

better understand the service developments and participant's aspirations for day services.

It was found that introducing five additional patient services – Blood transfusion clinic; Progressive Supranuclear Palsy support group; Motor Neurone Disease clinic; Multi System Atrophy support group and a Carers' support group – led to a 27% increase in attendances. Staff, patients and their families were recruited to three research projects by three hospice staff as a core part of their role, and five staff contributed to qualitative studies or data collection. The qualitative data indicated that staff were pioneering the new well-coordinated services but were challenged by the time available to capture data. The management team had a vision for further expansion of sustainable services and innovative approaches of working in partnership with the local acute trust and community care providers.

In conclusion, a diversification of day services offered to patients and carers can be facilitated with engaged managerial and professional staff without a significant increase in core workforce.

P-195 **PALLIATIVE CARE AS AN INTRINSIC PART OF INTEGRATED CARE – DOES THE MODEL FIT?**

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Introduction Integrated Care(IC) (Ham and Alderwick, 2015) is a model of delivering health and social care, adopted by a number of Clinical Commissioning Groups across East London. This facilitates professionals to work with their external partners, to streamline the patient pathway, and improve patient outcomes. Within this model it is expected that multi-professional teams within the acute and community services, spanning all disciplines, work in collaboration by meeting regularly to proactively plan holistic, person-centred care, rather than focus on separate diseases or co-morbidities, or psycho-social issues, thus aiming to avoid working in silos, in relation to patient care.

Aims One of the main aims of IC is to work towards agreed strategies to avoid hospital admission, and support patients to remain in their own homes. St Joseph's Hospice community palliative care team are active partners in the integrated care teams, and work with other health and social care providers to ensure patients in the last years of life are enabled to be cared for, and die in their preferred place.

Methods In this presentation we will describe how all relevant professional groups, from all care settings, and involved in patient care meet monthly within every GP practice across the borough in Integrated Care meetings. The focus of these meetings is patient focused, where the most vulnerable patients within the practice are discussed, and a holistic plan of care is agreed using the knowledge and expertise of all the professionals present. This model has replaced palliative care specific meetings where the meeting was focused only on patients approaching the end of life. Through these changes, we will demonstrate the changing nature of referrals to the community palliative care team, which may have implications for the future direction of the hospice.

P-196 **CLINIC OR HOME**

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Background In September 2012 the increasing number of patients referred to St Catherine's Hospice Clinical Nurse Specialist (CNS) service, gave the opportunity to explore another option for patients to receive an assessment other than at home. An outpatient clinic service was commenced.

Aims To enable the CNS team to be more responsive to patient referrals. Assessing patients who are well enough in clinic will allow more time for those patients who need to be seen in their own home. A range of other benefits and also some challenges were identified:

- Maintain patient independence
- To optimise patient choice
- It supports the first introduction to a hospice
- Reduce travel costs for CNS team
- Patient may not have transport
- The patient may not feel emotionally able to attend a hospice
- Patients have so many appointments it may be more comfortable for them to be seen at home
- Precedents set by other health professionals that the CNS visits all patients at home
- A change of culture for community nurses who are accustomed to seeing patients at home.

Methods Initially the clinic idea was quite simple in its design; a weekly clinic at the hospice providing four appointment slots.

Results There have been regular audits since 2012 which resulted in further development of the CNS clinics; leading to the current service of two clinics per week. One held at the hospice and a second clinic at the premises of a local cancer charity; providing ten appointment slots per week.

Conclusion It is recognised that patients assessed in clinic are a small percentage of the CNS clinical workload. The aim is now for each CNS to have their own caseload clinic in the community. This is currently being piloted by one CNS having a fortnightly clinic in a GP practice (February 2016).

P-197 **THE IMPLEMENTATION OF OUTPATIENT NURSE LED CLINICS BY THE COMMUNITY HOSPICE NURSE SPECIALIST TEAM**

Paula Taylor. *Wigan and Leigh Hospice, Wigan, UK*

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During a Strategic Away Day in November 2013, the Hospice Nurse Specialist Team (HNST) at Wigan and Leigh Hospice identified the necessity to increase responsiveness to patients' needs during periods of high demand upon the service, by considering ways of increasing overall efficiency. It was agreed to introduce nurse-led clinics for those patients functionally able to attend the hospice, using the WHO performance status tool for guidance.

The HNST have provided face to face assessments in the homes of their patients for many years. Nurse-led clinics was a significant change in approach to the model of care and