

P-186 WIRRAL END OF LIFE CARE CHARTER

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The concept for the creation of a Wirral end of life care charter was born from the necessity for the Wirral Palliative Care and End of Life Care Partnership Group to focus on the need to take stock of a whole range of policy and guideline directives to create and deliver services for patients, their families and carers during the difficult journey through the last year of life and up to the days and hours before death.

The challenge was how could we as health and social care providers, patient and carer representatives and commissioners focus on efforts to effectively deliver the levels of quality care and support, with the necessary skills and compassion in a coherent way, and importantly one which patients carers and families and the community of Wirral can relate to.

We decided what was needed was a set of pledges in the form of a charter that explains what patients and those close to them may expect from providers of care and support, and of equal importance what providers must do to resource and support staff to deliver first class quality care for palliative patients at the end of their lives.

The launch took place with a range of key speakers to both set the scene in terms of supporting Dying Matters Week and to inform as wide an audience as was possible of developments and challenges facing palliative and end of life care in the future. We are proud to say that all Wirral statutory deliverers of health and social care duly signed up and pledged support. "One year on" an endoflifecarewirral.org website has been launched.

P-187 WORKING IN PARTNERSHIP ACROSS CHARITABLE AND STATUTORY SECTORS – MAKING A REAL DIFFERENCE TO CHILDREN AND THEIR FAMILIES

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The challenge is for the hospice to set up a community service, across a number of different counties, to deliver regular respite as well as palliative and end of life care for children and their families.

The only way that this can be achieved is to work in partnership, both formally and informally, with other organisations. In order to introduce a new community service in Wiltshire, a formal partnership has been agreed between the hospice and another community hospice provider.

To ensure collaboration with existing service providers in the area, a 'Wiltshire Partnership group' has been formed, which includes representatives from the hospice and three other charitable organisations (2 of which are community hospice services) as well as one statutory service. Each service currently delivers slightly different support to children with life limiting and life threatening conditions. The benefits of working together are many, including; seamless delivery of care for children and families, improved communication between services, shared referrals across organisations, improved choice of care, reduce parental

anxiety and increased access to support, as well as improved access to end of life care at home with all organisations contributing to a shared rota to cover 24/7. A model highlighted in a recent report titled; NHS at Home: Community Children's Nursing Services (DOH, 2011).

Other benefits include raising the profile of the hospice world among statutory organisations and encouraging health and social care professionals to think differently about how children's hospice services might be accessed to better meet the needs of children and their families.

This is a two year pilot project. Success will be measured in terms of number of new referrals to the service as well as capturing those families that we have been able to 're engage' with the hospice via the new community service; those that are referred and accepted to the hospice, but have been too frightened to access. Feedback will also be obtained from children, young people and parents every six months.

P-188 A PARTNERSHIP APPROACH TO END OF LIFE CARE DISCHARGES

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Getting patients from acute hospitals into the community at the end of life is difficult. The problems include:

- Patients and carers having a poor experience at the end of life
- Complaints to the acute trust
- Patients not achieving their preferred care setting or place of death
- Beds being blocked in the acute trust.

The problem is caused by:

1. The complexity of discharging a patient at the end of life
2. Lack of rapid access to care in the community.

Getting care right at the end of life is of paramount importance. There is only one chance to get it right and meeting preferred place of care can be very important to a patient and carers.

A pilot project between an acute trust, hospice and charity has been in operation since January 2015 and works in two ways:

- A new role was created in the trust, discharge liaison practitioners, to identify patients at the end of life and case manage their discharge to their preferred place of care
- The charity and hospice partners collaborated to provide a team of HCAs in the community rapidly available to support patients with short packages of care until statutory services are able to take over.

The project objectives include:

- Improving the experience of patients at the end-of-life
- Increasing the percentage of patients achieving their preferred place of care and death
- Reducing discharge delays at the end-of-life
- Saving bed days for the acute trust.

The project has supported over 500 patients and is currently being evaluated by the charity partner with results due in September 2016. The project partners will then determine the project future based on the learning from this evaluation.

This has national and regional implications as this model could be replicated in any region in the UK.

P-189 IS GETTING HOME FROM HOSPITAL TO DIE REALLY ACHIEVABLE?

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Time is of the essence to facilitate a swift transfer home from hospital when someone is dying. The George Eliot Hospital NHS Trust, Mary Ann Evans Hospice and local community services have worked together to enable rapid discharge – one of the key NHSE transform agendas – and become embedded into practice.

This model is innovative as the hospice's senior health care assistants visit the acute trust over seven days of the week and assess themselves for the service to become involved. This ensures fast response and rapid access to care at home in a cost effective way.

A small team, including community services, worked together to establish how services could work together to make swift home discharge possible and a 'RIPPLE' (Realising Individual Patient Preferences at Life's End) pathway including documentation was produced for use across all the hospital.

Evaluation is ongoing and is led by the hospital team. The hospice receives feedback from grateful families and annually surveys families to ensure services are meeting needs of local people.

The outcomes are dying people's choices and preferences are enabled and where possible they die in the place they wish and in the surroundings they most want to be in. Family carers are supported by an integrated care approach as all services communicate, plan and work together to make home death possible.

This successful service is highly relevant to national policy and demonstrates how using skill and expertise of the local services in an innovative and integrated way can truly make an impact.

The services receive some funding from the local commissioning group however, for significant increases in numbers of people requiring swift discharge to home to die then additional funds to increase resources would most likely be needed.

P-190 HOSPICE BEYOND THE BUILDING – REACHING OUT INTO THE COMMUNITY

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Background Often hospices cover large geographical areas, where mobility, public transport issues and costs could act as barriers to accessing hospice care. Patients and carers might also be reluctant to come to a hospice building. We wanted patients and carers to have access to our services on their door step. We sought one central place within local communities that patients and families felt safe to visit, apart from a hospice building, where they could access our care and support.

Aims

- To reach more patients and families, so that Hospice care and support was available and accessible to all
- To access facilities in our local community, working in partnership securing premises for clinics and hubs

- To explore what our patients and families wanted.

Approach

- We approached local groups, hubs and links to see if they would support us with free or low cost venues.
- We talked to local people on the street about their local hospice and what it meant to them.
- We spent time educating our partners in hospice work, our vision and moving things forward.

Outcomes Three community settings that cover our geographical areas offering clinics have been set up. Nurses can pre book appointments near where patients live. We provide regular drop ins in our town centres. We take information out to towns and villages on a regular basis ensuring visibility and accessibility.

Conclusion This approach has improved local awareness of our services, patients' choice of attending a clinic locally. This new service has provided reach beyond the building, reaching out to the community. We have noticed this also provided a cost effective way of delivering clinical service.

P-191 BUILDING THE POTENTIAL AND THE POTENTIAL IN THE BUILDING – CHALLENGING TRADITIONAL DAY SERVICES

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Introduction With an emphasis on future services needing to meet the needs of more people, more of the time, we have embarked on a process of revolutionising how our day services and outpatient care could rise to this challenge.

Aims of project

- To reach those people who would not have traditionally used day services
- Development of planned sessions, group work and open access with the aim of creating a flow through the building which sees independent movement
- Ensure patient led goals are central, working towards the promotion of rehabilitation, enablement and self-help
- A change of focus for our volunteers with an emphasis of empowering and enabling service users
- Extend and welcome other groups who provide support across the community to deliver it from our building.

Evidence and experience to date During January 2016 there was an opportunity for us to take a moment in time to stop and reflect as well as having the opportunity to be able to work together as a team to review and revise the future of our day services and outpatient care. A new philosophy and vision has been created that sits firmly within the strategic plans of our hospice. A change of focus for the volunteers with the emphasis of empowering and enabling those who use our services has been one which has taken much longer to embed. New roles have been established to support planned day care and a self-management programme and access to various activities which promote well-being are now underway.

Conclusion The process of changing the philosophy and structure of our day services has not been without challenge. A new vision looks to build on the potential of those people accessing and working out of the building, whilst also seeking new opportunities to work in partnership.