share knowledge, tools and techniques for improving care for residents.

Using the impetus of "Dying Matters" week in May 2016, the Devon Care Home Kitemark group have now established a plan for a peer-review pilot of End of Life Care in their homes.

The initial pilot visits will be undertaken in Summer 2016, with a view to developing a process to be used across all 60 sites.

Methods included will be:

- Site visits undertaken by peers, with the support of the local specialist palliative care team where appropriate.
- Completion of peer review feedback sheets to clarify strengths and challenges for each home.
- The process will be developed and refined over time, according to feedback from staff, residents and managers.

Rather than using existing models of teaching and training in care homes (eg. Six Steps, GSF for Care Homes), which have to date been led by "experts", this work has uniquely been driven by care homes themselves. The aim is that homes will be able to make quality improvements in a meaningful, sustainable way.

By looking carefully at generic challenges for the Kitemark Homes in the local area, a further key aim will be to identify how to improve End of Life care across boundaries for our care home residents.

P-161 ABSTRACT WITHDRAWN

P-162 CHAMPIONING SPECIALIST CARE AT HOME IN EVERYDAY DYING

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10.1136/bmjspcare-2016-001245.184

The cancer story is changing, by 2020, almost one in two people will get cancer and 47% of those who died that year will have had cancer. We are reminded that choice at the end of life is so important and Macmillan wants everyone to have more choice.

This session looks at the Macmillan Specialist care at Home partnership approach to providing palliative care to people in the community. It's based on the successful model developed in Midhurst where people experienced less frequent A and E attendances, decreased hospital stays and a majority of people died in their preferred place. Macmillan have since identified and supported six innovation centres that have adopted this model.

Each centre has adopted the model of person-centred care, which emphasises principles such as having a consultant led multidisciplinary team – doctors, nurses, clinical nurse specialist, occupational therapist, physiotherapists and counsellors; flexible teamwork between specialists, generalists and trained volunteers in the community. This has enabled timely referral, home-based clinical interventions and close, flexible collaboration between primary care and other community-based services. Each centre is working in partnership with many different partners such as commissioners of end of life care, community/hospital providers and hospices.

The philosophy that makes the Macmillan Specialist Care at Home approach so successful is to ensure that the person and their families feel well supported and they receive personalised, coordinated care and this session will showcase some of the findings of this project.

P-163 THE PALLIATIVE CARE PARTNERSHIP...THE STORY SO FAR

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10.1136/bmjspcare-2016-001245.185

Introduction In April 2013 the Palliative Care Partnership, a collaboration between a NHS Community Palliative Care Team and a charitable Hospice at Home service was commissioned to provide community palliative/end of life care for patients in the local area.

Aims of service Improve outcomes for all patients locally with palliative/end of life care needs, regardless of diagnosis

Improve patient and carer experience

Maximise use of existing resources by reducing duplication and optimising efficiency: "right care, right time, right place".

Methods More joined-up approach to care/support achieved by:

- Single point of access 24/7 via telephone hub, manned by NHS and hospice staff
- Joint triage system
- 7 day week visiting service
- Shared electronic patient record system
- Joint multidisciplinary meetings
- Joint governance framework
- Collaboration with other services.

Results

Successes:

- Key Performance Indicators (KPIs) met/exceeded
- Reduction in inappropriate hospital admissions (>10/month, a saving of at least £200,000/annum to local health economy)
- Dying in Preferred Place of Care increased to 89%
- Telephone hub activity increased by over 50% out of hours
- 64% increase in first year in number of referrals with highly complex needs
- Carer feedback shows 83% received help as often as they needed
- Excellent feedback from local services
- Rating of "Outstanding" for responsiveness in Trust's latest CQC inspection.

Challenges:

- Demand on telephone hub soon exceeded capacity. Given the cost effectiveness of the service and impact on outcomes, additional resource was awarded by the commissioners
- Merging two organisations with different cultures, funding arrangements and systems. The common goal of high quality patient-centred care helped to overcome these challenges
- Data collection has been time consuming. We are currently refining our processes.

Conclusions Partnership working can significantly benefit patients and carers and be cost effective. KPIs need to be reviewed regularly to drive further improvement. Data collection and audit are key for service development.

P-164 VOLUNTEERS AT LIFE'S END – VALE – IN THE COMMUNITY

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10.1136/bmjspcare-2016-001245.186