update was delivered to all staff utilising the resuscitation council ‘lifesaver’ app. As there are no hospice specific resuscitation guidelines, our was updated in line with adapted guidance for primary care and community hospitals, to incorporate the skills of rotational doctors with advanced life support certification. An emergency trolley was introduced to centralise equipment, with an added laryngeal mask airway and a pre-connected bag and mask, and a second AED was purchased to provide quick access for the whole hospice.

Conclusions There are no specific best practice guidelines for managing cardiac arrest in the hospice setting. Following a clinical incident, we have adapted the resuscitation council guidance to develop a local policy. In the future, as we care for more patients earlier in their illness, this contentious issue is likely to present more frequently. Developing a local policy could help ensure high quality resuscitation care within the hospice in response to the changing needs of palliative care patients in the future.

124 ONE HOSPITAL TEAM, THREE SITES

Background Northumbria Healthcare NHS FT specialist palliative care hospital liaison service (HLT) is a unified team working across three acute hospital sites with one Specialist Emergency Care Hospital (NSECH). Patients are admitted to specialties wards in NSECH for urgent assessment and treatment. If their condition is stable but requires them to stay in hospital for longer than 48 hours they are transferred to one of the other two ‘base’ hospitals (WGH or NTGH) for ongoing medical, and palliative, care.

Methods Data were collected using a standardised database across the three sites. Age, diagnosis, Australian modified Karnofsky Performance Scale (AKPS), phase of illness, and duration of episode of care (time from referral to discharge/death or transfer) were analysed for three sites between August 2018 and August 2019.

Results Data demonstrates that patients in NSECH were younger, more likely to have cancer (66%), and had a mean duration of episode of care of 1 day. In contrast, patients in the base hospitals were older, with 66% and 73% of patients respectively, over 75: in NTGH 40% of patients were over 85 years old. These patients were more likely to have non-malignant disease (45% with non-malignant disease), and frailty was the primary diagnosis in 13%; frailty and dementia combined were the primary diagnoses in 18%. In spite of this, AKPS was similar across all three sites, with the majority of patients being 30% or less.

Discussion Acute services across the whole trust have been transformed since NSECH opened, and the HLT patient population across the three sites has radically changed. This is a responsive team which has adapted to patient need on the individual sites, and reconfigured in an iterative manner according to this need. Future palliative care services must be able to adapt and respond to the increasingly dynamic demands of the population.