

purpose-led leadership particularly resonates with Millennials who have a strong social conscience and see the charity 'brand' as an extension of their personal brand and value set. This could provide competitive advantage over the for-profit sector in terms of attracting and retaining Millennial talent. Innovations to create Purpose-led Governance are suggested to improve stakeholder engagement and inclusivity. A bespoke Purpose-led model that encapsulates emergent findings is proposed to support sector sustainability.

Parallel session 3.1 – Workforce spotlight; upskilling and resourcing (Tuesday 7 November 2023, 10:45 – 12:00)

0-09 WHEN LESS IS MORE – THE POSITIVE IMPACT OF LOW-FIDELITY SIMULATION IN A HOSPICE SETTING

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10.1136/spcare-2023-HUNC.9

Background Simulation is considered a mainstay methodology for healthcare education (Jeffries. Simulation in nursing education: From conceptualization to evaluation. 2020), however, it has been under-utilised in end of life care (Bassah, Seymour, Cox. BMC Palliat Care. 2014; 13(1):1–0). Challenges exist surrounding the design of end of life simulations in non-traditional environments who lack ultramodern equipment and space to run high fidelity simulations. High fidelity simulation is often pursued by the simulation community in the belief that it leads to greater learning (Carey & Rossler. The how when why of high-fidelity simulation.) Simulation, however, is a technique not a technology (Gaba. BMJ Qual Saf. 2004; 13 (S1): i2–10), and there is significant evidence to suggest that low fidelity simulation may be superior (Massoth, Röder, Ohlenburg, et al. BMC Medical Educ. 2019; 19:1–8) as it is less anxiety-provoking and leads to a less burdensome cognitive load for participants (Lapierre, Arbour, Maheu-Cadotte, et al. Simulation & Gaming. 2022; 53(5):538–63).

Aims To design and deliver a low-fidelity simulation programme for roll out across the hospice, with relevant subject matter that engages both our clinical and non-clinical teams across the organisation, leading to clear learning.

Methods A rolling simulation programme with sessions at least twice a month was run from March 2022 to Dec. 2022. Our sample was 160 participants who took part in 29 simulations. Prior to the beginning of the simulation programme, baseline data was collected via questionnaire. After 10 months of simulation implementation, the questionnaire was repeated to analyse the impact of low-fidelity simulation on the organisation.

Results Baseline questionnaires showed 35% of the organisation had never heard the term 'simulation', and over 40% felt anxious around simulation. Following participation in simulations, the repeat questionnaire showed awareness of simulation within the organisation had increased to over 90%. Anxiety around simulation participation dropped by 10%, and we saw a 30% increase in the confidence of staff to undertake challenging conversations. Based on our significant findings, we also developed Cards against Calamity – an end of life simulation game – and began to share this with other hospices.

Conclusion Low-fidelity end of life simulation can be used with positive effect for clinical and non-clinical staff in the hospice setting.

0-10 EMBEDDING PALLIATIVE EDUCATION AND LEARNING INTO CARE HOMES: A PROSPECTIVE PILOT STUDY OF OBSERVATIONAL FEEDBACK AND ROLE MODELLING

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10.1136/spcare-2023-HUNC.10

Background The Ambitions for Palliative and End of Life Care (2021) highlight the need for all staff to be prepared to care. This includes ensuring staff working in care homes can support their patients' palliative care needs. Palliative education is a good first step to ensure this quality care and prevent inappropriate admissions to hospital from care homes echoed in a report by Public Health England (2014) which noted increases in care home deaths and called for training in end of life care recognition. But how do we guarantee this education is embedded? Bandura's social learning model (1986) highlights the importance of learning within the care setting.

Aims This pilot study aims to harness an educational approach which will consist of observational feedback and role modelling. Intention is to give real time education that will be embedded.

Methods A pilot has been designed taking place from May 2023 to June 2023. The care home educator gained agreement of two homes to deliver this pilot over two sessions. The educator will create a transparent real-time observational and role modelling approach. Feedback will be offered to individuals and overall, to the care home. Consent has been obtained from both homes to conduct this pilot. All learning will be documented within an observational template collating evidence of observations and resulting learning. Embedding of learning will be monitored on subsequent sessions. This evidence will be reviewed to highlight themes and findings. All evidence will be anonymised.

Conclusion An observational and role modelling approach could allow embedding of real time learning into practice. The aim is to ensure all care home staff are prepared to give high quality palliative care to their residents. This pilot aims to provide evidence to allow further such initiatives within other care homes.

0-11 FUTURE-PROOFING THE PALLIATIVE CARE CLINICAL NURSE SPECIALIST WORKFORCE

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10.1136/spcare-2023-HUNC.11

Background The shortfall in health care professionals at all levels has been accentuated in the specialist palliative care workforce recently (Buchanan & Campbell. BMJ. 2013; 347: f6201). Internationally, this is described as reaching a 'crisis' (Mahase. BMJ. 2023; 380: 713), whilst simultaneously, the population needing palliative care is increasing (Sleeman, de Brito, Etkind, et al. Lancet Glob Health. 2019; 7:e883–92). Retirement of Clinical Nurse Specialists (CNSs) led to unfilled

vacancies in our specialist team, which could not be filled locally with experienced CNSs.

Aim To employ fully competent CNSs to work in the CNS team in the first instance, whilst training new CNSs to fill the gap in the long-term.

Methods With more people working remotely through the COVID-19 pandemic, successfully supporting patients, it was decided to create several Virtual CNS (VCNS) roles. Appointing experienced CNSs from across the UK and Europe, to work remotely, triaging, taking and making calls and offering virtual CNS visits through technology, addressed this gap. Alongside this, a trainee programme was devised to train and offer progression for less experienced nurses wanting to advance their careers in palliative care. Four very experienced VCNSs, and five TCNSs were successfully recruited into the team. Whilst the TCNSs undertook a two-year training programme, the VCNSs filled the immediate workforce gap.

Results The hospice experienced a 50% increase in referrals over the last eighteen months. The VCNSs and TCNSs augment the existing team, allowed the hospice to cope with the increased need to triage these referrals and manage a subsequent 25% increase in caseloads. The training of CNSs, alongside the augmentation to the experienced team, means that this increased capacity is set to continue and will help address the predicted increase in future numbers of local people requiring hospice care.

Conclusion Although the problem of an ageing workforce remains, we have found a solution which allows us to address the immediate problem and simultaneously created a career pathway for less experienced nurses.

0-12

HOSPISCARE ESCALATION IN ACTIVITY TOOL (HEAT) – BALANCING SAFE STAFFING WITH PALLIATIVE PATIENT COMPLEXITY

Ann Rhys. *Hospiscare, Exeter, UK*

10.1136/spcare-2023-HUNC.12

Background When the UK went into COVID-19 lockdown, we had no foresight into how our referrals would change in the forthcoming years. Average time on caseload has reduced to eleven days (Hospiscare. 2023. Clinical Quality Presentation Q1) and increases in complexity are evident (All-Party Parliamentary Group. The Lasting impact of COVID-19 on death, dying and bereavement. 2023). This meant increasing concern for patient safety and staff wellbeing.

Aim To identify and design a hospice specific tool that considers safe staffing alongside patient complexity to always ensure clinically safe and effective patient care.

Methods Hospiscare worked with an independent company to develop a risk management framework alongside clinical acumen that triangulates safe staffing, patient complexity, and demand on the service. For the purposes of planning, four levels of RAG escalation were identified. Each team input their staffing levels daily, and dependency data is extrapolated from our EPR. An email is then sent to all clinical staff ensuring an awareness of our organisational level and actions can be taken to mitigate any risk in real time. If a BLACK status is recognised, a prepared statement is utilised by teams to communicate with external colleagues.

Results From commencing the HEAT tool, we have been able to extract data which demonstrates pressure points enabling us to be agile and responsive as a service. This includes:

- Actively managing staffing levels from 70% to 20% in the RED during times of pressure within our clinical service.
- Gaining an understanding of the complexities of our patients on any day. For example, by utilising OACC measurements we identify that 80% of our patients are either unstable or deteriorating within our caseload.
- In addition we can monitor fluctuation in activity levels across our clinical coordination centre, monitor bank usage and understand on a daily basis level of referrals coming into the organisation.

Conclusion By utilising HEAT, we have greater overview and are able to respond quickly to changes in staffing and demand within our service using the data to make evidence-based decisions. By considering information from this tool, we have been able to safely make temporary changes in operational provision and consider future service need through ICB discussions.

Parallel session 4.1 – Insights into inclusivity (Tuesday 7 November 2023, 13:30 – 14:45)

0-13

CO-PRODUCING A TOOLKIT OF APPROACHES AND RESOURCES FOR END-OF-LIFE CARE PLANNING WITH PEOPLE WITH LEARNING DISABILITIES

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10.1136/spcare-2023-HUNC.13

Background Reviews and inquiries into end of life care for people with learning disabilities consistently recommend that services involve them in end of life care planning. However, there is limited evidence on how to do this.

Aims To co-produce a toolkit of end of life care planning approaches and resources that are welcomed by and are useful for people with learning disabilities, and workable within adult social care services.

Methods (a) A scoping review of existing resources and (b) focus groups with key stakeholder groups, including people with learning disabilities, family carers, support staff, learning disabilities service managers, professionals working in learning disabilities and/or palliative care and policy makers (n=55); these informed (c) Six Experience-Based Co-Design workshops including representatives from these stakeholder groups and researchers with and without learning disabilities. Workshops included agreeing on key principles and preferred approaches, assessing existing resources and developing new resources to fill identified gaps.

Results (a) A shortlist of 21 resources included 9 accessible resources to be used with people with learning disabilities. However, most resources were not underpinned by empirical evidence. (b) Stakeholders identified 4 distinct parts of end of life care planning: talking about dying; what matters to me; planning for illness; and after-death/funeral planning. This affected views on when end of life care planning should start, with who, and why. (c) The co-design groups created a