## P-48 UTILISING THE ADVANCED SKILLS OF OUR SENIOR SPECIALIST NURSES ON OUR FIRST ON CALL ROTA

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10.1136/spcare-2023-HUNC.69

**Background** Staff working out of hours need clinical support with complex patient care. Our Senior Specialist Nurses (SSpNs) have extensive skills and knowledge in managing complex clinical and emotional issues for palliative patients. They are well positioned to be flexible and support an innovative change in practice, driven by changing circumstances in healthcare, by participating in the 'First-on-call' rota. A Palliative Care Consultant is always second on call.

**Aims**

- To utilise the advanced skills of our SSpNs by their participation in our 'first-on-call' rota, providing expert out of hours support.
- To role model the advanced skills of our SSpNs (Health Education England. Multi-professional framework for advanced clinical practice in England. 2017) inspiring junior colleagues to undertake training, improve their own advanced practice, for their personal development and the organisation's benefit.

**Method** SSpNs were included in our 'first-on-call' for a three-month trial period. Responsibilities to include: Assessing and prescribing for inpatient unit; Providing support to the Clinical Nurse Specialist on call for complex issues for our community patients; Offering advice about symptom control and clinical decisions to paramedics and primary health care colleagues. Feedback collected from service users.

**Results** Feedback demonstrated a highly successful pilot:

- SSpNs can manage many of the issues that arise out of hours.
- Consultants confident that SSpNs conduct thorough assessments and seek advice when needed (e.g. with complex symptoms/medical problems in accordance with the organisation's Independent Prescribing Procedure).
- SSpNs inclusion in the rota provides clinical leadership and flexible cross-cover with 'first-on-call' doctors.

**Conclusions** SSpNs utilise their advanced skills and expertise dynamically to successfully support out of hours working across internal and external services. This has enhanced SSpN practice and inspired development in junior nurses; creating a clear career pathway contributing to both healthcare and personal job satisfaction. Ensuring seamless specialist support for patients and carers.

## P-49 USE OF NON-MEDICAL PRESCRIBERS IN OUT-OF-HOURS SPECIALIST PALLIATIVE CARE

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10.1136/spcare-2023-HUNC.70

**Background** The use of non-medical prescribers is explored extensively in the literature with the benefits to patients receiving palliative care grounded in empirical research (Latham & Nyatanga. Br J Comm Nurs. 2018; 23(2): 94–98). A current review of the literature reveals a theme of a range of challenges in practice in palliative care (Dawson. J Prescribing Pract. 2020;2(8): 434–439; Osborne & Kerr. Int J Palliat Nurs. 2021; 27(4): 205–212; Willmott, White, Yates, et al. Palliat Med. 2020; 34(4): 524–532). The benefits of non-medical prescribers to other services and the wider health economy in palliative care at such a challenging time has not recently been demonstrated.

**Aim** To demonstrate the benefits of non-medical prescribers in out-of-hours specialist palliative care.

**Methods** Since the pandemic the clinical nurse specialist team have ensured the weekend rota is inclusive of a non-medical prescriber during the working day. Retrospective analysis of six months of non-medical prescribing data from the community clinical nurse specialist team was performed. Correlated with referrals from specialist palliative and end of life telephone coordination service to out-of-hours GP team (ongoing).

**Results** Data analysis is ongoing but reveals a difference during seven-day week periods. Monday to Friday non-medical prescribing focuses significantly on preventative prescribing, for example, just in-case medications. Weekend non-medical prescribing is predominantly crisis management response. Data from GP out of hours service on referrals from specialist palliative care and end of life coordination service showed no referrals from our service. Comparable pre-existing data not available due to change in practice post pandemic of ensuring an independent nurse prescriber on duty at the weekend.

**Conclusion** This audit data demonstrates the benefits to other services and the wider health economy, not just the individual patient themselves. This is inclusive of prevention of hospital admissions, impact on pharmacies, and cost effectiveness.

**Innovation** Learning and innovation is ensuring ongoing training and funding of programmes for clinical nurse specialists for non-medical prescribing in the community. Nationally, pre-pandemic the growth in non-medical prescribers was minimal in relation to total community palliative care prescribing activity in England (Ziegler, Bennett, Mulvey, et al. Palliat Med. 2018;32(4): 767–774) therefore, this needs to be an area of expansion and priority.

## P-50 FINDINGS FROM THE EVALUATION OF THE LOTHIAN URGENT OUT OF HOURS SERVICE

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10.1136/spcare-2023-HUNC.71

**Background** The challenges faced by patients and families in the out of hours period are well documented (Marie Curie. The better end of life report. 2022). In attempt to address these, an urgent out of hours service ('Rapid Response') was developed in partnership between Marie Curie and the local health and social care partnerships. Working alongside an NHS team, a Marie Curie Registered Nurse and Healthcare Assistant, with expertise in palliative care, are available to respond by telephone or in person to any urgent request for support in the out of hours period. The service launched in June 2022.

**Aims** To evaluate the impact of the Rapid Response (RR) service for patients and those close to them. To explore what is working well and what could be better.

**Methods** This evaluation used mixed methods. We interviewed four members of the Rapid Response team and two service

users. We also surveyed seventeen professionals, primarily from district nursing, who had worked with the service. We also collected data from home visits and phone calls from a six month period. Qualitative data were thematically analysed and presented alongside descriptive statistics from quantitative data sources.

**Results** The evaluation indicated that the service provides person-centered support in a timely manner. This, paired with the flexibility of the RR team – which enabled its members to spend as much time as possible with patients – led to both patients and those close to them feeling more informed and reassured. The results of the evaluation also suggest that the service helps to avoid hospital admissions and facilitates preferred place of care and death for their patients.

**Conclusions** The results of this evaluation indicate that the RR service is meeting its aims, by providing quality care in a timely manner. Further work is needed to raise awareness of the RR service and improve communication with referring services.

## P-51 PROVIDING HOSPICE FAST TRACK CARE IN PATIENTS' OWN HOMES

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10.1136/spcare-2023-HUNC.72

**Background** Research suggests that deaths in the community are likely to increase (Bone, Gomes, Etkind, et al. Palliat Med. 2018; 32(2): 329–36). Currently there appears inadequate data to identify if people who die at home can access the treatment and care that they need, or whether their care is well co-ordinated (Baylis, Chikwira, Robertson, et al. Dying well at home: Commissioning quality end of life care. The King's Fund, 2023).

**Aims** To operationalise a domiciliary model of palliative care which is responsive, productive and equitable to community need.

**Methods** Commissioners proposed a four times a day care package for up to five patients to aid rapid discharge from hospital/additional care at home. Recruitment was open to anyone wanting to develop a career in care. A bespoke educational package was delivered to staff to enable them to provide holistic care. Patients were deemed eligible for the service if they met the criteria for Continuing health care fast track funding. Once patients have an initial assessment and are accepted onto the service, they have further reviews at weeks 4 and 8. If the patient has plateaued/improved conditionally, an exit strategy is planned with district nursing colleagues.

**Results** Following a review of the service, it was identified that four visits a day wasn't needed for every patient, therefore, we could support more patients in their homes. Within the first year of operationalisation of the service, 156 referrals have been received; from this 75 people have been supported to die in their own home. Response rate from referral to care placement was within 24–48 hours.

**Conclusion** The above data demonstrates that a well co-ordinated service, delivered by a team who have the knowledge and skills to provide the hospice ethos of end of life care can support choice at the end of life.

## P-52 IMPROVING ACCESS TO HOSPICE CARE AT HOME: PROVIDING CHC FAST TRACK NIGHTS

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10.1136/spcare-2023-HUNC.73

**Background** Pendleside Hospice at Home (H@H) service has been the single point of access (SPOA) for fast tracks for night care in the locality since May 2021. A proposal for the service to be part of the provider framework to deliver the night care was put forward to the Clinical Commissioning Group.

**Aim** To increase the amount of funded specialist palliative care night support for patients in their own home and to process applications in a timely manner. To raise the profile of the hospice and reach out to a wider group of patients ensuring sustainability of services.

**Method** Submit a proposal to commissioning services. Work collaboratively with other community providers to ensure a seamless service for patients and families. Recruit staff to deliver the proposed service.

**Results** Pendleside H@H were successful in their bid to be part of the night sit tender which has enabled the service to provide additional funded night care to patients on the caseload in addition to charitable funded nights (a requirement of the bid). There is an increased number of patients being identified earlier and accessing hospice services who may otherwise have not been referred.

**Conclusion** Commissioners aim to support patients whose preferred place of death is home, by means of providing an end of life care respite service enabling patients to remain in their usual place of residence. This service will support carers and family members to take breaks from caring for their loved one, whilst knowing they are in safe hands. This allows for continuity for patients and an overall better experience for patients and families.

## P-53 SUCCCESFUL IMPLEMENTATION TO EXTEND HOSPICE AT HOME RESPITE SERVICE TO DELIVER MULTI-VISIT PERSONAL CARE

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10.1136/spcare-2023-HUNC.74

**Background** Wirral Hospice St John's (WHSJ) has been providing a Hospice at Home (H@H) service for 10 years, of 3 hours day slots for 'carer respite sits' as well as 11 hours overnight support.

In 2021–22 NHS winter pressures had a negative impact on access to end-of-life care at home. In view of the detrimental effect on patient care, local Commissioners approached WHSJ to support the system by providing personal care for end-of-life patients. Within budget 4 month pilot programme of reduced respite sits and six personal care visits per day 9–5, 7 days a week was commenced. Providing responsive care alongside Community Nurses to those in the last weeks and days of life. With an ICB award of c£100k enabling recruitment of three Band 2 HCAs working across both H@H services, this service continued throughout 2022. The key outcomes were Referral to Death interval 11 days, and 92% died at home. Due to positive outcomes, Commissioners