months with good symptom control including improvements in pain and delirium. One patient was agitated and died despite treatment before the effects of the zoledronic acid would have been apparent.

Conclusion For frail patients approaching the terminal phases of their illness having treatment at home is potentially beneficial to both the patients, people important to them and has cost saving benefits due to admission avoidance. There is a plan to ratify the SOP for wider use within Manchester.

39 AN AUDIT OF THE BELFAST HEALTH & SOCIAL CARE TRUST'S (BHSCT) 24/7 SPECIALIST PALLIATIVE MEDICINE TELEPHONE ADVICE LINE IN 2022

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Introduction Equitable access to out of hours (OOH) Specialist Palliative Care (SPC) advice has been highlighted as a key priority for Northern Ireland (NI) since 2016.[1] The National Audit of Care at the End of Life (NACEL) 2021 emphasised gaps in hospital and OOH SPC services in NI, with only 30% of hospitals having a 24/7 SPC telephone advice service in 2021.2 NACEL recommended that NI should work towards developing 24/7 SPC services throughout the region.[2]

BHSCT currently runs a 24/7 SPC telephone advice line. The line is staffed by Trust Palliative Medicine Consultants and Registrars 9am-5pm Monday to Friday, and by a commissioned external Specialist Palliative Medicine UK service for OOHs. The Trust has a robust governance structure for this OOH advice.

Methods Audit of SPC Advice Line, collating data from advice sheets completed during each call. Excel used to analyse number and distribution of calls, profession of caller, reason for call and Palliative diagnosis.

Results 344 calls in 2022, with 171 occurring between 9am-5pm at weekends or bank holidays. Middle grade doctors where the most common caller, followed by Registrars and Foundation Year 1 doctors. 25% of patients were already known to SPC Services; 69 Inpatient and 19 Community. Documented malignant diagnoses accounted for 203 calls, with 129 calls for patients with non-malignant diagnoses. Complex Symptom Advice was the most common call (254), of which pain was most prevalent symptom (218). 45% (156) of the calls were for patients approaching End of Life.

Conclusion The use of the service has demonstrated a clear need for a 24/7 Specialist Palliative Advice Line. Advice was sought by a wide range of healthcare professionals for patients with both malignant and non-malignant diagnoses, reflecting the broad need of Specialist Palliative input for patients with complex and advanced illness across different care settings.

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REFERENCES

1. Review of the Implementation of the Palliative and End of Life Care Strategy, January 2016. RQIA. Available online at:1c349f45-1c38-49bbaeeb-e6a363f4c5ad.pdf (rqia.org.uk) (accessed 12.01.23)
2. National Audit of Care at the End of Life 2021, Round 3 Report. NHS Benchmarking. Available online at: NACEL Audit Outputs — NHS Benchmarking Network (accessed 12.01.23)

40 WORKING ALONGSIDE LANCASHIRE COMMUNITIES TO BUILD SUSTAINABLE BEREAVEMENT SUPPORT

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10.1136/spcare-2024-PCC.58

Background Compassionate Communities approaches are well documented world-wide including India, Australia and Europe. Our St Catherine's Hospice Compassionate Communities project in Northwest England began in August 2022 with an 'open brief' to investigate assets within our communities of Central Lancashire, to listen, identify gaps, and work with each community to trial solutions.

Method In the town of Chorley, we co-produced listening events with council and NHS partners to establish what residents valued and felt was missing around bereavement support. This coincided with a request for support from a town centre church. We provided staff, training and hospice volunteers to help establish a bereavement café in partnership with the church. We then identified an accessible location in a second area (Leyland) to set up another bereavement café and provided similar resource.

Results Both groups were trialled monthly for six months. Average attendance at Chorley was six people per session and at Leyland was five people per session. Qualitative feedback was positive for both cafes, and the majority of people were repeat attenders.

After six months, both bereavement cafes were handed over to volunteers and continue to run without the input of paid staff. However, the second café that was proactively established by us does not have volunteer input from the hosting organisation and requires a funding source for room hire.

Conclusions We reflected that responding to an identified need from a well-established community organisation led relatively quickly to a 'self-sustaining' intervention. A similar intervention has been well received but continues to require external funding and commitment from external agencies. Learning from this, we have been approached by a place of worship and a community growing group in Preston and are confident initial support and training from hospice staff will enable them to set up and sustain bereavement groups.

41 MOUNTBATTEN HAMPSHIRE PLACE OF CARE REVIEW

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10.1136/spcare-2024-PCC.59

Background The NHS long term plan (NHS England. Available at: https://www.england.nhs.uk/publication/the-nhs-long-term-plan/ [Accessed 01/10/2023]) aspires to reduce avoidable emergency admissions and increase community care for people towards the end of life. Mountbatten Hampshire (MH) conducted a review to determine whether hospital admission of patients known to our service were appropriate.

Methods From a caseload of 864 patients, 259 were cross-referenced with hospital data to find the number admitted to hospital over 12 months. 247 cases were analysable. A retrospective notes review to determine appropriateness of hospital admission was undertaken by two reviewers (every 5th set of notes of admitted patients sampled (n=20); 2.3% total caseload, 8% of data analysed by hospital).

Results 45% (111) of analysable cross-referenced group were admitted to hospital (mean age 94 years, 45% male). Of patients sampled, 70% (14) were known to our service. All admissions were unplanned. MH was contacted in 4 cases prior to admission. In one case it was felt we could have prevented admission if the patient had been reviewed at home by our community rapid response team. Ten patients were admitted without immediate prior contact to our service by carer or health professional. On review, 3 of these admissions could potentially have been prevented if the patient had been assessed by our community rapid response team prior to being taken to hospital.
Conclusions More patients were known to our service at admission compared to a previous review (70% cf 33%). 71% (10/14 hospital admissions were appropriate; 29% (4) admissions could have been avoided. Had our team been contacted we could potentially have prevented 30% (3) admissions. There was a predominance of patients >90 years with non-malignant diagnoses. The findings suggest more work is required to alert patients, carers and health professionals to our 24-hour service to ensure people, particularly with non-malignant diagnoses, are cared for in the appropriate setting.

42 URGENT RESPONSE: EVALUATION OF A HOSPICE VIRTUAL WARD PILOT

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Background Virtual Wards present a safe and efficient alternative to in-patient care. Patients approaching the end of their lives may have rapidly changing and complex needs which can result in potentially avoidable or unwanted hospital admissions. An End-of-life Virtual ward offers opportunities to increase the capacity for same day community assessment with ongoing daily monitoring and support for patients living with a life limiting illness during time of crisis (significant symptoms, rapidly changing the clinical picture, complex dying or suspected palliative care emergency).
Method A one-year Hospice Virtual Ward Pilot is being undertaken in partnership with the Integrated Care Board (population 237 000). A daily huddle supports multi-disciplinary working and coordination of care. Increased capacity within an established integrated specialist palliative care service facilitates responsive, proactive care by experienced clinicians and increased hospice-at-home care shifts. Close working with other community providers enables efficient delivery of care.

Ongoing PDSA cycles refine the model of delivery, with data and patient feedback collated.
Results During the initial 3-month pilot (July – August 2023), there were 100 admissions (6 beds, average length of stay: 3.88 days.; occupancy rate 86%.; total bed days: 354 days). 78 remained at home, with 19 hospice admissions, 2 hospital and 1 Care Home transfer. 18 patients died in their usual place of residence, whilst supported by the virtual ward. Patients and family report high levels of satisfaction with care, and staff report improved job-satisfaction.
Conclusion Hospice wards have the potential to provide same day specialist palliative care assessment for complex patient's during times of crisis, enabling early discharge, and preventing admission to inpatient beds. They providing care in keeping with the individuals values and preferences, and improving patient and care experience. This pilot will inform future models of specialist palliative care service delivery.

43 MEASURING EFFECTIVENESS USING IPOS SCORES: AN UPDATE ON 'TRIGGER SERVICE' AT THE MARGARET CENTRE SPECIALIST PALLIATIVE CARE UNIT

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Background Studies suggest patient-reported outcome measures (PROM) enhance clinical judgment. This approach identifies changes in patient condition and encourages communication between patients and their healthcare professionals (HPCs).
Aim To review a method of assessing palliative care physical symptoms (i.e. pain, breathlessness).
Methods The IPOS (Integrated Palliative care Outcome Scale) is a concise assessment tool that evaluates a range of palliative care problems across domains, including physical and psychological symptoms, social and spiritual; communication, information needs, and practical concerns. It enhances practice by assessing the patient's quality of life, improving healthcare interventions, and facilitating the development of other PROMs. Retrospective analyses of admission clerking to Margaret Centre was collated over a span of one week.
Results 12 new patients admitted in the first week of April 2023.

- 16.6% (2/12) of the admitted patients had one or more clinical issues quantitatively evaluated.
- 0% had quantitative evaluation of all the physical symptoms.
- 0% (0/12) of admitted patients had one or more psychological issues quantitatively evaluated.

Test of change: IPOS was integrated into the admission clerking template. The criteria previously used lacked clarity and did not provide any specific methods to measure both physical and psychological symptoms.

- After the test of change was implemented, 91.6% (11/12) of the admitted patients had one or more clinical issues quantitatively evaluated.
- 83% of patients had quantitative evaluation of all the physical symptoms.
- After the test of change was implemented, 91.6% (11/12) of admitted patients had >1 psychological issue quantitatively evaluated.
- 66% (8/12) of patients had quantitative evaluation of all psychological issues.

Conclusion IPOS helps somewhat in triaging and addressing prevailing and distressing symptoms experienced by some.

44 VR AS A THERAPEUTIC TOOL FOR PALLIATIVE AND END OF LIFE CARE STAFF WELLBEING

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