P-15 CHANGE MANAGEMENT – EMBRACING A NEW OUT OF HOSPITAL CARE MODEL

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This area's hospital death rate is higher than the national average; in 2019, 49% of all deaths were in hospital (compared to 22% at home, 21% in a care home, and 7% in a hospice setting). Plans to reduce hospital admissions/deaths evolved as an Out of Hospital (OOH) model in partnership between the hospice, CCG and community health provider.

The model aims to strengthen community-based care pathways through proactive multi-disciplinary case management at a Primary Care Network (PCN) level that anticipates additional health and social care needs to reduce crisis. Additionally, work has started on the development of a Care Coordination Centre for specialist/complex cases that can no longer be dealt with at PCN level.

The model required a new way of working for the hospice Clinical Nurse Specialist (CNS) Service. The hospice developed a detailed leadership programme to equip the CNSs to have the confidence and skills to be assigned to a Primary Care Network and attend MDT meetings in their locality. In particular, the proposed OOH model was shared with the team, and they were asked to present the model (and their role in it) back to the Senior Leadership Team (SLT).

Results This has resulted in the CNS team developing their presentation skills and confidence levels before moving to the PCN aligned model. The CNS team showed their understanding of the model, and SLT were able to 'correct' where appropriate; it has been noted by the CCG that hospice staff have grasped the model and adapted quicker than non-hospice colleagues.

Conclusion The OOH model is a long-term project, but progress has helped the hospice to free up hospital beds and lower the numbers of people aged 65+ from dying in hospital [974 (18/19), 1,052 (19/20), 843 (20/21), 822 (21/22)].

P-16 OUT OF HOSPITAL MODEL – GETTING A HEAD START AT CARE COORDINATION CENTRE (CCC) AND PLANNING ALL CARE TOGETHER (PACT)

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Introduction West Essex Clinical Commissioning Group (CCG), in line with NHS Long Term Plan (2019) intends to introduce an 'Out of Hospital' model to help patient care. St Clare Hospice recognises this to be an opportunity for improved working relationships with our community colleagues giving rise to the ability to reach more people and influence positive end of life care patient experience. This contributes to the hospice's strategy.

Process The work requires improving community relationships, which is being addressed by:

- Regular weekly meetings with district nursing teams.
- Piloting named nurses in one primary care area and then reaching across all teams.
- Virtual weekly meetings and monthly face-to-face with some teams.
- Being an integral member of the CCC working group to agree working policies.

Direct clinical care is improved by:

- Increased number of joint visits with community colleagues for patients with complex symptom management needs.

Educational work is carried out by:

- Bite-size teaching as well as bedside support learning.
- Educational opportunities through the hospice including access to monthly masterclass and quarterly 'Care of the Dying' webinar study days.

Analysis The first meetings started in December 2021 with one area. Over four months these were extended across the patch with five regular weekly meetings now. All Gold Standards Framework meetings are supported with the model of meeting being advice and support for palliative patients not necessarily registered with the hospice. Furthermore, support with advance care planning joint visits is provided to support difficult conversations.

Conclusion Quantitative data shows that hospice is reaching more people and able to influence and support their care needs. Qualitative data shows satisfaction of community colleagues is on the increase.

Presence at the Care Co-ordination Centre joint working group ensures palliative care will be embedded from the pilot planned for July 2022.

P-17 HOSPICE USE OF THE 'EASE' COURSE TO IMPROVE PUBLIC CONFIDENCE AND SKILLS AROUND DYING, DEATH AND BEREAVEMENT

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Background Friends and family play an important supportive role when someone is caring, dying or grieving, but can lack confidence, knowledge and skills. Public education can support development of skills and knowledge, and the End-of-Life Aid Skills for Everyone (EASE) course was developed by the Scottish Partnership for Palliative Care for this purpose. The Prince & Princess of Wales Hospice partnered with the Scottish Partnership for Palliative Care to offer the online EASE course.

Aim(s) To evaluate public appetite for EASE among Prince & Princess of Wales Hospice's public networks and its impact on participants' confidence and skills.

Methods The course was advertised through hospice networks and delivered by accredited EASE facilitators three times over 12 months. Pre- and post- course evaluation questionnaires were collected.

Results Each course ran at capacity (n=15). Questionnaire responses indicated the course increased participants' knowledge, skills and confidence around the subject matter.

Conclusions There is an appetite for the EASE course among Prince & Princess of Wales Hospice's public networks. Participation improved people's confidence and skills. Other Scottish hospices could consider offering EASE as part of their own public health initiatives.