

members in East London have used a Compassionate Community-style approach, acknowledging end of life care as a social process, and everyone's business.

Aim To develop a culturally inclusive, BAME-community-led befriending and advocacy service, working with those who are isolated, terminally ill or reaching end-of-life. The intention is to work in partnership, with a focus on cultural, spiritual and social needs, rather than to replace existing provision.

Methods Since its start in 2013, Eden Care has provided an end-of-life service which is open to needy people from all communities. There are currently 35 Eden Care volunteers, most of whom are 'experts-by-experience' after experiencing terminal illnesses alongside family members or friends. 15 of the volunteers have undergone a DBS check and vetting process, and received specialist training to provide high-quality, non-discriminatory and non-judgmental services.

Results 15 people/clients have been paired with a befriender providing support with personal, social and spiritual needs. A Rapid Response Team can carry out 24/7 visits when a person is nearing death. The grassroots, responsive approach means that additional work is now also being done with a support service for Muslim burials; and on giving voice to those nearing end-of-life and the wider community, thereby enhancing the local statutory end-of-life strategy.

Conclusions Clients and families who might be considered 'hard to reach' by statutory providers are served in truly responsive and culturally appropriate ways when communities lead the work.

P-100 THE ADVANCE CARE PLANNING SERVICE

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Our hospice has developed a model of advance care planning support that helps patients to explore what they want to do and how to achieve it. This has resulted in their wishes and preferences being met including achieving their preferred place of death.

The model takes a partnership approach between the clinicians at the hospice and the patients they support, helping them consider choices and preferences for future care and treatment. Those clinicians can then refer in to the hospice's advance care planning service where a social work assistant supports the person to write an Advance Statement and record their wishes. The patient holds a copy and anyone else as appropriate and consented to by them. The service supports patients who want to write an Advance Decision to Refuse Treatment as well. They talk to a doctor or nurse who knows them well so to be sure that they understand any potential implications of declining treatments.

The documents are reviewed every six months unless the person wants to make changes before or a review is prompted in some other way. Records indicate when reviews are due and documents are updated and disseminated again if required.

This has proved to be a more fluid and efficient system in providing this kind of support as it relieves the clinicians of the administrative elements of writing, storing and disseminating the documents.

If the patient wants to register a Lasting Power Attorney (LPA) the social work team manager can act as certificate provider for their applications. Although anyone can register LPAs via the Office of the Public Guardian, many people are either referred

to, or seek the help of solicitors which can be costly. The service provides equitable access for those are unsure how to register or unable to afford.

P-101 EXPERIENCES OF ADVANCE CARE PLANNING WITH PEOPLE LIVING WITH CHRONIC PROGRESSIVE NEUROLOGICAL CONDITIONS

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The recent 2016 NICE guidance 'Motor Neurone Disease: Assessment and management' describes a model of multi-disciplinary holistic care. This includes providing opportunities to plan for end-of-life care. The Mental Capacity Act 2005 clarified the legal status of advance care planning but patients need to be in receipt of accurate information to be able to make plans, especially if they have not experienced treatments they might wish to refuse. When the hospice started an initiative to increase access to patients living with neurological conditions a number were referred for advance care planning. At the time (2011) the 'Preferred Priorities for Care' document was in use but staff had little experience in discussing or documenting patients' decisions regarding future refusal of treatments. This took place when patients visited the local Motor Neurone Disease (MND) Care Centre but for patients living with other progressive neurological conditions, it was unclear if they had any opportunities at all. A lead consultant was referred all the patients who might want to write an advance care plan. In order to ensure the resulting document would be 'valid' the consultant created a decision-aid that contained instructions on what details to include. To ensure these decisions were 'applicable' examples of scenarios involving potentially life-saving treatments were laid out for the patient to consider. The decision-aid underwent a number of revisions as exemplars were added to illustrate how the patient might document their decisions.

To date, 18 patients have completed combined Advance Decisions to Refuse Treatment/advance statements. One patient completed but never signed, one documented his decisions informally. The decision-aid, an analysis of the decisions the plans include, how these vary across the different diseases, who supported the patient in writing it, whether they have been revised and reflection on our experiences will be displayed in this poster presentation.

P-102 "4 EASE" – A DEDICATED SELF-MANAGEMENT EDUCATION PROGRAMME

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Background The aim of Wellbeing Services is to optimise patients' function, wellbeing and enable them to live independently with the best quality of life. To help achieve this we follow a rehabilitative model to empower patients to live life to their full potential for as long as possible. Education sessions have been designed with self-management as the focus.

Method A 12-week programme is delivered on a rolling basis within Day Hospice which provides a 'tool box' of self-help techniques to help maximise symptom control/quality of life. Sessions