

access to specialist palliative care services and poor overall quality of care in the last three months of life.

Aim To describe the inpatient population of a hospice ward and to explore the relationship between level of deprivation and the prevalence of co-morbidities.

Methods Data were collected from patient notes, nursing documentation and computer systems for 30 patients (total number of beds) over 1 week. Scottish Index of Multiple Deprivation quintiles (SIMD 1 – most deprived; SIMD 5 – least deprived) were assigned to assess level of deprivation based on patient postcode. Data were analysed using t-test on Graphpad PRISM.

Findings The sample comprised of 15 female and 15 male patients ranging in age from 56–88 years. Eighteen had been admitted from home, 11 from hospital and one from the hospice outpatient clinic. Primary disease was more commonly malignant than non-malignant (26:4 respectively). Fourteen were from SIMD quintile 1 (most deprived), but only two were from SIMD 5 (least deprived). Patients from areas of high deprivation had nearly double the number of admissions to hospital in the preceding 12 months (SIMD 1–2 mean 3.7 (95% CI: 2.4–5.1); SIMD 3 and above 2.1 (1.4–2.7) $P = 0.02$). The number of co-morbidities ranged from a single disease to nine; there was no correlation with SIMD quintile.

Conclusion The patients captured in this study were predominantly from more deprived areas, which reflects the local population. Importantly, these patients had significantly more admissions to hospital compared with patients from less deprived areas. More research is required to understand the reasons for this, including the extent to which these admissions are occurring out of hours, and to determine the level of need for patients and families living and dying in deprived areas.

P-97 HOSPICE WORKING IN PARTNERSHIP WITH THE HOMELESS COMMUNITY

Sue Scully, *St Barnabas Hospice Trust, Lincoln, UK*

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Hospice day therapy staff have been engaging with the homeless community via local services who support them, enabling those who have a life limiting condition(s) the equal opportunity to take control of their lives through the support of our specialist palliative rehabilitation service regardless of their homeless status.

Our aim is to optimise a person's physical function and emotional wellbeing, consistent with their choice, goals and priorities. We work together with patients and those who are important to them using our expertise, to equip them with new tools to maximise wellbeing.

The majority of patients that we care for who are part of this vulnerable and marginalised community, usually present with underlying mental health illnesses and may have alcohol and/or drug addictions. They experience significant ill health and the average age of death is 47 years.

It can be difficult for these people to engage with our services, due to their transient life styles and their psychological and emotional problems. The holistic assessment can be completed at point of contact or at the Day Therapy Centre. If patients do not attend with consent we continue to have contact with their support worker, housing officer.

Other members of staff and students are invited to attend from the Trust. This highlights to other professionals the ongoing difficulties that these patients have and proves that as a Hospice

Trust we are committed to making our service accessible, demonstrating the diverse groups that we support.

With monthly engagement with the services we have forged strong professional relationships with support workers/housing officers and managers and referrals are starting to increase.

Statistics Mean = May 2015–May 2016 monthly contact/discussion with 10 service users

Service users who accessed the centre during this period = 5

Service users who engaged at point of contact = 4.

P-98 WE HEAR NOW AND THEN: A SECONDARY QUALITATIVE ANALYSIS OF INNER CITY LONDON MINORITIES' EXPERIENCES WITH HOSPICE CARE

Munikumar Ramasamy Venkatasalu, *Universiti Brunei Darussalam, Gadong, Brunei Darussalam*

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Background Hospices undertake diverse social inclusion strategies to enable hospice access for minority population. Yet, utilisation and access to hospice care among British minorities remain scanty.

Objective To explore perspectives of older British South Asians on use of hospices at the end-of-life.

Design A constructivist grounded theory study.

Methods A secondary qualitative data analysis was taken on views of 55 older British South Asian participants, recruited using purposive sampling. Participants were approached through their community leaders and at open meetings of 11 local South Asian community groups of East London, England. Five focus groups and 29 semi-structured interviews were conducted. Thematic analysis was taken.

Results Three themes arrived: misconceptions, expectations and strategies. Participants described misconceptions related to hospice access including payable hospices and image of nursing home care as hospice care. Analysis also shows that lack of experience often created such misconceptions. Expectations include change in physical and emotional surroundings and enabling home care hospice services. Participants reported various ethnic-centred inclusion strategies to promote hospice concept among this minority population.

Conclusion Current social inclusion strategies of hospice seems to promote the spread of hospice concept among these older inner city minorities. However, access and utilisation of hospice services remain 'distant' to real usage. Future strategies should focus micro-level social interventions and mass media based interventions to promote hospice usage among this population.

P-99 A CULTURALLY INCLUSIVE, BAME-COMMUNITY-LED SERVICE FOR THOSE REACHING THE END OF LIFE

Muhammad Abdullah, Caroline Mawer, Rupina Begum, Abu Mumin, *Edencare UK, London, UK*

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Background People from BAME communities are known to have specific palliative care needs. Different cultural approaches may have substantial impacts both within families, and on service use. Despite this, services are often provided 'for', rather than 'developed with' Muslims. In response to this, Muslim community

members in East London have used a Compassionate Community-style approach, acknowledging end of life care as a social process, and everyone's business.

Aim To develop a culturally inclusive, BAME-community-led befriending and advocacy service, working with those who are isolated, terminally ill or reaching end-of-life. The intention is to work in partnership, with a focus on cultural, spiritual and social needs, rather than to replace existing provision.

Methods Since its start in 2013, Eden Care has provided an end-of-life service which is open to needy people from all communities. There are currently 35 Eden Care volunteers, most of whom are 'experts-by-experience' after experiencing terminal illnesses alongside family members or friends. 15 of the volunteers have undergone a DBS check and vetting process, and received specialist training to provide high-quality, non-discriminatory and non-judgmental services.

Results 15 people/clients have been paired with a befriender providing support with personal, social and spiritual needs. A Rapid Response Team can carry out 24/7 visits when a person is nearing death. The grassroots, responsive approach means that additional work is now also being done with a support service for Muslim burials; and on giving voice to those nearing end-of-life and the wider community, thereby enhancing the local statutory end-of-life strategy.

Conclusions Clients and families who might be considered 'hard to reach' by statutory providers are served in truly responsive and culturally appropriate ways when communities lead the work.

P-100 THE ADVANCE CARE PLANNING SERVICE

Kevin Chesters, Michelle Baskerville. *Douglas Macmillan Hospice, Stoke on Trent, UK*

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Our hospice has developed a model of advance care planning support that helps patients to explore what they want to do and how to achieve it. This has resulted in their wishes and preferences being met including achieving their preferred place of death.

The model takes a partnership approach between the clinicians at the hospice and the patients they support, helping them consider choices and preferences for future care and treatment. Those clinicians can then refer in to the hospice's advance care planning service where a social work assistant supports the person to write an Advance Statement and record their wishes. The patient holds a copy and anyone else as appropriate and consented to by them. The service supports patients who want to write an Advance Decision to Refuse Treatment as well. They talk to a doctor or nurse who knows them well so to be sure that they understand any potential implications of declining treatments.

The documents are reviewed every six months unless the person wants to make changes before or a review is prompted in some other way. Records indicate when reviews are due and documents are updated and disseminated again if required.

This has proved to be a more fluid and efficient system in providing this kind of support as it relieves the clinicians of the administrative elements of writing, storing and disseminating the documents.

If the patient wants to register a Lasting Power Attorney (LPA) the social work team manager can act as certificate provider for their applications. Although anyone can register LPAs via the Office of the Public Guardian, many people are either referred

to, or seek the help of solicitors which can be costly. The service provides equitable access for those are unsure how to register or unable to afford.

P-101 EXPERIENCES OF ADVANCE CARE PLANNING WITH PEOPLE LIVING WITH CHRONIC PROGRESSIVE NEUROLOGICAL CONDITIONS

^{1,2}Lorraine Petersen. ¹Arthur Rank Hospice Charity, Cambridge, UK; ²CUHFT

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The recent 2016 NICE guidance 'Motor Neurone Disease: Assessment and management' describes a model of multi-disciplinary holistic care. This includes providing opportunities to plan for end-of-life care. The Mental Capacity Act 2005 clarified the legal status of advance care planning but patients need to be in receipt of accurate information to be able to make plans, especially if they have not experienced treatments they might wish to refuse. When the hospice started an initiative to increase access to patients living with neurological conditions a number were referred for advance care planning. At the time (2011) the 'Preferred Priorities for Care' document was in use but staff had little experience in discussing or documenting patients' decisions regarding future refusal of treatments. This took place when patients visited the local Motor Neurone Disease (MND) Care Centre but for patients living with other progressive neurological conditions, it was unclear if they had any opportunities at all. A lead consultant was referred all the patients who might want to write an advance care plan. In order to ensure the resulting document would be 'valid' the consultant created a decision-aid that contained instructions on what details to include. To ensure these decisions were 'applicable' examples of scenarios involving potentially life-saving treatments were laid out for the patient to consider. The decision-aid underwent a number of revisions as exemplars were added to illustrate how the patient might document their decisions.

To date, 18 patients have completed combined Advance Decisions to Refuse Treatment/advance statements. One patient completed but never signed, one documented his decisions informally. The decision-aid, an analysis of the decisions the plans include, how these vary across the different diseases, who supported the patient in writing it, whether they have been revised and reflection on our experiences will be displayed in this poster presentation.

P-102 "4 EASE" – A DEDICATED SELF-MANAGEMENT EDUCATION PROGRAMME

Jane Finnerty, Kelly De Souza, Carolyn Fillingham. *Willowbrook Hospice, Prescot, UK*

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Background The aim of Wellbeing Services is to optimise patients' function, wellbeing and enable them to live independently with the best quality of life. To help achieve this we follow a rehabilitative model to empower patients to live life to their full potential for as long as possible. Education sessions have been designed with self-management as the focus.

Method A 12-week programme is delivered on a rolling basis within Day Hospice which provides a 'tool box' of self-help techniques to help maximise symptom control/quality of life. Sessions