

Sikhs account for 12.8% of the population although only 1% of referrals to local hospice are Sikh.

**Method** A qualitative study, facilitating interviews in Punjabi and English, using interpretative phenomenological analysis to analyse the transcribed data.

#### Results/Discussion

- Five super-ordinate themes identified:
- Factors leading to the caring role;
- Emotional effects of caring on the carer
- Impact of caring on the wider family
- Influence of the health care services
- Religious and cultural influence

Lack of support from health care professionals emerged as an overriding theme. An overwhelming sense of duty pervaded each family sustaining them to cope. The option of their relative being nursed in care home/hospice was unlikely as participants reported fears that care could only be received if it was paid for. Culture and religion played an important role in the caring role.

**Conclusions** GPs and hospices need to take a major role in identifying patients with non-malignant disease to ensure referral to other services. Access to equipment is uncoordinated. Financial concerns over care are apparent in this population. Sikh carers need to be educated and supported to continue to support their relatives.

**Applications to hospice practice** Allows equity of care to patients dying of non-malignant disease. Improves bereavement support for this population. Engagement with community may need to extend to outreach clinics to raise awareness within this population. Extends education on end-of-life issues to this minority ethnic group.

#### P21 COMFORTING TOUCH AT HOME

Sue Williams, Helen Birch, Bernadette McDonald. *Queenscourt Hospice, Southport, UK*

10.1136/bmjspcare-2013-000591.43

**Aims** Hospice at Home service works with other community services to fill gaps in end of life care for patients, whose preferred place of care is home. A twenty four hour / seven days a week sitting service is delivered predominantly by trained Healthcare Assistants (Aides), who recognised that anxiety and breathlessness might benefit from immediate, simple non pharmacological interventions.

**Methods** Similar interventions are provided by appointment at the hospice and the Hospice at Home team were trained in simple skills and techniques (basic hand and foot massage, the importance of touch, and anxiety and breathlessness management). Regardless of the severity of condition, touch can always be safely administered and studies show massage as the second most commonly administered non-drug strategy to reduce symptoms. Hospice at Home Aides were encouraged to use these skills and techniques with patients, and teach them to families and informal carers where appropriate.

**Results** We present audit and survey results of this positive partnership between hospice, Aides, complementary therapists, families and community services.

**Conclusion** Families described better outcomes, empowered by doing something practical instead of feeling inadequate and helpless. Patients' symptoms were relieved immediately in the home instead of waiting to attend the Hospice, and confidence levels and job satisfaction increased amongst the Hospice at Home staff because they could respond immediately by providing a non-

pharmacological technique for these distressing symptoms in the patient's place of choice - home. A cost effective, one stop shop!

#### P22 PATIENTS HELP TO SHAPE NEW DAY HOSPICE PROGRAMME

Kathy Birch. *Princess Alice Hospice, Esher, England*

10.1136/bmjspcare-2013-000591.44

**Background/Context of the work** Princess Alice Hospice had a thriving therapeutic but traditional model of Day Hospice. Staff identified, however, that some patients declined attendance or stopped attending after a short time. Feedback indicated this was due to the inflexible nature of the model.

**Aim and approach used** A period of consultation was planned, with main stakeholders, to explore opinion and different models of care. Meetings were held with patients, staff, referrers, Trustees, hospitality and driving volunteers. A questionnaire was subsequently developed and sent to these stakeholders to provide further data. One hundred and fourteen questionnaires were returned and analysis of data provided evidence to support change while retaining some of the traditional model of care.

#### Outcomes

- A redesign of the weekly programme to include three days of the traditional Day Hospice model and two days of new individual and group activities.
- Increased flexibility in the service
  - Patients accessing different elements of the service at different stages of their journey
  - Full day, half day and one hour appointments
- Additional carer support activities.
- Opportunities for staff and volunteer development.
- Ongoing re-evaluation of the programme and adaptations as needed.
- A service which is now more receptive and open to change.

**Application to hospice practice** Hospice services are being challenged to consider their future and plan strategically to meet the changing needs of the people they support<sup>1</sup>. Day services should not be exempt from this scrutiny. Changing a model of care can be difficult and painful, but services must ultimately meet the needs of the people they support to be viable. In a changing social and medical world Day Hospice services need to be flexible and open to change in order to deliver and sustain a future proofed service.

#### REFERENCE

<sup>1</sup> Calanzani et al (2013) *Current and future needs for hospice care*. Help the Hospices, London.

#### P23 NEW MODEL OF DAY THERAPY SERVICES WITHIN LINCOLNSHIRE - OPENING DOORS

Mark Mumby, Rachel Jones. *St Barnabas Lincolnshire Hospice, Lincoln, UK*

10.1136/bmjspcare-2013-000591.45

Historically the predominant case mix for Day Care was elderly patients, those in their last year of life and with primarily a cancer diagnosis.

In 2011 we reviewed how services could be provided county-wide for a rural county population circa 712,000 (1) that would assist patients earlier in their palliative journey, those with non cancer diagnosis and attract younger patients. We aimed to

## Abstracts

increase the capacity to support more patients within existing resources and deliver a wider range of therapeutic interventions.

To achieve accessibility for the maximum number of patients, services were established in eight different locations including providing therapy within GP practices and community halls, and also inreaching to meet the needs of dementia patients in a nursing home setting.

Whilst the philosophy was unchanged, the service was redesigned and continues to develop responsively and with flexibility. A diverse range of therapeutic interventions are available and a plan of care is tailored to meet the individual patient and carer needs following assessment. New volunteer roles with specific profiles were developed to augment the nursing staff. The community engagement officer increases awareness to diverse and often hard to reach groups.

Evidence from patient reported outcome measures, piloting and evaluation enable creative and on going service design to meet emerging needs. Structured training programmes for staff and volunteers continue.

Increased access to the service is evidenced by data collection, demonstrating a 51% increase countywide, with 70% increase of 18-64 age group and 74% increase in non cancer patients, demonstrating greater opportunities for those with life limiting illnesses to be supported to reach their full potential.

This service will be sustained and enhanced by working in partnership, signposting, and through additional innovation such as commissioned Carers Assessment.

- Lincolnshire Research Observatory.

<http://www.research-lincs.org.uk/Latest-Population.aspx>

### P24 TESSERA AND BEYOND

<sup>1,2</sup>Jannette Smith, <sup>1</sup>Julia O'Neill. <sup>1</sup>Hospice Care for Burnley and Pendle, Burnley, Lancashire, <sup>2</sup>East Lancashire Hospitals NHS Trust

10.1136/bmjspcare-2013-000591.46

For the past 10 years, Pendleside have made one of their Day Therapy days available to non palliative patients. The day referred to as Early Diagnosis Day (EDD) was essentially aimed at patients with a recent cancer diagnosis being treated with curative intent.

Whilst the EDD was innovative and popular initially, more lately it had become stagnated and predictable. It was also recognised that it was not fully in line with the work being done locally and nationally which has "survivorship" as a key element.

Patients were consulted and responded enthusiastically to the ideas suggested for service improvement. Indeed the TESSERA name was chosen by a patient group.

It is acknowledged that a cancer diagnosis can be shattering and life changing. With appropriate support patients can and do rebuild their lives. It was on this basis that the name was chosen. A Tessera is an individual tile used in creating a mosaic. Which was thought to be an ideal representation of rebuilding in the finest form.

#### TESSERA:

Together,  
Experience,  
Solace,  
Survivorship,  
Empowerment,  
Rehabilitation,  
Adapt.

TESSERA offers an eight week rolling programme of activities, presentations and interactive workshops delivered by outside agencies in addition to Hospice and Trust staff. This is further complemented by peer and healthcare support including an extended MDT.

The day runs from 10am – 3pm.

Sessions are offered using a menu 'pick and mix' system. Attendance can be one session or a full day (and anything in between). Graduated arrival enables higher patient flow.

Exercise classes, Tai Chi, Emotional Wellbeing and Fatigue Management groups are timetabled as fixed sessions. These all contribute to the ultimate aim of empowering patients to regain a lifestyle that is enriched both emotionally and physically.

### P25 TRANSFORMING DAY CARE SERVICES ACROSS BOUNDARIES

Gabrielle Linehan, Caroline Snow. *St Raphael's Hospice*

10.1136/bmjspcare-2013-000591.47

South of England Hospice, population of 370,000-380,000, 14 inpatient beds and community team supporting approximately 300 patients.

Day care services previously delivered via a care model unchanged in twenty years; all day attendance with no defined focus.

A service review in 2011 demonstrated that on average 33 patients attended over four days from a community case load of approximately 300 (cost £4545.45 per patient). Referrals from the CNS team took on average two to three weeks to be processed to arrange a 'look around'. Following this 40% of patients were unable to attend due to condition deterioration. A CNS caseload review demonstrated the patient demographic was changing to younger more discerning patients wanting specific treatments for attendance.

Day care services were suspended in May 2012 for a refurbishment project. This allowed a rethink on the parameters of the service, aiming to focus, energise and engage.

Service reopened in October 2012 delivering morning or afternoon sessions each with a specific focus. Lead for day care changed to a therapist with nurse support. Activities include, Hope course, art and craft, yoga, music therapy, bathing service on one afternoon, complimentary therapies, lunch clubs and an information centre once a month for all patients /relatives.

Focus of engagement changed from CNS referral to direct patient contact with a choice in activities. Attendance: STEP 1- three months accessing two sessions weekly plus a lunch club: then STEP 2- choice of one activity monthly and a lunch club. Eliminates need for discharge and allows for ongoing monitoring and engagement with hospice.

In the six months to March 2013 there has been engagement with 89 patients', representing an increase of 166.8% over the 6 month period reducing the cost per patient to £1685.39.

User feedback is positive and active ongoing service review and development is planned.

## Community engagement and volunteering

### P26 ESV IS JUST THE START

Karen Filsell, Gillian Levy. *Children's Hospice Association Scotland, Edinburgh, UK*

10.1136/bmjspcare-2013-000591.48