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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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