Models of care were not specifically prescribed, hospices' ICP commissioning arrangements meant that there were different starting points and local requirements, but it was agreed that measures of success might be:

- Number of patients supported and the number of interventions offered.
- Patients managed in preferred place of care.
- Number of hospital admissions and primary care interventions avoided.

Hospices also agreed to provide compelling patient stories to 'bring to life' the power of the work they could do as 'community anchor' organisations to support the wider system and to reduce health inequalities. Pilots were diverse and successful, many have now become part of core services.

P-210 COVID-19 SILVER LININGS – ENHANCED COLLABORATION WITH HOSPICE PARTNERS

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10.1136/spcare-2021-Hospice.225

Background The COVID-19 pandemic, whilst challenging for all, acted as a catalyst for collaboration between NHS partners and hospice colleagues to improve service delivery across all settings.

The directors of care from four hospices met weekly with commissioners to provide support for one another and to work collaboratively to ensure increasing demands were met and good practice shared. This collaborative effort paid off with a successful joint bid for additional funding to enhance 24/7 care and support for care homes. Key outcomes were delivered and care enhanced through new and different ways of working.

Aim Our main aim is to learn from this experience to transform care for people receiving palliative and end-of-life care across our Integrated Care System. Emerging from the second wave, the four hospices were keen to learn from this experience, to optimise opportunities and improve quality of care for patients, their families and bereaved clients. A joint Hospice Collaboration Project group was set up with fortnightly meetings to develop key collaborative projects.

Methodology The group will work collaboratively to:

- Identify population health needs in relation to palliative and end-of-life care.
- Create a model of partnership which influences and shapes best practice, that is sustainable and maximises statutory and voluntary income to meet the outcomes of the needs analysis.
- Meet the requirements of the national, regional and local population health agendas.
- Share best practice and offer joint solutions where possible demonstrating the ongoing 'added value' of hospices in care delivery.

Results At this stage the project is at the outset of shaping a sustainable way ahead, working with system partners including the Palliative and End of Life Care Delivery Group and commissioners and learning from other hospice approaches. Our methodology has backing from the ICS and regional strategic clinical network.

Conclusions It's early days but there's great energy, inspiration and willingness for continued improvement to service delivery as demonstrated during the pandemic.

P-211 LESSONS IN END-OF-LIFE COMMISSIONING: A BRAVE MOVE?

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10.1136/spcare-2021-Hospice.226

Background Mid Nottinghamshire's population has a higher than average population of over 85s and a steadily increasing death rate, set to increase by over 50% in the next 30 years (Popnat). Providing quality care for this cohort is a huge challenge to the NHS and social care.

Aims Mid Notts CCG contracted a joint contracting mechanism to test whether a combined contract could produce savings whilst increasing quality. End-of-life care including specialist palliative care was the second service to adopt this approach.

Methods Mid-Notts End of Life Care Together Alliance (EOLCT) was commissioned in 2016. With a collaboratively designed strategy we were given a £3million envelope to provide services for a population of 356,000. A 10% QUIPP target applied in the first year. The budget was ringfenced: surplus could be used to improve services.

One acute trust, ambulance trust, one community trust, two independent hospices, two third-sector organisations and primary care partnered together, with close engagement with social care.

A care-coordination service (Call4Care) was started and staffed 24/7 with access to specialist palliative care nurses. Five key metrics were agreed. Our GSF-based EPaCCS template was used by all community partners with notifications to EMAS and 111. The A&E department had a readable version. EOLCT went live in October 2018.

Results EPaCCS (trend 2017-2020)

- Larger trusts provided financial assurance to third-sector partners.
- Earlier patient identification (0.22-0.66%).
- Those on register DIUPR (54.7-87%) with 61.9% overall. Nottinghamshire average fell to 56.6% during this time.
- Reduced hospitalisation and system savings.
- Better outcomes for individuals (commendations, fewer complaints).

Conclusion True partnership working arose from the process. The savings target was achieved and at a time where end-of-life admissions were rising, Mid Notts dropped. Further evaluation is planned with a view to possible further expansion.

P-212 RESPLENDENT: A SYSTEM-WIDE MODEL OF COORDINATING A CRISIS RESPONSE AND TRANSFORMING CARE

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10.1136/spcare-2021-Hospice.227

'*Resplendent*' is the Silver Command group which has met weekly, flexing to need, initially as an operational necessity to coordinate work in the first wave of COVID-19. Membership

includes primary care, acute, community services, public health, local authorities, the hospice and commissioners.

The group has developed into a highly-integrated strategic group that is able to facilitate and enact decisions and change based on the collective understanding and insight of the complex system. Rather than a group of individuals, this group now works and delivers as a strong and effective team. The effect of which is alignment and effectiveness in the system in a time of significant uncertainty and ambiguity.

Some key reasons for the success of this team is their focus on relationship and respect of and for all members, the lack of hierarchy and a collective focus, which is COVID-19.

During periods since March 2020 where COVID-19 was retreating, the group has considered 'wicked problems' within the local system, spending time considering urgent care, care homes and end-of-life and palliative care.

From the hospice's point of view, some of the key successes and contributions include:

- Offering to expand the catchment of the hospice rapid response service to provide additional overnight resource to district nursing.
- Seconding the hospice's rehabilitation team to provide additional community capacity where this was challenged.
- Being able to access COVID-19 vaccinations quickly and promptly by accessing vaccination capacity from partners from community services.
- Understanding pressures elsewhere in the system and better understanding system trends, giving the hospice insight into when demands on services are likely to peak.
- Enabled the hospice to tailor service provision to meet emerging needs, such as establishing a coordinated response to bereavement support with other local providers.

P-213 A VISION FOR SYSTEM WIDE INTEGRATED PALLIATIVE AND END-OF-LIFE CARE

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10.1136/spcare-2021-Hospice.228

Integrated Care Systems (ICSs) are central to the delivery of the *NHS Long Term Plan* and designed to bring together local organisations to redesign care and improve population health, creating shared leadership and action. In an ICS, NHS organisations, local authority and third sector partners such as hospices have the opportunity to 'take collective responsibility for the management of resources to improve the health of the population they serve'.

With these strategic opportunities on the horizon the BaNES, Swindon and Wiltshire (BSW) Palliative and End of Life Care Oversight Group, a combined provider and commissioner collaborative led by the three local hospice leads (Dorothy House, Prospect and Salisbury) formed in September 2020.

Over six months the group, made up of 30 provider organisations working in partnership with ICS commissioners, co-created a new strategy for palliative and end-of-life care based on:

1. National and local policy and strategy documents.
2. Quantitative analysis of local demographic and outcome data.

3. Qualitative/lived experience feedback obtained from an ongoing survey of patients', carers' and families' experiences of end-of-life care.

4. Mapping of services against items 1, 2 and 3 above.

5. An ambition to deliver services that are value for money and delivering demonstrable positive outcomes for the local populace.

The strategy is framed by eight high level recommendations which highlight how success will be measured. The first, and arguably most innovative and/or controversial recommendation, is the creation of an ICS wide, hospice led, Palliative and End of Life Care 'Alliance'. With delegated budgetary authority this 'Alliance' will have accountability for ensuring equitable, outcome driven and cost efficient palliative and end-of-life care.

In June 2021 with unanimous ICS approval of the strategy, delegated transformation funds and hospice leadership, the 'Alliance' began meeting with an ambition to transform palliative and end-of-life care at scale across the system.

P-214 STRATEGIC ALLIANCE TO INTEGRATE QUALITY DEMENTIA SERVICES ACROSS NORTH STAFFORDSHIRE

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10.1136/spcare-2021-Hospice.229

Background and Aims Approach Dementia Support and the Douglas Macmillan Hospice (Doug Mac) joined together, in 2018, as a Strategic Alliance to ensure that local people affected by dementia are able to access the right support at the right time and live their life in the way that they choose, as dementia prevalence and impact increase nationally and locally.

Our vision is... to work together to integrate quality dementia services across our heartland of Stoke-on-Trent and North Staffordshire.

Our mission is... to respond effectively to the growing need for cohesive dementia support across our heartland by collaborating as two organisations with a shared ethos of compassion for the most vulnerable in our community.

Methods and anticipated Results To fulfil our mission and vision, we have prioritised the following strategic aims, which are to:

- Enable a consistent journey from dementia diagnosis to end-of-life.
- Share resources as required to ensure the right support at the right time.
- Increase staff knowledge, skills and resilience as part of a team.
- Develop a carer enablement program from diagnosis to end-of-life.

The introduction of a comprehensive assessment tool allows individuals, carers, Approach and Doug Mac staff to assess the dementia stage of an individual, thus referrals can be made to the right services for their needs. One such service is the face-to-face support at the Dementia Services Centre, on-site at Doug Mac, delivered in partnership by the Dementia Liaison Coordinator and Dementia Wellbeing Activity Officer to provide carer support in addition to an interactive stimulating activity session for the person living with dementia.