P-210 BREAKING INTO PRISON – RE-ESTABLISHING A PALLIATIVE CARE SERVICE FOR IMPRISONED PEOPLE

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Background The UK prison population is growing older and sicker with deaths from natural causes increasing by 77% in the last 10 years (Hospice UK. Dying behind bars – How can we better support people in prison at the end of life? 2021). Those in prison are identified as at risk of experiencing poorer end of life care (Care Quality Commission. A different ending: end of life care review. 2016). Our hospice catchment area includes a prison accommodating 1200 men.

Aims This service evaluation aimed to develop the hospice input to the local prison, improving communication and support for prison healthcare staff. Whilst patients were referred historically, expertise was held by a sole clinician who subsequently left the team.

Methods Data was analysed for all patients referred from July 2021 to the present. Attendance at a weekly virtual prison MDT commenced in November 2022 to improve communication.

Results From July 2021 – March 2022 no referrals were received. In the last year referrals have steadily increased; a consultant and specialist paramedic practitioner have been assigned to lead on the service and attendance at a virtual MDT established. 7 patients in prison have been supported with an average age of 61yrs (n=47–75). Diagnoses include cancer (n=5), CVA (n=1) and end stage renal failure (n=1). 8 prison visits, with 22 face-to-face encounters, and 14 MDTs have occurred. Hospice input has involved symptom control advice, explanation of test results and treatment; advance care planning; applications for compassionate release and bereavement support. 6/8 visits have been done jointly and a hospice policy written to allow knowledge gained to be held and shared by the wider team.

Conclusion Commitment to the virtual MDT strengthened communication and relationships with prison healthcare staff and improved care for patients. Designating two clinicians to lead the service ensured continuity and momentum to successfully re-establish the service, whilst policy writing and joint visits across the team has allowed the growth of knowledge and expertise within our organisation.

Workforce and workplace

P-211 COLLABORATIVE STRATEGY CONSULTATION LEADS TO A CHANGE IN HOSPICE’S STRATEGIC AMBITION

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Background Post-pandemic, after major structural changes and with a new CEO, the children’s hospice needed a new organisational strategy.

Aims To create a collaborative strategy relevant to external and internal stakeholders, address service provision inequity and position the hospice within the health and social care system.

Methods Consultation: Nov. 2021- Feb. 2022 – internal and external stakeholders consulted widely. Questions included their requirements from the children’s hospice service 2022-26. Five meetings with 21 parents, children, and young people (CYP) and 19 meetings with 30 stakeholders from hospitals, social care, and integrated care boards (ICBs) took place.

Needs analysis: An analysis which overlayed national and local ONS (Office for National Statistics) and NCMD (National Child Mortality Database) prevalence and bereavement data. Sought to understand the discrepancy between the prevalence data of 7500 life-limited children and young people, and the actual 276 deaths in our area.

Finalisation: to receive Board and stakeholder approval; to work with external consultant on formalisation.

Results Consultation: Parents highly value hospice’s advocacy role. Multiple requests from NICU and PICU wards to support bereaved families. Hospices must integrate within the healthcare system.

Needs analysis: The hospice does not reach the most deprived families (IDACI Score 5) and only reaches 20% of families whose child has died. 276 children die in catchment area annually, 50% of those are under 7 days old (area covers 9.4% England child population).

Finalisation: Mar. 2022 – Sept. 22 – worked with consultant on a strategy map, implementation plan and performance measures. Presented to external and internal stakeholders for comments. Internal engagement included wider staff consultation, 86/147 (60%) staff attending briefing events. 67% positive feedback received. September 2022, Board approved final strategy.

Conclusions The new strategy changes the organisation’s ambition to include ‘all families whose child has died’. The organisation has ongoing conversations with stakeholders and works collaboratively solving problems faced by children, young people and families.

P-212 A HOSPICE STRATEGY BASED ON PUBLIC HEALTH PALLIATIVE CARE

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Background Communities play an integral role in developing social networks of care to support people experiencing dying, death and loss. Built upon a public health model, the hospice strategy strives to create a partnership between the clinical services it provides and the communities it serves.

Aim Hospices are the experts in dying, death and loss. The hospice’s aim is to share these skills more widely via a compassionate communities strategy with three inter-dependent workflows: (1) Clinical: change organisational culture and align clinical practice with compassionate community. (2) Hospice-led: pump prime community activity with the aim of handing over. (3) Community development: work alongside groups and organisations to find out what’s strong and then co-produce activity that will empower the community to feel more comfortable around dying, death and loss.