November 2020. This was complemented by input from a Clinical Nurse Specialist over a total of six months.

Results Between 1 January and 31 May 2021, 56 patients were referred. 69% from the hospital palliative care team. 46% of patients had cancer. Four patients died before they were assessed. 68% of patients were seen within seven days of referral. 29 patients died during the project timescale and 93% of deaths were in a care home. The only hospital admission was precipitated by an acute event. We found evidence that documentation of ACP and escalation of treatment plans improved by our intervention. Potential hospital admissions were avoided in 14 cases due to ACPs. There were challenges for carers in attending education, with 172 attendees over 34 sessions. With regard to visiting during a time of societal restrictions, 28% of review appointments took place face-to-face.

Conclusions Education was well-received but further work is required to improve accessibility and to assess longevity of benefit. We responded clinically in a more timely manner, as compared to 'normal care'. We identified a theme of inadequate and inconsistent documentation of future care planning.

P-120 HOSPICE AT HOME SERVICE: ENABLING PERSON-CENTRED CARE

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Background A collaborative project between the clinical and research teams at a hospice in Scotland highlights a person-centred model of Hospice at Home being developed and utilised with a focus on 'what matters to patients and families'.

Aims

- Evaluate the impact and potential benefit of Hospice at Home and identify the factors that underpin these.
- Support the development of a model of care that underpins the Hospice at Home service.

Methods The evaluation part of the project was informed by a pluralist approach, allowing for evaluating the complexity of a service by taking into account its organisational context. The pluralist model encourages participation of stakeholders and takes account of varied data sources. Within this study this consisted of:

- Interviews and focus groups with managers and the new Hospice at Home team.
- Descriptive quantitative data.
- 15 patients' case stories.

Results During the period of the study 140 patients were admitted to the service. The most frequent reason for the service being requested was for psychological support, the average length of stay in the service was 17.1 days with the majority of patients staying in the service for 8.0 days.

The model of care underpinning the new Hospice at Home service enabled person-centred care in patients' homes. Three key elements of the model were identified: flexible and responsive care; relationship based care; and empowering patients and family members. The key outcomes of this model of care were identified as family members feeling supported

and patients being able to be cared for and die in their preferred place.

Conclusion The person-centred care model of the Hospice at Home service enabled a level and focus of care that adds a new layer to care within the community. This person-centred model of care may be meeting the needs of patients with less clinical/medical palliative care needs and be more appropriate than the more traditional medical model.

P-121 ENHANCING OUT OF HOURS PALLIATIVE CARE SUPPORT IN HIGHLANDS DURING COVID-19 AND BEYOND

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Background During the first three months of the COVID-19 crisis in Highlands, the local palliative care helpline was put on pause to allow out-of-hours practitioners to cope with increasing demand on acute services. An enhanced helpline was introduced in August 2020.

Aim To provide improved support and advice to members of the community with palliative care needs, at home or in residential care, using existing resources more effectively.

Method A partnership was established with NHS Highland and Highland Hospice to staff an out-of-hours enhanced Palliative Care Helpline (PCH) seven nights/week. Shielding nursing staff working with the NHS who had previous knowledge and experience in palliative care were invited to work remotely alongside nursing staff in the Highland Hospice. Staff involved were consulted and supported with three online induction sessions.

Results During the six-month pilot, 470 calls were made to the Palliative Care Helpline of which 55% were put through to the PCH nurse. The data from the pilot period was compared to pre-pilot data. Calls were more likely to be dealt with by giving advice (to patients, families and care staff) resulting in reduced home visits and fewer hospital admissions. Qualitative feedback from out-of-hours practitioners was positive. The assessment and triaging of the patients by the PCH nurses was felt to be 'often better', and 'Far more timely for patients... Far fewer OOHs home visits/contacts required'.

Conclusion A palliative care helpline staffed by nurses with palliative care experience can provide additional support to palliative patients in the community resulting in fewer house visits and hospital admissions.

P-122 INTRODUCING A COMMUNITY SPECIALIST PALLIATIVE CARE OVERNIGHT/OUT OF HOURS (OOHS) VISITING SERVICE

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10.1136/spcare-2021-Hospice.139

Background Access to a 24/7 service supports people at the end-of-life, enabling them to be cared for and to die at home. Prior to this project all overnight/out-of-hours (OoHs) calls were dealt with by the hospice staff giving telephone advice, often referring to the 111 service. Delays in the delivery of

care and lack of specialist face-to-face support often resulted in unnecessary/unwanted admissions to hospital.

Aims To question the need for an out-of-hours visiting service and to develop the future planning of services to support people at the end-of-life to die at home.

Method Three-year funding was secured, and the service was introduced in 2019. The service provides a clinical nurse specialist and healthcare assistant out-of-hours to deal with calls from known and unknown patients in our communities. The service offers telephone advice, face-to-face consultations and accepts new referrals for people often in crisis. The service works in collaboration with London Ambulance Service (LAS), out-of-hours general practitioners and district nurses.

Results Joint working with LAS developed an appropriate care pathway for all end-of-life patients in the three boroughs. Most calls into the service are for symptom management and emotional support, however, new patient referrals have increased with the team often seeing people in crisis. The activity of the service has increased significantly from year 1 to year 3 with 50% of calls from patients and 50% from professionals.

Conclusion The benefits of the service are evident in the data reports and the patient experience feedback, it has enhanced the community service by ensuring a seamless service for people at the end-of-life and supporting next of kin and professionals 24/7. The service has prevented admissions to hospital reducing the pressure on the acute sector. The data provides evidence for the need of 24/7 visiting and we are currently exploring funding options to continue the service.

P-123 THE ROLE OF A PARAMEDIC IN A COMMUNITY HOSPICE/PALLIATIVE-END-OF-LIFE CARE TEAM

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Introduction The evolution of the paramedic role over recent years has changed dramatically, with an increased emphasis on treating more patients in the community rather than conveying to hospitals unnecessarily. Paramedics see and treat a diverse range of patients from acute events to chronic conditions, many patients have co-morbidities and polypharmacy in an aging population. Thus, the modern paramedic must be equipped with holistic clinical skills over a wide variety of specialties.

Multi-disciplinary working in hospices is well established but does not typically include paramedicine. Paramedicine has changed in recent years extending beyond the typical emergency response model to encompass community paramedicine with paramedics working in primary care but the role within hospices is still to be developed.

Method Paramedics draw on a multitude of skill sets from symptom management, physical assessment, signposting, referrals and many more, and are adept at talking and communicating with people in the very worst of situations showing empathy and care, a baseline for all palliative care. My role as a paramedic in the hospice team is to conduct assessments, using my experience of visiting patients within the community and deciding on a course of action/referral or input required.

Outcomes Mountbatten Isle of Wight has seen two paramedics integrate well with the community palliative care team.

Paramedics have been able to give IV infusions to patients within their homes to help avoid clinical environments. Paramedics have extensive patient assessment and diagnostic skill-sets and these have been added to by in-house training on catheterisation/advance care planning and end-of-life care supplementing the care provided by nursing staff within the community team.

Conclusion The role of the paramedic within hospice community teams is still in its infancy. We know that hospice services work differently across the country and therefore there are no hard and fast rules for what a paramedic may do.

P-124 FROM HOSPICE VOLUNTEER TO COMPASSIONATE CITIZEN: SHIFTING THE BALANCE OF CARE AND POWER

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Background *Compassionate Neighbours*, originated from the Public Health Palliative Care model, is a community development project aimed at developing mutually beneficial relationships that also helps build social capital and capacity within our communities. One hospice located in Scotland developed such an approach by expanding the role of volunteers within the hospice. Whilst hospices have long valued volunteers for their support in the provision of a de-medicalised, holistic approach to care, this new initiative reflects a longer-term, citizen-led investment that can equip communities to help one another during times of increased health need, loss and grief. Initiated and sustained during the COVID-19 pandemic, the project used an online blend of discussion, reflection and learning before matching *Compassionate Neighbours* with local people known to the hospice.

Aim To capture 'compassionate neighbours' experience and the impact of transitioning from a traditional volunteering role to a role reflecting the ethos of compassionate citizen.

Method Focus group inclusive of 10 volunteers that were part of the compassionate communities initiative and interviews with six people in the community they were 'matched with'.

Results Analysis of the data so far has highlighted how:

- The partnering process enabled the building of reciprocal relationships between volunteers and those they were matched with; vital to the success of the initiative.
- The *Compassionate Neighbours* negotiated, developed and sustained a mutually beneficial relationship with those they were matched with, reflecting the compassionate communities approach within the Public Health Palliative Care model.

Conclusion Central to the project's early success and future growth has been the emergence of a different kind of volunteer; one who sees him or herself as part of a community-led social movement involving ordinary people capable of responding in practical and compassionate ways to shared problems and needs in their own communities.

P-125 THE CREATION OF HOSPICE OUTREACH DISCHARGE SUPPORT (HODS) TEAM

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