The 12 month pilot has provided a blueprint for the continuation of a palliative virtual ward at place. This poster presents the learning and development of the model over the last 12 months, identifying the operational challenges and opportunities and patient impact over the last year. The poster presents the next key areas for development in the implementation of the medical oversight for the palliative virtual ward for the next 12 months and alignment as part of the national virtual ward implementation.

P-92 COLLABORATION AND PARTNERSHIP – HOW A REMOTE VIRTUAL CONSULTANT MODEL CAN ENRICH AND SUPPORT HOSPICE AND COMMUNITY SERVICES

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10.1136/spcare-2023-HUNC.113

Background There are increasing challenges to providing consultants in palliative medicine which are contributing to unit closures or reduction in beds. These include: deficit of more than 70 consultants nationally; part-time workforce on increase; fewer doctors becoming consultants; 30% of workforce are over 50 years old.
Aims To establish a solution to provide a unique remote-based consultant model with a robust governance system. This would ensure a rapid response, improved team dynamics and reopening of units or prevention of unit closure.
Methods Initial set up of service level agreement with a hospice that was threatening unit closure due to inability to recruit consultant establishment. Services included daytime support of board rounds and MDTs to inpatient units via videoconference, with a secure system to record management plans, outcomes of board rounds, clinical supervision sessions and case debriefs.

Senior consultants facilitated a remote clinician to clinician telephone consultation service 24 hours a day, 365 days per year to support services. Service reviews were carried out after a month, 3, 6 months, and annually to evaluate services and gather feedback from users.
Results Over 60 organisations have SLAs for our services leading to enhanced confidence and autonomy with clinical decision making and improved team dynamics. Reopening of units or prevention of unit closure. Partnering organisation benefits from the added assurance of governance team who review all advice, response times and feedback on any identified training needs.
Conclusion Although on site consultant is the preferred method, evaluation of the unique remote model feedback gathered shows hospices, NHS organisations and communities benefit from collaboration and partnership with this independent solution.

P-93 VIRTUAL OUTREACH SERVICES: SUPPORTING WELLBEING, INCLUSION AND REDUCING SOCIAL ISOLATION

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Background During the COVID-19 pandemic and in line with public health guidance, like all other hospices, we had to close all our Outreach Services (ORS). As a quick response to this and to the changing needs, we set up a virtual service, initially intended to replace face-to-face outreach services.
Objectives Enhancing communication through virtual means suddenly became a key priority to be able to support people in their own homes, improving online access, providing ongoing psychosocial support, and reducing digital exclusion and isolation. This meant being able to extend our care beyond our hospice walls whilst patients continued to self-isolate and stay safe.
Results This choice in provision has already proven to support patients' wellbeing, reduce isolation; increasing confidence around the use of technology, supporting, and making vital connections even up to a patient's death. As restrictions eased, outreach strategies and re-models of working meant that we could continue to offer virtual services to patients along with in-person services; it also enables us to support patients who have become too unwell or decline to access in-person services as well as supporting patients on their discharge.
Sustainability The virtual platform is still a popular choice by patients; ORS continue to grow the digital maturity and support through digital education/awareness, digital drop-in support sessions, hybrid working, holistic support assistants and a team of digital volunteers to support our people.

These approaches enable us to continue to support and develop 'our people' including patients, volunteers, and staff, both pre- and post-bereavement, increasing confidence and competence. The digital provision has even extended to cover the use of virtual reality equipment which is proving to be particularly helpful in supporting patients confined to their homes. The next steps are to create a digital library of equipment to further support people in their own homes.

P-94 THE JOURNEY OF IMPLEMENTING A FAMILY PORTAL – AN INNOVATIVE ONLINE SERVICE TO ENABLE GREATER ACCESS FOR FAMILIES TO SERVICES

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Background Pre-pandemic, Acorns commenced a project for a new and innovative online service which would enable families to have remote access to information about all aspects of services being delivered to their child and their family. The project was placed on hold during COVID-19 and finally launched in July 2022.
Aims (1) Parents will be empowered and have further control over their child's care. (2) Enable Acorns care staff to provide even more tailored support to the child in response to family input of data via the portal.
Methods Stage 1. Series of workshops held with software developers, families, and project team. Stage 2. Governance processes developed. Training provided and user guidance developed. Stage 3. Portal roll-out phased across three hospice sites. Stage 4. Portal helpdesk established.
Results Successfully implemented a 24/7 online service for families which enables information to be shared at a time that is most convenient for families. Parents are sharing information about their child either prior or during a stay. They are adding information for nurses to view specific food their child likes, the way they like to be held if they are babies or very young, or any information they feel would make their child

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