

documentation of outcome (100% vs 80%) and rationale for this (85.7% vs 40%). Decisions on prophylaxis were deemed to be appropriate. The study was limited by its small sample size (n=8 for each single day snapshot audit of cases). Further work will need to be done on: the appropriateness and timing of re-assessment of VTE risk; and discussion about decision-making around VTE prophylaxis with patients and their relatives.

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ARE WE LEARNING FROM DEATHS? EVALUATING A NEW ACUTE HOSPITAL FRAILTY, STROKE MEDICINE AND SUPPORTIVE & PALLIATIVE CARE (SPCT) TEAMS MORTALITY MEETING

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10.1136/spcare-2023-PCC.137

Background A new monthly mortality meeting (MM) between SPCT/Frailty/Stroke Medicine teams was launched to review & learn from selected hospital deaths. Learning from deaths is a key aspect of medical education, registration, ethical obligation and contributes to meaning derived from our roles. However, few organisations use a validated approach despite availability of toolkits. The aim was to evaluate the effectiveness & utility of the MM.

Methods MM attendees were invited by email to complete an anonymised, semi-structured cross-sectional online survey twelve months after MM inception. Questions covered practical aspects surrounding MM access plus understanding of process. Results were fed back to the MM where joint participant discussion informed next steps required.

Results Response rate 32%. Majority of respondents were Consultant (7/20)/CNS (6/20). Positives to MM included access, timing and lessons learnt. 95% (19/20) satisfied with monthly frequency, 85% comfortable with meeting timing. SJR process was either 'understood'/'partly understood' by 75%. MDT nature of learning widely valued. 85% reported meeting had positively impacted their reflective learning. However, 65% unaware of case selection criteria, 40% unfamiliar with SJR process/wanted to understand more. 35% participants preferred advance notice of cases. Following feedback of results to MM, the selection process was clarified as were plans to develop cross site participation.

Conclusions The meeting was seen as a beneficial intervention. Operational and content aspects have been incorporated to improve future MM effectiveness and utility.

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SPOKEN LANGUAGES OF PATIENTS KNOWN TO A HOSPITAL SPECIALIST PALLIATIVE CARE TEAM AND ACCESS TO INTERPRETING SERVICES

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10.1136/spcare-2023-PCC.138

Background Conversations that are 'honest, informed and timely' are essential to achieving good end of life and palliative care. The 2011 CENSUS highlighted that 1 million people living in the UK could not speak English well or at all. In 2021–22, 74.7% of people who died within this large, 3 site city based hospital trust had their 'ethnicity'

identified as White British. This project aims to describe the 'ethnicity' and primary spoken language for patients seen by the hospital specialist palliative care team (HSPCT) and establish areas for detailed audit and quality improvement work.

Methods Patients were included if they were referred to the HSPCT and died or were discharged in August 2022. Paper notes of HSPCT activity and electronic clinical systems were reviewed. The whole clinical record was not reviewed. Information collected included the persons' documented primary language, whether interpreting services were used and 'ethnicity.'

Results 227 people died or were discharged following referral to the HSPCT in August 2022. 77% had their 'ethnicity' identified as White British. The primary languages spoken were Gujarati (4%), Punjabi (2.21%), Hindi (0.44%), Persian (0.44%), Romanian (0.44%), Turkish (0.44%) and English (91.6%). Spoken language information was missing for 1 person. 2 people whose primary language wasn't English died or were discharged before seeing the HSPCT. For people who spoke a primary language other than English, 15% (2/13) had reviews with an independent interpreter, 77% (9/13) with family members translating and 7.5% (1/13) with a staff member translating.

Conclusions The HSPCT sees people who speak a range of languages but communication must improve with those who speak a primary language other than English. An immediate change in practice has taken place to ensure that the HSPCT can book interpreters directly, removing the step of relying on ward teams to do this.

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LET'S TALK: ADVANCE CARE PLANNING. HOW CAN WE IMPROVE THE QUALITY OF ADVANCE CARE PLANNING BOTH IN HOSPITAL AND COMMUNITY?

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10.1136/spcare-2023-PCC.139

Background End of life care (EoLC) and advance care planning (ACP) conversations can be challenging for staff and patients. Drawing on published guidance and building on previous local work¹⁻⁴ this Trustwide project aims to improve the experience of patients, carers and staff in engaging with ACP discussions and to measure progress.

Method(s) This project is led by an ACP Nurse Specialist, overseen by the EoLC clinical lead and Deputy Head of Nursing. NHS Quality improvement methodology underpins the work which is supported by a steering group and governance structure.

Implementation of our previously developed 'Let's Talk' resources (supporting information to aid understanding of ACP: videos, leaflet, website⁵), building stakeholder relationships, staff education, clinical visibility and role modelling were undertaken to increase engagement in ACP. A Gap Analysis Action Plan (GAAP) was developed by benchmarking against recommendations from the Care Quality Commission (2) and used at strategic and governance meetings to engage key stakeholders and agree measureable actions.

Data were collated from audits, patient and staff surveys and website viewing clicks.

Results Over 900 staff have received bespoke training. Changes from pre- to post-implementation include: increased

awareness of and staff-reported use of materials (respectively 20%/ 90%; 21%/ 75%), increased staff confidence in ACP (30%/ 75%), increased documented use of materials to support cardiopulmonary resuscitation discussions (6%/ 9%). 65% of staff who used materials stated patients/families found them helpful. Website clicks increased (520/572) and staff webpage (270/424). Data show increased access to resources and what we hope is a meaningful and sustainable improvement to ACP.

Conclusion(s) Our data suggests that our approach to embedding use of our 'Let's Talk' materials improves staff and patient engagement with ACP. More work is needed to fully develop our Trust framework including a focus on staff and patient education.

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DEVELOPMENT OF A NATIONAL COLLABORATIVE: THE UK PALLIATIVE CARE INTERSTITIAL LUNG DISEASE GROUP

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10.1136/spcare-2023-PCC.140

Background The United Kingdom (UK) Palliative Care Interstitial Lung Disease (ILD) group (UPIG) was devised by a team of respiratory and palliative care clinicians from Birmingham who noted an absence in the UK of a dedicated national collaborative focusing on the provision of supportive and palliative care services for patients with ILDs.

Method 62 delegates attended the inaugural meeting of UPIG from across the UK online or in person in November 2022. Healthcare workers specialising in palliative care and respiratory medicine accounted for the majority of the attendees, which included doctors, nurses and allied health care professionals. The findings of the meeting and future direction of the group including those discussed in the interactive workshop will be summarised here.

Results Inconsistencies nationally in supportive and palliative care services offered to ILD patients and the desire and need for improvement were clear. This meeting showcased innovative practices currently being delivered and provided a unique setting to network and collaborate with others who are passionate about this field across the UK. This sparked reflection into current clinical practice and consideration of potential local service development, such as dedicated patient focused supportive care ILD multi-disciplinary teams and cognitive behavioural therapy.

Future direction To act as a national platform to collaborate, teach and share practices shone out as the most welcomed and accessible first goal of this initiative. UPIG could provide a means to perform national audits, high impact research and guideline generation. Careful consideration of where UPIG will sit in relation to already established clinical bodies is required to ensure the success of this collaborative.

Conclusions UPIG is an exciting multi-disciplinary, national collaborative that hopes to provide a platform to transform the supportive and palliative care of patients with ILD through in the first instance the sharing and teaching of practices and ideas.

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DEVELOPMENT OF A NURSE-LED SPECIALIST PALLIATIVE CARE IN-REACH SERVICE TO AN EMERGENCY DEPARTMENT AND ASSESSMENT AREAS

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10.1136/spcare-2023-PCC.141

Background In November 2019 A Macmillan funded QI project was commenced within the Emergency floor of the University hospitals of Leicester. Aiming to improve the experience and care of patients with an uncertain recovery, palliative/end of life care needs or at risk of dying in hospital. This followed evidence collected from the End of Life Hospital Improvement Programme (ELCHIP) which the trust embarked on following a CQC inspection. Previous proactive Input from Specialist palliative care to the Medical Admissions unit in 2015/16 had demonstrated benefit to patients and staff early in admission.

Method(s) 2 band 7 CNS's created the Specialist Palliative and End of Life Timely Intervention Project (SPELTIP) to deliver a proactive model providing a dedicated service to patients following an emergency admission. A data collection tool was used to assess the timing and impact of their interventions with patients. This tool included the use of the majority of the Outcome Assessment and Complexity Collaborative measures (OACC). Patients were identified through existing IT systems and tools such as the Clinical Frailty Score alongside an improved referral process. A training needs analysis (anonymous on-line questionnaire to all staff groups) identified staff education training needs and innovative training packages were created and delivered. Adaptations were made during the pandemic.

Results Increased knowledge, confidence and skills in staff, assessed by receiving formal feedback, increased referrals to palliative care (by 33% in first 3 months), reduced length of stay with a monthly average 50% of pts seen not being admitted to main hospital flow. Admission avoidance and rapid discharges facilitated where community teams had capacity to accept. OACC used to evidence the complexity of patients seen by this route.

Conclusion(s) Patients benefitted from early palliative care input, with symptom management and length of stay being improved. The role became permanent in May 2022 after a successful business case submission, and support has been provided to other trusts to develop a similar care model.