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.

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

Hilary Williams, Farida Malik, Rannie Nahas. East Sussex Healthcare Trust

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 pan-ward teams to do this.

Changes from pre- to post-implementation include: increased participation 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 measurable 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

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

Joanna Bate, Marsha Dawkins, Irene Carey. Guys and St Thomas NHS Foundation Trust

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.

**Methods** This project is led by an ACP Nurse Specialist, overseen by the ACP 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, website). 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 measurable actions.

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DEVELOPMENT OF A NATIONAL COLLABORATIVE: THE DEVELOPMENT OF A NURSE-LED SPECIALIST
BMJ Supportive & Palliative Care

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 on 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, help 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.

REFERENCES

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

Louise Crowley, Molly Bird, Anjali Crawshaw, Davinder Dosanjh, Jon Tomas. University Hospitals Birmingham, University Hospitals Coventry and Warwickshire

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.

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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.

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

Karen Murray, Stacey Kerkslake and Specialist Palliative Care Team. University Hospitals of Leicester NHS trust

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) 1 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 benefited 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.