(SPCT) collaborated with ED clinicians and mangers to provide a 5-day service working proactively into the ED while also delivering an 'on-the-floor' teaching package. Prospective data regarding the patient outcomes were collected over the course of one year (to November 2021) and compared to data from the SPCT database from the previous year. A retrospective evaluation of the impact of the education package was conducted.

Results In 2019/20 5 patients were seen by the SPCT in the ED: in 2020/21 this had risen to 168. 38 patients were discharged home for end-of-life-care from the ED: 37 were transferred to a Palliative Care Unit (PCU) from the ED and 91 were admitted to other wards within the hospital. 2 patients died in the ED with support from the SPCT. 30 clinicians participated in the training, and demonstrated an increase in confidence scores in 3 key domains: setting up a syringe driver, discharge from the ED and prescribing of anticipatory medication in the ED.

Conclusion Targeted palliative care input within the ED can support patients with symptom control and to be in their preferred place of care. An 'on-the-floor' education package can be successfully delivered even in a pandemic. Specific skills are required from SPCTs in this hyper-acute environment.

P-107 ROLE OF CLINICAL PHARMACIST IN A CROSS ORGANISATIONAL ROLE OUT-OF-HOURS

Janki Patel, David Barclay, Declan Cawley. *St Wilfrid's Hospice, St Michael's Hospice*

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Background East Sussex has two hospices, St Wilfrid's Hospice (SWH) and St Michael's Hospice(SMH), sandwiched between one acute trust(ESHT), that spans community services as well as the Clinical Commissioning Group. The clinical pharmacist role has seized the collaborative opportunity with organisations investing in this approach offering continuity, scanning opportunities for co-creation of projects and an understanding of issues across the health and social care space. The need for this role within hours is self-evident but the out of hours need is uncertain.

Method Data was prospectively collected, identifying frequency, nature and context of call as well as caller details, over a four month period (August - November 2021) where the pharmacist was not within their contracted hours but advice sought.

Results 18 contacts were made out of contracted hours; 28% (5/18) from SMH, 55%(10/18) from SWH and 17%(3/18) other (CCG, GP and ESHT) with 44%(8/18) contacts being doctors (4(senior clinician)) and 56%(10) from other healthcare professionals. 39%(7) calls were procurement related calls with calls ranging from 2 to 65 minutes. (39%)7 of the calls were made for non-hospice community patients and 61%(11) from in-patient units. Calls varied from 3- 6 per month, with 61%(11/18) of calls answered needing a clinical pharmacist involvement whilst others (7/18), could be dealt with by another healthcare professional.

Conclusion The data supports the need for clinical pharmacist advice out-with their contracted hours but across the wider health and social care space. As Integrated Care Systems (ICSs) evolve, the need for access to emergency medications particularly, in managing a patient at the end of their life is critical, needs careful consideration. Specialist commissioned access to specialist pharmacist advice across organisations and out-of-hours is a great opportunity to co-create a system wide service that aims to service the very professionals, patients and their families at the very heart of wider integration.

P-108 ST OSWALD'S HOSPICE AMBULATORY CARE SERVICE DEVELOPMENT

Jolene Brown, Owen Lever, Kath Clark, Jennifer Saunderson. *St Oswald's Hospice*

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Background For patients with chronic, life limiting haematological conditions such as Myelodysplastic syndrome (MDS), regular transfusion for relief of symptoms of anaemia requires frequent attendance to acute hospital. Literature demonstrates MDS is associated with significant impairment and poor prognosis with critical palliative care needs.[1] Opportunities to address these needs can be challenging in an acute environment.

The Covid-19 pandemic led to a revision of services offered in St. Oswald's Hospice Day Services with the development of a new Ambulatory Care service for patients requiring blood transfusion. This involves working with specialities to offer services to patients who would benefit from earlier palliative care support.

Method Following a successful pilot service we have continued to capture patient experience, patient need to access services available from palliative care MDT whilst working collaboratively with Haematology and Oncology services.

Records were kept of MDT services accessed alongside collated patient feedback.

Results From March to October 2021 there have been 13 patients with 86 attendances for blood transfusion:

- All patients had initial assessment with a senior palliative medicine Doctor
- 5 patients have engaged in Advance Care Planning discussions
- 3 patients reviewed by Physiotherapy
- 6 patients received complementary therapy
- 1 patient reviewed by social worker
- 5 patients had medical review for specific symptom management
- 1 patient assessed by lymphoedema specialist
- 2 patients referred to music therapist
- 1 patient admitted to the inpatient unit for observation overnight
- 1 patient admitted for end of life care after outpatient attendance
- Feedback has been very positive from patients and their families

Conclusion Patient feedback has been very positive with patients accessing palliative care services and engaging in ACP. Increasing the number of referrals to the service will continue to widen access to patients not typically referred until later in their disease process, promoting improved quality of life and Advance Care Planning.

REFERENCE

1. Nickolich M, El-Jawahri A, LeBlanc TW. Palliative and end-of-life care in myelodysplastic syndromes. *Curr Hematol Malig Rep* 2016;**11**:434–440.