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.

Conclusions The piece of work is visually represented to ensure that a model of care can be clearly articulated to all stakeholders be they internal or external. This helps funding in terms of our charitable donations as patrons know what we do and for external commissioners with what we do that is different to other providers. Ongoing evaluation in terms of patient experience and cost effectiveness is pivotal.

P-178 PARTNERSHIP WORKING – A HOSPICE ADVANCED RENAL DISEASE NURSE WORKING IN COLLABORATION WITH HOSPITAL TEAMS – A NOVEL APPROACH TO SUPPORTING PATIENTS

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Background It is well recognised that people with advanced kidney disease should have their supportive care needs assessed and have access to palliative care (NSF Renal Services 2005). Despite this, referrals to palliative care services remain low – our hospice received three referrals for patients with End Stage Renal Failure (ESRF) 2014/15 (<1% of all referrals). The number of patients with ESRF is increasing (due to ageing population and associated comorbidities), hence there is increasing unmet need. In order to increase the number of renal patients having access to palliative care, we set up an innovative renal partnership.

Aims

- Increase number of patients with ESRF having supportive needs assessed.
- Increase access to palliative care services for ESRF patients.
- Provide opportunity for Advance Care Planning.

Method Following discussion with hospital and regional renal teams and our palliative care team, a new post ‘Advanced Renal Disease Palliative Care Nurse’ was created. Funded by the hospice but working across all settings – new pathways and referral criteria were agreed. The nurse undertakes a parallel hospital clinic with the renal consultant and takes referrals from the renal nurse specialists. Patients are offered clinics at the hospital, hospice or home, including opportunity to discuss Advance Care Plans.

Results In the first three months of the service there have been 15 referrals (compared with three the previous 12 months). Average age 76 years, 76% male. Two thirds have completed advance care planning whilst the range of referrals to other palliative care services demonstrates the unmet need of this group of patients (three referrals to physio, three to Day Hospice, three to Community Companions and one to the carer support group).

Conclusion Early results show this model of care is effective – achieving a 19 fold increase in patients having access to palliative care. Further results including outcome measures available at Conference.

P-179 JOINT HOSPITAL AND HOSPICE CANCER CLINICS – ENCOURAGING EARLY ACCESS AND IMPROVING COORDINATION

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Background Transitions of care between acute hospital cancer services and palliative care services can be challenging for patients. This, combined with the limitations of time and clinic space at our local acute hospital, led us to develop joint clinics with cancer site specific clinical nurse specialists (CNSs) and specialist hospice staff, at the hospice site.

Aim

- To provide increased support for people with a cancer diagnosis who have a palliative prognosis
- To improve coordination of care for this group and provide access to the combined expertise of cancer site specific CNSs and specialist palliative care health professionals
- To encourage earlier access to specialist palliative care services and to smooth transitions between acute care and palliative care.

Methods The clinics were first piloted with patients with upper gastrointestinal (GI) cancers and cancers of unknown primary. The CNS for this tumour site provides clinics collaboratively with a palliative care specialist senior staff nurse. A lung cancer clinic was then started, which is run with the CNS and a palliative care specialist physiotherapist, providing multidisciplinary support. Each clinic attendee is assessed holistically and action is taken as necessary according to this assessment. This may include psychological support, symptom management or referral to other services. Follow up appointments are booked according to patient need.

Results Since the start of the clinics, 134 patients have been supported, attending 198 appointments between them. Of those who have attended the joint clinics, 80% have gone on to access other hospice services. Patient feedback has been very positive and working relationships between the acute hospital and the hospice have been much improved.

Conclusion A collaboration between a hospice and an acute hospital has provided improvements in co-ordination and quality of care, as well as early access to hospice services for patients with upper GI and lung cancer.

P-180 STRENGTH IN NUMBERS – THE CUMBRIAN HOSPICE ALLIANCE PARTNERSHIP

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Cumbria covers an area of 6,767 km sq making it the second largest county by area in the country.

Cumbria's age profile is older than the national average. By 2037 the proportion of residents aged 65+ is projected to increase to 32.9% (projected national proportion is 24%)

Demand for good end-of-life care will increase nationally but there will be greater demand in Cumbria.

Five independent Hospices working across the county:

- Hospice at Home West Cumbria
- Hospice at Home Carlisle and North Lakes
- Eden Valley and Jigsaw
- St Mary's Hospice
- St John's Hospice (Hospice in Lancaster but covering parts of South Lakeland)

Formation of the “Cumbrian Hospice Alliance” in November 2015.