Conclusion The Alliance will develop a joined-up, holistic model of dementia support for the local community which puts the individual at the centre of their support, thus providing an integrated dementia support offering for local people from diagnosis to end-of-life.

P-215 MAKING AN IMPACT: TRANSFORMING PALLIATIVE AND END-OF-LIFE CARE IN LIVERPOOL

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10.1136/spcare-2021-Hospice.230

Palliative and end-of-life care services across Liverpool and South Sefton have been transformed over the last year to ensure that patients and their families have access to the right care from the right people when needed via a single phone number.

Patients and their families struggled to navigate previously complex health care systems in Liverpool. There were many different teams providing care across the hospitals, hospices, and community, usually requiring a referral for each new encounter resulting in duplication of work, multiple handoffs between services, and confusion amongst referrers. This meant that there was inequity in the level of service patients received and some patients were unable to get the care they needed.

The IMPaCT (Integrated Mersey Palliative Care Team) model is a consultant-led service to support patients nearing the end-of-life which was developed by reorganising existing services with key stakeholder involvement in the design. The essence of its success is collaborative working between services to prevent crises and timely response to problems as they arise. There are regular multidisciplinary meetings to ensure that services are directed to the areas of most need and ensuring that patients do not 'slip through the net,' especially on discharge from hospital.

There were 1320 patients supported by IMPaCT in April 2021. Referrals and calls for help come from any healthcare professional or patients and families themselves. Each call or referral is handled by a nurse specialist from the hospital, hospice or community specialist palliative care teams based in one of the two hospice hubs who assesses the patient's needs and arranges intervention by the most appropriate person, removing the need for the patient to contact multiple agencies and reducing stress. The patient stays on the IMPaCT register unless they die, move away, or their illness is cured.

P-216 AMBULATORY MEDICAL CARE: ACUTE PALLIATIVE CARE IN THE COMMUNITY

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10.1136/spcare-2021-Hospice.231

The IMPaCT (Integrated Mersey Palliative Care Team) model of care is designed to improve access for patients, their families, and professionals. The COVID-19 pandemic enabled implementation more quickly than envisaged.

Waiting times for medical appointments in our integrated palliative medicine service were in excess of two weeks, restricting the clinic system's ability to deal with acute problems. The team recognised that routine medical review of patients is often unnecessary, and with this in mind, all the referrals for outpatients are now assessed by a nurse specialist triage coordinator and those requiring routine follow-up are now fed into the nurse-led telephone assessment clinics for monitoring. There is a junior and a senior palliative medicine doctor assigned to the ambulatory medical clinic in the IMPaCT hub at Woodlands Hospice from Monday to Friday.

There are a small number of pre-planned appointment slots for follow up, but the rest are used for urgent assessment of patients in person, by video consultation or by phone. Domiciliary visits can be undertaken if needed on the day.

All admission requests and advice calls to the ward now come to the hub which means that the calls come into doctors with the necessary time to deal with issues as they arise, co-ordinating with other members of the team as needed. This also means the medical team on the inpatient unit have more time to see their patients. Co-location of the ambulatory medical clinics with the nurse triage coordinators has improved working relationships and means that all settings have an awareness of which patients are most complex. Admissions to the hospice are now appropriately more complex and the waiting time reduced to within 24 hours in the majority of cases in December 2020. Waiting times for medical assessments has reduced to within 24 hours of the request.

P-217 PROMOTING COLLABORATIVE WORKING BETWEEN HOSPICE AND RESPIRATORY TEAMS TO IMPROVE PATIENT OUTCOME

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10.1136/spcare-2021-Hospice.232

Background The Care Quality Commission states that the pandemic has highlighted the benefits of local health services collaborating and working in partnership (Care Quality Commission. Better care through collaboration, 2021). Collaboration can improve communication, reduce duplication of effort, improve working relationships and provide a better experience for health service users (Integrated Care and Support Pioneers Programme, 2014). With this in mind, we saw an opportunity for our hospice team to work in partnership with the community respiratory team, as historically there has been limited collaboration between the two.

Aims To improve and promote a respective understanding of each organisation's services. To promote the benefits of referring patients with advanced lung disease to the hospice at an earlier stage so they can fully benefit from our range of services.

Methods Two hospice physiotherapists were each seconded one day per week to the community respiratory team to assist patients with breathlessness management. The physiotherapists were allocated a caseload and from this they identified those patients who were currently also under the care of the hospice and those who could benefit from a referral.

Results In the first month, a total of 24 patients were seen. Eight patients were known to both teams, whilst 15 were identified as being suitable for referral to the hospice. One patient has not yet met the referral criteria. In November, half yearly results will be presented.

Conclusion This ongoing secondment is demonstrating that a significant proportion of patients under the care of the community respiratory team are suitable for referral to the hospice team. The physiotherapists are encouraging the community respiratory team to refer patients at an earlier stage, to enable patients to benefit from the range of palliative services including specialist symptom control and rehabilitative palliative care. The secondment is also proving to be a valuable way of building better relationships between the teams and a greater understanding of what each team can offer.

P-218 PROVISION OF A CONSULTANT NURSE LED ACUTE HOSPITAL END-OF-LIFE CARE UNIT TO MEET UNMET NEEDS OF DYING PATIENTS

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10.1136/spcare-2021-Hospice.233

Introduction In October 2019 within the acute hospital on the Isle of Wight we saw an increase in patients choosing to die in hospital if they were in the last days of life. This equated to 23% of the palliative and end-of-life care teams caseload and while this was recognised we also identified a consistent number of patients dying in the emergency department, CCU and ICU that were in the last hours to last day of life and had not been offered alternative preferred places of care due to high acuity needs.

Aim This resulted in a bold case being put forward to develop a 3-6 bedded nurse- led end-of-life care unit.

Method The proposal was supported as a pilot, underpinned by working with key partners which included Mountbatten Isle of Wight. Referrals are made to the IPET team who assess; if appropriate and in agreement with medical team, patient and family, then transfer to the Wellow Unit. The Unit is managed by an experienced palliative care sister and overseen by the consultant nurses and IPET team.

Outcomes On average the Wellow Unit cares for 34 patients per month and in January 2021 at the height of the second wave of COVID-19 we cared for 64 patients. In total over the last 12 months the unit has cared for 320 patients. After a successful 12 months of being in place and increasing beds to meet COVID-19 demand in 2020-21, the unit has now been made permanent.

Conclusion This development rightfully challenged this partnership working which ultimately strengthened the position we now find ourselves in. In sharing knowledge, skills and workforce resources we are now in a position to consistently meet the needs of the dying patient in the acute hospital.

P-219 KEEPING AN EYE: NURSE- LED TELEPHONE SURVEILLANCE IN THE HOSPICE SETTING

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10.1136/spcare-2021-Hospice.234

Prior to the start of the COVID-19 pandemic, Woodlands Hospice Wellbeing and Support Centre ran several regular groups plus nurse-led clinics for patients well enough to attend the hospice. When the pandemic started it was clear that this would no longer be an option as most of the patients were in the shielding category.

Clearly the needs of these patients would not go away but the community palliative care and district nursing services could not be expected to take on the role that the hospice had previously played, as they also faced increased demand due to the pandemic.

Out of necessity and working towards a new city-wide integrated palliative care model, a decision was made to move to a system of triage coordinators and regular nurse led telephone clinics to monitor these patients. The nursing team underwent an education programme to enhance their triage and symptom management skills and they had ready access to the medical team for support if there were problems.

Consultations are carried out by telephone or video consultation as well as face-to-face where needed. The nursing team gradually took over the surveillance role of the medical clinics to free capacity for urgent medical appointments so patients could be assessed by the doctors when problems arise or when symptoms are more complex. The triage coordinator now looks at all referrals coming into the hospice and assesses the patient's needs to ensure the patient is linked into the most appropriate services. All this integrated working has reduced the time from referral to comprehensive specialist nursing assessment in the hospice from two weeks to within five working days. The working relationships with all teams has become closer and more effective, and patients are still able to access services despite the restrictions that the pandemic has brought.

P-220 NEVER A DULL MOMENT!

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10.1136/spcare-2021-Hospice.235

Introduction As Mountbatten grew and expanded its locality, I was asked to consider working with hospital colleagues across two hospitals- one a District General Hospital and the other a University Trust - to build on existing relationships whilst forging new ones. This was a daunting prospect, considering myself a community nurse for the last 24 years! I also returned as a Clinical Teaching Fellow to University, delivering palliative and end-of-life care education to pre- and post-registration students.

Aim To build and grow new and existing relationships, sharing and developing nursing practice.

Method Working clinically with acute teams to augment patient care and deliver Enhanced Supportive Care clinics in a University Trust in parallel with a Medical Consultant to effectively double the clinic capacity. Also, delivering education and training around palliative care initiatives to both staff and students.

Outcomes The diversity of environments has taken me from practice in the community working with patients and families one day, such as supporting a couple to renew their wedding vows after many years together, knowing that time is short, to delivering care in an acute setting such as ICU the next day where a patient and family need support in symptom