

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

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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).