cycle 1 (30%) to cycle 2 (55%). Additionally, there was a decrease in the mean length of time from recommendation to administration (213 minutes 1st cycle and 172 minutes 2nd cycle).

Conclusion Initial interventions including educating ward staff and palliative care link nurses, plus the introduction of syringe driver board magnets to highlight patients with CSCI may have had some impact on CSCI practice at LRI. Continued work is needed to maintain the momentum of this project and sustain change. Incorporating CSCI alerts and reminders into the hospital electronic system represents an important next step, along with empowering and supporting wards to monitor their own practice routinely. The work is due to be replicated at other UHL sites.

106 NOT ANOTHER BLOODY AUDIT

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Background Red blood cell transfusion has historically been used to treat the symptoms of anaemia in palliative care. However it has been demonstrated that investigation of anaemia and alternative treatments may improve symptoms without the risk of transfusion associated complications.[1]

Aims To evaluate blood transfusion practice in Marie Curie Hospice Bradford and compare this to National Institute for Health and Care Excellence Guidelines,[2] and Recommendations for Palliative Care Practice from a National Comparative Audit in red blood cell transfusion.[1]

Method A retrospective analysis of electronic notes for the period 2018–2020 was undertaken to identify all patients referred for red cell transfusion. Notes were reviewed in detail to establish the clinical information around each transfusion.

Results Out of a total of 38 patients referred for consideration of transfusion, 35 (92%) went on to receive red cells. Only 47% of patients had haematinics checked prior to transfusion. 74% of patients received 2 units of blood in one treatment episode but only 14% had their weight assessed. A TACO risk assessment was documented in 66%. Discussions with the medical team identified that patients referred to the service had the expectation of receiving a blood transfusion prior to the completion of a medical assessment at the hospice, and that these expectations impacted upon the decision to offer transfusion.

Conclusions An 'Anaemia Assessment Clinic' was developed. An electronic template now prompts clinicians to ensure patients have haematinics investigated and managed, a weight recorded and a discussion about the evidence based risks and benefits of transfusion. Guidance was written for both the outpatient and inpatient settings to ensure a restrictive transfusion threshold is used and to reduce the risks of transfusion associated circulatory overload.

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107 AMBITIONS FOR PALLIATIVE AND END OF LIFE CARE: FINDINGS FROM A MAPPING SURVEY ABOUT THE USE OF THE NATIONAL FRAMEWORK

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Introduction The Ambitions for Palliative and End of Life Care: a national framework for local action (2015) and relaunched in 2021 for an additional five years. Developed through partnership, the Framework provides a vision for action focused on six ambitions underpinned by eight foundations.

Methods An online survey to map usages of the Framework comprised of closed and open questions. Survey questions sought information on: primary Ambition(s) guiding the work; how the Framework was understood to enable this work; and, perceived challenges to use of the Framework. Responses were accepted between 30th November 2021 and 31st January 2022 via the JISC online survey platform; only full responses were recorded minimising missing data. Data for closed questions were analysed for frequency. Answers to the question about policy context were coded by content to produce a quantitative overview. Other qualitative free-text comments were analysed to identify recurring themes.

Results A total of 45 examples were collected covering all geographical areas. Most examples came from hospice and/or specialist palliative care settings. Each person is seen as an individual (Ambition 1) was most frequently identified as a primary focus for services. Each community is prepared to help (Ambition 6) was least frequently identified as a primary focus for services. The Framework is most frequently being used to provide guiding principles and to support education and training. Survey respondents perceive the Ambitions Framework to be providing a shared language about what matters in palliative and end of life care.

Conclusion Our findings suggest that there is appetite for further education and knowledge exchange about the Framework and how people have used it. We identified current gaps in the implementation of the Framework and suggestions on how to use the Ambitions document. A full report is available (Borgstrom et al. 2022).[1]

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108 SERVICE EVALUATION REGARDING THE IMPLEMENTATION OF THE NATIONAL EARLY WARNING SCORE 2 (NEWS2) IN PALLIATIVE CARE

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Introduction NEWS2 has been shown to improve outcomes in areas including mortality and serious adverse events.[1, 2] Little is known about its use in palliative care. A CQC review recommended NEWS2 be implemented at Barnsley Hospice to aid identification of deteriorating patients. This raised concerns whether this would impact on individualised holistic hospice care. Our neighbouring hospice St Gemma's kindly shared

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their guidelines and escalation form regarding incorporating NEWS2. Following implementation all patients on admission would have an escalation form documenting discussions regarding frequency of routine observations, baseline NEWS2, escalation and resuscitation status. The purpose of this service evaluation was to assess whether the escalation tool and NEWS2 could be appropriately embedded within the hospice and enhance patient care.

Methods Data was collected weekly from 9.10.22 to 25.10.22 recording whether patients had an escalation form completed on admission. It also recorded whether they had a NEWS2 and whether this had been escalated appropriately, based upon their clinical status and agreed treatment plan.

Results A total of 51 data sets were collected. This included 26 patients, some of whom had multiple data sets due to admission length. All 51 data sets had an escalation form completed. 76% had a NEWS2 chart in place. The remaining 24% were all supported by a last days of life care plan. Out of the 111 observations recorded only one was not escalated appropriately. In this case twice daily observations had been part of the treatment plan but on one occasion they had only been done once daily. There was no clinical impact of this.

Conclusions The NEWS2 was appropriately implemented at Barnsley Hospice to support the recognition of patients who are clinically deteriorating and may benefit from escalation. In addition, rather than detract from delivering holistic care it has supported escalation discussions and advance care planning.

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109 EFFECT OF AN INTEGRATED PALLIATIVE AND ONCOLOGY CO-ROUNDING MODEL ON AGGRESSIVE CARE AT THE END OF LIFE – SECONDARY ANALYSIS OF AN OPEN-LABEL STEPPED-WEDGE CLUSTER-RANDOMIZED TRIAL

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Background We recently reported on an integrated palliative care and medical oncology co-rounding model that significantly reduced hospital bed days. We postulate that the co-rounding model may also have an effect on reducing care aggressiveness.

Objectives To compare the effect of a co-rounding model versus consult model (usual care) in reducing receipt of aggressive treatment at end-of-life.

Methods Secondary analysis of an open-label stepped-wedge cluster-randomized trial comparing two palliative care models within the inpatient oncology setting. The co-rounding model involved pooling specialist palliative care and oncology into one team for daily rounds, while the consult model constituted discretionary specialist palliative care referrals by the oncology team. We compared the odds of receiving aggressive care at end-of-life – acute healthcare utilization in last 30 days of life, death in hospital and cancer treatment in last 14 days of life between decedents within both arms.

Results A total of 2145 patients were included in the analysis, and 1803 patients died by 4th April 2021. There was no significant difference in survival between either model of care ($p = 0.12$). Compared to the consult model, the co-rounding model was not associated with significant differences in aggressive care at the end-of-life. The odds ratios and 95% confidence intervals were: 0.67 (0.26–1.51) for ICU admission, 0.91 (0.60–1.36) for 2 or more ED visits, 1.16 (0.87–1.53) for 2 or more hospitalizations in the last 30 days of life; 1.03 (0.83–1.28) for death in hospital; 1.27 (0.66–2.38) for chemotherapy in the last 14 days of life.

Conclusion The co-rounding model within an inpatient setting did not reduce aggressiveness of care at end-of-life. This could be due in part to the overall focus on resolving episodic admission issues.

110 SPECIALIST PALLIATIVE CARE PARAMEDICS

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Background Globally, community healthcare teams struggle to meet the growing demand for effective and responsive palliative care enabling patients to remain at home when appropriate. With this in mind, Swansea Bay University Health Board (SBUHB) have implemented an innovative service development, in which paramedics with enhanced training and support, help achieve this.

Methods Six paramedics were given tailored training in advanced communication skills, end-of-life assessment and symptom management. A review of the triage, circumstances and outcomes of all 157 paramedic visits during one month was conducted to determine unmet need, effectiveness of the paramedic model, its congruity with ongoing community nursing models and its impact upon primary and secondary care workload.

Results Most calls came from relatives of patients already known to the Specialist Palliative Care Team (SPCT). 80% of visits were carried out due to a sudden deterioration in condition or urgent symptom control need. 16% required either prescription and/or administration of 'just in case' medication. Over 50% of GP visits and 22% of secondary care admissions were avoided.

Conclusions Coupled with exceptional feedback from recipients and care providers alike, this review demonstrates palliative paramedics' ability to provide expeditious face to face assessments, symptom management and vital reassurance, as well as to triangulate care between primary and secondary care providers. Issues in relation to procuring and administering prescribed items could prompt new prescribing regulations for Palliative Paramedics. Further review should help streamline this model and could see its expansion in SBUHB and its adoption by other health boards.

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