

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 case-load 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 SUCCESSFUL 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

agreed further funding for a permanent H@H personal-care service.

Current The new service delivers personal care to patients in the last four weeks of life. With referrals from the local hospital discharge and community nursing teams. The service anticipates a case load of 6–9 patients, with two teams delivering up to three calls with two carers daily, 8am–8pm. The staff team consists of: 12 WTE HCAs, 1.4 WTE Band 4 Coordinators, 1.4WTE Band 5 RNs. Ongoing recruitment enabled incremental service extensions.

Key outcomes (8 weeks' post expansion):

- Referral to death interval 14.4 days.
- Deaths at home, 87.5%.
- Referral to care start ≤24hrs 86%.
- 4 patients in receipt of care for more than 28 days.

Key learning Community Nursing and Hospital discharge team prognostication was reliable. Families were well supported without the 4 calls a day usually requested from Continuing Health Care. Partnerships with Community Nursing, Hospital Discharge team, Commissioners and Continuing Health Care are essential.

P-54

REACHING BEYOND THE WALLS OF THE HOSPICE; PROVIDING OCCUPATIONAL THERAPY SUPPORT FOR SYMPTOM MANAGEMENT OF BREATHLESSNESS AT HOME

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10.1136/spcare-2023-HUNC.75

Background Personal symptom experience of breathlessness can mean not everyone is able to attend onsite to see an Occupational Therapist (OT) for help with their breathlessness (HWB), or manage effective telephone or virtual consultations. We needed to challenge our current service model. The team explored whether it was possible to provide this service in an individual's own home.

Aim/s To provide equitable OT HWB service for all patients referred to our service. Understand barriers to community accessibility due to the individual's own lived experience of breathlessness. Create opportunities to open functional/advance care planning conversations around living well at home, and future environmental considerations. Work collaboratively with carers, internal and external NHS services to support individuals managing their breathlessness both medically and 'non-medically'.

Method 9-month Hospice UK grant-funding enabled the service to commence. Patients referred need to be under our organisation's Consultants' care and feel unable to attend the existing onsite service/s or effectively hold a telephone or virtual consultation. 1 x OT HWB home visit is offered in place of their onsite attendance. Person-centred (functional) goals are established alongside Likert scale and Barthel index. Follow-up visits are offered if clinically necessary such as equipment check reviews. Goal attainment is completed through telephone reviews alongside user/carer/wider professional feedback.

Results (ongoing findings): Physical and psychological safety can be a common factor in helping understanding someone's breathlessness experience and community accessibility barriers. Assessing an individual's home environment helps create

personalised OT HWB strategies. Involving carers/loved ones adds visceral understanding of the impact of breathlessness on an individual's lived experience. Collaborative networking helps support individuals and their loved ones make connections and future care considerations. Personalised goals and treatment plans can support acquisition of functional resilience skills. Outcomes measures through numerical data collection is, however, proving challenging.

Conclusion There has been a demonstrated need to provide Occupational Therapy home visiting for patients who cannot attend their onsite clinic, or manage effective telephone or virtual OT breathlessness management consultations. This has now formed an established part of the core OT service provision.

P-55

DEVELOPING A SPECIALIST PALLIATIVE CARE TELEPHONE ADVICE LINE FOR HEALTHCARE PROFESSIONALS

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10.1136/spcare-2023-HUNC.76

Background This project was undertaken at an independent hospice in the West of Scotland, serving a population of over 76,000 (National Records of Scotland, 2022). Feedback from colleagues in primary care highlighted the need for a dedicated advice line to improve access to specialist palliative care (SPC) and to facilitate timely referrals to our service.

Aims To develop a dedicated SPC advice line for healthcare professionals (HCPs) in primary and secondary care. To evaluate the effectiveness of the advice line in improving access to specialist palliative care.

Method Development. Process mapping was undertaken to understand steps between receiving a call and feedback to the patient's parent team. Decision was made that referrals for inpatient hospice care could be made via the advice line. Virtual landline platform was used. Advice/referral proforma was created on our patient record system (Crosscare). Specialty Doctor, Clinical Fellow or Advanced Nurse Practitioner (ANP) staffed the advice line with a Consultant available if required. The advice line was made available 0900 – 1700, Monday to Friday. Posters and cards with dedicated advice line number were shared with primary and secondary care colleagues.

Evaluation. Data from virtual landline platform and Crosscare analysed for total number of calls and referrals generated, referral sources, patient demographics and outcomes.

Results Feedback from users has been positive.

Feb – April 2023:

- 72 contacts relating to 49 patients, 31 of which were new referrals.
- 38.8% of contacts from primary care (General Practitioners, ANPs and District Nurses).
- 9.7% of contacts received from professional carers in the community and care homes, who were not previously able to refer directly to hospice.
- 16.7% of contacts resulted in hospice admission, 36.1% in SPC clinician review, 45.8% in advice only.

Conclusion This specialist palliative care advice line has improved access to specialist palliative care advice and streamlined our referral process. Future directions: extension of