Name	**Worthing collaboration between Western Sussex Hospitals NHS Foundation Trust and St Barnabas House hospice to improve EOL care for patients with liver disease: Advanced Liver Disease MDT and community based Advanced Liver Disease Nurse**
Type of project	Service development and evaluation
Aims/objectives	• Increase access to specialist palliative care and hospice services for patients with advanced liver disease • Reduce unwanted or inappropriate hospital admissions for patients with advanced liver disease • Reduce unwanted or inappropriate hospital interventions for patients with advanced liver disease • Increase numbers of patients with liver disease able to die in their preferred place of care
Inclusion/exclusion criteria	Criteria for discussion at MDT is deliberately loose – roughly based on the Bristol Poor Prognosis Score but not limited to this – any patient with advanced cirrhosis (usually Child Pugh C) whether a transplant candidate or not. Criteria for referral to the hospice Advanced Liver Disease nurse is possible prognosis of less than one year.
Description of intervention	Patients discussed at monthly MDT – presence of hepatology and palliative care consultants, community liver disease nurse, alcohol liaison services, social worker and hospital palliative care team. Meeting enables identification of those who would benefit from referral to the community liver nurse and other services, as well as agreement on appropriate medical interventions for next decompensation, and coordination of care. Patients referred to the community liver nurse receive a palliative care holistic assessment including assessment of carer's/family needs. Patients given opportunity to participate in advance care planning, to express their priorities for future care and interventions and their preferences for place of death. Anticipatory care plans then created and held with patient, on EOL register for paramedics to access and in hospital notes.
Measures used to assess progress	• Numbers of referrals to liver disease nurse and other hospice services. • Number of admissions to hospital in last year of life. • Admissions or interventions appropriately avoided, through following the anticipatory care plans. • Place of death. • Numbers of death in preferred place of death. • Feedback from patients, carers and healthcare professionals
Resources required	• Team willing to commit to monthly MDT. • Community advanced liver disease nurse (or engaged community palliative care nurse) • EPaCCs (or other electronic EOL register) or other format for storing and sharing advance care plans and anticipatory care plans
Progress	At end of one full year (Jan –Dec 2017), 80% of patients dying of liver disease had had contact with specialist palliative care. Half had been referred to the community liver nurse. Reduced hospital deaths from 73% (national figure) to 60% overall, but for the cohort of patients known to the community liver nurse and hospice services, only 26% died in hospital – remainder died at home or in the hospice. Most of these achieved their preferred place of death.

Lessons learnt	Challenges in ensuring all teams have access to the anticipatory care plans – including paramedics and hospital admitting teams (and that these healthcare professionals know to look for the plans) Significant challenges for community and hospice services: dealing with emergency events, supporting chaotic lifestyles.
Future plans	
Resources available	
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