

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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**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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**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.

## Conference Papers 3a

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

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