The hospice strategy 2020 committed to reshaping services to provide easier access to help and support as many people as possible with life-limiting illness. This was implemented during COVID-19 by establishing the Access Team; a single point of contact for all clinical services. The team has reshaped access to St Columba’s hospice care at the front door:

- Triage referrals to all hospice services and respond to advice calls from professionals, patients and families.
- Respond by phone to all referrals within 48 hours (urgent)/7 days (routine) (KPIs) and keep referrers updated.
- Provide initial assessment and support from first contact.
- Manage all referrals and coordinate admissions to inpatient beds.
- Provide same day response for urgent unscheduled advice requests from patients/families, community/acute health and social care colleagues; and,
- Established stronger and more collaborative links with wider palliative care colleagues.

Establishing a single point of contact for all hospice services has widened access to evolving hospice care. The team has evolved year on year in line with increased demands on hospice services and strategy:

- Increased triage to evolving hospice services, now comprising: Hospice at Home (incorporating – virtual ward, care at home, two locality community teams), Allied Health Professionals, Family Support Team, Wellbeing Service, Compassionate Neighbours service, and Inpatient Unit.
- 26% increase in new referrals over three years.
- Increased unscheduled advice calls (primarily from patients/families for physical symptom control advice and social support issues).
- Proactive carers’ support and social work at the hospice front door.

The Access service has developed within a context of global, national and locally emerging need, providing agile and responsive support to health and social care colleagues, and directly supporting patients and their families by telephone. This has been managed through teamwork and communication.

**Background**

With the demand for hospice care rising and staffing levels unable to increase to meet demand, it was agreed to explore implementing a Single Point of Access (SPA) (Hosking, Gibson. J Med Eng Technol. 2016, 40(5): 265–269) to help support the flow of referrals and ensure referrals go to the right service at the right time. The project is ongoing and has been split into phases, with phase one exploring referral registration pathways (Ewebank, Lamming, Cream, et al. Admin matters: the impact of NHS administration on patient care [Internet]; 2021 Jun 24) and improving the recorded number of referral outcomes.

**Aim**

Re-designing the referral registration process to create a standardised method of inputting referrals and increase the number of recorded outcomes to 75%.

**Methods**


**Results**

Clinical administration use one standardised method of registering patient information, increasing cross cover and reducing silo-working for annual leave and sickness where previously there would be a pause in referral registration. Reduction in paper (one team now 100% paperless at referral). Referral outcomes are now reported through SystmOne with a clear auditable journey. Clinical staff have increased control over flow of referrals and inappropriate referrals being declined at an earlier stage. Quantitative data is still being processed. Initial data shows 75% of recording referral outcomes is being achieved. The data will continue to be analysed and demonstrated through run charts.

**Conclusion**

Following data results, to introduce a single point assessment into the registration pathway to further support the flow of referrals into services and create an online referrals portal for all future referrals into the hospice.
followed by a supported transition to appropriate partner community services. A process evaluation was conducted to explore REACT team members’ experiences of the establishment of the new service model.

**Aims** To evaluate the implementation of the REACT service – what has worked well and what could have been better.

**Methods** We conducted and thematically analysed eight semi-structured interviews with professionals who helped set up and deliver REACT.

**Results** The analysis identified the determination and passion of the REACT team and the culture of collaboration in Bradford as key enablers of the successful implementation of the service. Recruitment issues were highlighted as a major issue, particularly where night shifts were required. There were also recommendations made about the training requirements of the REACT team, because the evolving requirements when establishing a new service created a need for continuous learning.

**Conclusions** This evaluation of the REACT service demonstrated the importance of the confidence, commitment and drive of project staff to the establishment of a new service. It also identified the significance of a broader collaborative approach. Points for consideration were also identified when replicating similar service models in other areas.

**P-43** ADMISSION AVOIDANCE – PREVENTING UNNECESSARY HOSPITAL ADMISSIONS IN THE LAST PHASE OF LIFE

Ross Chirgwin. St Helena Hospice, Colchester, UK
10.1136/spcare-2023-HUNC.64

**Background** With the increased strain on healthcare nationally, all healthcare providers have a duty to prevent inappropriate admissions to an acute hospital (Local Government Association, 2021). Hospices are in a unique position to support patients to remain in their preferred place of care (PPC) by utilising the skills and knowledge of the multidisciplinary team (Spencer. Int J Palliat Nurs. 2015, 21(5):245).

**Aims** To evaluate the role of the hospice in preventing inappropriate admissions to hospital. For the purpose of the audit, admission avoidance was defined as: preventing someone from being admitted to an acute hospital and allowing them to be supported and die within their PPC. The intervention taken place must prevent admission for at least 72 hours.

**Method** The audit took place within the hospice in the home multidisciplinary team over a two-week period. Clinicians informed the auditor if their intervention prevented an admission into hospital. The data was then collated and at the end of the two weeks each patient record was reviewed to confirm that the intervention prevented admission.

**Results** 19/19 patients reviewed were able to remain in their PPC and were prevented from being unnecessarily admitted to hospital. The hospice rapid response team prevented the most admissions, however, this was expected due to the nature of the role and 24/7 working pattern.

Common themes included:

- Rapid assessment, prescribing and symptom control.
- Initiating urgent care packages via the hospice virtual ward.
- Timely advance care planning allowing informed decisions about their future care.
- Urgent admission into the hospice or nursing home placement.
- Joint working with the ambulance service supporting patients to remain in their PPC.
- Provision of urgent equipment.

**Conclusion** The audit has provided evidence that the hospice is actively preventing admissions into the acute hospital. The interventions taken place have supported patients to remain in their PPC by providing timely person-centred care.

**P-44** HOSPITAL ADMISSIONS AVOIDANCE PROJECT

Rachel Mills, Sarah Harries. Hospice of the Valleys, Ebbw Vale, UK
10.1136/spcare-2023-HUNC.65

**Background** There are numbers of unnecessary hospital admissions whereby individuals have been admitted for social reasons and for treatment that could be given in their own home. Working in collaboration, we look to reduce the number of hospital admissions to promote better outcome for individuals and their family/carers.

**Aims** The Hospital Admissions Avoidance Project (HAAP) aims to prevent hospital admissions for patients who are acutely unwell and may require extra support whilst treatment options are administered at home. HAAP also supports carers who are in crisis, therefore preventing an admission.

**Methods** A team of Health Care Assistants will provide day/night care for a period of 5 -7 days. The team can provide personal care, encouragement with food and fluids, prompt medication and offer comfort and reassurance for the individual and carers. Referrals can be made by both medical professionals and social care professionals.

**Results** January 2022 – December 2022. Numbers of referrals: 83. Number of hospital admissions avoided: 78. Feedback received:

“Just to say the two Carers were amazing, not only for my dad, but for myself and my husband. We felt that we could face another day with hope. They were the kindest, patient, and loveliest of human being, I thank them both”.

“It was such a relief to have help, the overnight sits meant that, not only my dad had a night’s sleep (he was exhausted), but we all as a family slept better”.

**Conclusion** Our Hospital Avoidance Admissions Project has steadily grown since its introduction. It has provided support to those within our local community and allows individuals the chance to remain in their preferred place of care.

**P-45** THE DEVELOPMENT OF A PALLIATIVE CARE TRIAGE TOOL

Jenny Warren, Louise Greenaway. Compton Care, Wolverhampton, UK
10.1136/spcare-2023-HUNC.66

**Background** It is common for care to be coordinated by a range of health care professionals and administration staff with varying backgrounds and experience. Many services rely on clinical judgement as their triage tool, potentially resulting in a variation in the type of service and response time offered. A triage tool was devised to enable a standardised response to improve patient experience.

**Aims of the triage tool** Categorise urgency and aid responsiveness. Equitable and fair access to services with a consistent