Advanced clinical practice skills can be part of a wider clinical solution.

**P-61 ADVANCED LIVER DISEASE – WORKING COLLABORATIVELY TO IMPROVE PATIENT CARE**

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**Background**
Advanced liver disease is the second leading cause of premature mortality. With high symptom burden, frequent hospital admissions and poor quality of life, this patient cohort has substantial palliative care needs. Early provision of palliative care can lead to improvements in physical and psychological symptom burden and reduced health-care use. Prior to March 2020 a joint (Palliative Care/Gastroenterology) monthly advanced liver clinic existed at our hospice.

**Aim**
To provide early specialist palliative care (SPC) intervention for patients with advanced liver disease.

**Method**
The pandemic forced a natural temporary closure of this face-to-face clinic. Review of data from this clinic demonstrated: Late referral to the SPC team; High non-attendance rates; Lack of flexibility regarding SPC clinical review. This led to the need for a different approach to support this patient cohort. Between 2020–2022 direct referrals to the SPC community medical team increased and specialist liaison was supported by the new IT developments that we all witnessed in the pandemic. In 2023 an advanced liver disease MDT was established between the hospital-based gastroenterology team and the SPC team at the hospice. Currently bi-weekly virtual meetings discuss new referrals to SPC, obtain patient management advice from the specialist colleagues and update on shared-care patients.

**Results**
This service development has so far:
1. Facilitated regular meetings and additional liaison between the two specialties.
2. Increased referral rates to SPC.
3. Improved referral process into SPC services.
4. Decreased the waiting time from referral to clinical review by SPC teams.
5. Supports recent NICE guidance – mandatory to discuss the consideration of an indwelling peritoneal catheter (pleurX) at an MDT.

**Conclusion**
Symptom burden in advanced liver disease is high. An advanced liver disease MDT provides opportunity to identify and discuss the supportive care needs of patients, establish reasonable ceilings of care, and clarify management plans.

**P-62 NEURONETWORK – THE LAUNCH OF THE NEUROLOGICAL COORDINATOR ROLE**

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An estimated 1 in 6 of the population is either affected by or diagnosed with a neurological condition at some point in their lifetime. The complex needs of these patients need a comprehensive approach to care that addresses the physical and psychosocial needs, often this group of patients are supported through Living Well or Day Therapy Units. As we returned to a new normal after the pandemic, several support groups locally had discontinued. In response to this local gap in services, we recruited a Neurological Conditions Coordinator and launched the NeuroNetwork. The role was developed to bring together healthcare professionals to help facilitate an integrated holistic approach to supporting those with complex needs. Key specialist nurses now join monthly to network and share knowledge. The initial relationship building further impacted on positive MDT working, and early identification of patients who may benefit from our services.

With around 800,000 hospital admissions resulting from the effects of living with neurological conditions, we further expanded with a Clinical Nurse Specialist with a specialist interest recruited into our specialist palliative care team to not only support complex symptom management but also conversations around advance care planning.

We have also started a support group for patients which empowers those with a neurological condition to get involved with physical activities, in addition to keeping minds active and giving the opportunity to meet new people. Often this group provides an initial introduction to Compton Care in a safe social environment. The coordinator’s role can range from signposting and supporting patients to achieve their goals, which could be anything – from supporting one of our transition patients going to college, to finding a job, to working with a patient with Parkinson’s Disease in feeling more confident with enjoying trips out.

**P-63 LIVING WITH A PROGRESSIVE NEUROLOGICAL CONDITION – THE DEVELOPMENT OF A THERAPEUTIC GROUP**

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**Background**
Prior to COVID-19, St Christopher’s Hospice operated under a hospice day care model. The need to develop a therapeutic approach for individuals with Progressive Neurological Conditions (PNCs) became evident based on feedback from day centre visitors. A number of individuals with PNCs attended the centre on a regular basis and had multiple referrals within the hospice. These individuals could not traditionally be discharged from the hospice and expressed the lack of peer support and isolation within the community.

**Aims**
Provide a therapeutic programme with peer support. Focus on the individual, rather than condition. Empower and enable individuals and carers to live fully. Facilitate discussions between ‘patient’ and ‘carer’, exploring roles and identities.

**Methods**
During lockdown, a programme was developed by the MDT offering all therapeutic services the hospice has to offer. This was conducted via Zoom, offering professional therapeutic intervention, combined with social activities. The last session of the programme ended with feedback and discussion to enable the future development of the programme.
Results Patient and carer feedback was collated using satisfaction surveys. Feedback highlighted the lack of psychosocial support in community. For participants with communication issues, the Zoom format did not work. Participants reported that hour long sessions with SaLT, dietetics, physiotherapy was not necessary as they had access to these services in the community; what was beneficial was therapeutic services such as art and music therapy, complementary therapy and psychosocial services.

Conclusions As a result of feedback provided, the programme was adapted, adopting a holistic approach. A five-week face-to-face programme was developed with a focus on providing psychosocial and spiritual intervention, peer group support and familiarising the patient group with hospice care. This was in line with the hospice-wide approach, shifting to a rehabilitative palliative care model with focussed therapeutic intervention and individualised goal setting. Feedback continues to be collected to evolve the programme.

P-65 POSITIVE IMPACT OF THE CHILDREN'S HOSPICE NURSE IN-REACH ROLE WITHIN THE ACUTE SETTING: CREATING A SEAMLESS APPROACH TO PALLIATIVE CARE
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Aims To educate and provide specialist palliative care in the acute hospital setting. Acute hospitals often have minimal understanding of the range of holistic palliative care services available to children, their families, and the wider professional network. To identify children who meet criteria for referral when they access acute services and support existing service users throughout acute admissions. Educate and support acute staff on the care of children with complex health needs to develop confidence and skills to improve the patient experience.

Methods Placement of a nurse within the acute paediatric ward one day a week, with an honorary contract and access to clinical utilities. Presence at core meetings to understand the needs of the acute staff and services. Deliver bespoke training to the acute team. Educate on referral criteria and services available to children and families. Provide respite for the caregivers during a child’s admission. Promote the hospice services on the wards. Be recognised as a member of the multidisciplinary team so that children and families are introduced to the concept of hospice services at the beginning of their journey, addressing myths and anxieties. Regular meetings with Matrons to continually review the service. Reciprocated education: Nurse to have opportunities to update acute clinical competencies.

Results Hospice care becoming embedded within the multidisciplinary team. Children and families being identified and referred earlier, improving their experience and journey. A change in the perception of what palliative care can offer. Increase in referrals, reaching more children who can benefit from the services. Collaborative working to provide seamless, holistic care to families. Breaking down barriers and addressing myths surrounding the word hospice. Supporting acute staff to provide quality care.

Conclusion Children being referred earlier. Established a strong link with one acute NHS trust, now developing this model with other NHS trusts that cover the hospice’s geographical areas.

P-66 SUPPORTING FAMILIES BEYOND NURSING CARE: THE IMPLEMENTATION OF A PRACTICAL SUPPORT SERVICE
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Background Completing everyday tasks such as gardening, cleaning or painting may not be a focus for families who have a child with a life-limited or life-threatening condition. The hospice strategy (2016 – 2021) set out to provide much more supportive care in the child or young person’s own home. The outcome of this project was to place trained volunteers in families’ homes to support with everyday household tasks. A pilot project assessed participants’ perception, identified immediate and long-term impact and monitored activities undertaken.