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.

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

Charlotte Healey, Paula Hall. Supportive Care UK Ltd, Cheadle, UK

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.

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**VIRTUAL OUTREACH SERVICES: SUPPORTING WELLBEING, INCLUSION AND REDUCING SOCIAL ISOLATION**

Kelly De Souza. Willowbrook Hospice, Prescot, UK

10.1136/spcare-2023-HUNC.114

**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.

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

Susan Hayward, Jessica Ashe. Acorns Children’s Hospice, Birmingham, UK

10.1136/spcare-2023-HUNC.115

**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**


**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...
happier during their stay. With non-communicative children, even the smallest of familiarity they can get from Acorns will help them to feel more relaxed. In the first 9 months there were 247 log-ins to the Family Portal, 47 families accessing online booking and information sharing.

Conclusions Whilst there are relatively small numbers of families who are accessing the portal, those that are using the portal are doing so consistently as a preferred choice of communication.

How innovative or of interest is the abstract? We hope that sharing our learning will benefit colleagues from across the wider palliative care sector.

INTRODUCING VIRTUAL REALITY TO AID SYMPTOM CONTROL IN A DAY PATIENT SETTING

Wendy Pepper, Helen Cardlip, Lynn Porch, Karen Tudge, Jade Crowbie, Dorothy House Hospice Care, Winsley, Bradford-on-Avon, UK

Background Virtual Reality (VR) is a computer generated environment with scenes and objects that make you feel that you are immersed in the surroundings. Studies into VR to aid symptom control have been widespread in recent years, with over 8,000 studies published to date.

Aims To trial VR alongside traditional medicines and therapies in a day patient setting to help with pain and/or anxiety, prior to roll-out to the wider hospice community and inpatient setting.

Methods All patients are routinely screened using the Integrated Palliative Care Outcome Scale (IPOS). Those scoring highly in either pain or anxiety are offered VR, given an information leaflet, and asked to sign a consent form. They have the option to stop the experience at any time. In each session, patients can choose from a menu of experiences ranging from a trip to space, to underwater or a relaxation session. Pain and anxiety are assessed pre- and post-session using a visual analogue 0–10 scale. Comments are also captured.

Results Eight patients have used VR to date. Preliminary data show reductions in pain and anxiety scores after use of the VR system (median pain score pre-session = 5, median pain score post-session = 3.5; median anxiety score pre-session = 5, median anxiety score post-session = 2). Only one incidence of an increased score (pain by +1) has been reported. Comments include: “This is the most relaxed I have felt in weeks”; “If I could buy one right now I would”; “These are the things I’m missing out on in my life”.

Conclusions We recognise this trial is in its early stages, however, early signs suggest its use is associated with a reduction in pain and/or anxiety levels in our patients. Data from a larger number of patients will be available for presentation at the Hospice UK Conference.

TRAINED VOLUNTEERS HELP TO CREATE ADVANCE CARE PLANS WHICH ARE UPLOADED TO A SHARED DIGITAL SYSTEM

Amy Giles. Somerset Foundation Trust, Taunton, UK


Aim A project commenced in April 2021, stakeholders involved included NHS, Social Finance, and a charity. Partnership working aimed to find an effective way to provide consistent and accessible ways for all adults (18+) with a county GP to develop their ACP.

Methods The charity provides training and support to volunteers who help people complete their ACPs. Referrals are received by telephone, email, self-referral or from someone else. The Volunteer Coordinator contacts the person, and a visit is made. Once created and uploaded to a county-wide digital system, they can be accessed and updated by the health or social care staff looking after them. The person receives their own copy to share with others.

The ACP Lead, EOLC Education team and charity provide ACP training and attend public engagement events, such as death cafes, social media, library presence, creation of an upcoming ACP week, the End of life care county-wide website. Leaflets and information packs sent to GP surgeries, care homes and hospitals. Education is key to understand the importance of ACP. Numbers of referrals received, completed ACPs and those declining the service are counted and statistics updated.

Results ACPs are being created and saved on the county-wide system. Year 1 – high referral, low conversion (3.5%). Year 2 – low referral (22%), high conversion (51%). Reflection during the first year noted ‘warm’ referrals were more likely to result in a completed ACP. Currently, we are monitoring the number of referrals received and the conversion rate, aiming for this to increase. Data and learning are being captured each year and will be able to determine the outcomes and recommendations for the future.

HPAL – A UNIQUE WEB-BASED CLINICAL DECISION TOOL, COMBINED WITH A PLACE-BASED SERVICE DIRECTORY, TO SUPPORT HOSPICE COORDINATION HUBS

Ros Taylor, Poppie Freeman. Harlington Hospice, Harlington, UK; Medindex Ltd, London, UK

Aim To provide a web-based clinical decision tool, aligned to national and local ICS guidelines and services, to support the frontline triage staff in the new Hillingdon Palliative Coordination Hub.

Background Recent national guidance has emphasised the need for less fragmented care, coordination of support, together with more accessible palliative information for clinicians and family carers. HPAL (https://hpal.medindex.co.uk) was initially developed as an innovative clinical information tool for the London Borough of Hillingdon and has now expanded to support the eight boroughs in the North West London Integrated Care System (ICS). It is a unique website, providing trusted curated clinical expertise (2 minute read time) linked to a place-based service directory for each borough.