

We plan to use our findings to educate local GPs about the risk factors that should trigger early palliative care referral. A tool to aid the early recognition of risk is currently in development and will be integrated into Pilgrims Hospice referral forms in the future.

P-92 IMPROVING TIMELY ACCESS TO SPECIALIST PALLIATIVE CARE, USING QUALITY IMPROVEMENT (QI) METHODOLOGY

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The aim of the project is to enable more people who are triaged as appropriate for admission by the multi-disciplinary team, to be admitted and receive timely specialist in-patient palliative care.

Background

The rationale behind the project was that:

- Data indicated an increasing demand on specialist palliative care beds
- There was evidence of the impact of delayed discharges on achieving timely access
- There is need to educate society about the changing role of specialist palliative care.

Aim The aim is to increase the number of appropriate admissions from 70% to 75%.

Method The project uses Quality Improvement methodology as the mechanism for improving practice. The driver diagram below demonstrates how we structured our project.

Small change ideas are being used to slowly make improvements that are effective and sustainable. An example of one change was to review the referral form and admission documentation to ensure from the point of referral that patients understand the reason for their in-patient hospice care and the potential for discharge.

The project is based on the Model for Improvement tool.

Results We are using a measurement strategy to map and evaluate our progress. We are making significant progress as for the last

eight months we have surpassed our original target and reached 79%. There are further change ideas that we intend to explore to help with sustainability and spread. One of these is holding a round table discussion with external partners to look at ways they can support the discharge process.

Opportunities We are intending that this project will enable us to maximise available resources whilst at the same time improve access to specialist palliative care to more people in a more timely way.

P-93 REACHING OUT – IMPROVING CARE BEYOND OUR HOSPICE WALLS

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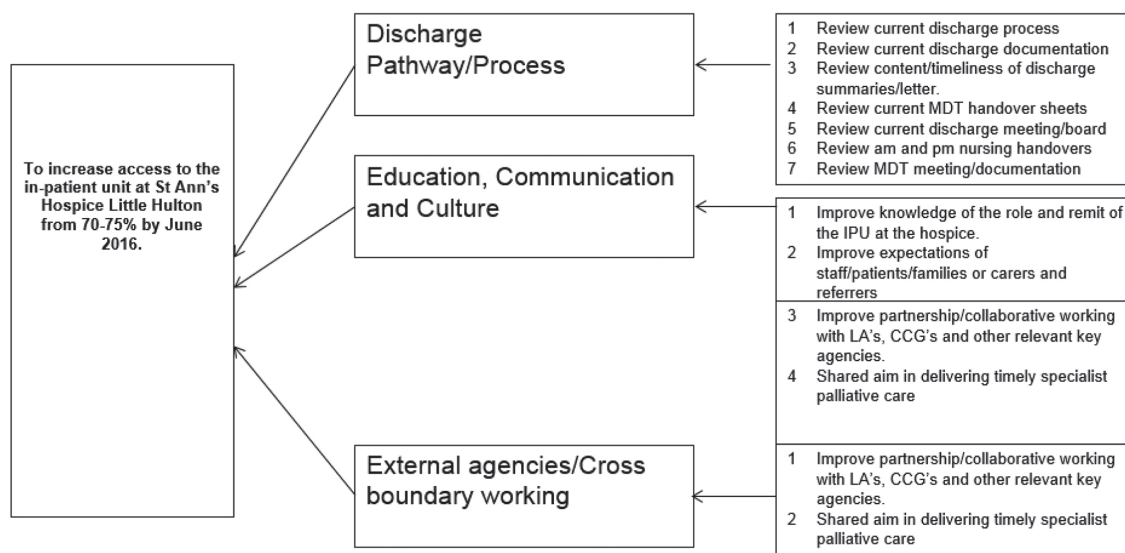
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Highland Hospice has a proud history of delivering and promoting high quality palliative care for our community, geographically the size of Belgium with a population of just over 220 000.

The sphere of influence of the hospice is far greater than the direct care we provide to patients, families and carers. It is acknowledged that while direct care can (and does) provide the highest quality response for the individual it is resource intensive. Indirect support can however potentially support many more people especially those who live in the more remote areas of our wide geographical area. As a result we are currently piloting a number of innovative and creative responses to deal with these geographic and demographic challenges using digital communication. In this way we are supporting more people to a higher standard at home or in a care home environment, increasing our value to the wider health and social care system and providing better quality care for those in need.

This outreaching of care is being developed in a number of different ways:-

- Using ECHO Highland Hospice Scotland – a collaborative web-based model of education and care management that moves knowledge without moving people.
- HHeLP – Highland Hospice electronically Linking People – an interactive, secure internet portal developed to provide



Abs P-92 Table 1

patients receiving palliative care with support and information in their own home.

- Helping Hands – a non-clinical volunteer support/befriending service supporting patients and their families in the last year of life at home
- Collaborative working with care homes in the NHS, Private and Independent sector to improve end-of-life care
- Working with community services currently being redesigned in several rural areas of Highland to support and improve end of life care closer to home.

This poster presentation will report on all these projects in action with updated results at time of publication.

P-94 IMPROVING ACCESS TO SPECIALIST PALLIATIVE CARE FOR PATIENTS WITH CHRONIC OBSTRUCTIVE PULMONARY DISEASE

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Background Chronic Obstructive Pulmonary Disease (COPD) is a life-limiting condition. In 2012 it contributed to 5.3% of the total deaths in the United Kingdom. Historically, patients with COPD have not accessed specialist palliative care services. However, there is evidence that patients with COPD have as disabling symptoms as those with cancer. It has been suggested that services need to engage with the COPD population differently due to the insidious disease course and trajectory.

Aim To investigate whether collaborative working has increased access for patients with COPD to palliative care services.

Methods Using the local hospice's CrossCare system we have investigated activity data for Wolverhampton patients in the hospice's different settings; community, day hospice, outpatient and inpatient unit. Data was collected from 2012–13 and 2015–16 to see the impact of a three-pronged strategy of education of the whole health economy, set up of a joint respiratory clinic and a multidisciplinary team meeting to discuss potential palliative patients. Patients with a primary referral diagnosis of COPD were included.

Results Collaborative working has increased access of patients with COPD to all hospice services from 2012/13 to 2015/16. There has been a 283% increase in patient numbers seen in day hospice. There was an 88% increase in patients seen by the community team and a 403% increase in the number of visits. There has been a 286% increase in patients seen in outpatients by the multidisciplinary team. There were no patients admitted to the inpatient unit in 2012–13 and 13 patients were admitted 2015–16 with 20 inpatient spells. This enabled four people with COPD to die at the hospice.

Conclusion Patients with COPD in the Wolverhampton area have demonstrable palliative care needs. This is an example of how collaborative working can improve access for this patient group.

P-95 IDENTIFICATION THROUGH INTEGRATION – INCREASING ACCESS TO PALLIATIVE AND END OF LIFE CARE

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Introduction Recognition that someone is entering the last year of life enables access to Palliative and End of Life Care (PEoLC). There is currently under-identification of people in the last year of life.

Aim To increase access to PEoLC through improved identification of the patients known to the Community Trust who are likely to be in the last year of life.

Method In 2014 all Community Trust specialist palliative care nurses (SPCNs) were integrated into seven community integrated care teams, each covering a population of c.100,000 people. The SPCNs were co-located and managed within those separate teams. Targeted PEoLC training was delivered to all staff.

The SPCNs were supported to improve PEoLC within their locality through an internal clinical network which included:

- Weekly Specialist Palliative Care multidisciplinary team meetings
- Senior SPCN leadership and support
- SPCN group clinical supervision
- Specialist Palliative Care clinical governance structure.

Results Two of the seven localities have been the most successful in improving identification of people in the last year of life with a 57% increase in number.

Abstract P-95 Table 1 Number of people identified as in last year of life on system1 two localities (annual snapshot march)

Year	2014	2015	2016
Number identified	183	223	288

These reflections from locality manager and SPCN appear key to improvement:

- Leadership from locality manager on integrating SPCNs
- Weekly locality multidisciplinary clinical meetings to share ideas, opinions, reflect, debrief, give informal education
- Increased visibility improves working relationships - more conversations, trust, respect, team-work, better understanding of roles/workload
- More shared care and joint visits undertaken
- SPCN facilitation of team action learning and clinical supervision
- Offer of uniform to SPCN.

Conclusion Integration of community SPCNs with leadership and support can significantly increase access to PEoLC through improved identification of people in the last year of life.

Next steps A comprehensive education programme is supporting staff development with the aim of further improving access to PEoLC and clinical outcomes. A PEoLC dashboard is in development to provide each locality with required clinical data.

P-96 A SNAPSHOT OF SOCIAL DEPRIVATION AND MULTI-MORBIDITY IN A HOSPICE INPATIENT POPULATION

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Introduction Recent research has suggested that people living with long-term illnesses in socially deprived areas have poor