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10.1136/bmjspcare-2013-000591.115

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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10.1136/bmjspcare-2013-000591.116

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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10.1136/bmjspcare-2013-000591.117

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

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service delivery and is already funding training, staff and services.

- District hospitals in Malawi are showing strong interest in developing palliative care services
- Project stakeholders are increasingly seeking extra funding and gifts in kind to support and develop children's palliative care services.

Discussion The collaborative implementation of this project has proved to be a catalyst for further development of palliative care than originally anticipated.

We would like to share our collaborative approach, together with more detailed results to inspire and encourage others to engage in partnerships to maximise impact and rise to the great challenge of meeting the huge need for palliative care internationally.

P96 A SURVEY FOR CHILDREN/YOUNG PEOPLE SUPPORTED BY A HOSPICE

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10.1136/bmjspcare-2013-000591.118

A survey for children/young people supported by a hospice

Introduction The Care Quality Commission requires agencies to enable services users to participate in the development of the service.

Aims This survey represents a children's hospice first attempt to hear directly from the children and young people they support as part of the organisations Clinical Governance process.

Methods Children and young people using hospice services have a wide range of needs, abilities and disabilities. Participants were encouraged to complete the surveys on their own if able or if needed with help from their siblings or parents/carers. The format was a simple questionnaire provided on paper and accessible on-line to offer participants a choice about how to reply.

Completed paper surveys were added to the on-line programme manually by the Clinical Governance Facilitators to aid collation and analysis.

Results Of the 438 forms sent out 67 (15%) were returned; some completed by the child/young person, on their behalf by siblings or parent/carer or siblings from their own perspective.

Respondents commented on activities they would like to see offered by the hospice such as DJ evenings and outings including holidays abroad. They also highlighted a few things they didn't like such as staying over at the same time as young children.

Discussion The survey offered children and young people with a range of complex needs the opportunity to comment on their experiences. The results will be shared with staff so they can discuss and consider ways of implementing changes to their practice in an effort to meet specific needs and improve the experiences of the service users.

Conclusion The survey has provided a starting point. In future we plan to review the survey and include other methods such as participant observation to offer more children and young people the chance to participate.

P97 DEVELOPMENT OF THE ADVANCED NURSE PRACTITIONER ROLE IN HOSPICE CARE: A MEDICAL MODEL

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10.1136/bmjspcare-2013-000591.119

Background/Context The role of the Advanced Nurse Practitioner (ANP) encompasses the provision of advanced levels of clinical practice, knowledge and skills. Whilst involving aspects of education and research, it is firmly grounded in direct clinical care. Responsibilities include assessing, diagnosing, planning and implementing programs of evidence based care and treatment. The drive to reduce junior doctors' hours in hospitals in the last decade led to further development in the ANP role, with increasing autonomy and application of expertise (RCN 2012). More recently, the ANP role has translated into hospice care, although generally these roles have developed within hospice nursing teams.

Aim Following the resignation of a Speciality Doctor it was decided to develop an innovative ANP role within an already established, experienced medical team.

Approach used An ANP role was defined for our local context with reference to national guidance and recommendations from the Royal College of Nursing. The role sits within the medical team, and involves the assessment and management of hospice patients, working autonomously but with support from the medical team. The ANP also participates in the medical on call rota, supported by the Consultant on call. The successful candidate had many years of nursing experience both in hospital and community, working at an advanced level within nursing.

Outcomes The ANP role challenges traditional professional boundaries. However, the ANP has integrated well into the medical team, and both medical and nursing staff have identified benefits from the skills and experience that the role has brought. The post has also provided a cost effective means of fulfilling many roles normally undertaken by a doctor.

Application to hospice practice Other hospices may wish to explore the development of Advanced Nurse Practitioner roles within their own medical teams.

P98 DEVELOPING AN ADVANCED NURSE PRACTITIONER ROLE IN HOSPICE CARE: A WORKFORCE TRANSFORMATION PROJECT

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10.1136/bmjspcare-2013-000591.120

Twelve hospices from the ECLIHP Regional group working with Skills for Health as part of a successful bid for £10,000 for a supported project.

The overall aim of this project will be to improve the quality of care for people with complex palliative and end of life care needs and their families by ensuring 24/7 direct admissions access to specialist inpatient hospice beds and emergency out of hours assessment in the community.

The intention of this project is to support delivery of a flexible and responsive 24/7 hospice admission and assessment service through redesign of the existing workforce to introduce an Advanced Nurse Practitioner (ANP) role within the team.

Impact will be measured by agreed Key Performance Indicators

Desired Outcome