management and psychological care to enable weaning from ventilation and a comfortable death.

Conclusion This new and unique role has reinforced the value of Consultant nursing practice at a clinical level, influencing and shaping nursing care in a live way. The transferable skills held have enabled dynamic nursing that could be seen as a blueprint for promoting a workforce development that is more resilient for the future, valuing the differing perspectives of nursing practice in both primary and secondary care.

P-221 A TALE OF TWO HOSPICES: THE DEVELOPMENT OF A UNIQUE SERVICE MODEL OF HOSPICE CONSULTANT SUPPORT

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10.1136/spcare-2021-Hospice.236

Background The Association of Palliative Medicine of Great Britain and Ireland (APM) state 'Palliative medicine is at a turning point in terms of delivering new service models' (Workforce Committee of the APM, 2019).

Ardgowan Hospice has had consultant recruitment challenges. Explanations include geography and no Clyde palliative trainee placements. There was an estimated 56 vacant UK consultant posts in 2018. Too few trainees and the removal of the CESR process means the number of prospective consultants is insufficient for service demand. A changing teaching curriculum and seven-day working creates concerns for junior-tier rotas which will impact the consultant on-call. With an ever-increasing demand of services, innovative staffing solutions are required so palliative medicine can continue to flourish in hospitals, hospices, and community.

Ardgowan Hospice (AH) and St Christopher's Hospice (SCH) developed an innovative service model for hospice consultant support.

Aim To develop and evaluate a remote consultant service model.

Method Quality improvement methodology enabled the design, development, and evaluation of remote consultant framework. Plan Do Study Act (PDSA) cycles, cause and effect analysis, field analysis, survey, and audit were all utilised.

Results

- In 2019, PDSA cycles showed that it was imperative that shared policies, guidelines, and protocols were established to provide seamless patient care.
- Quality improvement analysis highlighted important themes for cohesive working. These were team-work, flexibility and adaptability, continuity of care, as well as high quality handovers.
- Innovative IT solutions were developed to provide efficient communication within clinical governance structures.
- A 2021 audit showed 11 communications with SCH about 12 patients over a three-months period. This facilitated appropriate senior advice when required.
- A 2021 survey was conducted. The average satisfaction score was 8.5/10. A number of qualitative themes were identified.

Conclusion AH and SCH have shown that by completing a quality improvement project that it is possible to create an innovative remote consultant service provision model.

P-222 DESIGNING A MOBILE APP WHICH SUPPORTS UNPAID CARERS TO ADMINISTER SUBCUTANEOUS INJECTIONS

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10.1136/spcare-2021-Hospice.237

In the UK, most people wish to be at home when they die. Unpaid carers (family and friends) play a key role in ensuring a home death and many are willing to be trained to administer as-needed subcutaneous injections for breakthrough symptoms, to ensure timely symptom control for the person they are caring for. A team in North Wales developed the CARIAD package to train and support such carers, a new practice to most of the UK.

It is hypothesised that a digital app may be beneficial for both carers and the healthcare teams. It could provide more guidance, improve data collection, help facilitate monitoring through the real-time collection of data and support audit data collection. Therefore the Helix Centre, Central North West London (CNWL) NHS Trust and the CARIAD team have collaborated to design and develop a mobile app. We acknowledge that a digital product will not be right for every carer but it is essential to understand whether a digital offering can deliver the intended benefits.

A user-centred design approach was adopted by conducting moderated usability sessions with carers who had previously given subcutaneous as-needed medications. Testing user flows, content and barriers of using paper and digital versions together. After each round, we synthesised the qualitative feedback and made improvements. A pre-pilot study of the app is commencing imminently which will inform a formal pilot study in CNWL of a digital-first offering. If successful a healthcare practitioner view will be developed to aid remote monitoring and support carers.

The design process worked as intended. Unforeseen usability and accessibility issues were identified. Iterative improvement of the app has delivered a product that is well aligned with carers' perspectives and knowledge. We hope this will ensure that the app is easier and safer to use when supporting carers to administer and record as-needed subcutaneous injections.

P-223 SOCIAL WORK LED CARE COORDINATION WITHIN A COMMUNITY PALLIATIVE CARE TEAM

Catherine Thompson. Kirkwood Hospice, Huddersfield, UK

10.1136/spcare-2021-Hospice.238

The Kirkwood recognised through its user engagement with patients and carers that coordinating palliative health and social care for patients and carers can be extremely complex, confusing and stressful. It appeared to be a contributing factor to carer stress. The crossover from social care to healthcare was often very abrupt with no lead support along the way. It was identified that having a lead service able to remove some of the strain and pressure was needed with the right level of skills and knowledge to support and navigate the system.

The Kirkwood set up a two-year pilot project called the Care Coordination team. The team have developed a trusted assessor relationship with the Local Authority and Continuing Healthcare team and work across both services to better serve the patients and carers known to the team.

The Care Coordination team offer a telephone-based service with resource to complete home visits if required. The service is available seven days per week. The team have access to both health and social care records. They link in with PCNs, DN and Therapy services, carers' services, benefits advice etc. The team lead on Fast Track funding implementation and care planning and keep abreast of changing COVID-19 implications on care and care services.

The team has gone from strength to strength and from a standing start has now doubled the number of referrals it receives (data to be shared for final poster). The service supports patients and carers over time and maintains review contact checking in as and when the patient and carers requires it. The team plan to be developing their capacity to support more people by developing a volunteer role within the team and as part of a wider hospice development of drop-in hubs where they are able to share their health and social care skills and knowledge.

P-224 SOCIAL PRESCRIBING: FACILITATING THE INTEGRATION OF HOSPICE, PRIMARY CARE AND COMMUNITY DEVELOPMENT

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Social prescribing is a fundamental aspect of the NHS Long Term Plan. The roll-out of social prescribing is underpinned by the belief that individuals have the capacity to define and solve their own problems and that local communities are rich in social assets, skills and talents which can be tapped into to enhance and improve health and wellbeing. Social Prescribing Link Workers (SPLWs) aim to focus on what matters to each client holistically, looking at social, economic and environmental factors and creating personalised care plans to improve wellbeing linking in to local community resources and assets. This philosophy aligns with both the person centred ethos of hospice care and the Public Health model of Palliative Care.

Aims To adopt a partnership approach to develop and deliver social prescribing through hospice partnerships with local VCSE organisations and local PCNs to develop and deliver social prescribing. Commitment to learning and developing together rather than 'doing' social prescribing through service provision, drawing on the strengths of the local community and the partner organisations.

Actions

- Social prescribers in post fully funded through PCN with commitment for five years - links built with GPs, hospice and other services.
- Partnership approach embedded, service launch in March 2020 – impacted by COVID-19 pandemic, an opportunity and a threat.

Outcomes

- Social prescribing now embedded in local community and GP practices. Over 500 referrals received in year 1: bereavement,

end-of-life care plans, carers support identified as some of the key challenges people face.

- Data and case studies support difference Social Prescribing is making on individual and system perspective.
- NHS Graduate evaluation report completed.

Conclusion Involvement in a partnership approach to social prescribing is supporting the hospice in facilitating a public health model to palliative and end-of-life care being adopted as part of the wider system change.

P-225 ESTABLISHING A PATHWAY OF CARE FOR YOUNG ADULTS WITH LIFE-LIMITING ILLNESS

Clair Marshall. Nottinghamshire Hospice, Nottingham, UK

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Background Until April 2019, there was no clear pathway in our region for young adults to make the transition from children's hospice care to an adult hospice environment. There is a growing focus on making sure that young people with palliative care needs have a positive experience of transition from child to adult services (Marie Curie Cancer Care & the Transition Partnership, 2012).

The number of young adults with life-limiting and life-threatening conditions is much higher than previously thought and numbers are increasing. This increase has come about because children are now living into adulthood due to improvements in medical technology, such as night-time ventilation (Fraser, Miller, Aldridge, et al., 2013).

Aim To establish a clear pathway from children's to adults' hospice services.

Method Using funding awarded by the Albert Hunt grant, we worked alongside our local children's hospice to identify young adults being discharged from their service.

May – July 2019 consultations and co-production with young adults, their families, health professionals, links with partner agencies, television and radio promo. July 2019: first Open Day for consultation with young adults and their families. September 2019: second Open Day to launch the Young Adults' group.

Results Young adults accessing our services: 11 young adults attending the Young Adults' group: 7. In addition to young adults transitioning from children's hospice care, we also support young adults who are newly diagnosed.

Conclusion The Young Adults service is now fully embedded into the core offer of our hospice services.

P-226 ONE STOP DUCHENNE MUSCULAR DYSTROPHY CLINIC; A UNIQUE NHS – YOUNG ADULT HOSPICE COLLABORATION

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Background The driver for creating an integrated clinic came from patient feedback highlighting a lack of co-ordinated care across health care services, inappropriately equipped environments and multiple outpatient appointments. Studies have shown 'both quality of life and survival are better in neuromuscular populations treated in multidisciplinary clinics' (Pagoni, Nicholson, Leigh et al., 2017).