

played a central role in supporting the bereaved. We describe the impact on and response of these services to inform service development and policy.

Methods Mixed-methods explanatory sequential design in two phases: (1) Online survey (March-May 2021) of VCS bereavement services in the UK, disseminated via national organisations, networks and social media; (2) Qualitative semi-structured telephone interviews with staff/volunteers at case study VCS bereavement services (June-December 2021). Interviews explored challenges/innovation in bereavement support during the pandemic, with transcripts analysed using thematic analysis.

Results 147 organisations participated in the survey; 53% were regional, 16% UK-wide. 36% were hospice/palliative care services, 15% national bereavement charities/Non-Governmental Organisations; 12% local bereavement charities. During this period of the pandemic referrals increased for 46% of organisations and decreased for 35%. 78.2% changed services and 51.7% introduced new services (such as online/telephone support). 24 people across 14 organisations were interviewed. Challenges encountered included: rapidly setting up online/telephone provision and consequent changes to the therapeutic encounter; developing new policies/procedures; coping with fluctuating demand and clients' complex grief responses; supporting staff/volunteers working from home; and a loss of funding. Nevertheless, innovation and positive impacts were reported including: modernisation of services; expanding access for some groups (younger people, men, rural communities); increased cohesion amongst staff; and instigation of local collaborations.

Conclusions UK bereavement services rapidly transformed during the pandemic, despite significant challenges. Important lessons have been learned and providers generally advocate a blended approach for future provision of bereavement support. To ensure positive changes are retained, the experiences and acceptability of new/adapted services among clients and staff require further investigation, while services' ability to meet demand requires sustained or additional resources.

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DID THE GOLD STANDARDS FRAMEWORK (GSF) SUPPORT NIV WITHDRAWAL DURING THE COVID-19 PANDEMIC?

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Introduction Despite this year's challenges with Covid-19, the data collected by Dudley Group Foundation Team has offered assurance that GSF has continued to be embedded across the hospital with improved identification of patients in the last year of life, enabling an individual plan of care and continued use of data to drive improvements. There has been local variation with the level of Specialist Palliative Care (SPC) support for COVID-19 patients and withdrawal of NIV. Local guidelines vary and these can be compared with the Association for Palliative Medicine guidance developed. This review was carried out to look at practice in Dudley Group NHS Foundation Trust.

Method Retrospective review of 20 randomly selected COVID deaths whereby NIV had been used outside of the ITU setting between November 2020 and February 2021.

Results Over a third of patients were on NIV for 1 day only. A decision to withdraw NIV was made in 65% (13/20) of cases reviewed and the remaining 35% (7/20) died with NIV in place. Good discussions were documented around NIV withdrawal with the patients where they had capacity (7/13) and 100% with family. For those that died with NIV in place there were discussions with family regarding an individual plan of care.

Seventy five percent of cases reviewed had anticipatory medication prescribed, however, none required a syringe driver. None of the cases reviewed were referred to the specialist palliative care team and 100% had a DNACPR in place.

Conclusion The results illustrate that none of the cases resulted in referral to the SPC team, however, there was evidence of good discussions and provision of anticipatory medication via the sub-cutaneous route. This suggests that the GSF has supported the respiratory team in providing individualised, good end of life care without the need for Specialist Palliative care input for all cases of NIV withdrawal.

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HAS A GLOBAL PANDEMIC HELPED DOCTORS TALK ABOUT CEILINGS OF CARE, AND CAN WE KEEP IT GOING? LOOKING AT MEDICAL ADMISSIONS IN A DISTRICT GENERAL HOSPITAL AS IT RECOVERED FROM THE FIRST WAVE

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Background Admission to hospital is associated with significant mortality.¹ Admission should prompt early consideration of ceilings of care (CoC) to ensure appropriate treatment provision. Delays in these decisions can lead to care mismatched with patient wishes, inappropriate escalation, delays in palliation, less time to come to terms with prognosis for patient and loved ones, as well as difficulties for staff out of hours. The post-take ward round (PTWR) often represents the most appropriate time to discuss CoC, as comprehensive patient information and consultant support are available. During the first wave of the Covid-19 pandemic, emphasis was put on early decision making and communication of CoC.²

Aim To ascertain if one month after first lockdown, as the hospital was recovering and normalising, whether early decision-making regarding ceilings of care continued.

Method PTWR proformas and Respect forms for 50 medical patients admitted to Alexandra Hospital Redditch during February 2020 were audited for CoC documentation. Due to the covid-19 pandemic, the UK went into lockdown from March to July 2020. Over one month later, in August 2020, a second audit of 50 patients was completed

Results From pre-covid to one month after lockdown was lifted, CoC documentation at PTWR increased from 4% to 18%. For patients aged over 70, documentation increased from 6% to 23%.

Discussion Results were likely heavily influenced by the unprecedented covid-19 pandemic. These results are likely due to more pro-active clinical decision making as a result of the acute crisis, awareness of bed pressures and a shift in perception of the importance of CoC. Potential alternative reasons include raised public awareness prompting patient-led

discussions, or increased openness to care planning. Despite this, there is still room for further improvement in discussion and documentation of CoC as we continue to rebound from this crisis.

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ADVANCE CARE PLANS: CREATION, CONTENT AND USE DURING WAVE 1 OF THE COVID-19 PANDEMIC. AN ANALYSIS OF DATA FROM COORDINATE MY CARE, A LARGE ELECTRONIC PALLIATIVE CARE COORDINATION SYSTEM

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Background Mortality predictions as the COVID-19 pandemic began highlighted a need to prepare adults for possible severe illness, encouraging engagement with Advance Care Planning (ACP).

Aim To explore ACP activity and engagement during the COVID-19 pandemic.

Methods A retrospective cohort study, comparing the creation, content and use of Coordinate My Care (CMC) records, the Electronic Palliative Care Co-ordination System in London, during and prior to the onset of COVID-19. Records for patients aged 18+, created and published in the pre-pandemic period (2018–2019) and ‘wave 1’ (W1) of COVID-19 (20/03/20–04/07/20) were included. Demographics, the ACP-related content, and the use of CMC records created were compared using descriptive statistics.

Results 56,343 records were included (35,108 pre-pandemic period and 21,235 W1). During W1, the mean records created each week increased by 296.9% ($P < 0.005$). More people creating records at this time were aged below 80 (39.9% vs 35.1% pre-pandemic, $P < 0.005$) and had WHO performance status 0–1 (17.7% vs 11.63% pre pandemic, $P < 0.005$). Less people who created records during W1 had an estimated prognosis of days - weeks (9.0% vs 16.7% pre-pandemic, $P < 0.005$), were ‘Not For Resuscitation’ (61.8% vs 70.3% pre-pandemic, $P < 0.005$) and had a Ceiling of Treatment of ‘Symptomatic Treatment Only’ (8.1% vs 14.0%, $P < 0.005$). More patients in W1 listed hospital as their preferred place of care (PPC) and preferred place of death (PPD) (PPC: 13.3% vs 5.8% pre-pandemic, $P < 0.005$. PPD: 14.0% vs 7.9%, $P < 0.005$). Average monthly non-urgent and urgent record views rose by 320.3% ($P = 0.02$) and 154.3% ($P = 0.01$) in W1.

Conclusion A marked increase in ACP activity is shown during wave 1 of the pandemic. Amplified engagement, provision and awareness at this time is suggested by increased use among younger, more independent patients with longer prognoses and a higher preference for hospital care creating records in W1 compared to before the pandemic.

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THE IMPACT OF ADVANCE CARE PLANNING ON PLACE OF DEATH DURING THE COVID-19 PANDEMIC: AN ANALYSIS OF DATA FROM COORDINATE MY CARE, A LARGE ELECTRONIC PALLIATIVE CARE COORDINATION SYSTEM

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Background Anticipated severe illness at the start of the COVID-19 pandemic brought increased endorsement, awareness and provision of advance care planning in adults with serious illness. Place of death is often considered a surrogate quality indicator for end-of-life care.

Aim To examine the impact of advance care planning on place of death for patients who died during the COVID-19 pandemic with a Coordinate My Care (CMC) record, the Electronic Palliative Care Coordination System currently commissioned in London.

Methods Retrospective non-interventional cohort analysis of CMC records for patients aged over 18 who died between 20/03/20 and 05/03/21 with recorded place of death. Patient demographics, socio-economic position and advance care planning related factors associated with achieving preferred place of death were explored using logistic regression.

Results 11,913 records were included. 76.9% patients died in their preference place of death (57.7% Home, 31.4% Care Home, 7.5% Hospice, 3.3% Hospital, 0.1% Other). A higher likelihood of dying in the preferred place was associated with a ‘Not for resuscitation’ (DNACPR) status (OR=1.55, 95% CI 1.23 to 1.95), a Ceiling of Treatment for ‘Symptomatic Treatment’ (when compared to ‘Full active treatment’, OR=3.55, 95% CI 2.78 to 4.53), discussions with family regarding resuscitation recommendations (OR=1.53, 95% CI 1.34 to 1.74) and at least 2 non-urgent care record views in the 30days before death (OR=1.27, 95% CI 1.23 to 1.43). Patients from areas of lower socio-economic position had a decreased likelihood of dying in their preferred place (OR= 0.65, 95% CI 0.54 to 0.79).

Conclusion Components of Advance care planning carry potential to significantly influence place of death, even in times of crisis and when controlling for socio-economic and demographic determinants. Effective advance care planning is fundamental to achieving patient-centred, high-quality end-of-life care and factors relating to it must be considered in ongoing research on end-of-life outcomes.

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A SERVICE EVALUATION OF THE TELEPHONE CONSULTATION SERVICE AT ROYAL TRINITY HOSPICE

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Background During the Covid-19 pandemic, remote consultations were widely adopted. However, the evidence base is limited and the role in palliative care settings remains to be established.¹

At Royal Trinity Hospice, the majority of face-to-face community visits changed to telephone consultations from March 2020. The primary aim of this service evaluation was to assess patient and staff satisfaction with telephone consultations.