

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. Website5 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.

## REFERENCES

1. Talking about dying: How to have honest conversations about what lies ahead. Royal College of Physicians. October 2018. Available at: <https://www.rcplondon.ac.uk/projects/outputs/talking-about-dying-how-begin-honest-conversations-about-what-lies-ahead> [accessed 19/10/2022].
2. Protect, respect, connect – decisions about living and dying well during COVID-19. March 2021. Available at: [www.cqc.org.uk/publications/themed-work/protect-respect-connect-decisions-about-living-dying-well-during-covid-19](http://www.cqc.org.uk/publications/themed-work/protect-respect-connect-decisions-about-living-dying-well-during-covid-19) [accessed 19/10/2022]
3. Universal Principles for Advance Care Planning. NHS England. March 2022. Available at: <https://www.england.nhs.uk/publication/universal-principles-for-advance-care-planning/>[accessed 19/10/2022].
4. Dying to Talk – Let's Talk: Transforming End of Life Care Conversations. Guy's & St Thomas' NHS Foundation Trust. January 2019. Available at: [www.guysandstthomas.nhs.uk/news/dying-talk](http://www.guysandstthomas.nhs.uk/news/dying-talk) [accessed 19/10/2022].
5. Let's Talk: Advance Care Planning. Online resource and website – updated September 2022 [www.guysandstthomas.nhs.uk/LetsTalk](http://www.guysandstthomas.nhs.uk/LetsTalk) [accessed 19/10/2022].

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*

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.

121

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

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

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.