

Abstracts

- Volunteers are important to income generation, the quality and range of services offered and community engagement.
- Hospice sustainability is highly dependent on volunteers, however
- Current volunteering models may not be sustainable.

Implications This area is the first study of its kind to establish evidence about the dependence of hospices on volunteers. It identifies opportunities for practice development in planning and approach. A toolkit is being developed to enable organisations to identify areas for development.

04 ST JOSEPH'S 1ST CONTACT TEAM. A NEW INNOVATIVE MULTIPROFESSIONAL MODEL

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10.1136/bmjspcare-2013-000591.4

Background The development of a new innovative service the St Joseph's First Contact Team was identified in April 2012 as the critical project to commence the 3 year transformational change programme to develop community services. This pilot aspired to improve access to the 'front door' of St Joseph's, improving response times for patients, their families and carer's, ensuring all those referred were appropriately signposted to the whole range of services provided appropriate for them. The team consists of multi-professionals who are either in the team physically or as virtual members.

Aims of the Service were To provide high quality, patient and carer focused, value driven services and experiences To meet the changing needs of local communities

Be more responsive to our local communities

Meet the strategic priorities of local Clinical Commissioning Groups and GPs

Continue to meet the mission and core values of the Hospice
Encourage innovation and develop staff

Share specialist knowledge and skills of end of life care with community partners

Approach Used Utilising transformational change methodology, working groups were established to develop the project and to guide and influence service development. Patient and service users were consulted and their views informed the service model.

Outcomes Outcomes-were measured using quantitative data demonstrating activity, referrals response times and user feedback. Qualitative review of assessments undertaken by the FCT and other related professionals during the pilot period was undertaken. Various methodologies were used to collect data including user and staff surveys and the PAL care system.

Applications to Practice The first contact team has transformed how we respond to our referrals and has promoted multi professional working and greater understanding of the range of services offered to patients, carers and families. A working group led by the Lead Nurse will continue to develop and monitor the quality and service to meet the changing needs of our diverse communities.

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05 AN EVALUATION OF THE "JUST IN CASE" BAG ANTICIPATORY PRESCRIBING SCHEME IN DEVON 2011-2013

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10.1136/bmjspcare-2013-000591.5

Background "Just in Case" anticipatory prescribing schemes are seen as one way of ensuring that patients nearing the end of their lives can have access to rapid relief of symptoms at home. The Gold Standards Framework for End of Life care encourages this a mainstay of care. No large scale attempts to examine the practice have been undertaken.

Aims To assess the implementation of "Just in Case" bags in Devon over the first two years of the scheme. Feedback was sought from health professionals over the key features of the initiative, the drugs used and any problems encountered. A subsidiary aim was to assess the cost effectiveness of the scheme.

Approach used 83 GP practices in Devon were issued with a stock of "Just in Case" bags. A record was kept of when each bag was dispensed. Each bag was issued with a service evaluation form inside. The completed forms were returned to a central collection point allowing the total number of bags dispensed, and then used, to be measured. Data was collected between April 2011 and the end of March 2013.

Outcomes 1510 bags were dispensed during the period and 295 service evaluation forms were returned (20% return rate). The bags were well received by staff, patients and relatives alike. The most common four drugs prescribed were Diamorphine, Hyoscine Hydrobromide, Midazolam and Levomepromazine.

Application to hospice practice An attempt was made to calculate the overall cost of the project and any savings from the scheme. The information gathered from the 295 completed evaluation forms suggested that 121 admissions to Hospital or Hospice were prevented. The bags also offered peace of mind for patients and relatives. The challenges of organising a large-scale service evaluation across multiple professional teams and of assessing projected financial savings are also discussed.

06 'BEING THERE' - EVALUATION OF A NETWORK APPROACH TO 24/7 SPECIALIST SYMPTOM MANAGEMENT FOR CHILDREN AND THEIR FAMILIES

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10.1136/bmjspcare-2013-000591.6

Provision of 24/7 symptom management for children with life-threatening conditions via a whole network approach is unusual. We have evaluated this innovative service method, delivered by five clinical nurse specialists, across a predominately rural geographical area, aligned to a dispersed Children's Hospice Service. Service objectives were: symptom management support; open access to families and professionals; choice in place of care and death and collaboration to develop common approaches, shared pathways and management plans.

An 18 item questionnaire was developed to audit service standards; two open questions aimed to elicit good practice and areas for development. Stakeholders (n = 48 families, n = 121 hospice staff and n = 129 external professionals) were surveyed by internal or external mail. Overall response rate was 47% (families 54%; hospice staff 50%; external professionals 41%).

Two thirds of respondents reported that the team provided as much as needed with service standards. Around the clock symptom management support was highly valued (88% of

respondents reported as much provision as needed). Assessment of emotional symptoms and response to telephone queries within four hours were areas for development. High levels of satisfaction were reported ($n = 108$, 83%) and three quarters of respondents rated the team extremely responsive, reliable and flexible. Comparison between groups showed no significant differences except for: usefulness of support and advice given by the team; usefulness of the 'out of hours' call handling service and extent to which the team assessed a child's emotional symptoms. Qualitative data revealed that the team 'spanned organisational boundaries'; provided care 'any time of the day and night'; 'filled a critical gap'; 'gave families time' and was perceived by them as 'the glue between professionals' and a 'life line'.

The service had a much greater impact than expected in all key objectives and demonstrated that a network approach to service delivery is possible and highly effective.

07 RIGHT CARE, RIGHT TIME, RIGHT PLACE: THE EVOLUTION OF HOSPICE WITHOUT WALLS, FROM VISION TO REALITY

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10.1136/bmjspcare-2013-000591.7

Background This project charts a move from traditional inpatient hospice services, with week day specialist community services, towards the creation of a flexible, integrated 'hospice without walls' strategy. The steps that were taken to improve care over a five year period, including challenges faced, stepped approach taken and collaboration with other organisations to ensure the establishment of patient focused, integrated and proactive services are outlined.

Aims Hospice without walls aimed to understand and meet the needs of patients, carers and referring health care professionals, shaping finite resources most effectively to meet changing demographic needs and provide responsive multi-disciplinary care in all settings.

Approaches used Developments in a phased manner, incorporating staff and patient vision, improvement and change theory, with evaluation at each implemented stage. This included multi-user feedback, benchmarking service access and formal evaluation through the Marie Curie Delivering Choice Programme.

Outcomes IT and clerical support platforms were developed to remodel services which have included a central referral centre, patient, carer and health professional advice line, seven day a week community service, staff contractual changes, redeployment of consultant staffing into wider community service and extended MDT.

Evaluation has shown improved patient experience, increased inpatient acuity levels, increased and improved community case-load management, more patients remaining in their preferred place of care, strong linkage between the extended hospice and other end of life service providers with reduced hospital admissions at end of life.

Discussion The vision is becoming reality and staff can now see the benefits for patients and carers having a more flexible and responsive service model. Engagement with external agencies has been challenging but CCG revenue funding has now secured sustainable income streams and services.

08 CARE, COMPASSION AND GENEROSITY: BUILDING MODELS OF HOSPICE CARE IN DIVERSE AND RESOURCE POOR COMMUNITIES

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10.1136/bmjspcare-2013-000591.8

Background and Content People with palliative and end of life care needs are dying for change. Therefore "to allow people the deaths they want, end of life care **must** be radically transformed" Garber and Leadbeater (2010).

Aim

- Develop models of compassionate communities allowing greater access to social and therapeutic hospice services.

Approach Used

- Organisational collaborative working with the inception of a Task & Finish Group.
- A questionnaire to find out what satellite services people want and where they want those services delivered.
- Discussion groups in GP surgeries, community centres, carers groups and existing support groups.
- Analysing the 165 returned questionnaires. The data will inform the direction of the initial pilot project.

Outcomes

- Develop a community based service supported by volunteers.
- Recruit, train and supervise a voluntary Empowered Living Team (ELT) to support hospice professionals in delivering care in the community through initiatives such as hand massage, physiotherapy rehabilitation programmes, supporting people to practice mindfulness techniques in their own homes with the support of a CD of relaxation techniques, guided meditations.
- The satellite will also offer a space for bereavement services to establish a community presence and a greater resource for the Community Palliative Care Teams (CPCT) to refer patients and family to.

Application to Hospice care We will demonstrate how by increasing access to hospice services through a compassionate community model more people will be able to:

- Discuss preferred place and type of care they receive
- Plan for their preferred place of death
- Reduce the fear of accessing hospice services such as planned respite, outpatient services
- Through community support decrease the amount of emergency admissions to A&E
- Increase the chances of families experiencing a well-planned and a good death.
- Access a greater variety of services by more partnership working.

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09 USE OF VIDEO CONSULTATION AT THE END OF LIFE - SUPPORTING CARE AT HOME

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10.1136/bmjspcare-2013-000591.9