

patients receiving palliative care with support and information in their own home.

- Helping Hands – a non-clinical volunteer support/befriending service supporting patients and their families in the last year of life at home
- Collaborative working with care homes in the NHS, Private and Independent sector to improve end-of-life care
- Working with community services currently being redesigned in several rural areas of Highland to support and improve end of life care closer to home.

This poster presentation will report on all these projects in action with updated results at time of publication.

#### P-94 IMPROVING ACCESS TO SPECIALIST PALLIATIVE CARE FOR PATIENTS WITH CHRONIC OBSTRUCTIVE PULMONARY DISEASE

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10.1136/bmjspcare-2016-001245.117

**Background** Chronic Obstructive Pulmonary Disease (COPD) is a life-limiting condition. In 2012 it contributed to 5.3% of the total deaths in the United Kingdom. Historically, patients with COPD have not accessed specialist palliative care services. However, there is evidence that patients with COPD have as disabling symptoms as those with cancer. It has been suggested that services need to engage with the COPD population differently due to the insidious disease course and trajectory.

**Aim** To investigate whether collaborative working has increased access for patients with COPD to palliative care services.

**Methods** Using the local hospice's CrossCare system we have investigated activity data for Wolverhampton patients in the hospice's different settings; community, day hospice, outpatient and inpatient unit. Data was collected from 2012–13 and 2015–16 to see the impact of a three-pronged strategy of education of the whole health economy, set up of a joint respiratory clinic and a multidisciplinary team meeting to discuss potential palliative patients. Patients with a primary referral diagnosis of COPD were included.

**Results** Collaborative working has increased access of patients with COPD to all hospice services from 2012/13 to 2015/16. There has been a 283% increase in patient numbers seen in day hospice. There was an 88% increase in patients seen by the community team and a 403% increase in the number of visits. There has been a 286% increase in patients seen in outpatients by the multidisciplinary team. There were no patients admitted to the inpatient unit in 2012–13 and 13 patients were admitted 2015–16 with 20 inpatient spells. This enabled four people with COPD to die at the hospice.

**Conclusion** Patients with COPD in the Wolverhampton area have demonstrable palliative care needs. This is an example of how collaborative working can improve access for this patient group.

#### P-95 IDENTIFICATION THROUGH INTEGRATION – INCREASING ACCESS TO PALLIATIVE AND END OF LIFE CARE

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10.1136/bmjspcare-2016-001245.118

**Introduction** Recognition that someone is entering the last year of life enables access to Palliative and End of Life Care (PEoLC). There is currently under-identification of people in the last year of life.

**Aim** To increase access to PEoLC through improved identification of the patients known to the Community Trust who are likely to be in the last year of life.

**Method** In 2014 all Community Trust specialist palliative care nurses (SPCNs) were integrated into seven community integrated care teams, each covering a population of c.100,000 people. The SPCNs were co-located and managed within those separate teams. Targeted PEoLC training was delivered to all staff.

The SPCNs were supported to improve PEoLC within their locality through an internal clinical network which included:

- Weekly Specialist Palliative Care multidisciplinary team meetings
- Senior SPCN leadership and support
- SPCN group clinical supervision
- Specialist Palliative Care clinical governance structure.

**Results** Two of the seven localities have been the most successful in improving identification of people in the last year of life with a 57% increase in number.

**Abstract P-95 Table 1** Number of people identified as in last year of life on system1 two localities (annual snapshot march)

Year	2014	2015	2016
Number identified	183	223	288

These reflections from locality manager and SPCN appear key to improvement:

- Leadership from locality manager on integrating SPCNs
- Weekly locality multidisciplinary clinical meetings to share ideas, opinions, reflect, debrief, give informal education
- Increased visibility improves working relationships - more conversations, trust, respect, team-work, better understanding of roles/workload
- More shared care and joint visits undertaken
- SPCN facilitation of team action learning and clinical supervision
- Offer of uniform to SPCN.

**Conclusion** Integration of community SPCNs with leadership and support can significantly increase access to PEoLC through improved identification of people in the last year of life.

**Next steps** A comprehensive education programme is supporting staff development with the aim of further improving access to PEoLC and clinical outcomes. A PEoLC dashboard is in development to provide each locality with required clinical data.

#### P-96 A SNAPSHOT OF SOCIAL DEPRIVATION AND MULTI-MORBIDITY IN A HOSPICE INPATIENT POPULATION

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10.1136/bmjspcare-2016-001245.119

**Introduction** Recent research has suggested that people living with long-term illnesses in socially deprived areas have poor