health care record) and key themes (e.g. need for clinician education & communication skills, executive leadership and dedicated people & systems resource). A targeted QI strategy includes coordinated communication ‘do not attempt resuscitate’ pathways between care settings, dedicated training resource for rolling clinician education, fit-for-purpose documentation of treatment escalation considerations and a public awareness campaign.

Conclusion(s) The detailed exploration of EoLDM across the region has resulted in a targeted QI strategy. It acts as a springboard for future work to normalise EoLDM. Our vision is that everyone in North Wales can have discussions to support their EoL decision-making at the right time supported by skilled clinicians. Fit-for-purpose pathways and documentation should ensure decisions and preferences are acted upon, within a robust governance framework. Only by learning from one another have we been able to grow together for the people of North Wales.

98 SAINT CATHERINE’S HOSPICE MORTALITY REVIEW; SERVICE DEVELOPMENT AND AUDIT
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10.1136/spcare-2023-PCC.118

Background Following on from the National Guidance on Learning from Deaths (NHS England 2017), and in preparation for the new medical examiner system, we have formalised our mortality review processes. We developed a death analysis template to be completed after each patient death alongside a monthly mortality review meeting (MRM) with multi-disciplinary team (MDT) and hospital input. The template is completed by a patient’s key worker, reviewed in the weekly MDT meeting and those triggering certain criteria have an in-depth discussion at the monthly MRM. A random case is also always included.

Methods We performed a quarterly audit of numbers of patients with a completed death analysis template while the system was being embedded. We then performed a more in-depth audit of all patients discussed over the past year in the new MRM. This included both quantitative elements such as age and diagnosis and then also qualitative elements such as themes arising and actioned outcomes.

Results 93% of all patient deaths had a template completed and subsequent discussion at the relevant MDT meeting. 16% of those patients went on to be discussed in a MRM. Time of death to discussion at MRM was a mean of 39 days. Themes for improvement included missed opportunities for advance care planning, earlier referral to palliative care services and resources to improve overall patient wellbeing in the in-patient unit. Examples of actions taken forward include hospital-hospice handover work, positive feedback letters sent to carers and sourcing of an in-patient electronic audiobook library.

Conclusions We have put in place a robust structure to promote learning from deaths. Our work with the medical examiner service is about to begin to add breadth to this and will also importantly include family feedback. With ongoing refinement this new governance structure should continue to impact positively on patient care.

99 HOW ARE OUTCOMES OF SPECIALIST PALLIATIVE CARE MEASURED IN DIFFERENT PATIENT POPULATIONS AND SETTINGS?
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10.1136/spcare-2023-PCC.119

Background Outcome measurement is key to delivering effective, high quality, patient-centred care, as well as commissioning of services. The diversity of patient populations and service models in palliative care makes demonstrating efficacy and comparing services challenging.

Aims 1. To synthesise the evidence on how outcomes of specialist palliative care are currently measured in different populations and care settings.

2. To identify the evidence gaps where specialist palliative care services are under-evaluated.

Design A scoping systematic review of reviews.

Data sources Five databases (MEDLINE, EMBASE, CINAHL, Cochrane Library and Epistemonikos) were searched for reviews published between 2010–2021. Included reviews reported on outcomes of specialist palliative care in an adult population with life-limiting illness. Findings from the reviews were grouped, narratively summarised and compared.

Results 79 reviews met inclusion criteria. There was significant heterogeneity in the specialist palliative care services evaluated and the outcome measures and study designs used in the primary reviews. Health-related quality of life and symptom burden were the most frequently measured patient outcomes across care settings and populations. Health-system outcomes focussed predominantly on place of death and health service utilisation. There is a lack of evidence on outcomes of outpatient services, hospice care and telehealth services. The majority of evidence on population-specific outcomes is focussed on solid-organ malignancy. Evidence in populations with frailty, dementia, multiple long-term conditions and population ethnic groups is lacking.

Conclusion Palliative care research is limited by a lack of cohesion in use of outcome measures and under-evaluated areas of practice. Expansion and adaptation of services should be driven by a co-ordinated approach to outcome measurement, as well as increased efforts to capture experiences across the breadth of community settings and in non-malignant disease.

100 MULTIMORBIDITY AND DISEASE-COUNT AS PREDICTORS OF HEALTHCARE USE AND MORTALITY IN EMERGENCY DEPARTMENT ATTENDEES: A CROSS-SECTIONAL SECONDARY ANALYSIS OF ROUTINELY-COLLECTED DATA
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Background Having 2 or more chronic conditions (multimorbidity) is associated with increased mortality and healthcare use in community-dwelling populations. In order to develop a nurse-led intervention for people with multimorbidity and