

such as Eid, Humanist Day, Ramadan etc. We are also a Disability Confident Employer.

**Conclusion** The equality, diversity and inclusion work we are doing is ongoing, responsive to staff and to the communities we serve. We are building on networks and collaborating on events over the next year. We have built links with the multi-cultural and minority groups in North Cumbria. Our organisational values are to be inclusive, compassionate, collaborative, knowledgeable and innovative.

**P-195 COMMUNITY ENGAGEMENT TOOLKIT: COMMUNICATING WITH OUR DIVERSE COMMUNITIES**

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10.1136/spcare-2023-HUNC.215

**Background** Many hospices face the challenge of their patient demographic not representing that of their catchment (Tobin, Rogers, Winterburn, et al. *BMJ Support Palliat Care*. 2022; 12(2):142–151). Both real and perceived barriers to care exist. A multi-faceted approach is required to improve palliative outcomes for our communities (Hospice UK. *Equality in hospice and end of life care: challenges and change*. 2021), including: improving communities' hospice literacy and understanding local unmet need (Sallnow & Paul. *Crit Public Health*. 2015;25(2): 231–238).

**Aims** To evaluate our community engagement (CE) approach and understand its impact on awareness of hospice services locally. The identification and eradication of barriers to care.

**Method** Two new CE employees developed a 'CE toolkit'. Different engagement methods appeal to our diverse catchment and the groups we are underserving. The toolkit includes:

- Hospice 'Talk & Tours' for the public.
- Free workshops on advance care planning, bereavement, death literacy, hospice services.
- Community stakeholder database and map detailing local services and tracking outreach.
- Compassionate Neighbours project tackling loneliness and isolation. Also a tool for building links throughout the community.
- An internal CE Board and Working Group consisting of cross-department staff, ensuring an organisation-wide approach.
- Making hospice rooms available for free use by community/faith groups.

Our spiritual care lead is instrumental in engaging with under-represented groups and maintaining relationships with faith leaders who deliver workshops to share their beliefs and rituals at end of life.

**Results** This approach is ongoing. Further results will be included in the final poster presentation.

Oct. 2022 – April 2023:

- 30 meetings with community stakeholders.
- 30 trained Compassionate Neighbours.
- 3 Talk & Tours, welcoming 37 attendees.
- 4 workshops delivered to organisations.
- 1 Community Pride event planned.
- 2 creative events about grief in collaboration community groups.
- 1 Dying Matters Week campaign including outreach at homelessness hostel.

- 2 talks on death by faith leaders to palliative care staff.

**Conclusion** We have built new links with underserved communities, developed creative and collaborative ways of reaching people, improved death literacy, awareness of hospice services and our own awareness of our communities' needs.

**P-196 INCLUSIVE PALLIATION: CREATING A SPECIALIST PALLIATIVE CARE SERVICE FOR VULNERABLE PATIENT GROUPS**

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10.1136/spcare-2023-HUNC.216

**Background** Author 1, a GP with expertise in caring for vulnerable patient groups (VPGs – e.g. homeless people, prisoners and substance misusers), works part-time in a city-based hospice alongside Author 2, the hospice's lead palliative care consultant. It was noted that the hospice was receiving an increasing number of referrals for the palliative care of patients belonging to VPGs, and that their needs were increasingly complex. It is already known that high quality palliative care is achievable for patients belonging to VPGs, but that often novel techniques are required (Stienstra, Chochinov. *Palliat Support Care*.2012;10(1):37–42). It is also known that certain VPGs – e.g. prisoners – have particularly complex circumstances (Turner, Peacock. *J Correct Health Care*. 2017;23(1):56–65). It was decided to put Author 1 onto a new contract, majoring in specialist palliative care for these VPG patients.

**Aims** To evaluate the effectiveness of a new service for the specialist palliative care of patients belonging to VPGs.

**Methods** Spring 2022: literature review, evaluation of existing service, and service planning. Autumn 2022: launch of new service. Spring 2023: first cycle audit of service, and minor modification of service. Autumn 2023: second cycle audit of service, formal review of service, and recommendations for service development.

**Results** First cycle audit: there was a marked upturn in the number of VPGs referred internally to Author 1 for specialist management. Second cycle audit: the 2023 Hospice UK Conference coincides with the first anniversary of this service; the full audit cycle will be made available to the conference. Service development: evidence-based plans to develop the service will be presented.

**Conclusions** There is increasing demand for bespoke specialist palliative care for patients with VPG backgrounds. A city-based hospice piloted the deployment of a hospice GP with expertise in the care of VPGs. Data from the service's first year will inform further service development.

**P-197 ACCESS TO SPECIALIST COMMUNITY PALLIATIVE CARE SERVICES ACROSS YORKSHIRE: MEETING THE NEEDS OF THE POPULATION**

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**Background** Sixty million people worldwide need palliative care annually, but only 14% receive it (World Health Organization. *Palliative care: key facts*. [Internet] 2020). Barriers to

access include: age, sex, ethnicity, socioeconomic position, accessibility of services, and diagnosis (Allsop, Ziegler, Mulvey, et al. *Palliat Med.* 2018; 32(8): 1322–1333). Access to community specialist palliative care (CSPC) services may reflect this.

**Aims** To identify, 1) patterns in the populations accessing CSPC services, and 2) underserved populations.

**Methods** A retrospective evaluation of all referrals made to three CSPC services in one calendar year. Time in days calculated for: referral to discharge/death, and discharge to death in the cases discharged before death. Index of Multiple Deprivation (IMD) deciles (a surrogate for socioeconomic position) and straight-line distances between patients' residence and hospice were obtained. Access to palliative care was considered in terms of patients receiving a referral, and the duration under care in time from referral to death (days).

**Results** 2579 referrals (47% female, median age 76, 59% White British). Cancer was the modal diagnosis (72%). The modal IMD decile was 10 (least deprived), and median 7. Most referrals lived 5–10km from hospice. The median time from referral to discharge or death was 20 days, and from referral to death, 46 days. Younger age groups, cancer diagnoses, higher IMD decile and White British ethnicity had longer median referral to death times.

**Discussion** Fewer referrals were made for those with a non-cancer diagnosis, lower socioeconomic position, non-white British ethnicity, and residence further from the hospice. Those with non-cancer diagnoses, lower socioeconomic position, and older age groups, received fewer days of CSPC. CSPC remains aligned to the needs of less deprived, older, white British patients with cancer. Introducing palliative care referral to guidelines for management of terminal conditions and education on the benefits of early referral to SPC (Aldridge, Hasselaar, Garralda, et al. *Palliat Med.* 2015; 30(3): 224–239), and increased collaboration with underserved communities to design services aligned with their needs is required.

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#### OPPORTUNITIES AND CHALLENGES FOR INVOLVING PEOPLE WITH LIVED EXPERIENCE OF INCLUSION HEALTH AS CO-RESEARCHERS IN PALLIATIVE AND END OF LIFE RESEARCH: A RAPID REVIEW AND THEMATIC SYNTHESIS

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10.1136/spcare-2023-HUNC.218

**Background** Co-research promotes involvement of individuals with relevant lived experience as equal members of a research team. Recently, the importance of co-research within palliative and end of life care has been highlighted. However, few recommendations exist regarding best practice for involving people from inclusion health groups as co-researchers in palliative and end of life care research (i.e., people from socially excluded groups, who typically experience multiple disadvantages that contribute to poor health).

**Aim** To identify and synthesise qualitative literature outlining barriers and facilitators for involving people from four inclusion health groups (individuals with lived experience of: homelessness, substance use disorders, incarceration or

exchanging sex for money) in palliative and end of life care research.

**Methods** Rapid review with qualitative evidence synthesis. Three electronic databases were searched (2012 – 2022). Data was extracted from the perspectives of both academic researchers and lived experience co-researchers, including both first order-data (quotes from individuals with lived experience), and second order data (original authors' interpretations). Analysis followed thematic synthesis methodology.

**Results** Three eligible papers were identified. Two involved individuals with experience of incarceration, and one involved people with experience of homelessness. This corresponded to eighteen individuals with lived experience. Challenges for involvement included: facilitating appropriate reimbursement; overcoming stigma and reluctance to share power; protection vs. patronisation; how lived experience affects positionality (bias and scepticism); and the emotional burden of research. Benefits included: advanced level of insight, two-way learning opportunities and the relatability of lived experience co-researchers.

**Conclusions** There are few, good quality studies offering insight into barriers and facilitators for lived experience co-researcher involvement in palliative and end of life care research. Greater understanding of and recommendations for safe and impactful inclusion is needed to support and encourage researchers to involve people from inclusion health groups as co-researchers in palliative and end of life care research.

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#### CO-DEVELOPING SKILLS IN WORKING WITH INTERPRETERS IN CONVERSATIONS ABOUT END OF LIFE

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**Background** Personalised communication is essential in effective palliative care (Silva, Genoff, Zaballa. *J Pain Symptom Manage.* 2016;51(3):569–80; Jaitly, Bronnert. *BMJ Support Palliat Care.* 2023;13:A52). However, language barriers coupled with diversity in cultural and faith backgrounds can make personalising information, dialogue and care planning complex. The lack of teaching around this subject in UK medical schools compounds the problem. The 2021 UK census shows that 8.9% of the population does not identify English as their primary language, making it a pressing concern for healthcare providers.

**Aims** This project aims to co-develop, pilot and evaluate learning resources for working with interpreters during end-of-life consultations. We report here on developing this work.

**Methods** Facilitated workshops drew on the experiences from a diverse range of stakeholders, who had delivered and/or received care, where the primary language was not shared. Discussion centred on real-life scenarios in advanced illness and end of life care involving complex discussions with interpreters.

**Results** The workshops highlighted that culture, as well as language, both played a significant role in communicating with non-English speaking patients. In an ideal situation, family and friends should not be expected to interpret consultations, especially in the emotional context of end-of-life discussions. The complexity of reality makes this challenging.