

- to provide emotional support to the dying and their families
- to facilitate increased understanding about the emotional and social needs of the dying, and their families, within the community and across the hospital environment.

Methods On the whole, healthcare professionals refer patients/families to the service manager who then meets the patients/families to understand their needs. An appropriate “companion” is allocated by the service manager and the “companion” is then introduced to the patient/family to provide face-to-face support tailored to their needs.

The service is evaluated on a continuous basis, using:

- Stakeholder feedback: from patients/families, staff and “companions” to explore the impact of the service on improving emotional support
- Activity data: completed by the “companions” capturing what support was delivered.

Results An earlier review suggested that hospital staff, dying patients and their families had very positive experiences of the service, with nursing staff seeing benefits in terms of patient and family wellbeing and their own stress levels.

The initial pilot has increased from three adult wards to supporting all 20, and has received over 250 referrals since launch in August 2014.

The service is the only one of its kind in the country, and was outlined in the Care Quality Commission report as an example of outstanding practice.

P-173 THE HOSPICE FRIENDLY HOSPITALS PROGRAMME IN IRELAND

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Background Almost 30,000 people die in Ireland each year. 43% of people in Ireland die in acute hospitals; that’s around 35 people every day. The Irish Hospice Foundation identified a deficit in the care of patients and their families at the end of life and in 2007 established the Hospice Friendly Hospitals (HFH) Programme in partnership with Ireland’s National Health Service Executive. The programme was established in order to introduce hospice principles into hospital practice

Aim The HFH Programme seeks to ensure that end of life, palliative and bereavement care is central to the everyday business of Irish hospitals.

Methods The HFH Programme designed a suite of quality improvement interventions for hospital staff. The programme

- Developed the *Quality Standards for End of Life Care* and a suite of guidance documents for hospital staff.
- Improved the culture of end-of-life care through education initiatives, a national nurse practice development programme and promotion of symbolic resources.
- Influenced the health system to raise the profile of end of life care by establishing.
 - End-of-Life Care Coordinator posts.
 - End-of-Life Care/Bereavement Care Committees in hospitals.
 - Three national leadership networks for hospital staff.

Results

- Over 40 public and private hospitals are linked to the HFH Programme. This represents over 90% of public hospitals in Ireland.
- Palliative, end-of-life and bereavement care is a core component of hospital operational plans.
- Hospitals have established a governance structure (committee) to oversee quality improvement projects.
- Symbolic resources e.g. the end-of-life symbol are used widely.
- Over 20 refurbishment projects complete e.g. mortuaries, family rooms, bereavement suites through the Design & Dignity Grants Scheme.
- The Quality Standards for End of Life Care underpin new national standards for bereavement care in maternity settings.
- The HFH Programme is working with organisations in Northern Ireland, the UK and Canada to disseminate learning.

P-174 TRANSFORMING END OF LIFE CARE IN THE COMMUNITY AND ACUTE HOSPITAL

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Background The Transforming End of Life Care in the Community Programme was based on the success of the Transform Acute Hospitals programme. Both programmes aim to promote multi-professional team communication and to improve end of life care. Two local Clinical Commissioning Groups provided funding for the community programme, which launched in April 2015, following introduction of the programme to health-professionals by means of masterclasses.

Aim The hospital programme aims to accommodate patients *going back* to their preferred place of care/death. The community programme aims to *keep* people in their preferred place of care/death. It intends to promote the use of supportive care registers and improve the incidence, quality and recording of future wishes, preferences, wishes and values – Advance Care Planning (ACP).

Jointly, both programmes are facilitating implementation of the new Electronic Palliative Care Co-ordination System.

Methods The hospital programme utilises teaching time with hospital staff. In the community, Protected Education Training time in GP practices is used, incorporating district nursing teams.

Training covers ACP, DNACPR and end-of-life care, and has extended to community therapy teams and nursing/care homes, with stand-alone sessions for NWS and PTS. It incorporates the ‘One Chance to Get it Right’ and the ‘NICE Guidance for the Care of the Dying Adult’ documents. The education is measured with both pre and post impact and evaluation.

Results The number of people trained as of 31/03/16 is 628. Completed figures from cohort one indicate a 56% increase in the number of people identified as being in their last year of life. Records of ACP and DNACPR discussions have increased by almost 21%.

In 2008, average local DiUPR figures were 33.8% (England 37.8%). In 2014, these figures were 39.2% and 44.7% respectively. We wait to see whether this education initiative, in combination with other aspects of local strategy will lead to a further improvement in DiUPR.

P-175 **JOINT COMMISSIONING: CHALLENGES AND POSSIBILITIES**

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Introduction In 2014 the hospice became a joint commissioner with the CCG for end-of-life care in North East Essex.

We are commissioned to host the local EPACCs, locally called the My Care Choices Register, as well as provide the local 24 hour single point of access. We commission the Marie Curie night service as well as transition services from the J's hospice.

Joint Commissioning has allowed us to develop a strategic role in end-of-life care across our community.

Key initiatives include the following:

1. Care home education, role shadowing and EPACCs promotion.
2. Partnership working with the local hospital influencing locality key performance indicators.
3. Shared initiatives with the paramedic service involving education and promotion of the use of the My Care Choices register.
4. Partnership working with community health providers, recently expanding the My Care Choices register to allow incorporation of the community health team frailty register.
5. A primary care grant to support administration costs associated with the My Care Choices register.

Results The proportion of deaths in hospital is falling faster locally than the average figure for England. Currently 43% of deaths locally occur in hospital. England average 47%.

Over 2200 people currently have their choices recorded on the My Care Choices register. One in three people who died in our area in 2015 had recorded choices in the register. Over 70% die in a place of preference.

Advantages of joint commissioning

1. A raised profile in end-of-life care
2. Increased income from the NHS and subsequently from fundraising
3. A 50% increase in the number of people accessing a hospice service
4. Increased influence in service development across the locality.

Challenges

1. Reputational risk
2. Financial risk of expansion and increased dependence on NHS funding
3. Responsibility for other provider service quality.

P-176 **'BLURRED BOUNDARIES' – PARTNERSHIP WORKING IN HOSPICE CARE**

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Although agencies may be in partnerships where they have formalised contracts, it is when they collaborate – that is they work together, that the impact will be seen. Identifying the growing needs of patients within our communities, this case presentation will explore how collaborative working between charities, the NHS, and social and private care strengthens our flexibility to

adapt to those needs. Ellis (2015) states 'good care means that people get the right services, at the right time, in the right way'.

Many hospices work with other providers in the statutory and voluntary sectors, and such partnerships are central to getting care right in the future. Hospice UK (2013) suggests that as small organisations hospices are inherently flexible and should capitalise on their ability to experiment with new ideas, turning them into action. Following the disease trajectory of a patient with advanced Motor Neurone Disease with emotional and physical complexities, whose package of care was no longer sustainable at home due to impact and distress on carers, Nightingale House Hospice decided to examine a new initiative.

In discussion with other agencies the idea was proposed to transfer the patient to the hospice in-patient unit, and to transfer her package of care from other providers to be further supported by us as a specialist team. This initiated effective collaboration between organisations to support the patient's needs and her preferred place of care and death while sharing financial and emotional impact on each agencies resources.

NHS Wales (2007) propose that effective collaboration relies on trust, appropriate leadership, and the need at the outset of collaborative initiatives to understand the reasons organisations seek to work together. A number of factors needed to be explored and central to this were the patient and her family, and acknowledging the advance care planning wishes she had made.

P-177 **HOSPICE SERVICES ARTICULATING CARE DELIVERY WITHIN A PLATFORM OF EXTERNALLY COMMISSIONING SERVICES**

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Background Non-malignant diseases have advocated for the involvement of palliative care services to help deliver end-of-life care for patients and carers. The challenge comes within a fiscally constrained health economy when the drive is to cut and ultimately balance budgets. Therefore palliative care needs to be clear with its stakeholders in articulating the needs of the populations it serves and how it will deliver care in tandem with existing services across the multiple settings of care.

Aim To articulate a service specification in terms of care delivery for non-malignant disease couched within the wider remit of the health economy commissioning groups.

Method An iterative process of baseline review, literature review, horizon scanning with other providers and involvement of specialist and generalist teams.

Results A working group with professionals tasked internally with delivering care within non-malignant diseases was convened, with an action plan using a solution focused approach guiding the process. Each nominated person was responsible for devising a model of care that would ensure effective care delivery embedded within an environment of structured holistic assessment ensuring consistency, clarity and uniformity. This approach was guided by aligned work from the sustainability and transformation plans (STPs) within the external Clinical Commissioning Groups (CCGs). Discussion with external stakeholders and testing of proposed approaches was proposed to ensure suitability, feasibility and piloting of any new practice will deliver in terms of patient and carer experience and cost effectiveness.