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.

Background Northumbria Healthcare NHS FT specialist palliative care hospital liaison service (HILS) is a unified team working across three acute hospital sites with one Specialist Emergency Care Hospital (NSEC). Patients are admitted to speciality wards in NSEC 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 and August 2019.

Results Data demonstrates that patients in NSEC 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 NSEC 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.
agreement regarding i) the use of advanced analytics on specific clinical scenarios and ii) the critical aspects when using these applications on the frame of PC. The sample included professionals from different countries and disciplines with expertise on chronicity, geriatrics and/or PC. Consensus was defined as >70% of subjects agreement.

**Results** At this time, fifteen experts have answered the questionnaire (37.5% of whom invited to participate). 78.6% were women, 71.4% were working in a clinical setting >15 years as physicians (57.1%), nurses (35.7%) and psychologists (7.1%) 80% of them considered that the strategy based on an automatic tool (BD based) combined with front-line healthcare staff is the best way for identification of patients who could benefit from early PC approach. They assessed as ‘very’ and ‘extremely useful’ the use of BD models on research applications, both as a population health management tool (clinical clustering) and as a tool to improve the prediction of an outcome risk. However, the need for clinical validation and the dearth of evidence of practical benefits are the main critical aspects on the implementation of these tools.

**Conclusions** The view of experts can contribute to guide BD applications on advanced stages of illnesses. The consensus about the opportunities and gaps on the implementation of these tools will support clinicians in decision making processes.

**127 EVALUATION OF THE PROCESS OF SENDING OUT OACC QUESTIONNAIRE TO PATIENTS, PRIOR TO THEIR FIRST PALLIATIVE CARE NURSE SPECIALIST VISIT/ APPOINTMENT, JUNE 2019**

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The OACC Assessment Questionnaire is sent out to all appropriate patients at telephone triage who are assessed as needing to be seen within 1–2 Weeks. The Questionnaire looks at IPOS as part of OACC.

This process allows for the Patients to have more time to review their symptoms and to think about their main problems of concern over the last week, along with any practical problems resulting from their illness, prior to their Palliative Care Nurse Specialist visiting them in their own home for their first holistic assessment.

By enabling an opportunity for the Patients to complete the Questionnaire themselves, it reduces reliance on Healthcare Professional Staff assisting them, and gives more autonomy/direction about key issues for them. It can also be used as a channel for Patients and Families to have some open conversation prior to their first visit/assessment, and to give insight into areas we will cover, which are different to a District Nursing assessment.

This review aimed to establish the benefit of sending out the Questionnaire. Also to examine if the action of recording data within the process was robust, and to identify any areas that could be improved.

A random sample of 34 patients was selected for retrospective review of activity from sending out the Questionnaire to examination whether this was completed by the patient or helped by the nurse to complete on the first visit, and scrutiny of the data recorded on Crosscare thereafter.

Overall, it was found that there was benefit of sending out the OACC Questionnaires with 50% of Patients completing this prior their PCNS visit. However, following analysis of the data recorded, we established that we needed to revisit training, particularly for PCNs for navigating the IPOS windows and recording data therein.

**128 PALLIATIVE CARE FOR HOMELESS PEOPLE: A SYSTEMATIC REVIEW OF SYSTEMATIC REVIEWS FOR AN EVIDENCE BASED CLINICAL GUIDELINE**

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**Background** Homeless people die much younger and have higher rates of ill-health compared to the general population. This systematic review of systematic reviews seeks to understand 1. views and preferences of homeless people regarding palliative care, 2. barriers and facilitators to homeless people accessing palliative care and 3. evidence for advance care planning interventions in palliative care for homeless people. This informed the development of a guideline for use by healthcare professionals providing palliative care for homeless patients.

**Methods** Searches took place of PubMed, Embase, PsycINFO, CINAHL, Web of Science, Medline and Cochrane Library from inception to December 2019. The quality of the studies was assessed using SIGN Methodology checklist 1. The GRADE system was then used to assess the quality of the evidence and strength of the recommendations. Themes were identified following data analysis.

**Results** Five systematic reviews met the eligibility criteria. Three were rated as moderate quality, one as poor quality and one as unacceptable quality. Nine types of themes were then identified. First, views and preferences; homeless people recall poor experiences of healthcare in the past and have unique concerns regarding their health. Five barriers to palliative care were also identified, namely; lack of basic needs being met, having competing priorities, being ill-informed about their condition, hospice and hostel staff having insufficient knowledge, and poor co-ordination of care. The emerging facilitator was that homeless patients trust the staff they already know. Finally, many homeless patients benefit from advance care planning interventions, if they feel able to engage in the process. The quality of the recommendations was moderate to low. The strength of the recommendations was mostly strong.

**Conclusions** In this review, the views, preferences, barriers, facilitators, and interventions in palliative care for homeless people were established, informing a new clinical guideline.

**129 IMPLEMENTATION OF TREATMENT ESCALATION PLANS (TEP) AND DNACPR DECISIONS AT ST GEORGE’S UNIVERSITY HOSPITALS NHS FOUNDATION TRUST**

Amy Hawkins, Megan L Papworth. St George’s University Hospital NHS Foundation Trust

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**Introduction** Treatment escalation plans (TEP) are a tool to promote advance care planning, appropriate decision making and good communication between professionals, patients and