P-35 WE ARE THE FIRST HOSPICE IN THE UNITED KINGDOM TO BE AWARDED VETERAN AWARE STATUS

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The hospice has been formally recognised as Veteran Aware by the Veterans Covenant Healthcare Alliance (VCHA), a group of NHS healthcare providers in England committed to providing the best standards of care for the Armed Forces community, based on the principles of the Armed Forces Covenant. The Armed Forces Covenant, which recently passed into law, is a promise by the nation ensuring that those who serve, or who have served, in the Armed Forces, and their families, are treated fairly.

The aim is to develop, share and drive the implementation of best practice that will improve Armed Forces veterans' care, while at the same time raising standards for everyone. We identify veterans as soon as they are referred or admitted as a patient to ensure they receive the right care and support. The hospice has appointed Veteran Aware champions and has been reaching out to work with local Armed Forces organisations. We have also shared information and useful links with staff to share with veterans who may need signposting towards additional support.

Over the last year we have identified 56 of our 1,714 patients as being a veteran, a total of 3.3%, which is in line with the most recent census results that showed 3.8% of the United Kingdom population is a veteran. The Veteran Covenant Healthcare Alliance is committed to improving armed forces and veteran care whilst raising standards for all.

P-36 THE SEARCH FOR PARITY: DEVELOPING 24/7 COMMUNITY CARE MODELS AT A CHILDREN'S HOSPICE

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Background Community case palliative and end-of-life care for children and young people (CYP) under the care of a children's hospice in England is provided locally by both statutory and voluntary services using ad hoc funding. NICE guidelines (National Institute for Health and Care Excellence. End of life care for infants, children and young people with life-limiting conditions: planning and management. [NG61], 2019) state that children and young people should have access to face-to-face nursing provision 24/7. However, these services are currently not equitable across the hospice catchment area, which includes three integrated care boards (ICBs).

Aims Funded by Hospice UK, our aim is to scope existing services within one ICB area to demonstrate need, understand gaps, and develop equitable models of care.

Method Data were collected from January 2021 to March 2023 (26 months) examining the number of: (1) children with symptom and end-of-life needs managed at home, and (2) nights the hospice community team were actively on call. Current end-of-life service provision by three children's community nursing (CCN) teams within the ICB was collated.

Results The community team were on call for 14 children (10 for end-of-life support and 4 for symptom management support) and provided a total of 128 active nights on call alongside a silent rota. All CCN teams have different staffing levels and service provisions ranging from 5 to 7 days/week, with some teams flexing according to commissioning and some on goodwill. Developing and delivering equitable service models is complex. A stepped approach to implementation will be necessary and initially, two bespoke models tailored to the needs of each service have been developed: figure 1.

Abstract P-36 Figure 1

CCN Teams 1 and 2:	CCN Team 3:
During the week: Routine syringe driver changes by CCN Teams 1 and 2 and to ask for support from the hospice where needed (not funded).	**During the week:** Routine Syringe driver changes by CCN Team 3 and to ask for hospice support where needed (not funded).
Out of Hours and Weekends: Monday-Friday 1 hospice nurse on call (17.00–08.00) as a second nurse supporting CCN Teams 1 and 2.	**Out of Hours and Weekends:** Monday-Friday 2 hospice nurses on call (17.00–08.00). Second nurse can be a video checker and not required for visit (needs to be risk assessed for each child/visit).
Weekends: 1 hospice on-call nurse supporting CCN Teams 1 and 2 with routine driver change during the day on Saturday, Sunday and Bank Holidays. 1 hospice nurse on call (08.00–08.00 24 hours) as a second checker for CCN Teams 1 and 2.	**Weekends:** 2 hospice nurses to complete routine syringe driver changes during the day on Saturday, Sunday and Bank Holidays. 2 hospice nurses on call (08.00–08.00 24 Hours). Second nurse can be a video checker and not required for visit (needs to be risk assessed for each child/visit).

Conclusions The hospice community team delivers a high volume of care, however, inequitable CCN service provision across the hospice catchment impedes compliance with NICE guidelines. Wide variation in service provision necessitates a stepped approach and two distinct service models. Next steps will be to pilot the models and formalise service delivery/governance to demonstrate sustainability and robust funding need. Pilot implementation and evaluation commencing Autumn 2023.

P-37 RIPEL: RAPID INTERVENTION FOR PALLIATIVE AND END OF LIFE CARE. IS CARE AT HOME USEFUL OR SUSTAINABLE?

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Background Most people would prefer to die at home (Office for National Statistics. National survey of bereaved people (VOICES). 2016), yet less than 50% do (Nuffield Trust. End-of-life-care. 2023). Oxfordshire is an outlier for persons with three or more non-elective admissions during the last 90 days of life at 8.82% (English average 7.4%), (Office for Health Improvement and Disparities. Atlas of variation (Palliative and end of life care), 2018).

Aims To facilitate personalised care including fulfilling end of life choices, whilst reducing days spent in hospital. Analysis of individual elements will indicate cost:benefit ratios to aid conversations around sustainability.

Methods RIPEL consists of four elements: A Home Hospice (HH), Hospital Rapid Response (HRR), Palliative Care Crisis Team (PCCT) and an Enhanced Palliative Care Hub. HH, initiated in April 2022, provides care at home with oversight from the Palliative Care MDT. HRR, launched October 2022, facilitates rapid support and provisions for patients in hospital who are dying, and who have expressed a preference to be at home at the end of their life, to get them home. PCCT focuses on palliative care support to a patient's own home. Alongside expanding our Palliative Care Hub, this facilitates an integrated response to help patients remain in their place of choice. 29 quantitative and qualitative KPIs are assessed across the four elements each month.
Results In year 1, RIPEL accepted 645 referrals, enabling each person on average 15 more days at home instead of hospital in their last year of life. This totals to 6755 days, translating to a net benefit of £587,327. We will provide an update at 18 months.
Conclusion The first two live arms of RIPEL have exceeded expectations. Key to success is co-ordination between elements. Patients are reviewed together daily as a virtual ward facilitating continuity of care and MDT oversight. Complexities are acted on promptly. The final two elements will launch soon, looking to build on the successes so far, allowing many more people to be cared for in their own homes, where this is their choice.

This project receives funding and support from Social Finance, through Macmillan Cancer Support, and from Sobell House Hospice Charity.

P-38 HOSPICE COMMUNITY PALLIATIVE CARE TEAM – A MULTI-FACETED APPROACH TO IMPROVE RESPONSIVENESS

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10.1136/spcare-2023-HUNC.59

Background Demand for our community service has exceeded available capacity for years, leading to longer waiting times and some referred patients dying before being seen. A successful business case allowed team expansion, together with a focus on working more efficiently.
Global aim All referred patients to have a clinical assessment prior to death, and to see 50% more patients.
Methods/actions Adopted continuous improvement methodologies with whole team ownership. We identified a range of actions:

- To support recruitment, we established Clinical Nurse Specialist (CNS) development posts, supported through a structured competency and mentorship programme to become CNSs.
- A new community consultant post.
- Every patient receives an IPOS questionnaire prior to the first assessment, focussing assessments.
- Reviewed holistic assessment documentation.
- Streamlined processes for patients discharged from hospital under rapid discharge pathway including individualised end of life care assessment template.
- Established an urgent response team.
- Established a new cluster structure; developed in the footprints of the Primary Care Networks, to support collaborative working.
- Embedded new triaging structure based on complexity and urgency, managed within clusters.
- Continued to provide the hospice 24/7 advice line: new documentation and processes.

Results/impact Community consultant recruited and two team members have now achieved CNS status with a further two in development. During Quarter 3 2022/23 the number of new patient assessments completed increased by 61% compared with 2021/22, with January and February 2023 increasing by 59% and 73% respectively. Deaths before assessment were lower for each quarter 2022/23 compared to the year before despite increased referral numbers; 44% reduction overall.
Conclusions/future Continue to utilise continuous improvement methodologies, learning from experience and data. Further work needed to reduce number of those dying before assessment. Complete review of 2022 referrals and their timeliness. Projects will focus on ensuring referrals are received earlier, e.g., a collaborative project proposed with our renal team to establish a best supportive care renal clinic.

P-39 A 10 YEAR RETROSPECTIVE OF A SINGLE POINT OF ACCESS

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10.1136/spcare-2023-HUNC.60

Background Palliative and end-of-life care (PEOLC) should be coordinated (Ambitions for Palliative and End of Life Care, 2021) and include access to out-of-hours care (NHS England. Palliative and end of life care: Statutory guidance for integrated care boards. 2022). It is recommended that high-quality out-of-hours community services need to be prioritised as deaths are predicted to increase (All-Party Parliamentary Group Hospice and End of Life Care, 2023). The SinglePoint of access was launched in 2013. The 10-year anniversary offers an opportunity to reflect on the challenges and successes of the last decade.
Aim To develop a telephone triage service for people in the last year of life in North East Essex, including a rapid response visiting service for people in the last year of life.
Method Beginning as a 12-hour service, it was quickly expanded to 24/7. In 2020, due to the first wave of the COVID-19 pandemic, it expanded into a PEOLC hub, coordinating discharges from hospital, fast track continuing health care, and referrals to the community nurse palliative care team, the hospice rehabilitation team and the virtual ward service for people in the last weeks of life. In 2022 the team was expanded by four rotational paramedic roles in collaboration with the local ambulance trust. Its work is supported by a well-embedded Electronic Palliative Care Coordination System.
Results In 2022/23 the service included 32 full time equivalent roles, including call handlers, senior nurses, non-medical prescribers, night time health care assistants, occupational therapy, physiotherapy, and a therapy assistant, in addition to the four new rotational paramedic roles. Last year SinglePoint of access received 45,554 calls relating to 2553 people and delivered 1103 rapid response visits. The average wait for a visit was