

update was delivered to all staff utilising the resuscitation council 'lifesaver' app. As there are no hospice specific resuscitation guidelines, our was updated in line with adapted guidance for primary care and community hospitals, to incorporate the skills of rotational doctors with advanced life support certification. An emergency trolley was introduced to centralise equipment, with an added laryngeal mask airway and a pre-connected bag and mask, and a second AED was purchased to provide quick access for the whole hospice.

Conclusions There are no specific best practice guidelines for managing cardiac arrest in the hospice setting. Following a clinical incident, we have adapted the resuscitation council guidance to develop a local policy. In the future, as we care for more patients earlier in their illness, this contentious issue is likely to present more frequently. Developing a local policy could help ensure high quality resuscitation care within the hospice in response to the changing needs of palliative care patients in the future.

124 ONE HOSPITAL TEAM, THREE SITES

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Background Northumbria Healthcare NHS FT specialist palliative care hospital liaison service (HLT) is a unified team working across three acute hospital sites with one Specialist Emergency Care Hospital (NSECH). Patients are admitted to specialty wards in NSECH for urgent assessment and treatment. If their condition is stable but requires them to stay in hospital for longer than 48 hours they are transferred to one of the other two 'base' hospitals (WGH or NTGH) for ongoing medical, and palliative, care.

Methods Data were collected using a standardised database across the three sites. Age, diagnosis, Australian modified Karnofsky Performance Scale (AKPS), phase of illness, and duration of episode of care (time from referral to discharge/death or transfer) were analysed for three sites between August 2018 August 2019.

Results Data demonstrates that patients in NSECH were younger, more likely to have cancer (66%), and had a mean duration of episode of care of 1 day. In contrast, patients in the base hospitals were older, with 66% and 73% of patients, respectively, over 75: in NTGH 40% of patients were over 85 years old. These patients were more likely to have non-malignant disease (45% with non-malignant disease), and frailty was the primary diagnosis in 13%; frailty and dementia combined were the primary diagnoses in 18%. In spite of this, AKPS was similar across all three sites, with the majority of patients being 30% or less.

Discussion Acute services across the whole trust have been transformed since NSECH opened, and the HLT patient population across the three sites has radically changed. This is a responsive team which has adapted to patient need on the individual sites, and reconfigured in an iterative manner according to this need. Future palliative care services must be able to adapt and respond to the increasingly dynamic demands of the population.

125 CAN THE SPICT BE APPLIED RETROSPECTIVELY TO IDENTIFY PATIENTS WITH UNMET SPECIALIST PALLIATIVE CARE NEEDS WHO ATTEND ED WITH BREATHLESSNESS?

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Background There has been growing recognition that patients with the symptoms of breathlessness frequently attend the Emergency Department (ED) as they progress towards the end of life. This may represent a cohort of patients who have unidentified and unmet palliative care needs. We investigated whether the SPICT could identify these patients during an acute attendance to the ED.

Methods Retrospective data collection from electronic records on patients who attended ED in December 2018 aged over 65 and had 'breathless' equivalent in their triage. A data collection tool was created in Excel. Patient demographics, number of previous admission in the preceding 2 years, presenting complaint were collected, and then assessed against SPICT. Data on the same patients was then collected until December 2019 on further admissions, attendances and mortality. They were then re-scored against the SPICT.

Results A total of 2767 attendances in December met the criteria. The first 2 days of December were analysed. Data was collected on 16 patients. Of these, 7 patients met the SPICT criteria. In 70% admission was due to exacerbation of chronic disease. 1 year later 5 patients were still alive. On re-assessment only 4 out of 7 met the SPICT criteria. Patients who met the SPICT had a mean number of attendances to ED of 5.4, compared to 3.8. Both patients who died met the SPICT criteria.

Conclusions Our data suggests that the SPICT cannot be applied retrospectively or electronically to identify patients in the acute setting who would benefit from specialist palliative care input. Trends were that patients who did meet the SPICT had a greater number of attendances to ED. Limitations include small sample size, and reliance on correct data entry at the time of attendance. We suggest further data needs to be collected to create a tool specific to ED.

126 BIG DATA ON EARLY IDENTIFICATION OF PATIENTS WITH PALLIATIVE CARE NEEDS: BARRIERS AND OPPORTUNITIES

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Introduction The aim of this study was to explore the views of experts on the use of big data (BD) advanced analytics (i.e: machine learning, deep learning or artificial intelligence techniques) on the identification of frail older patients with non-malignant diseases who could benefit from early palliative care (PC).

Methods This descriptive study corresponds to the first round of a Delphi study currently under performance. Participants were asked through a questionnaire survey about the level of