

challenged the community's expectations that the community service will only be delivered in patients' homes.

The HNST comprises of three clusters, each having two nurse specialists and one associate nurse specialist and a team manager. Initially each cluster was allocated one afternoon clinic session with 4 × 45 minute slots per session. The use of the clinic slots was audited and recommendations made.

In the following months there was increase in the flexibility of clinic allocations and an increase in the availability of clinic rooms. There was a greater promotion of nurse led clinics at initial assessments and clusters were reminded to consider clinics during team meetings and at MDT.

A second audit confirmed an increase in the use of nurse led clinic slots:

- 23/6/14 – 31/12/14 (6 month period) 51 clinic appointments booked (1<sup>st</sup> audit)
- 1/6/15 – 31/8/15 (3 month period) 101 clinic appointments booked (2<sup>nd</sup> audit)

Failure to attend clinic appointments were relatively low at 11%.

Changes in the service model have:

- provided patients and their carers with greater accessibility to the HNST
- increased responsiveness to needs
- given patients more choice about their care provision
- patients have expressed that clinics greatly reduced their fears of the hospice environment and services.

#### P-198 YOU CAN LEAD A PATIENT TO A HOSPICE BUT YOU CAN'T MAKE THEM ENTER THE DOOR

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Patients diagnosed with metastatic breast cancer can experience years living with their cancer (Reed and Corner 2012). This group are often referred late in their cancer trajectory to palliative services. In an attempt to reverse this trend a Secondary Breast Cancer CNS (SBCCNS) post was funded by the local hospice as a three-year fixed term trial. The SBCCNS works as a member of the hospice and oncology team providing an in-reach key worker role to oncology clinics and wards.

The evaluation of the role is on-going. Initial review after six months of the role has identified the following benefits:

- Patients are providing positive feedback. Having a named key worker who can be available in primary and secondary care is seen as reassuring.
- Undertaking joint home review visits with the primary care CNS. Improve communication between the primary and secondary care teams.
- Holistic needs assessment and individualised care planning that encourages early referral to services including financial assessment, family support/counselling, dietetic input etc.
- Instances of admission avoidance to the acute Trust or directing admission to an appropriate setting e.g. hospice in-patient unit.
- Offering an alternative venue in day hospice for symptom control clinics and blood transfusion administration.

Patients with secondary breast cancer may spend years receiving anti-cancer treatment and trying to live their lives. This can result in reduced access to palliative services provided by hospice teams. Taking the service to the patient and introducing the potential benefits of palliative care services appears to be an initiative that patients accept.

#### P-199 ABSTRACT WITHDRAWN

#### P-200 DEVELOPMENT OF A RAPID RESPONSE TEAM TO FACILITATE 24 HOUR END OF LIFE CARE FOR CHILDREN AND YOUNG PEOPLE IN THEIR PREFERRED PLACE OF CARE

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**Background** Prior to the Merseyside End of Life (EOLC) pilot, palliative and end-of-life care for children and young people (CYP) across NHS Merseyside has been provided by the specialist palliative care team for advice and home assessments visits on a 24/7 basis and supported on an ad hoc basis by local Children's Community Nursing (CCN) teams and/or adult district nurses.

None of the existing CCN services across this footprint (6 Clinical Commissioning Groups – CCGs) were commissioned to provide the 'step up' support for EOLC at home, including the availability of 24/7 CCN support, which potentially limited realistic choice in place for EOLC for children and their families.

Unlike adult EOLC one of the major challenges of providing care for children is that diagnosing dying is difficult as children often have peaks and troughs in their condition and therefore, sustainable services that are responsive to provide a step up, step down approach are essential.

The North Mersey Paediatric QIPP programme identified specific gaps in service provision for EOL care and also reflected on the small numbers of children's deaths for each CCG. They noted that there were significant challenges for existing CCNT to maintain skills and expertise in this specialist field and a potential solution was a collaborative partnership approach with Claire House (CH).

The proposed pilot was for a Hospice to Home Team who are skilled and experienced practitioners to provide a 24-hour rapid response service for EOLC across the Mersey footprint, working in partnership with existing CCN and SPC Teams.

The aim was to facilitate this for between 15 and 23 children, enabling them to have an equitable, responsive and realistic choice for EOLC at home. This development supported the increase in home based EOLC to meet the best in England.

In order to make a success of the pilot collaborative working was key. An operational stakeholder group was formed which had representation from hospice, SPCT and CCNT. Shared referral pathways, key communication messages, procedures and policies were jointly formulated and endorsed. This group met fortnightly initially whilst essential operational documents and governance issues were discussed then as the pilot became open to referrals this became monthly. Case discussion and reflection was paramount for group learning and for continuous service improvements.

A steering group provided a mechanism for feedback on the pilot's progress and monitored governance, risk and acted as a critical friend. The steering group ensured that preparations were

in place to present to commissioners at an appropriate time so they could consider future commissioning.

The service has now been commissioned by the six Merseyside CCGs as a model of service delivery.

### P-201 AN INNOVATIVE MODEL OF CARE ENABLING A HOSPICE IN-PATIENT UNIT TO REACH MORE PEOPLE

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**Background and context** Within the UK, there is a general consensus that hospices should be extending their reach to care for more people, providing equity for those with a broader range of conditions. However, it is acknowledged that we are caring for people with increasingly complex needs and in reality there is a greater demand on beds. When viewed alongside nursing recruitment issues in hospices nationally, there is a need to review services to ensure we meet needs effectively and remain relevant.

**What we are doing** As a result of the changing context for palliative and end-of-life care, we have conducted a strategic review of our in-patient services. We plan to implement a new model of working, piloting two distinct wards each with a different nursing structure. One [specialist palliative care] ward will look after patients who have a high level of complex needs; this necessitates greater input from the multi-professional team, most notably the medical staff. The other will be a nurse-led [general palliative care] ward caring for a wider spectrum of patients who require less complex interventions. As well as caring for a greater number of patients, the model will also enable us to reach out to more people through education and training, offering clinical placements to our colleagues from non-specialist settings.

**Evaluation** The new way of working will be evaluated using an adapted action research approach at three-monthly intervals over a nine-month period with a final evaluation at 12 months.

**Implications for practice** It is anticipated that the new model of working will provide greater flexibility in the ways we can deploy our beds and resource, allowing us to care for more patients and 'reach more people' by sharing our knowledge, thereby improving the quality of care being delivered in other settings.

### P-202 NURSE CONSULTANT LEADERSHIP IN AN INTEGRATED HOSPICE SERVICE: EVALUATION OF IMPACT

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**Background** More people die in hospital than wish to do so and many are from an older age group. Without action this is likely to be a growing problem. By 2030, 44% of all people dying will be over 85 years old.

In 2013 a business case supported the appointment of a hospice nurse consultant with a remit to work across hospice services, particularly those provided in hospital. The aim of the post was to reduce emergency admissions, length of stay and hospital deaths.

Key objectives were to:

- Increase use of the hospital palliative care team
- Ensure further integration of services
- Address the needs of the 'older old'
- Connect palliative care expertise in and out of hospital
- Develop strategies to meet growing demand.

**Methods** This evaluation draws together qualitative data and presents compelling evidence of impact against each objective. Establishing new systems and processes for referral to the hospital team and enabling rapid discharge has led to a significant reduction in deaths in non-critical hospital wards. The evaluation reviews the challenges and considers further developments.

**Results** Outcomes include:

- Referrals to the hospital team up 25% and hospital team visits up 89%
- A 58% increase in referrals from the hospital team to the hospice community teams
- A 7% decrease in deaths in non-critical hospital wards
- Almost 8 out of 10 patients discharge achieved within one week
- Increased reach to people with non-malignant disease.

**Conclusion** The initiative has had significant impact, far outweighing the investment required.

### P-203 SHARING THE LEARNING FROM AN INNOVATIVE PERINATAL HOSPICE SERVICE IN THE UK – AN INTEGRATIVE APPROACH TO ENABLING CHOICE

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Due to advances in imaging technology and routine screening many life-shortening fetal anomalies are detectable in the early antenatal period. Whilst this allows families the opportunity to make extremely difficult decisions surrounding the progression of the pregnancy, families report a vast lack of support when deciding to continue the pregnancy in the knowledge that their baby may die before birth, during birth or shortly after.

In March 2014 the hospice was successful in securing funding for a one-year perinatal in-reach project with its initial aim of working more closely with regional neonatal units and facilitating choice for families. Due to the success of the first year's project the hospice saw a vast increase in referrals and interest in its services, in particular the support that could be offered for an early detection, in utero baby with a life shortening anomaly.

In the twelve months prior to the project the hospice received one neonatal referral. In the past 24 months the hospice has supported 53 families having received referrals from 24 neonatal families and 29 families in the antenatal period. As a result of the continuing interest and rise in referrals into our perinatal service the hospice has been fortunate enough to have secured a further three years funding enabling further development of our specialist perinatal service.

Offering families the opportunity to access specialist perinatal palliative support from point of diagnosis (whether in the antenatal or neonatal period) has immense benefits to all involved. It allows for an individualised, consistent and integrative approach to care, ensuring that families are offered the choices of place of care, place of death and the services they feel most beneficial to them as a family, resulting in a more compassionate and positive experience.