

**P-175** **JOINT COMMISSIONING: CHALLENGES AND POSSIBILITIES**

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**Introduction** In 2014 the hospice became a joint commissioner with the CCG for end-of-life care in North East Essex.

We are commissioned to host the local EPACCs, locally called the My Care Choices Register, as well as provide the local 24 hour single point of access. We commission the Marie Curie night service as well as transition services from the J's hospice.

Joint Commissioning has allowed us to develop a strategic role in end-of-life care across our community.

Key initiatives include the following:

1. Care home education, role shadowing and EPACCs promotion.
2. Partnership working with the local hospital influencing locality key performance indicators.
3. Shared initiatives with the paramedic service involving education and promotion of the use of the My Care Choices register.
4. Partnership working with community health providers, recently expanding the My Care Choices register to allow incorporation of the community health team frailty register.
5. A primary care grant to support administration costs associated with the My Care Choices register.

**Results** The proportion of deaths in hospital is falling faster locally than the average figure for England. Currently 43% of deaths locally occur in hospital. England average 47%.

Over 2200 people currently have their choices recorded on the My Care Choices register. One in three people who died in our area in 2015 had recorded choices in the register. Over 70% die in a place of preference.

**Advantages of joint commissioning**

1. A raised profile in end-of-life care
2. Increased income from the NHS and subsequently from fundraising
3. A 50% increase in the number of people accessing a hospice service
4. Increased influence in service development across the locality.

**Challenges**

1. Reputational risk
2. Financial risk of expansion and increased dependence on NHS funding
3. Responsibility for other provider service quality.

**P-176** **'BLURRED BOUNDARIES' – PARTNERSHIP WORKING IN HOSPICE CARE**

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Although agencies may be in partnerships where they have formalised contracts, it is when they collaborate – that is they work together, that the impact will be seen. Identifying the growing needs of patients within our communities, this case presentation will explore how collaborative working between charities, the NHS, and social and private care strengthens our flexibility to

adapt to those needs. Ellis (2015) states 'good care means that people get the right services, at the right time, in the right way'.

Many hospices work with other providers in the statutory and voluntary sectors, and such partnerships are central to getting care right in the future. Hospice UK (2013) suggests that as small organisations hospices are inherently flexible and should capitalise on their ability to experiment with new ideas, turning them into action. Following the disease trajectory of a patient with advanced Motor Neurone Disease with emotional and physical complexities, whose package of care was no longer sustainable at home due to impact and distress on carers, Nightingale House Hospice decided to examine a new initiative.

In discussion with other agencies the idea was proposed to transfer the patient to the hospice in-patient unit, and to transfer her package of care from other providers to be further supported by us as a specialist team. This initiated effective collaboration between organisations to support the patient's needs and her preferred place of care and death while sharing financial and emotional impact on each agencies resources.

NHS Wales (2007) propose that effective collaboration relies on trust, appropriate leadership, and the need at the outset of collaborative initiatives to understand the reasons organisations seek to work together. A number of factors needed to be explored and central to this were the patient and her family, and acknowledging the advance care planning wishes she had made.

**P-177** **HOSPICE SERVICES ARTICULATING CARE DELIVERY WITHIN A PLATFORM OF EXTERNALLY COMMISSIONING SERVICES**

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**Background** Non-malignant diseases have advocated for the involvement of palliative care services to help deliver end-of-life care for patients and carers. The challenge comes within a fiscally constrained health economy when the drive is to cut and ultimately balance budgets. Therefore palliative care needs to be clear with its stakeholders in articulating the needs of the populations it serves and how it will deliver care in tandem with existing services across the multiple settings of care.

**Aim** To articulate a service specification in terms of care delivery for non-malignant disease couched within the wider remit of the health economy commissioning groups.

**Method** An iterative process of baseline review, literature review, horizon scanning with other providers and involvement of specialist and generalist teams.

**Results** A working group with professionals tasked internally with delivering care within non-malignant diseases was convened, with an action plan using a solution focused approach guiding the process. Each nominated person was responsible for devising a model of care that would ensure effective care delivery embedded within an environment of structured holistic assessment ensuring consistency, clarity and uniformity. This approach was guided by aligned work from the sustainability and transformation plans (STPs) within the external Clinical Commissioning Groups (CCGs). Discussion with external stakeholders and testing of proposed approaches was proposed to ensure suitability, feasibility and piloting of any new practice will deliver in terms of patient and carer experience and cost effectiveness.