

Results The presentation will present improvements in: service transformation; volunteering; staff wellbeing and development; equality, diversity and inclusion; retail/commercial development; fundraising; and stakeholder engagement.

Conclusions Despite significant difficulties, COVID-19 has presented opportunities to be creative and energetic with our future thinking, expanding the 'art of the possible'. We have used the opportunity positively, bringing staff and board along with us and are a stronger, more confident hospice as a result.

P-106 AN OVERVIEW OF THE DIGITAL HEALTH INTERVENTIONS ADAPTED AT ONE HOSPICE IN RESPONSE TO THE PANDEMIC

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Background Palliative care services have responded rapidly and innovatively to the challenges of the COVID-19 pandemic (Dunleavy, Preston, Bajwah, et al., 2021; Etkind, Bone, Lovell, et al., 2020). Digital health interventions (DHI) have the potential to improve service provision (Finucane, O'Donnell, Lugton, et al., 2021; Bush, Perez, Baum, et al., 2018), with increasing evidence supporting the use of video consultations in palliative care as a safe and effective adjunct to face-to-face patient contact (Sutherland, Strickland, Wee, 2020).

Aim To evaluate the extent to which two digital health interventions were adapted by one hospice in response to the COVID-19 pandemic.

Method An electronic health record system was already in use (SystemOne) at the hospice and these new digital health interventions were incorporated in response to the pandemic:

- Video consultations.
- 'Authority to Administer' (ATA) electronic charts on SystemOne, authorising administration of injectable medications by community nurses for people at end-of-life being cared for at home. These were in addition to paper community drug charts, usually completed by GPs, community or hospice prescribers.

Results

- Video consultations: From none (pre-pandemic) to a monthly average of 68 in early 2020, nearly doubling to an average of 132 in early 2021.
- ATAs increased from a monthly average of five (mid 2020) to 27 (first quarter, 2021).
- 35% of ATAs (49 out of 144 in a 42 week period) were completed at weekends or late evening, with likely patient benefit as delays awaiting completion by urgent care prescribers were potentially avoided.

Conclusion Digital health interventions are firmly embedded in the day to day provision of palliative care services. As well as using NHS approved software such as accuRx for secure video consultations, staff have also innovated in using this technology to communicate more effectively with patients, such as sending clinic letters, symptom assessment questionnaires, patient information leaflets and text summaries of medication changes directly to patient devices. There is huge scope to incorporate digital health interventions further within palliative care to meet the changing needs of local communities.

P-107 EARLIER SPECIALIST PALLIATIVE CARE INPUT ON THE ACUTE ONCOLOGY ASSESSMENT UNIT: IS IT BENEFICIAL?

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Background Emerging evidence suggests early palliative care (PC) is beneficial in the care of patients with cancer (Berman, Mola, Elliott, et al., 2018; Mola, Campbell, Berman, et al., 2018; Temel, Greer J, et al., 2010). Clinicians' views also require consideration as they aim to support and optimise care for these patients (Popescu, Schafer, Califano, et al., 2014).

Aims To evaluate our model of earlier PC on the Oncology Assessment Unit (OAU), assessing the effect on patients and clinicians.

Methods Two PC doctors attended the OAU at a tertiary cancer centre, for 45 sessions. PC intervention consisted of face-to-face review or advice. The number of, and reasons for referrals were recorded. Patient and staff questionnaires provided feedback. Staff responses were independently analysed to identify themes.

Results

- 41 referrals: 32 face-to-face reviews; 9 advice only.
- 16/41 not previously known to PC services.
- Seven patient and 10 staff questionnaires returned.

All patients gave positive feedback and would recommend PC to family/friends. Thematic analysis of staff responses identified three themes:

1. Access to/engagement with PC services: Removing barriers to PC services, providing good links to Community PC Services. *'Discussion with the PC doctor seemed to de-mystify/take away some of the fear associated with PC referral'*
2. Quality of care: Good patient care, efficiency/patient flow, expertise in symptom control. *'It has improved patient care on the two occasions I referred'*
3. Improved outcomes
4. Preferred place of care, advance care planning, education/teaching. *'This was highly beneficial to the patients as they wanted to be at home and we were able to carry out their wish safely'*.

Conclusion Access to palliative care has been widened, quality of care and patient outcomes improved. Patients and staff were positive about early palliative care in this setting. Consideration is required to ascertain if this model of care is (a) the optimal use of resources and (b) transferrable to other settings.

P-108 A LONG TERM VENTILATION (LTV) SERVICE-DEVELOPMENT OF SENIOR CARE ASSISTANTS

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Background The number of children and young people with Long Term Ventilation (LTV) needs accessing hospice services continues to increase. This paper outlines the provision of a

hospice-led LTV service initially by specialist nurse roles, evolving further with the development of a novel senior care assistant role (SCA).

The LTV service From April 2020 to February 2021 the LTV service supported 68 children and young people with level 1, 2 or 3 ventilation needs, children and young people with a tracheostomy and those with complex respiratory care needs. The service supports discharge planning, coordinates care outside of hospital, provides specialist clinical education for families and professionals and has supported care at end of life for LTV children and young people. Care is overseen by two clinical nurse specialists (CNSs), two LTV nurses and two SCA. Full theoretical and practical training is in place with education cascaded by specialist team and tailored to individual hospice staff needs.

SCA role development The development of the SCA role was perceived as innovative and cost effective way to support the CNS in delivery of LTV care as the caseload and complexity of LTV children and young people developed. From April 2020 to February 2021, SCAs spent 69% of their time on clinical tasks, 17% teaching and 8% on practice development. Key elements of the SCA role (with CNS oversight) are:

- Teaching/training/mentoring nurses and care assistants. Training and supporting families.
- Developing child specific portfolios.
- Advocating for children and young people in MDTs and professional liaison.
- Sourcing equipment.
- Assessment of stable and unstable children and young people, planning and evaluating care.

Conclusion Developing this innovative SCA role has ensured patients receive increased professional contact, enabled their own personal professional development and makes best use of the organisation's available workforce in a cost effective way. The SCA acts as role model, demonstrating that safe and effective care is possible with the introduction of a skill mix for children and young people with LTV needs in the region.

P-109

LITTLE HAVENS CHILDREN'S HOSPICE STAY AND PLAY GROUP

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Introduction Parents using the children's hospice fed back that they would like to access a play group where they can meet other families in similar situations and feel safe and cared for with their children. We introduced a 'stay and play' group to meet the identified need and improve access for children with additional needs and improve service provision.

Aims

- Reduce inequality in access to play groups for children with different needs.
- Provide a play group for under 4s for children who have different needs.
- Improve parents' ability to adapt and play with their children.
- Help children meet their potential through play.
- Enable parents to meet others in similar situations and build their own network.

- Enhance parent and carer confidence and resilience, transferable to the community setting.
- Introduce families and children to the hospice through a less daunting approach.

Method

- Whole case load reviewed with a newly introduced holistic assessment.
- Parents with children under 4 identified they were not accessing play groups because their child's needs could not be met.
- Parents identified as socially isolated.
- 26 families were identified as having a child under 4 from the patient administration system.
- Parents were invited to attend the 'stay and play' group.
- At four weeks a questionnaire was administered with parents to evaluate the group.
- Four weekly questionnaires are planned.

Results

- At four weeks the 'stay and play' group was positively evaluated.
- Families feel safe.
- Families can talk to other families who understand their child's needs.
- Decision to continue with the group and continue to evaluate regularly.

Conclusion This is a safe space for families to attend, allow their child to play and feel supported and understood. Plans to extend the age range to five and under and develop this concept further.

P-110

DEVELOPING A CHILDREN'S HOSPICE COMMUNITY SERVICE DURING THE COVID-19 PANDEMIC

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Brian House children's hospice on the Fylde coast in the North West of England provides palliative and end-of-life care for children and families with complex needs and life-limiting conditions. A recent research study, although ongoing, identified that some families were not accessing a service that was available to them in their local area. The team developed an action plan to build a community service enabling palliative and end-of-life care to be delivered in the community, therefore reaching out to the families identified in the study. COVID-19 implemented restrictions that impacted on the respite available to families due to reduced capacity; we had to react to this. COVID-19 empowered the team time to reassess the community service action plan ensuring a service was delivered in line with government guidelines and restrictions.

A proposal of a community service was presented to parents, their initial reaction was hesitance. Despite parents' hesitation Brian House launched the community service. Our community team reacted to the pandemic successfully as more and more families came on board with this different way of accessing care provision. We networked and created links that are invaluable and crucial to developing a community service that would meet the needs of our children and families.