

### P-105 OPENING THE DOORS TO WIDEN ACCESS VIA THE HOSPICE COMMUNITY DROP-IN CAFÉ

Julie Waite, Sharan Watson. *Treetops Hospice, Derby, UK*

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**Background** Service evaluation identified attendance within the support and information service was below expected levels. Although underuse of health services is common, this could contribute to significant suffering (Berwick & Fox, 2017. *Milbank Q.* 83: 691). Prior to the pandemic, this service was offered by appointment only. To improve the quality and delivery of better care, services needed to adapt and change to meet the comprehensive health and wellbeing of local populations by becoming more personalised.

**Aims** To remove appointment-led consultations and develop a drop-in support and information café. This initiative was relevant in removing barriers, whereby people could access the service in a time that's personalised for them (Hawley, 2017. *Palliat Care.* 10).

**Methods** Stakeholder groups were engaged early in the initiative to facilitate collaboration and to increase support. The integrated team were: Management, Volunteers, Staff, and Other health professionals.

Both qualitative and quantitative data were collected for the purpose of analysing results:

- Likert Scale.
- Evaluation forms.
- Thematic analysis.

A mixed method approach was used to understand contradictions in results to ensure the findings were grounded in participants' experiences (Tashakkori & Creswell, 2007. *J Mix Methods Res.* 1: 207).

**Results** An upward shift in attendance demonstrated that the service improvement had been successful. The dominant attendee type was the person affected by a life-limiting illness. The desired impact was achieved with high attendance figures, showing not only a need for this service but the quality and effectiveness of this service through feedback.

**Conclusion** This exciting innovation is ongoing due to the needs of the service pre, during and post pandemic. This is to ensure people feel supported and have access to services in a timelier way.

### P-106 INTRODUCTION OF A COMMUNITY CLINICAL LEAD ROLE

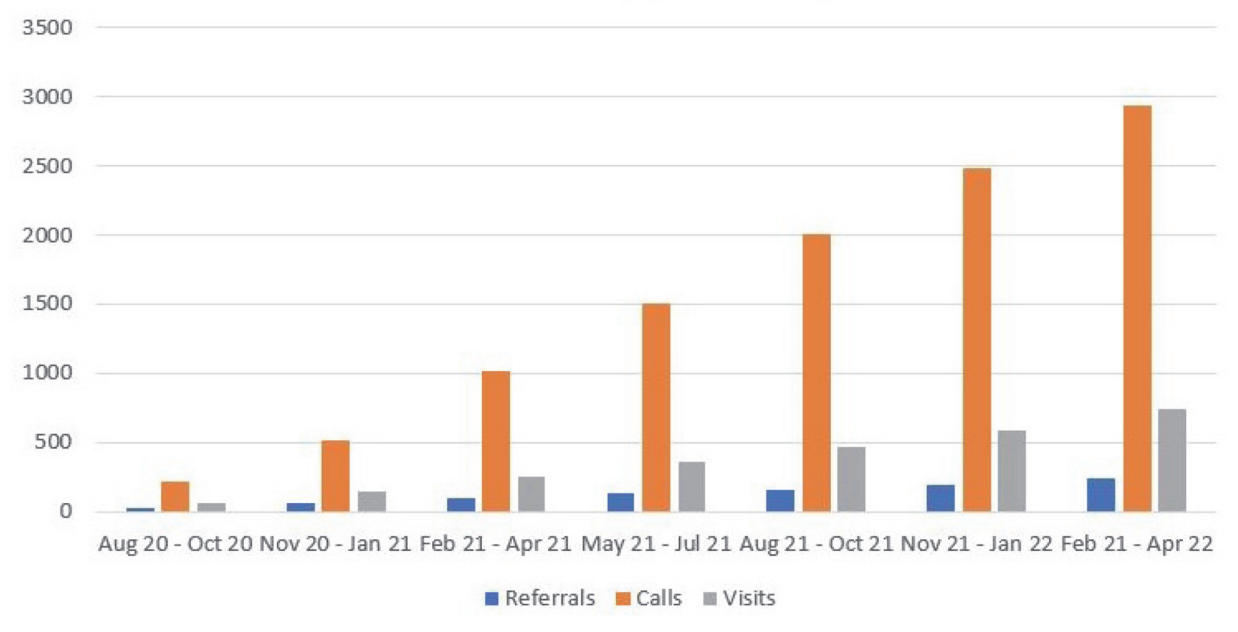
Ann Hurcomb, Emma Husbans. *Great Oaks Hospice, Coleford, UK*

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**Background** At the beginning of the COVID-19 pandemic, our hospice had to close its day centre. Through patient feedback and referrals analysis, we identified a need to bridge the gap between those people with 'uncomplicated' life-limiting illness who were being supported in the community and unable to access the usual supports such as day hospice and direct access to hospice nursing support. This led to us introducing a Community Clinical Lead.

**Aims** The initial aims of the role were to act as a bridge between the District Nurses and our local Specialist Palliative Care Team (who are employed by our local acute trust), to support patients in their own home in a holistic manner (National Palliative and End of Life Care Partnership, 2021) and to help people to live with their illness (Hospice UK, 2015). The role also enabled a smoother transition between hospice services when patients needed this.

Cumulative Clinical Support Data by Quarter



Abstract P-106 Figure 1

**Methods** A band 6 role was established with money from a charitable donation. Local primary care services were informed of the role and how to refer. Governance processes were established internally and with our specialist palliative care colleagues.

**Results** Monitoring of IPOS and RAG showed that when things were fluctuating, we were responding to the needs of the individual. Universally positive feedback was received from users and fellow professionals. [See Figure 1].

**Conclusion** We have quickly established the benefits of this role. Alongside the direct impact for patients, there have been indirect benefits such as education/training for district nursing teams. Despite the challenging times, most referrals have been from external teams, demonstrating the impact locally. Our future plans include introducing more robust outcome measures; formalising the caseload reviews with the Specialist Palliative Care team; and conducting a full-service review including cost-analysis, to ensure continued service development.

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#### MANAGING THE COMMUNITY CASELOAD TO DELIVER THE BEST PATIENT, FAMILY AND CLINICIAN EXPERIENCE – AN EVOLUTION FROM INDIVIDUAL, TO TEAM, TO LOCALITY CASELOADS

Jenny Strawson, Tracy Christmas, Gabrielle Tamura-Rose, Rebecca Trower. *St Raphael's Hospice, Cheam, Sutton, UK*

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**Background** As referral numbers rise and hospice community teams face the challenges presented by the recent pandemic, with periods of unprecedented staff shortage, models of community working have required careful consideration.

**Aims** This service evaluation aims to track the evolution from individual, to team, to locality caseloads, whilst considering the advantages and disadvantages presented by these different approaches to caseload management.

**Method** The hospice community manager, consultant team and clinical director reviewed the model of community working prompted by themes identified through mortality reviews, reflection following complaints and staff feedback. Team meetings were held using the Grow Model (Grant, 2011. *The Coaching Psychologist*. 7: 118) to identify current challenges and options for change putting the team at the centre of plans for transition. Individual caseload models of working were considered in keeping with the hospice's previous approach and the current predominant model across hospice community teams.

**Results** Whole team communication allowed a successful transition from the one team caseload to smaller locality caseloads of 4-5 practitioners, looking after approximately 100 patients. Each locality is led by a team leader who co-ordinates monthly caseload reviews, joined by a consultant. This has resulted in improved work satisfaction, continuity of care for patients and families, and a more manageable telephone follow-up list. Regular caseload review has prompted the identification of stable patients for discharge, as well as creating the opportunity to invite external community practitioners to join the team for collaborative learning.

**Conclusion** Considering different models of caseload management allows community teams to manage fluctuating referral

numbers alongside unpredictable workforce numbers, whilst providing the best care possible for patients and families. During the height of the COVID-19 pandemic a one team caseload allowed the team to operate with restricted team numbers. Once the team had stabilised transition to a locality caseload has seen an improvement in continuity of care and staff satisfaction.

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#### HOSPICE BASED FAST TRACK SINGLE POINT OF ACCESS

Anne Huntley, Alice Thompson. *Pendleside Hospice, Burnley, UK*

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**Background** The historic fast-track process involved paperwork being sent directly to the Commissioning Support Unit (CSU) for processing. Hospice-at-Home were not aware of which patients had been fast-tracked with a tendency to refer to the service at point of crisis.

**Aim** Develop a Hospice-at-Home Single Point of Access (SPOA) for fast-track administration. Timely sourcing of care packages, streamlining administration and avoiding unnecessary delays. Hospice-at-Home would be aware of all fast-tracked patients who would access services earlier in their journey, preventing crisis situations and supporting advance care planning. A pilot group of domiciliary care providers worked collaboratively with the SPOA to provide night sit packages, whilst day care packages were forwarded to CHC/CSU.

**Method** A fast-track template was designed and available within the shared record. Once completed, the SPOA would be informed, template reviewed and notified domiciliary care providers would respond within two hours if they could accept the patient. If no response, the application was forwarded to the CSU. The template was accepted as a referral into Hospice-at-Home, ensuring patients accessed timely palliative care.

**Results** The SPOA processed 495 Fast-track applications (342 patients) between 01-May-2021 and 31-March-2022.

Nights: 106 applications

Days: 245 applications

Days/Nights: 116 applications

Other: 28 applications (Nursing Homes, change of provider)

86.5% Night sit applications: sourced from Hospice-at-Home/Domiciliary care providers within two hours.

33.5% increase in Hospice-at-Home patient contacts.

8% increase in Hospice-at-Home caseload.

**Conclusion** The project demonstrated 86.5% night sit fast-tracks were processed within two hours and increased the Hospice-at-Home caseload. The SPOA aligned to the palliative care ambitions document (National Palliative and End of Life Care Partnership, 2021): each person getting fair access to care and care is coordinated. EMIS shared-record minimised duplication with one template for referral and fast-track application. Domiciliary care received the fast-track application, reporting this information was invaluable, supporting coordinated care.

**Innovation** EMIS shared-records minimised duplication, maximising information sharing. Several organisations worked collaboratively to support patients receiving care in a timely manner.