The format was kept the same (discussion regarding advice lines calls, all referrals, agreeing the number of beds offered and the patients to be allocated to these beds). The change was to have active input (via MS Teams link) from the referring teams and up-to-date information about the referred patients.

**Aims** To evaluate if the new model of meetings integrating the community and hospital SPC teams would change perception of fairness and equitable use of beds in our hospice IPU.

**Methods** A short evaluation questionnaire was sent to the participating teams with a combination of open/closed questions and opportunity for comments.

**Results** The respondents said the service has improved the admission process, the patients are discussed in enough detail to enable prioritisation, decisions about admissions are fair and consistent, the meetings are extremely beneficial, the view of each team is always respected and all teams work well together to ensure the most appropriate patient is admitted.

**Conclusion** This new model of collaborative working has proven beneficial for prioritisation of hospice referrals in real time and has also contributed to an improvement in communication and team work.

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**REFERENCES**


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**INNOVATIVE THINKING- COLLABORATIVE WORKING: A NOVEL APPROACH TO PRIORITISING INPATIENT REFERRALS BY CHANGING COMMUNICATION METHODS**

**Aurelia McCann, Lisa Tate, Jennifer Klimiuk, Hephzibah Shanti, Jenny Gallagher. Bolton Hospice**

**Background** Hospice referrals for inpatient unit (IPU) admissions are discussed daily by the hospice medical and nursing teams, with decisions to admit based on the referral information and multidisciplinary team decision-making. The referring teams were previously not directly involved in these decisions. Our recent development was the introduction of virtual meetings, aiming to involve the referring community and hospital palliative care teams to the daily decision making process regarding inpatient bed allocation at our hospice.

The new initiative started in February 2022 as Microsoft (MS) Teams meetings coordinated by the patient liaison nurse. Attending members were: hospice team, allied health professionals, social workers and community and hospital specialist palliative care (SPC) teams.

The format was kept the same (discussion regarding advice lines calls, all referrals, agreeing the number of beds offered and the patients to be allocated to these beds). The change was to have active input (via MS Teams link) from the referring teams and up-to-date information about the referred patients.

**Aims** To evaluate if the new model of meetings integrating the community and hospital SPC teams would change perception of fairness and equitable use of beds in our hospice IPU.

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**IMPLEMENTING RESPECT DURING THE PANDEMIC – OUR EXPERIENCE AND LESSONS LEARNT**

**Hannah Jennens, Nicola Wise, Benoit Ritzenthaler, Mark Whitney. The Royal Wolverhampton NHS Trust**

**Introduction** ReSPECT was implemented in The Royal Wolverhampton NHS Trust and across the wider Wolverhampton health economy on 1st September 2021. This was the culmination of a year’s planning and preparations during the first and second waves of the COVID pandemic.

**Methods** A ReSPECT implementation group was established across the organisation in September 2020 which focused on areas including writing a revised resuscitation policy, agreement for and design of one-off mandatory modules for awareness and authorship training and development of a trust wide communications campaign. Amendments to the policy have allowed expansion of authorship to selected groups of non-medical staff including senior specialist nurses and ACPs with appropriate expertise.

The group liaised with partners to ensure a successful city-wide launch including primary care and hospice colleagues. An organisation wide roll out was supported by ward ‘ReSPECT Champions’ in each area.

**Results and Lessons Since Launch** Mandatory training modules for ReSPECT authorship and awareness training were developed for approximately 7000 clinically facing staff with a target of 75% training compliance prior to launch. Training compliance was monitored weekly in preparation for launch and then subsequently, monitored monthly once target compliance was achieved. Over the last year ReSPECT has become embedded within the organisation and across the city. This has included a change in culture from the previously used DNACPR forms. Developments following launch include an addition to e-discharge document to include whether a ReSPECT form is in place and from this a monthly quantitative audit has begun across inpatient areas. Collaborative working has continued across the city to enable clear

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**REFERENCES**


Understanding the Benefits and Limitations of a Blended Approach (Mixing Virtual and Face-to-face Consultations) to Medical Outpatient Palliative Care Services: A Mixed-Methods Study

Caradoc Morris, David Waterman, Lesley Anne Henson. St Ann’s Hospice

Background: The Covid-19 pandemic led to a rapid increase in the use of virtual technologies (telephone; video) across healthcare. For palliative care patients, further evidence is required to inform integration of virtual technologies with traditional face-to-face consultations.

Aim: To understand the benefits and limitations of a blended approach (mixing virtual and face-to-face consultations) to medical outpatient palliative care consultations.

Methods: A mixed-methods study with a concurrent triangulation design was conducted. Phase 1 comprised an anonymous online survey of palliative medicine physicians in the UK. Survey questions were derived following a review of the literature and explored physicians’ experiences and opinions of different consultation modalities. Phase 2 comprised qualitative semi-structured interviews with palliative medicine patients exploring their perspectives of virtual and face-to-face outpatient clinics. Patients were recruited from palliative medicine outpatient clinics and interviewed via Microsoft Teams. Results from both phases were integrated and recommendations for clinical practice developed.

Results: The online survey received 48 responses from professionals, and eight semi-structured patient interviews were conducted. Patients and physicians felt face-to-face consultations were necessary for clinical assessments and improved communication and relationship building. The main challenge was the physical burden from travel. Telephone consultations were useful for simple and finite problems such as medication reviews, but the physical separation introduced communication barriers and prevented clinical assessment. Video technologies supported physically-limited patients to access clinics and allowed for some clinical assessment to occur. The most appropriate modality for breaking bad news and/or providing psychosocial support was felt to be patient and situation dependent.

Conclusion: The use of a blended approach to palliative medicine outpatient clinics is acceptable to patients and physicians and has the potential to capitalise on the benefits of each modality to deliver an effective and efficient service.

Improving End of Life Care Decision Making Across North Wales

Charlie Finlow, Alison Foster, Gemma Lewis-Williams, Marlise Poolman, Ben Thomas. Betsi Cadwaladr University Health Board

Background/Introduction: Treatment and care towards the end of life (EoL) often involve decisions that are clinically complex and emotionally distressing. Patients’ decision-making needs to be supported by appropriate, individual, timely discussions with clinicians and those important to them. In North Wales, the support for end of life decision-making (EoLDM) is fragmented and uncoordinated.

Aim: We undertook a detailed exploration of EoLDM in North Wales to inform a quality improvement (QI) strategy.

Methods: We mapped components of EoLDM and examined those via individual and group interviews with stakeholders based on normalisation process theory constructs. We checked alignment with local and national guidance, contextualised findings utilising previous regional work, and prioritised QI topics.

Results: Examination of EoLDM components (discussions, documentation, acting on decisions and governance) revealed well-known barriers (e.g. time constraints, lack of universal