P-31 ALLIANCE: ENHANCING THE QUALITY OF LIVING AND DYING WITH ADVANCING FRAILTY THROUGH INTEGRATED CARE PARTNERSHIPS

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Background Frailty is a state of vulnerability that can lower physical and mental ability and increase the risk of disability, hospitalisation, and admission to residential care (Clegg, Young, Iliffe, et al., 2013. Lancet. 381: 752). Frailty affects around 10% of people aged over 65 (Clegg, Young, Iliffe, et al., 2013. Lancet. 381: 752), increasing to around 65% of people aged over 90 (Gale, Cooper & Sayer, 2015. Age Ageing. 44: 162), death from frailty is common. Older people with advancing frailty have complex care needs (NHS. The NHS long term plan. 2019). These needs require integrated health, social and third sector care, and a palliative care approach orientated towards living with, as well as dying from, advancing frailty (Evans, Ison, Ellis-Smith, et al., 2019. Milbank Q. 97:113). However, care is often not integrated and this can lead to poor quality end-of-life care for older people living with frailty and their families (Nicholson, Green & King, 2021. *In*: 17th World Congress of The European Association for Palliative Care).

Aim To develop a cross-sectoral partnership to improve end-of-life care coordination for community-dwelling older people living with advancing frailty.

The partnership ALLIANCE brings together three diverse regions of England: South East England, South West London and the East Midlands. Partnership members include stakeholders across the NHS, social and third sector care, local government, academic institutions, frail older people and their families.

The approach ALLIANCE uses a co-production approach and places older people and their networks at the centre of every activity. This includes Patient and Public Involvement and Engagement systems being embedded throughout. ALLIANCE also draws on Cooke's framework (2005. BMC Fam Pract. 6,44) for developing research capacity in care settings to support partnership members to become research-ready.

The phases

- Phase 1. Working together: Establish the Partnership, co-produce ground rules, and identify key contacts.
- Phase 2. Learning together: Map baseline activity in each region regarding current clinical services and research capacity and capability.
- Phase 3. Growing together: Support provider services to become research-ready and begin developing potential research questions.
- Phase 4. Building together: Establish research priorities and questions and develop research proposals.

Overarching outcome To develop co-produced, translational research proposals focused on enhancing the quality of living and dying with advancing frailty.

P-32 IMPROVING OUTCOMES FOR OLDER PEOPLE WITH FRAILTY: SHARED DECISION MAKING ACROSS COMMUNITY (CARE HOME) AND HOSPITAL SETTINGS

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Background Post COVID-19 and with anticipated winter pressures, there was a clear need to ensure older people with frailty had timely assessments, with access to high quality end-of-life care and support.

Aim To provide a rapid, coordinated response, to improve quality of care and decision making between patients, families and health care professionals across hospital and community settings and reduce hospital admissions from care homes (CH).

Methods The CCG funded a dedicated rapid response end-of-life care team: 2 senior nurses (1.6 WTE), medical consultant (0.2 WTE) working alongside existing services. They coordinated inter-agency working through face-to-face and digital communication, prioritising face-to-face review and involvement of relatives. We trialled new approaches to triage requests for support and provided interventions in CHs including quick access to medications, fluids and/or diuretics.

Results Over 11 weeks, 138 patients were assessed (mean age 88 ±7.5 years, 68% female). Half had diagnosed dementia, half had clinical frailty score of 8. Two thirds were in nursing homes. 39% were referred by their GP, 24% by the CH and 18% from hospital on discharge. 50% were seen face-to-face on the day of referral; 81% within a week. In 17.4% acute hospital conveyance was avoided by shared decision making between GP, LAS, CH staff and families. Treatment escalation plans were initiated for 56% and updated for a further 32%, including generation of shared electronic care plans. For 50%, single conversations with relatives were needed to support decision making; for a third this was more complex with multiple discussions over time. 36% died, with only 2 deaths in hospital. Whilst COVID affected 18 patients, only 2 of those died.

Conclusion Flexible, integrated working enabled patients to receive care and die supported in their usual residence. Care homes need focussed resources and support to hold uncertainty in this disadvantaged group who traditionally don't get access to specialist palliative care.

P-33 MAKING TREATMENT ESCALATIONS PLANS WORK IN A CARE HOME SETTING: INTEGRATED WORKING AND HOLDING RISK

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Background Older people with frailty living in care homes (CHs) are vulnerable to sudden deterioration and death. Unnecessary and unwanted conveyance to hospital could be avoided by robust treatment escalation plans (TEP). However,