Methods Referrals between 1/1/16 and 12/5/16 were examined retrospectively. Patients were RAG rated at referral. The Integrated Palliative Care Outcome Scale (iPOS) and phase of illness (POI) were recorded at the first visit. Higher iPOS scores, 'Unstable/deteriorating/dying' POI or shorter time between first and second contacts were taken as proxies of greater palliative care need, with lower iPOS scores, 'Stable' POI or longer time between contacts indicating lower need. One way ANOVA compared RAG to total iPOS scores and time between contacts. Chi-Square tested the association between RAG and POI ('stable' versus 'unstable/deteriorating/dying').

Results 296 patients received a RAG rating. Of these, 217 had an iPOS and 207 had a POI completed at the first visit. Red patients had a mean iPOS score of 21, Amber 18 and Green 15 ($p=0.001$). The mean number of days between initial contacts was 3 for Red, 8 for Amber and 11 for Green ($p=0.001$). There was a significant association between RAG triage category and POI (Chi-Square=36.9, $p=0.000$). This was in the expected direction with 67% of patients triaged as Green assessed as 'Stable' at the first visit, compared with 46% of Ambers and 3% of Reds. 97% of Red patients were 'unstable/deteriorating/dying' at first visit, compared with 54% of Ambers and 33% of Greens.

Conclusions These findings support the RAG triage system as a way of prioritising new referrals to a SPC service.

0-10

COLLABORATIVE MULTIDISCIPLINARY CLINICS INCREASE ACCESS TO PATIENTS WITH NON-MALIGNANT DISEASE

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Background Few patients with non-malignant disease access hospice care despite having similar care and support needs to cancer patients.

Aims To increase access to hospice care and advance care planning for patients with non-malignant diseases, and to enable choice in end of life care and improved carer support.

Methods Separate hospice-based multi-disciplinary clinics were established for patients with advanced heart failure; respiratory and Parkinson's disease; and end-stage renal failure. The four clinics are staffed by a disease-specific physician, a palliative medicine physician, a hospice-based multidisciplinary staff and volunteer team and NHS-based disease specific clinical nurse specialists. Clinical assessments focus on quality of life, advance care planning and carer support, making onward referrals to other services as required. We report four years' experience of this new model of care.

Results Between April 2013 and March 2017, a total of 435 patients attended the clinics, with 1036 attendances. Patients with heart failure were the largest group (30%); with 29% being respiratory patients; 23% Parkinson's disease and 18% renal failure. 318 patients (73%) engaged in advance care planning discussions, with 66 patients completing formal advance statements and 28 completing advance decisions to

refuse treatment. 289 (66%) patients have made decisions to refuse cardiopulmonary resuscitation. 67 (15%) of patients had died by the end of March 2017, of whom 52 (78%) were supported to enable death in community settings (home 39%; hospice 22%; care homes 13%; other 9%). Only 12 patients (18%) died in hospital. Clinic patients and carers report improved quality of life and accessed multiple hospice and community based services as a result of initial clinic review.

Conclusions Collaboration between hospice, acute hospital and community trust health professionals has enabled mutual support and learning and provided a popular care model for patients with non-malignant diseases.

0-11

THE CHALLENGES OF A MODERN NURSE-LED PALLIATIVE AND END OF LIFE CARE UNIT

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Background This innovative project has brought together the knowledge and expertise of providing palliative nursing care from an NHS Trust with a local charity dedicated to ensuring patients have choice within their local area.

Aims From its inception at a public meeting to providing care to patients in a purpose-built six-bed unit, this project aims to provide quality care in a non-institutionalised setting. Its innovative approach comes from the nurse-led model where the patient's own local GP retains oversight and leadership of the medical care. It has been provided within a specified financial envelope, utilising the valuable skills of volunteers to support the care provided by nursing and support.

Methods The team has overcome and embraced a range of challenges. These have included:

- Ensuring positive engagement with local GPs – this includes raising awareness of a new service to encourage referrals, and engagement about offering a different approach to palliative and end of life care
- positive engagement with other referrers – the team has worked hard to establish their presence in the local community, even visiting every single ward of a neighbouring hospital to encourage engagement and referrals
- continuing healthcare resources – balancing the ethos of supporting patient choice with the availability of other health resources in the community through other care providers
- a bespoke staffing model, which meets financial efficiencies while ensuring an effective response to local needs. This has also given autonomy to Band 6 nursing staff and development opportunities for students.

Results Our innovative model has supported:

- increased patient choice in the locality good
- engagement with other professionals
- an equal balance between physical and spiritual care.

Conclusions The project has proved the innovative concept of a nurse-led model can effectively support greater patient choice and improve experience in a community setting.