

the community at the start of the COVID-19 pandemic. In response we worked with the local NHS Hospital Trust to develop and provide an urgent community service and Single Point of Coordination that responded to patient need.

Aim To ensure that those patients that required end-of-life care in the community received a co-ordinated local expert response.

Methods In wave 1 of the pandemic, government directive required patients to be rapidly and urgently discharged from hospital. Clinical pathways were redesigned to ensure that patients who needed to be diverted away from acute hospital settings received a responsive end-of-life service. A Single Point of Coordination was initiated to ensure that patients, families and health and care professionals had access to a single telephone number for advice, care and contact.

Results The urgent community team response received positive patient and family feedback in response to the service being mobilised. A coordinated approach resulted in improved expert experience for patients and families when it is most needed. The Single Point of Coordination continues to take an average of 45 calls per day totally up to 6000 calls over a six-month period through 19/20. Patients were able to die with family members present. No patients referred to the service were inappropriately admitted to hospital.

Conclusion Evaluation of the services are ongoing in response to maintaining business continuity. Following positive feedback from patients and key stakeholders we have continued to provide Single Point of Coordination to serve the local population in line with the 'Ambitions for Palliative and End of Life Care' (National Palliative and End of Life Care Partnership, 2021).

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EXPLORING PATIENTS AND FAMILIES EXPERIENCES OF SERVICE ADAPTATIONS IN THE CONTEXT OF COVID-19

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Background In March 2020, care within hospices had to be dramatically altered to comply with COVID-19 government guidance. Some services at Dorothy House Hospice were rapidly suspended, others adapted due to safety restrictions. Frequently, the human touch, typically enshrined in hospice care, was replaced with virtual/remote connections including video (Zoom) and telephone calls.

Aim To identify and understand the impact of communication changes on patients', clients' and families' experiences of Dorothy House Hospice in the context of COVID-19 and explore their future communication preferences.

Method In July 2020 a postal survey was sent to all who had used Dorothy House Hospice services since March 2020. Using closed questions plus free text comments, the survey asked about people's experiences of services since March 2020 including levels of satisfaction with communication, difficulties encountered and preferences for future communication types. Data were analysed using frequency counts, with exemplar quotations extracted.

Results Responses were received from 218 participants comprising: patients (62%), family/carers/friends (28%) and

bereaved people (10%). 189 (87%) of respondents reported receiving the right amount of information despite service changes, and 185 (85%) were happy with the format of contact received. 172 (62%) respondents did not want to receive video calls in future, however, 71% (n=10) of respondents aged 18-44 were happy with this method, compared with 12% (n=18) aged 65+. Respondents reported minor technical difficulties with Zoom and regret at restrictions on face-to-face interactions. Concerns surrounding privacy during remote consultations at home, and hearing difficulties, were occasionally raised.

Conclusion The majority of responses were overwhelmingly positive; patients, clients and families were reassured and appreciative that they were still able to access Dorothy House Hospice services, albeit sometimes in alternative formats. Steps to improve online access and technical support/education are needed to support older service users to access services with confidence.

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A LONDON HOSPICE'S EXPERIENCE AND RESPONSE TO THE COVID-19 PANDEMIC: A SERVICE EVALUATION

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Background The COVID-19 pandemic resulted in increased demand for specialist palliative care, however, there is little description in the literature of the impact on specialist community services (Bone, Finucane, Leniz, et al., 2020). Service-level changes were made by an inner London hospice and community team to respond to changing needs and pressures on local acute hospitals and primary care.

Aims To explore how the COVID-19 pandemic impacted local hospice referrals made and describe how inpatient and community services adapted across the first and second waves.

Methods A retrospective analysis of referral data was conducted, comparing first and second COVID-19 waves (5 March 2020 - 31 May 2020 and 5 November 2020 - 23 February 2021 respectively) with 'control' data for the same periods, one year prior. Qualitative methods were used to describe new interventions and adaptations to the delivery of care across the service during this period.

Results There was little change in referrals for hospice services, when comparing control waves with COVID-19 waves. Several adaptations were made which ensured that safe delivery of care could continue across all settings including early fit-testing for staff, vaccinations, regular testing and the introduction of inpatient COVID-19 referral pathways. Referrals for COVID-19 positive patients to the inpatient unit increased between the first and second waves. Despite improved attendance at virtual care home MDTs, fewer referrals were received compared with the control waves.

Conclusion Though overall referrals to the service did not change when compared with control waves, the number of referred COVID-19 patients increased between first and second waves. This may reflect adaptations in and improved use of dedicated COVID-19 pathways by acute hospitals. The reduction in number of care home referrals may represent lost referrals due to a preference for remote advice over face-to-face reviews and deterioration of residents before referral could be made.