

Friday staffed by experienced nurse specialists and administration support. The focus during this period was on defining patient need and priority, response, team capacity, ability to give specialist symptom management advice and support, referring and signposting to other appropriate services, reduction in hospital admission, patient, carer and health care professional satisfaction and improved caseload management. These initial service outcomes have shown significant increase in responsiveness and improved assessment of patient need and priority. The process was robust and is transferrable across other internal services at the hospice which could impact on time and cost effectiveness.

Conclusion The dedicated Triage Service will launch 26 June 2017 followed by the launch of the dedicated Advice Line in October 2017.

P-213 WIDENING ACCESS TO HOSPICE BEDS USING A NURSE-LED MODEL OF END OF LIFE CARE

Catherine Malia, Jayne Upperton. *St Gemma's Hospice, Leeds, UK*

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Background Nationally, it is recommended that dying patients have choice in where they spend their final days nominating a preferred place of death (PPD) (Department of Health, 2008; NICE, 2015). Where patients choose hospice, they may be ineligible due to lack of complex symptoms required to meet specialist palliative care eligibility criteria. Responding to identified need, we developed a nurse-led service offering end of life care (EOLC) to dying patients with generalist palliative care needs within a hospice environment.

Aims This project aimed to widen access to hospice beds enabling patients without specialist needs to die in their PPD.

Methods

- Innovating for Improvement award from the Health Foundation enabled project pilot
- Nurse Consultant appointed as project lead
- Nurse Consultant accountable for total patient care supported by a team of nurses trained in non-medical prescribing. This innovative approach is unique in an in-patient setting.
- Steering group of local stakeholders formed to direct the project
- Operational group formed to develop and drive the project
- Four beds within existing IPU designated EOLC beds
- Outcome measures identified to enable project evaluation
- VOICES survey adapted for carer feedback.

Results To date, 115 patients have achieved their PPD and would not previously have had this option. Median length of stay is four days.

We have:

- widened access, particularly to non-cancer patients (42%) and elderly (mean age 88)
- successfully tested a safe, effective model which is now a permanent service
- received positive feedback from patients, relatives and referrers
- increased bed occupancy maximising use of hospice beds
- reduced in-hospital deaths
- developed nurses' skills, knowledge and confidence.

Conclusions This project has enabled us to widen access for end of life care to a greater number of patients, particularly non-cancer patients and the elderly known to be disadvantaged in terms of access to hospice care (Health Select Committee, 2015). We have developed and sustained a successful and replicable model of end of life care.

P-214 PALLIATIVE CARE OUTPATIENTS IN THE HEART OF THE COMMUNITY

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Background The hospice is based in a large urban community with a diverse population. Traditional hospice CNS first assessment was in the person's home. The hospice designed a primary care clinic pilot based in GP surgeries to work alongside this model.

Aims

- Increase referrals from low-referring communities
- Provide choice of service in the patients' locality
- Provide efficiencies in CNS working in mileage and time.

Method

- Engagement with communities, referrers and primary care to scope and design the model with continued engagement
- Three weekly clinics piloted; two in GP Practice and one at the hospice, all in areas with diverse demography
- Referrals assessed as appropriate for clinic at first contact
- Mobile working enabled on remote site
- Use of IPOS for assessment and follow up.

How do we measure outcomes?

- Patient experience questionnaires
- Use of integrated palliative care outcome scale (IPOS) for assessment and monitoring
- A steering group of GP, patient representative, clinical leads and fundraising monitor progress and outcomes

Results

- 71 new patients seen across three clinics in 10 months
- 94 follow-up appointments
- 165 total consultations at clinic.

This is approximately 8% of total caseload.

Mileage costs and time are reduced. Mobile IT enables efficiencies and access to records. Clinics have created choice for those who do not wish to be seen at home. The hospice clinic has created an opportunity to experience the hospice environment. Complex holistic care can be managed in a clinic setting. Questionnaire feedback demonstrates; appreciation of choice and improved quality of life.

'We are feeling more positive with the future and understand that we are not alone. Thank you'

Conclusion CNS Outpatient clinics can lead to efficiencies in CNS working and improved primary care relationships. Clinics are a useful option to have alongside usual home assessment. Future plans are to increase clinic sites and develop integrated team working at sites.