission and have low rates of advance care planning (ACP) in place.³ It is not clear how best to support GP practices to engage with these patients, have the confidence to broker ACP conversations early.

Aims TTA is linking local hospice and primary care in one area of south-east England supporting people to plan their future care/wishes and early hospice referral.

The pilot's aim was to determine how TTA works to refine the intervention and evaluation methods for future roll out.

Methods Moderately frail patients from two GP practices, identified through the electronic frailty index⁴ were invited to a 'Think' information session about ACP. Invites were sent to 1050 patients; 88 attended one of 11 sessions (with 67 additional guests).

Surveys with attendees/non-attendees, semi-structured interviews with a sample of attendees and GP practice staff, documentary analysis of the reflections of 'Think facilitators' were used to evaluate the 'Think' pilot.

Results 'Think' attendees (n=102), indicated that the session was informative and materials provided were useful to support ACP. They would like further support to help write their plans, navigate conversations with their GP/families. Findings indicated that review of the invitation letter is needed.

Conclusions 'Think' was acceptable to attendees, GP and hospice staff with some adjustments e.g. getting the wording in the invitation letter right was of particular importance.

A larger roll out and evaluation of the programme to other areas over a longer timeframe to follow up patients would be recommended to understand if 'Think' has a positive effect on patient outcomes. A pilot of 'Talk' is currently underway.

Impact In the longer term it is anticipated that TTA could:

- increase the number of ACPs,
- increase patients accessing hospices services (and earlier)
- help patients achieve their preferred place of care/death.

REFERENCES

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