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

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10.1136/bmjspcare-2017-hospice.238

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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10.1136/bmjspcare-2017-hospice.239

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.

P-215 THE SHAKESPEARE HOSPICE TRANSITIONAL CARE SERVICE INNOVATION IN PRACTICE

Angie Arnold, Hazel Godwin. *The Shakespeare Hospice, Stratford upon Avon, UK*

10.1136/bmjspcare-2017-hospice.240

Background In 2014 a bespoke Young People's Hub was opened within our adult hospice setting to provide transitional care. This was the culmination of three years' preparatory work, including consultation with life-limited young people. This model of care is unique within the adult hospice setting and was recognised in 2016 by winning a prestigious national award from Glaxo Smith Kline in association with the King's Fund.

Aims The aim of the service is to provide a seamless transition for young people with life-limiting conditions aged between 16–24 years of age. The focus is to provide specialist, age-appropriate respite day care that supports every individual to achieve their maximum potential.

Method Consultation took place with all key stakeholders from health, education and social care to provide a homely social hub. Within this bespoke facility is also a wet room and specialist equipment to enable some of our young people, who do not have these facilities at home, to relax and bathe. Counselling rooms; play therapy room; a sensory room and a courtyard garden are also provided.

Conclusion Whilst developing this model of care, we reviewed our vision and mission statements to incorporate this new service. Alongside the transitional care service, the Young People's Hub also houses a Children's Bereavement Service and our Young Carers support group. Since its inception at the Shakespeare Hospice, we have received referrals from Warwickshire, Birmingham, Solihull, Worcestershire and Oxfordshire. Our unique model of care is well known within the West Midlands Region and our team have presented our journey in developing transitional care on many occasions at various events across the UK.

P-216 ADULT AND CHILDREN'S PALLIATIVE CARE SERVICES WORKING TOGETHER TO TRANSFORM TRANSITIONS

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10.1136/bmjspcare-2017-hospice.241

Background There is growing evidence of the increased number of young adults (YA) living with life-limiting conditions in Scotland (ChiSP Study, 2015), as well as evidence of their unmet needs and poorer outcomes (Care Quality Commission, 2014). As a result adult hospices have been challenged to acknowledge the role they have in supporting YA and their families (Together for Short Lives, 2013). To support the above transitions the Prince and Princess of Wales Hospice (PPWH) recognised the need to ensure their staff had the appropriate knowledge, skills and competence to support YA and their families. Recognising a gap in these areas the hospice sought potential support and collaboration with Children's Hospices Across Scotland (CHAS).

Aims

1. Develop and support hospice staff to deliver a high standard of care to YA and their families, identifying gaps requiring further training and education

2. Establish relationships and trust between children and adult hospice services, YA and their families
3. To inform the development of the hospice service model.

Methods

- Provision of joint workshops to identify staff's anxieties and learning needs around YA care
- Development of 18 month seconded programme to CHAS open to all hospice staff
- Post-secondment evaluation informed by feedback from workbook; staff questionnaire, 1:1 and group reflection.

Results To date 13 clinical and non-clinical staff have taken part in the secondment programme.

- All staff have reported a greater understanding of the needs of YA with increased confidence and empowerment to meet these
- Greater relationship and trust with YA and their families resulting in increased referrals
- Greater opportunity to engage with YA and their families which has informed the development of the YA Service Model.

Conclusion This partnership working has been an effective way of influencing and managing change. Directly impacting on patient and family experience, staff skills and confidence and co-production of a service model.

P-217 PAEDIATRIC PALLIATIVE CARE TRANSITION – A SERVICE EVALUATION OF SUPPORT FOR TEENAGERS WITH LIFE-LIMITING CONDITIONS IN SOUTH WALES

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Background With the increasing survival of children with life-limiting conditions, support through teenage years and into adult services is of vital importance to children and families. The All Wales Paediatric Palliative Care Team has identified the need to implement a robust transition service.

Aims Undertake a two stage service evaluation of transition support in South Wales:

- 1) An audit of current provision against national transition guidance from NICE (2016) and Together for Short Lives (2015)
- 2) A qualitative assessment of the transition process by staff and families.

Method A retrospective notes audit was completed using hospice and hospital records. Care provided for 20 patients of transition age (14–17 years), and 10 patients post transition (18+) was assessed. Semi-structured interviews were conducted with eight families and 17 staff working with transition patients in a variety of roles.

Results For 25% of families, transition was the main concern they had when considering their child's future. During transition planning, all families had their ethical and cultural needs considered, with family wishes/aspirations for adulthood recorded in 63% of cases. 13% had documented goals for transition. There was no documented support for developing identity/sexuality/relationships, or spiritual development. By transition age, 37% had their needs met by an appropriate adult service. Two-thirds of families felt well supported during their transition. 67% felt poorly informed regarding adult