

Abstracts

- Personal care and support
- Night care

Although the elements of service are provided by different providers, they work together to ensure care is seamless 24/7.

Outcomes The GCP was commissioned as a “test and learn project”; now in its 3rd year, the service has developed in response to local need and resources have been flexibly allocated to provide responsive, high quality care.

Each provider has signed up to the success of the project and each has an equal stake in ensuring that the service meets its key performance indicators.

The project has succeeded in supporting an increase in home and hospice deaths and a reduction in hospital admissions, length of stay and deaths.

Application to hospice practice The model and contracting arrangements have attracted National interest amongst Hospices and commissioners, and has been cited as a model of good practice for others to build on.

Thinking strategically about the role of hospices

The GCP model is a natural extension of the Hospice service, producing efficiencies and quality improvements. With the current proposed model for palliative care funding, Hospices will need to take on the role as prime contractors in order to survive.

P91 PARTNERSHIPS: A PUBLIC HEALTH INTERPRETATION OF LIVING WELL AND DYING WELL

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Aim The overarching aims of the Cheshire Living Well, Dying Well Programme are to improve health and well-being by supporting a change in public knowledge, attitude and behaviour towards death, dying and loss and therefore make living well and dying well the norm.

Background St. Luke's Cheshire Hospice engaged in a community consultation process which highlighted that local partner organisations supported a co-ordinated public health approach to raise awareness and change behaviours in relation to death and loss. St. Luke's secured funding and a commitment of engagement from Macmillan Cancer Support, which included establishing a dedicated role to centrally lead and drive forward the agenda in Cheshire.

Methodology As death, dying and loss is a cross-cutting issue, it is important that a multi-faceted approach is developed and delivered in partnership. It is also important that the work is championed and embedded at strategic, operational and community level. The programme of work provides structure and support to enable partners to work together towards achieving the shared aim.

Findings and Recommendations Following consultation, six strategic areas have been identified; Partnership and Strategy Development, Financial Housekeeping and Future Planning, Resource Development, Public Education, Compassionate Communities and Healthy Workplace.

The work is also being championed at Health and Well-being Board Level.

Highlights include:

The formal launch and implementation of Cheshire Living Well, Dying Well Partnership

Identification of Cheshire Living Well, Dying Well Champions
Development and implementation of a range of resources (including support and training sessions for the public, staff and volunteers)

Development and implementation of Compassionate Community Volunteer Models

Presentation of the Programme at a local, regional, national and international level

Conclusion Improving the well-being of communities by normalising death and loss is a multi-agency issue and not singularly confined to those in the health arena.

This innovative approach identifies and enables partnership activity and the collation of evidence to progress further, with a view to mainstreaming the work.

P92 ISABEL HOSPICE BENEFITS ADVISOR PARTNERSHIP

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Isabel Benefits Advisor and East Herts Citizens Advice Service Partnership and supported by the Big Lottery Fund.

The partnership between the Isabel Hospice and East Herts Citizens Advice Service (EHCAS) was formed in 2010 to enhance the services for patients assessed as requiring support for financial, legal matters, employment, utilities, debt, housing, immigration and nationality, taxation and discrimination as well as relationship advice to ensure that the most up to date information is made available.

Evidence has shown that people living with life limiting illness such as cancer do not receive benefits and other forms of support for which they are eligible. The complexities of the welfare system can seem overwhelming at a time when they are struggling to come to terms with their situation. Isabel Hospice is the service provider for Specialist Palliative Care in Eastern Hertfordshire that has a population of around 358, 000.

From October 2010 to June 2012 the Isabel Hospice Clinical Nurse Specialists provided benefits assistance to more than 1,700 clients. The Benefits Advisor was then able to offer more specialist advice to 400 clients.

It is imperative that the Benefits Advisor role is kept fully up to date with welfare reform and able to ensure that the Clinical Nurse Specialists are kept updated with changes.

It is estimated that the annual amount awarded to those under the care of Isabel Hospice as a result of the Partnership was in excess of £368,000. The top five benefits in which assistance has been given were for Disability Living Allowance, Carers Allowance, Bereavement Support and funeral payments, council tax benefit and employment allowance.

The Partnership has enabled the East Herts Citizens Advice Service to reach clients that it would not have been able to before. At such a stressful time it can be difficult to fit in a further appointment or even travel to the EHCAS - working collaboratively has enabled more patients and carers to receive the appropriate services to enhance the challenges faced when living with Life Limiting Illness either in the home, Day Services or our In-patient Unit.

P93 THE HOSPICE OF ST FRANCIS SPRING CENTRE: COLLABORATIVELY REACHING MORE PEOPLE

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Context “Hospices will need to change is beyond doubt. The scale of the challenge ahead is dramatic and will require hospices to significantly increase the extent and scope of end of life services” (Calanzani *et al* 2013). Since 2007, cancer diagnoses have increased by 16% in Hertfordshire and over the next 10 years projected to rise a further 14%. This collaborative project with our neighbouring hospice provides a locality-wide community programme to support those recently diagnosed or living with serious illness, their families, carers, friends and the community. Over the next 3 years, The Spring Centre will reach over 1,000 more patients and their families.

Approach Re-aligning existing resources and community engagement is key to our programme. The St Francis Choir, Coffee Mornings and Film Club engage our community in regular activities throughout the year. Medical, nursing and therapists clinics provide physical, emotional and psychological support. Focused groups by our rehabilitation team range from fatigue management workshops, breathlessness groups, complementary therapy, gardening and creative therapies. Our Carers programme offers individualised support including benefits advice and relaxation classes. A variety of groups for bereaved adults, children and young people invite opportunities to share experiences, enjoy our gardens and even cooking classes! Outcome measures used to identify the effectiveness of attending the pilot fatigue group in 2012 showed that 80% of people felt they had the skills and energy levels to participate in more social or work activities. Feedback also highlights benefits, ‘the carers’ support group is a lifeline to me’.

Conclusion The Spring Centre at The Hospice of St Francis is an example of thinking strategically and collaboratively about the role of our hospice, re-aligning existing resources and delivering the care that people want and need.

P94 DEVELOPING A MOTOR NEURONE DISEASE (MND) SERVICE IN AUSTERE TIMES: THE POWER OF PARTNERSHIP WORKING

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Background Prior to the changes, pockets of good practice existed but services were uncoordinated and communication ineffective. Care was often reactive in response to crises and patients reported feeling unsupported and uncertain whom to contact should their condition change. A multi-disciplinary MND clinic existed; however this was hospital based, difficult to access and community service provision was patchy. The need to improve services was identified at a stakeholder event, which brought more than 60 people with MND, carers, professionals and commissioners together.

The post of MND Coordinator was developed in discussion with the local MND Association, and supported by the local NHS Primary Care Trust. The post was funded and based within our local hospice in Bedfordshire, with the aim to take the lead and establish a single point of contact from diagnosis to death, for people with MND.

Clinical outcomes

- Timely referrals to agencies for equipment, adaptations, therapy, information and support
- MDT clinic moved, making this more accessible, as well as promoting sensitive introduction of hospice and palliative care services – improving access and advanced care planning
- Domiciliary visits offered for support, monitoring and hospital avoidance
- Discharge planning from hospital/hospice to reduce length of stay
- Local organisations working together, promotes psychological and emotional wellbeing for people with MND and their carers and encourages self-management
- Health and social care professionals benefited from MND specific education delivered collaboratively by statutory and charitable services

Comments received ‘The clinic is in such a lovely setting and much better for patients to attend than hospital’

‘It is a hugely important role. Having someone there to monitor the health and wellbeing of people, who otherwise can fall down a hole.’

Recommendations Identify opportunities for collaborative working with local champions, using the voice of people living with MND and their carers to identify poor quality services and drive up standards.

P95 ABOVE AND BEYOND - THE POWER OF INTERNATIONAL PARTNERSHIPS

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Introduction This project brings together partners from India, South Africa, Malawi and the UK to expand children’s palliative care services in Maharashtra state in India and in Malawi.

The project results have prompted commitment to palliative care service development above and beyond the original project scope. It demonstrates how international partnerships can inspire and promote others to take on palliative care to meet the huge need for palliative care around the world.

Methods The project uses international donor funds to integrate children’s palliative care into existing services in both urban and rural settings.

Each partner brings to the project distinct skills and experience; ranging from project and donor management, paediatric palliative care knowledge, training and mentorship expertise, and advocacy skills.

Results The mix of these skills has seen the following key results:

- The development of children’s palliative care services in 5 new settings.
- The integration of children’s palliative care into health service curricula.
- The inclusion of children’s palliative care in draft palliative care policy.

The project has also prompted extended impact:

- The National Rural Health Mission (Jawhar, India) has committed to a wider programme of palliative care