

Background Complementary therapy is highly valued by palliative care patients (Armstrong, Kupeli, Flemming, et al., 2020. *Palliat Med.* 34:1332; Zeng, Wang, Ward et al., 2018 *J Pain Symptom Manage.* 56: 781). Suspended services in April 2020 due to COVID-19 restrictions highlighted our reliance on in-person therapies, with no alternatives for patient care. When services resumed in February 2022, we took the opportunity to reimagine our offering.

Aims To design services that could run both in-person and online. To define a wellbeing pathway that included in-person therapy, plus a wider variety of self-empowerment education. To offer more relaxation and mindfulness techniques (Proud, 2017. *BMJ Support Palliat Care.* 7:A55) that could be practised at home and did not depend on in-person therapy.

Methods In February to April 2022 a roll-out of services took place. Firstly, the reinstatement of in-person therapies, secondly the offering of online weekly relaxation sessions and in-person meditation sessions. From feedback and discussions with users and staff, education sessions were developed covering identified areas of challenge. All the education sessions, group relaxation and meditation services can be carried out online.

Results There has been a great uptake of services with patients embracing all avenues available.

- In-person therapies average 35 bookings per month.
- Online relaxation sessions have opened a new avenue for patients who are shielding.
- Education sessions are currently face-to-face but could be run online. All include techniques that can be carried out at home.
- Feedback has been overwhelmingly positive with 100% 'Very Good' ratings.

Conclusion The first phase of reopening complementary therapy services has been met with very positive feedback from our patients. Reimagining what we offer has expanded services and allowed more flexibility. Additional learning is that some patients actually prefer online sessions as they are easier to access and safer. These patients report the same high levels of positive feedback. We are planning to expand with music therapy (Gutgsell, Schluchter, Margevicius, et al., 2013. *J Pain Symptom Manage.* 45:822) and an online meditation and resources library.

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OUTCOMES FROM AN INDEPENDENTLY COMMISSIONED REVIEW OF ACORNS CARE SERVICES

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Background Acorns recognised that children's hospice care needs to evolve. In July 2020 we commissioned NCB to undertake an independent strategic review of our care service. We were presented with the final report and recommendations in Feb 2021.

Aim(s)

- To align future service and demand based on projected needs and local and national commissioning intentions.
- To sustainably and effectively resource and deliver services.
- To inform our Strategic Plan 2021 -2024.

Methods Jul. – Oct. Reviewed data/academic studies to estimate demand.

Sept. – Dec. Focus groups and stakeholder engagements.

Dec. – Jan. 2021. Sets of challenge panels with staff and service users to test recommendations.

Results The review made a strong case for evolution and change, acknowledging that children are living longer with life-limiting conditions resulting in greater clinical complexity in the conditions of many children. There were nine recommendations:

1. Strengthen the Family Teams' offer.
2. Jointly fund clinical posts.
3. Consider access pilots.
4. Develop an 'Acorns Care' tier of support for children receiving less intensive clinical input.
5. Review a clinical development strategy across the three hospices.
6. Monitoring bed occupancy and demonstration of value to commissioners.
7. Work with other providers to develop a shared vision for children's palliative care.
8. Establish inclusive staff working groups to support areas of change.
9. Key characteristics: Responsive, efficient, integrated, transparent, united.

Conclusions The Review provided a platform for change, as we emerge from the global pandemic there is appetite from our stakeholders for our specialist services to meet priorities for the future. Our change management programme is ensuring the views of the children and families remains central.

How innovative or of interest is the abstract? We hope that sharing our learning will benefit colleagues from across children's hospices by seeing a different optic into our specialist sector.

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REASSESSMENT AS A TOOL FOR INCREASING CONFIDENCE TO RE-ENGAGE WITH ACORNS CLINICAL SERVICES POST-PANDEMIC

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Background During the height of the pandemic and for many months after, as many families were readjusting to life with children going back to school, many families of children with life-limiting conditions were still securing themselves in their homes, afraid to send children to school, afraid of bringing disease back from shops or public places while feeling very isolated and thoroughly exhausted. Prior to the pandemic, Outreach provided vital short breaks in the home, allowing families and care givers to take a break to do some shopping, housework, take other children to an activity or birthday party, or spend some time looking after their own wellbeing by visiting the hairdressers or going to the gym.

Aims To determine the suitability of Outreach nurses reassessing children and adding a layer of confidence that families could allow children to return to in-house care at Acorns, or choose to continue with Outreach visits if they preferred that model of care. In line with our strategic plan for 2022-23,

we will increase our reach to unique children by offering Outreach as a core service.

Methods Reinstating outreach, a team of qualified nurses, in July 2021, re-engaging with families who had little or no contact with Acorns through the pandemic through reassurance that we kept children safe through effective use of immunisation, testing and PPE.

Results Capturing the changes in development and care needs of those who had not engaged with us in 18 months, other than by having regular virtual contact from the family team, we were able to reassure families that re-attending the hospice would be safe for children and give families the much needed break from the intensity of caring. Some families chose not to come in-house, but appreciated the outreach model.

Model to be rolled out to families newly referred to Acorns to build relationships with Clinical Services.

P-130 'HE HAD TOO MUCH LIVING TO DO TO TALK ABOUT DYING': AUDITING ADVANCE CARE PLANNING IN A YOUNG ADULT POPULATION

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Background Advance care planning (ACP) is a process and encourages individuals to have timely conversations regarding their future care needs with those they wish to have involved. Such discussions and planning require a whole 'community' approach – family, health, and social care - with the overall aim of improving the individuals' quality of life and ensuring that their wishes are known.

Unfortunately, discussions around a young adult's (YA) deteriorating health, their wishes, their preferences around escalation of treatment, their preferred place of care and preferred place of death rarely happen in practice as they are thought to be difficult to have or not appropriate during times of wellness.

Aims To access the documentation of ACP documents within electronic case notes at the hospice, and the completion of the ACP summary held on the regional health board clinical portal.

Objective To ensure that the YA's ACP, specifically their wishes and preferences, is completed and communicates effectively between their health care givers.

Results Despite developing solid therapeutic relationships with the YAs and their families on the caseload at PPWH, and often discussing worries about the future, ACP documentation is not consistently captured within the hospice; the shared clinical ACP on clinical portal is not being completed, and Key Information Summaries (KIS) are incomplete and out of date.

Discussion There is a lack of patient-centred end of life and ACP discussion and little evidence of effective sharing of information for this population: this is concerning in a group of YAs who are clinically exceptionally vulnerable and at risk of sudden deterioration. These discussions are best had throughout the individual's journey from diagnosis, incorporating regular, honest, and open communication initiated by those involved in the YA's care, allowing them to be documented and communicated quickly and succinctly to ensure if

something does change quickly, the YA's wishes are known, respected, and heard.

P-131 IMPROVING A HOSPICE ADMISSION PROCESS WITH THE RESPONDING TO URGENCY OF NEED IN PALLIATIVE CARE (RUN-PC) TRIAGE TOOL

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The North London Hospice is an 18-bedded hospice in North London, also providing community specialist palliative care to three local boroughs. Patients are admitted either for management of complex needs or for care in the last days of life, with an average length of stay of approximately two weeks.

The RUN-PC triage tool was developed in Melbourne, Australia and published in 2019 (Russell, Philip, Wawryk, et al., 2021. *Palliat Med.* 35:759). It was originally implemented at the North London Hospice in 2020 following staff and service user feedback expressing dissatisfaction with the length of time between referral and admission, particularly when patients did not achieve their preferred place of death.

Use of the tool was reviewed in 2021 as part of ongoing quality improvement work. Initially a period of observation was undertaken in order to first describe the current triage process, then to identify opportunities for improvement. Baseline data included; average waiting time, compliance with recommended response times as per the RUN-PC manual, and inter-rater reliability. The main areas identified for potential improvement were; frequent absence of a RUN-PC score when patients were initially prioritised at the daily bed meeting, lack of application of the recommended response times, and variation between scorers.

Interventions to date have included using the recommended response time to establish the order in which patients should be admitted, and the development of additional scoring guidance to reduce variability and minimise the impact of pressure from referrers, patients, and family members. Currently referrer satisfaction has improved with evidence of a reduced average waiting time. Efficiency of bed meetings has also improved with more reliable scoring providing confidence in the triage process.

P-132 IMPLEMENTATION OF A NURSE MANAGED BEDS SERVICE FOR END OF LIFE CARE AND AN AUDIT OF THE LAST SIX MONTHS' PRACTICE

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Background The Health Needs Assessment for end of life care in the city has clearly identified the need for hospice care for those in the last few days/weeks of life. Part of the hospice's five year strategy highlighted the intention to implement nurse-managed end of life care beds within the inpatient unit (IPU), offering end of life care to dying patients with