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.

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.

Aims 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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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). Speciality 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