

Results Response/learning from these events will be captured using film, questionnaires and focus groups and used to inform and update the hospice's dementia strategy. Key messages will be presented at conference with development of ongoing engagement and future research plans.

Conclusion Sharing experiences and displaying new, creative possibilities will aid understanding of those with barriers of memory and communication, unlocking gateways to connection with people living with dementia is possible.

P-20 THINKING AHEAD CLINIC – EQUITABLE PALLIATIVE CARE FOR LIVER DISEASE PATIENTS

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In early 2019 Keech Hospice Care was contacted by the consultant hepatologist at the local hospital who was concerned that liver patients were experiencing inequality of access to palliative care services. Due to the complexity of these patients they have high hospital attendances/admissions (over 70% of patients with advanced liver disease die in hospital), which could be prevented with increased shared care between the acute hospital and the hospice.

Two nurse practitioners from the hospice started working with the consultant hepatologist and commenced 'thinking ahead clinics'. A nurse practitioner joins the consultant in the hospital outpatient clinic to introduce hospice care, patients would then be invited to the hospice's nurse-led liver clinic.

The 'thinking ahead' clinic was initiated to talk about advance care planning, ensure the patient has access to all hospice services such as community support emotionally and physically; social work for help with finances, housing and will writing; carers support; talking therapies for emotional support; access to venepuncture, infusions and palliative doctor reviews, along with the rehabilitation team which facilitates keeping palliative patients well for as long as possible and our inpatient unit for symptom control or end-of-life care.

The community specialist teams accept referrals when there is complex physical or psychological needs. Until this time liver patients have limited access to services and support. By attending liver clinics we can ensure they have access to the right care throughout their illness so that plans are made before a crisis hits. This includes referring and working with community nursing teams, GPs, hospitals, the homeless and drug and alcohol services.

'The work we have been doing together, and the achievements are fantastic... an excellent example of what we can achieve by working together. I am very happy to know our patients have a better quality of life with our joint input' (Hepatology team: Acute hospital).

P-21 A COLLABORATIVE INITIATIVE TO PROVIDE SUPPORT TO A MENTAL HEALTH UNIT DURING A COVID-19 OUTBREAK

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Background In January 2021 there was an outbreak of COVID-19 at a local mental health unit. This adult unit with 67 beds cared for multiple psychiatric conditions. The appropriate transfer to the acute hospital of ill patients and support for the psychiatric team in managing those patients not for escalation was required.

Aims To promote equality of access for psychiatric inpatients who became ill with COVID-19 to appropriate management including from acute medicine and from palliative care.

Readily available palliative care support to medical and psychiatric teams regarding symptom control.

To enable decisions to be made re appropriately not escalating care to the acute hospital with the security of timely access to palliative care support.

Methods Establishment of a virtual ward round (VWR) at a set time daily attended by the psychiatric team, an Acute medical consultant and consultant or SpR in palliative care. Inclusion criteria were agreed for which patients to bring to the VWR. A treatment escalation plan was discussed for each patient.

Results VWR ran daily for three weeks and alternate days for a further two weeks. Twenty-five patients aged 20-80 years were referred to the VWR with a range of psychiatric conditions and medical co-morbidities. Twenty-three of the 25 were judged appropriate for escalation of treatment. Eight of the 23 were admitted to the acute hospital, two of whom died. For the remaining two patients the decision was made not for escalation, care to continue at MHU.

Conclusion The VWR provided a clear and timely process for referral and discussion of symptomatic patients. Treatment escalation plans were made in collaboration with the psychiatric team who knew the patients well, together with the expertise of acute medicine in the context of support from the palliative care service should the MHT need to care for those at end-of-life.

P-22 PALLIATIVE CARE FOR ADULTS WITH NEURODISABILITY: PARTNERSHIP WORKING TO ACHIEVE SUSTAINABLE SUPPORT

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Background Adults who have grown up with neurodisability experience multiple unmet needs (Solanke, Colver, McConachie, On behalf of the Transition collaborative group, 2018; PCPLD Network, NHS England, 2017). They are more likely to have unanticipated deaths, with limited opportunity for exploration of their holistic needs and wishes (Todd, Bernal, Shearn, et al., 2020), however, the unpredictable and long natural history of their condition makes it difficult to know when they would benefit most from palliative care input. Few adult palliative care services can sustain support to patients with a complex but stable condition who may live for many years.

Aims We explore a new model of collaborative working to sustainably address the unmet palliative care needs in this patient group. By regularly meeting with specialist clinicians from neuro-rehabilitation, respiratory medicine, intensive care, neurology, primary care and gastroenterology, palliative care specialists aim to:

- Identify patients who need holistic symptom assessment.
- Contribute to future planning and complex decision-making.
- Sign-post to support that is local to the patient.
- Advocate for improved person-centred care during hospital admission.
- Facilitate continuity of care during transition from children's services.

Methods and impact The cross-service multidisciplinary team meet bi-monthly. Data for all outputs and activity are recorded. Palliative care outputs of the meeting include plans for advance care discussions; symptom management advice; discussion with local community palliative teams; and referral to a bespoke young adult palliative care clinic. Additional benefits include peer support within the group and teaching opportunities with specialty teams. Further time is needed to evaluate the impact on patient experience although initial feedback from patients and professionals has been positive.

Conclusions We describe a new model of palliative care input for a patient group who are known to have multiple unmet needs. Outcomes to date demonstrate that the model is sustainable, supportive to staff, harnesses and enhances generalist palliative care skills, and is likely to improve patient experience and continuity of care.

P-23 HOSPICE HEARTY MEALS: TACKLING FOOD INEQUALITY DURING THE PANDEMIC

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10.1136/spcare-2021-Hospice.44

Hospice Hearty Meals was inspired by our patients in response to COVID-19. Due to reduced activity, some patients' function decreased, affecting their ability to cook nutritious meals. Others, who relied on family/friends to prepare meals, were impacted by shielding.

St Andrew's Hospice suspended outpatient services to comply with Government guidance and reduce the risk to vulnerable patients/carers. During telephone and video support calls a need was identified in accessing nutritious meals. Clients were no longer participating in regular exercise/activity and were losing function/dexterity and struggled to prepare meals, they became reliant on ready meals/snacks. Others depended on family/friends to support them with home-cooked meals and this wasn't an option. Carers advised the catering burden on them during the pandemic and lack of respite meant they were struggling and cooking less. Carers were fearful of visiting shops and having no-one to stay with their loved one.

Method Costings were included for a 12 week trial, for the most vulnerable patients/carers. A fresh, nutritious, two-course meal (soup/main or main/pudding) was prepared onsite and packaged based on requirements (for oven reheating or microwave). Delivered three times per week.

Results and conclusions 579 meals were delivered in the 12 weeks of the project. 100% of respondents rated the service as excellent. Feedback found this service to be invaluable during uncertain times. Patients/carers reported that they ate well, were less anxious and felt more able to cope.

'Great service especially when going through such a hard time.'

'This service has improved my health greatly by relieving some of the stresses of lockdown.'

'Excellent service which saved 'valuable time' to spend together[with loved one] before death.'

Moving forward Due to this success we applied for funding which allowed us to continue and to date we have provided over 1000 meals to patients/carers across Lanarkshire.

Mental health, wellbeing, bereavement and communication

P-24 WORKING IN BEREAVEMENT WITH PEOPLE WITH AUTISTIC SPECTRUM CONDITION

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Background A principal difference between neurotypical people and those with autistic spectrum conditions is reliance on structure and sameness (Cohmer, 2014). There is evidence that people with autistic spectrum conditions lack flexibility of thinking (Ciesielski & Harris, 1997). The ability to react to events or small changes can trigger anxiety. Little sabotages structure and sameness more than a death.

Aims Dealing with death is difficult, and for somebody with an autistic spectrum condition, it may introduce more challenges and anxieties. Routines change, people behave unusually, emotions can be all-consuming. People with autistic spectrum conditions can experience Alexithymia, the inability to differentiate between emotions (Poquérusse, Pastore, Dellantonio et al., 2018), highlighting the need for effective and immediate emotional support pre- and post- bereavement. Hospice social workers recognised the importance of providing effective and specialised support for people with autistic spectrum conditions pre- and post- bereavement.

Methods An example of this is the use of widgets to explain death, dying and bereavement to individuals with an autistic spectrum condition. Widgets are an augmentative communication system using words and pictures to enable understanding and to processing messages. They are an ideal way to refer back to a social story or schedule to consistently communicate a message. Examples of how widgets can be used are: what happens at a funeral, what is cancer etc.

Results Feedback has been good with a high level of engagement from people with autism and learning disability. This approach led to relationships developing with services and schools around the county that support people with these conditions, facilitating consistent organisational approaches.

Conclusions Objectives are to build on achievements in terms of inclusive support. The hospice now has an inclusion and diversity working group, delivering training sessions internally and externally to raise awareness and to support others to develop practice in this area.

P-25 SUPPORTING CHILDREN TO PREPARE FOR THE DEATH OF A PARENT – EXPERIENCES OF AN ACUTE HOSPITAL

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Background Annually across the world a substantial number of dependent children experience the death of a parent through