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-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
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STREAMLINING THE HOSPICE AT HOME TEAM

BMJ Supportive & Palliative Care

for referrals, preferred and actual place of death, caseload, symptom management and support night and day. Service data outcomes as providing specialist nurse visits 24/7 enables locally by our ambitions for palliative and end of life (Ambi-
nurse specialist shift (20:00–23:00) and an on-call nurse specialist shift (20:00–08:00). This is crucial to service outcomes as providing specialist nurse visits 24/7 enables symptom management and support night and day. Service data for referrals, preferred and actual place of death, caseload, discharge and disease, was collated. Funded by a local charity, quarterly board meetings direct service evaluation and development.

Results In two years, 198 patients died, 180 in preferred place of death (ppd) = 91%. 177 patients died at home or care home (ppd) = 98% avoided unwanted hospital admissions. Referrals and deaths increased by 50%. Overnight call-outs increased by 200%. Preventing admission = £755,333 yearly saving (average 10-day admission in final year of life). Average length on caseload = 96 days. Cost = £2,000 per patient.

Conclusion The Integrated Model for Specialist End of Life care is successful, and showcases future specialist end of life care at home.

Background

Douglas (BMJ. 1992, 304: 579) wrote about the hospice movement and innovative future care for the dying 30 years ago. Hospice at Home services have developed nationally in response to local demographics, resources and need. More people want to die at home (Ali, Capel, Jones, et al. BMJ. 2015, 9(1): 84–91), where care should be guided locally by our ambitions for palliative and end of life (Ambitions for Palliative and End of Life Care, 2021).

Aims On January 25th 2021, the Hospice at Home service began, with an aim to provide 24-hour specialist end of life care to enable patients to die at home as their preferred place of care.

Methods

The model is integrated within the health and social care delivery and voluntary sectors, including Marie Curie, Urgent Care Response, and hospice volunteers. Referrals are received for end of life care (General Medical Council, 2010). There are 5.7 whole time equivalent (wte) specialist nurses (Band 6) including an advanced nurse practitioner (Band 7), and 2.4wte assistant practitioners (Band 4). The 24-hour service works with 3-day shifts (08:00–20:00) and an on-call nurse specialist shift (20:00–08:00). This is crucial to service outcomes as providing specialist nurse visits 24/7 enables symptom management and support night and day. Service data for referrals, preferred and actual place of death, caseload, discharge and disease, was collated. Funded by a local charity, quarterly board meetings direct service evaluation and development.

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Conclusion The Integrated Model for Specialist End of Life care is successful, and showcases future specialist end of life care at home.

Abstracts

HOSPICE AT HOME: INTEGRATED MODEL OF SPECIALIST END OF LIFE NURSING CARE AT HOME

Mary Ashley, Royal Devon and Exeter NHS Foundation Trust, Exeter, UK; Hospice at Home, Sidmouth, UK

10.1136/spcare-2023-HUNC.67

Background

Douglas (BMJ. 1992, 304: 579) wrote about the hospice movement and innovative future care for the dying 30 years ago. Hospice at Home services have developed nationally in response to local demographics, resources and need. More people want to die at home (Ali, Capel, Jones, et al. BMJ. 2015, 9(1): 84–91), where care should be guided locally by our ambitions for palliative and end of life (Ambitions for Palliative and End of Life Care, 2021).

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STREAMLINING THE HOSPICE AT HOME TEAM’S PROCESSES TO IMPROVE EFFICIENCY AND JOB SATISFACTION

Emma Louise Fletcher, Charlotte Nickson, Alison Gray, Farleigh Hospice, Chelmsford, UK

10.1136/spcare-2023-HUNC.68

Background During the COVID-19 pandemic, the Hospice at Home (H@H) team were divided into three localities, resulting in an enlarged, but divided, team. Registered Nurses (RNs) within the team subsequently needed to co-ordinate the Health Care Assistant (HCA) workforce and assess patients for a prognosis of less than 12 weeks for funding purposes. Senior RNs in one team audited the processes, finding that six months into the new model, people in our care were not always being reviewed for health needs in a timely way; often received H@H care for longer than the commissioning 12 weeks; were difficult to assess remotely, and sometimes deteriorated whilst receiving only domiciliary care visits.

Aim To create a smooth pathway for managing the patients and the HCA workforce to greatest effect.

Methods

• Spreadsheet devised to track and monitor each patient through their time with H@H.
• Validated tools from the OACC suite of measures used to map people’s condition and deterioration.
• RN joint visits with HCAs to support, educate and facilitate performance of assessment during care visits to maximise input.
• HCAs taught to give complementary therapies during respite visits.

Results An increase in patients being discharged to Adult Social Care (ASC) if they stabilised, freeing up visits for those who were at end of life. Cross-charging to ASC when appropriate, saving money. Length of time of patients receiving H@H care reduced to the commissioned 12 weeks for the majority of patients, demonstrating the value of accurate identification of end of life. Better use of HCA time, increased job satisfaction and team bonding for the H@H team.

Conclusion HCAs felt supported and educated, whilst the patients benefited greatly from clearer identification of the end-of-life stage and more tailored care.