

Making a common 'Discharge Letter Preparation Table' Template, 2.'UP-TO-DATE' Whiteboard, 3. Changing to an electronic system for discharge letters.

Results After the first and second interventions the percentages of discharge letters meeting the target was 28% and 69% respectively. By the end of the 3rd intervention, this had increased to 78%.

Conclusion There has been a significant improvement in the percentage of discharge letters being sent to community teams within or at 24hrs of discharge, hence improving patient continuity of care. These changes are relevant to and could be replicated across clinical settings.

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WHAT'S THE DEMAND? DEVELOPING PALLIATIVE CARE RAPID RESPONSE SERVICE

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Background Coventry and Warwickshire Partnership Trust Community Nursing had manned an urgent access phone to respond to people requiring just in case medication or have a syringe driver. The Integrated Palliative Care Team, following investment, took ownership daily between 8am-8pm. The use and need of this phone had not been monitored previously.

Method We created a proforma to document the calls being received detailing date, time, patient demographic details, caller details, reason for call, response needed and whether the call was appropriate. The data for September 2022 were analysed on excel.

Results There were 130 calls to the phone in the month, between 8am and 8pm 7 days per week. 117 (90%) were deemed appropriate. The most frequent callers were family members, 66 (51%), the next most common group was health and social care professionals, 48 (37%). The phone was busiest between 4pm and 8pm with this accounting for 56 calls (43%), the quietest time was between 12-4pm accounting for 28 (22%) of calls. 69 (53%) of appropriate calls were related to symptom needs, the second most common reason for calling was for palliative support care, 13 (11%). 96 (82%) required a 2-hour response, 3 (3%) a 24-hour response and 18 (15%) advice was given.

Conclusion This review shows there is a demand for this service, and it is on the whole used appropriately by service users and professionals. The data has supported the team arranging planned work between 12-4pm as this is the quieter time. The majority require a 2-hour response but there is also an element of supporting people and professionals with advice. Anecdotally, this service been manned by the team has been positive for patients and professionals.

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VIRTUAL CONSULTATIONS: THE EXPERIENCE OF ONCOLOGY AND PALLIATIVE CARE HEALTHCARE PROFESSIONALS 'ONE SIZE DOESN'T FIT ALL'

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Introduction To maintain continuity of care during the Covid-19 pandemic, virtual consultations (VC) became the mainstay of patient practitioner interactions. Prior to this, little was

understood regarding healthcare professionals' (HCP) experiences in translating their care to this modality.

Aim Exploration of oncology and palliative care HCP perspectives on VC, the role of VC in varying stages of the treatment and management of patient care, and the future role of VC in patient care.

Method A cross sectional mixed methodology observational study of oncology and palliative care HCPs, analysed via an inductive thematic approach.

Results 87 surveys completed within a one-month period. Three master themes were identified. Personal, professional, and familial factors included factors of patient age, illness and VC skill in influencing HCPs' experience of VC. Relationships and connection highlighted the influence of VC in empowering patients, the importance of a therapeutic relationship. Here, there was a perceived loss in these domains with VC. Significant challenges were felt in sharing bad news and having challenging conversations. Many survey respondents emphasized that they preferred to have first time consultations face-to-face, and not virtually. Within the domain of logistical and practical implications reduced travel and increased accessibility were seen as a benefit of VC. The inability to examine patients and concerns regarding missing clinical signs was emphasised as a significant barrier, alongside the challenges faced with sometimes failing technology.

Conclusion VCs have a stronger role for those patients who are already known to professionals, when prior relationships have already been developed, and here they are perceived as practical and beneficial. VC for difficult discussions and for unstable patients were felt to be inadequate. Triaging patients with regard to suitability prior to offering VCs, with emphasis on the importance of patient choice, were seen as priority areas in this new era of VCs.

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IMPROVING VTE RISK ASSESSMENT FOR HOSPICE INPATIENTS

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Background & Aims Hospice inpatients are often at higher risk of developing venous thromboembolic (VTE) events, but also often have various contra-indications to VTE prophylaxis. Careful assessment based on a risk-benefit balance is important to ensure that decisions are made that support patients' quality of life and symptom control. A project was carried out to review the local hospice's practices on VTE risk assessment and management with primary prophylaxis, and documentation of this.

Methods An audit was conducted in February 2021, prompted by participation in the data collection for the national UK Palliative trainees Research Collaborative (UKPRC) VTE audit. A local VTE assessment tool was then developed based on NICE guidance and practices from hospices in other regions of England.1-2 The tool was then embedded into the electronic SystemOne software used by the inpatient hospice team. A re-audit of local practice was then performed in May 2022 to assess the impact of this intervention.

Findings and Discussion The electronic VTE assessment tool led to greater percentage of patients having a documented VTE risk assessment (87.5% vs 62.5%), and better