

Background/aims: Nationally, the death rate and need for palliative care is increasing annually, with predictions that this will increase by up to 40% by 2040. In a time when national shortages of experienced nurses, able to work at specialist level, is having an impact on clinical services, hospices are unable to fill vacant Clinical Nurse Specialist (CNS) roles, with suitable candidates. The vacancies left the clinical teams in this hospice struggling to fulfill commissioned service expectations and meet clinical demand. During the pandemic response, some CNSs worked remotely, but were still able to support the clinical team, which produced the idea of creating a 'Virtual' (VCNS) role.

Aim: To address the shortage of Clinical Nurse Specialists in one hospice team, by creating a new role of VCNS.

Methods: A scoping exercise was performed to establish the extent of the shortfall in service. Adverts were placed to determine whether the opportunity to work remotely, from a more distant area, would attract nurses already working at specialist level. Seven very experienced nurses applied and were interviewed, and all met stringent criterion. Five were appointed across three locality teams, and two joined the bank, to support all three teams. Problems of managing induction and equipment had to be resolved, and a network of education, support and supervision developed.

Results: Over the first six months of the one-year pilot, referrals increased by over 50%, and caseload numbers by over 25%. Although there has been no increase in face-to-face visits from the existing CNS team, which was one hope of the project, the appointment of VCNSs to support the workforce has allowed us to double (6677 from 3206) our telephone support, and to manage the increase in referrals and case-loads. The proven benefit of the VCNS role, means that we will be extending the one-year pilot.

Conclusions: The role of VCNS has been successful in bridging the gap in service and creating an original solution to cope with increased future pressures.

P 12.060 Experiences with Palliative Care for Head and Neck Cancer Patients at the Outpatient Clinic and Remote

B. van den Besselaar¹, K. van Hof¹, A. Sewnaik¹, M. Offerman¹

¹Erasmus MC, Otorhinolaryngology, Head and Neck Surgery, Rotterdam, Netherlands

Background/aims: The Erasmus MC set up an Expert Center to give structured attention to patients with head and neck cancer (HNC) in the palliative phase. After their palliative diagnosis patients can choose to remain visiting their physician at the outpatient clinic or to be monitored remotely in their home situation. This unique approach entails that each patient is assigned to an oncological nurse. Besides, these oncological nurses have regular contact with patients general practitioner and monitor symptoms with help of an electronic patient reported outcome structure ("Healthcare Monitor"). In this study we evaluate the experiences of patients and next of kin with this unique approach of care.

Methods: 60 patients with HNC in the palliative phase and 52 next of kin of deceased HNC patients were included. We evaluated their experiences with the palliative care through a specially developed patient reported experience questionnaire.

Results: The majority of patients and next of kin experienced the consultation with the physician and the following consult with the oncology nurse as pleasant. The physician and the oncology nurse communicated in an understandable way and there was enough room for questions. One third of patients and next of kin reported to have missed a topic during the consults, such as discussing life expectancy. Another 34% of the patients stated that it was not discussed in what situation they wanted to refrain from treatment. During the remote care the majority of patients and next of kin felt safe with remote monitoring, they were able to sufficiently clarify their problems and if necessary action was

taken in time. However, 35% of patients and 46% of next of kin reported that the provided psychosocial support was not sufficient.

Conclusions: HNC patients and next of kin were satisfied with the palliative care. They felt safe with the remote care and symptoms or problems were adequately monitored. However, there is room for more attention to discuss life expectancy and psychosocial support.

P 12.061 The Comprehensiveness and Correspondence of Place of Death Classifications: An International Comparative Analysis

A. Bruno de Sousa¹, B. Gomes^{1,2}, J. Cohen³, S. Lopes^{1,4}

¹University of Coimbra, Faculty of Medicine, Coimbra, Portugal, ²King's College London, Cicely Saunders Institute of Palliative Care, Policy and Rehabilitation, London, United Kingdom, ³Vrije Universiteit Brussel, Brussels, Belgium, ⁴NOVA University Lisbon, NOVA National School of Public Health, Public Health Research Centre, Comprehensive Health Research Center, CHRC, Lisbon, Portugal

Background/aims: Respecting preferences for place of death (PoD) is important. The first step is to classify PoD in a way that captures the full spectrum of places that are meaningful for individuals. We aimed to describe the comprehensiveness and correspondence of PoD classifications globally.

Methods: We sought information on PoD classifications from vital registries of 47 countries varied in UN Regions and Quality of Death Index. We describe the structure of PoD classifications (2020-21), cross-linking the categories and wording used in the countries. We focus attention on the entity "home" as it is the most common preference for PoD.

Results: Of 22 responding countries (16 EU), 21 use a single PoD classification structure and only Portugal uses a hierarchical classification (in 3 levels, with sub-categories within health institutions and specific services within hospitals, such as ICU and emergency department). Categories range 3 to 21, the most common (present in all countries) were: home (however the wording varies), hospital, health care or medical institution/health establishment (however differences limit comparability), and other/elsewhere. Home is captured in 1-3 categories per country, with wide-ranged wording: home, courtyard, domicile, home/non-institution, home of family members, home of friend, private house, private home, private residence and residential house. Cyprus and Luxembourg use the most comprehensive classifications (21 and 18 categories, respectively). Final findings from all countries will be presented at the conference.

Conclusions: There is scope to improve the comprehensiveness of PoD classifications and category correspondence. Although all countries capture "home," there are critical variations in wording. An exhaustive international PoD classification will allow better cross-country data and studies mapping preferred and actual PoD, critical to help provide choice on where people die across world regions.

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P 12.062 First Year of Implementation of Mobile Palliative Care Unit at National Oncological Center

M. Ivanetič Pantar¹, N. Golob¹, M. Ebert Moltara¹, R. Terbovšek¹, S. Crljenica¹, A. Riđič¹

¹Institute of Oncology Ljubljana, Department of Acute Palliative Care, Ljubljana, Slovenia

Background/aims: At our oncological center we provide specialised palliative care (SPO) for oncological patients. Apart from hospital care, outpatient clinic and telephone support, one year ago we implemented mobile palliative care unit to support patients and their caregivers at home.

Aims: To analyse mobile palliative care service provided in the first year of implementation.