

## P-204 BISPHOSPHONATE TREATMENT IN BONE METASTASES: AN INTERVENTIONAL OUTPATIENT CLINIC MODEL

<sup>1</sup>Kathe'rine Newton, <sup>1</sup>Ruth Keeble, <sup>1,2</sup>Nikki Reed, <sup>1</sup>Marie Curie Hospice, West Midlands, Solihull, UK; <sup>2</sup>Heart of England NHS Foundation Trust, Birmingham, UK

10.1136/bmjspcare-2016-001245.225

**Background** Patients with bone metastases can suffer from considerable pain and reduced quality of life, in addition to complications such as pathological fracture and spinal cord compression. Bisphosphonates can be used as an adjunct to treat pain in addition to conventional analgesia and radiotherapy.

**Aims** Our outpatient bisphosphonate infusion service at the hospice was set up in 2008, in conjunction with our local acute NHS trust oncology unit. The pilot service initially accepted patients with bone metastases from hormone refractory prostate cancer when pain was not controlled with conventional radiotherapy and analgesia.

**Method** Patients benefit from an outpatient appointment with a doctor and nurse to assess current symptoms using IPOS (Integrated Palliative care Outcome Scale), followed by bisphosphonate treatment on the same day. Referral into other services within the hospice, such as physiotherapy, occupational therapy, rehab services and our FAB (Fatigue, Anxiety and Breathlessness) clinic, can be made when needed.

**Results** Following review of the service we now accept patients earlier in their disease trajectory and treat patients with bone involvement from other diagnoses such as myeloma, sarcoma or renal cancer. Our referral numbers continue to increase on a yearly basis.

We have successfully treated patients with recurrent hypercalcaemia in the day case setting by monitoring levels closely and treating early with a bisphosphonate before they are symptomatic; thereby reducing morbidity, preventing the need for inpatient admission and reducing pressure on acute hospital services.

**Conclusion** Future expansion of this interventional outpatient clinic might include breast cancer patients who currently receive denosumab injections in the hospital. We could use this model of service to allow early integration of these patients into palliative care services and allow them to benefit from the diversity of therapies and services the hospice can offer at an earlier stage in their illness.

## P-205 HOW TO PROVIDE A VOLUNTEER BEFRIENDING SERVICE: RECOMMENDATIONS FROM A WAIT-LIST CONTROLLED TRIAL

<sup>1</sup>Catherine Walshe, <sup>1</sup>Steven Dodd, <sup>1</sup>Guillermo Perez Algorta, <sup>2</sup>Matthew Hill, <sup>2</sup>Nick Ockenden, <sup>1</sup>Sheila Payne, <sup>1</sup>Nancy Preston. <sup>1</sup>International Observatory on End of Life Care, Lancaster, UK; <sup>2</sup>Institute for Volunteering Research, NCVO, London, UK

10.1136/bmjspcare-2016-001245.226

**Background** Many innovations in palliative care are commenced without robust research to understand either their impact, nor explore the processes, barriers and facilitators to effective implementation of the service. Within the hospice sector there are an increasing number of volunteer befriending or good neighbour services, and evidence is needed on how best to provide these to improve outcomes.

**Aim** To make evidence based recommendations on how to deliver effective volunteer befriending services at the end of life.

**Methods** A wait-list controlled trial (ELSA) (with eight nested qualitative case studies) testing volunteer delivered befriending services across 11 hospice, charity and NHS sites. Participants were estimated to be in their last year of life, randomly allocated to receive the befriending intervention immediately or after a four week wait. Data collection at baseline, four, eight weeks assessed patient's quality of life, loneliness and social support. The case studies included in-depth qualitative interviews with staff, volunteers, patients and family carers. ISRCTN 12929812.

**Results** 195 people entered the trial, and interviews were conducted across eight case study sites with volunteers (n = 23), staff (n = 31), patients (n = 24) and family carers (n = 3). Key issues include strategies for maximising impact (e.g. frequency and length of visits, type of support provided, targeting patients), the precise nature of the volunteer role (social or practical, in home or getting out and about), effective running of the service (e.g. how to match volunteer and patient, supporting volunteers), and managing the different nature of a volunteer delivered service (e.g. volunteer training, negotiating boundary issues).

**Conclusions** We will provide evidence based recommendations on how to run a high quality volunteer befriending or good neighbour service in an effective, safe and well managed way which is likely to maximise impact. Funded by the UK Cabinet Office. See also oral presentation on volunteer befriending services on page (A6).

## P-206 REACHING THE WIDER NEED – A PILOT – THE ORCHARD SUPPORTIVE CARE CLINIC

Charlotte Williams, Glenys Le Poidevin, Bev Aplin. St Wilfrid's Hospice, Chichester, UK

10.1136/bmjspcare-2016-001245.227

Hospice care continues to meet the needs of only a minority of patients who have specialist palliative care needs, either because prognosis is uncertain, patients themselves are not ready to accept 'hospice' or referrer/referee do not directly consider palliative care needs or prognosis. Indeed, many patients with non-cancer diagnoses will never see a palliative care specialist despite complex symptomatology and psychological morbidity. Recognising this gap, St Wilfrid's Hospice developed a pilot clinic to bridge a gap in provision: accepting any patient with complex physical or psychological symptoms needing specialist clinical support/advice -associated with a chronic life-limiting illness of any diagnosis (or its treatment related symptom burden.) Prognosis could exceed 12 months (unlike hospice criteria) or be unestablished/uncertain. The clinic aims were to promote proactive management- including self-management of symptoms, provide information for both patient and carers, offer an advance care planning course and breathlessness/fatigue management course, and provide general emotional support. The multidisciplinary team included a palliative care consultant, 2 CNSs, occupational and physiotherapy, a complementary/art therapy and a volunteer.

65 patients were referred (9 declined input, one died before seen, six were too unwell), 40% of these had non-cancer diagnoses. 60% of referrals came from secondary care (commonest specialities-respiratory, neurology and urology.) Of the 49 patients seen in OSCC, 21 were later transferred to the main hospice caseload as their illness progressed; 12 then died once under the care of the main hospice, all of whom had completed advance care planning before transfer. Patients able to self-report symptoms completed Edmonton Symptom Assessment Scores (ESAS)

at initial and follow up consultation. Most striking was the significant degree of psychological distress reported by 85% of the patients and cited as the main reason for referral. This was reflected in higher ESAS scores in the psychological domain and an impact on wellbeing scores.

**P-207 ADVANCING PERSON CENTRED PALLIATIVE CARE: DEVELOPMENT OF A SEVEN DAY THERAPY SERVICE**

Kate Eagle, Helen Ankrett, Annette Edwards. *Sue Ryder Wheatfields Hospice, Leeds, UK*

10.1136/bmjspcare-2016-001245.228

**Background** Both the NHS Five Year Forward View (2014) and Ambitions for Palliative and End of Life Care (2015) advocate developing models of care organised around the needs of patients emphasising personalised care planning, fair access, collaborative working and care coordination. The hospice had an established team of therapists, however, it was recognised that there were gaps in service provision. The existing therapy service was reviewed in 2015 alongside NHS Improving Quality and adapted to provide a seven day service.

**Aims**

- Avoid unwanted admissions and facilitate patient's choices and preferred place of care
- Provide ongoing rehabilitation, preventing loss of function and maintaining independence
- Facilitate discharge over seven days
- Provide moving and handling assessments to reduce falls risk
- Increase collaborative working with our seven day community nurse specialist service and health and social care providers.

**Method** Following the service review, funding for two WTE therapists was secured from our CCG and charity corporate partner to pilot a revised service. This enabled cover to start from January 2016 for weekends and bank holidays and increased response times. Therapists assess and treat patients in both inpatient and community settings and possess core skills and specialist skills specific to each profession.

**Results** At the three month interim review an improvement in services and outcomes for patients was demonstrated. Most referrals were for urgent community visits to maintain patients at home or for falls prevention on the inpatient unit.

**Conclusion** Seven day rehabilitation helps to reduce falls and maintains occupational skills. Rapid intervention facilitates discharge planning for end-of-life care at home and supports a person to remain there through provision of equipment and education of patient/carers. Enhancing partnerships with community services provides inclusive care for patients with palliative needs.

**P-208 THE VALUE OF TRAINING VOLUNTEERS IN ENABLING COMMUNITIES: MINDFULNESS AND COMPLEMENTARY THERAPY GROUP**

Julie Nicholas, Jenny Waite, Nikki Archer, Martin Hill. *St Giles Hospice, Lichfield, UK*

10.1136/bmjspcare-2016-001245.229

In 2013 one of our volunteers (Jenny) voiced concerns that hospice clients attending a MS seated exercise class were finding the session less useful due to disease progression. Their weekly visit had proved to be invaluable to their wellbeing. Since becoming a volunteer with the hospice Jenny had done some basic complementary therapy training – reiki, “M” technique and chair massage. In conjunction with colleagues Jenny developed a 12 week programme for both clients and carers. The hour's session started and finished with a relaxation/visualisation 10 minutes – and the middle section offered a different therapy each week. Jenny recruited trained therapists to gift their time and deliver a range of therapies. For example; massage, reiki, mindfulness, sound baths, reflexology etc.

From the outset the volunteers and therapists involved with the group were encouraged to facilitate a rehabilitative and enabling approach “to actively support patients to integrate self-management behaviours into their daily lives”. (Tiberini, Richardson Pg. 32) Group members evaluated their pain, mobility, general wellbeing and concentration. Also the effect of the session, both immediately and whether it had a longer lasting effect and helped them during the week.

The group has evolved into a sustainable cost effective programme. Every second week Jenny offers a therapy, either with or without additional therapists. On the alternate weeks the group focusses on mindfulness, either with Jenny or if she is unavailable one of the group puts on a mindfulness CD and the group runs itself.

Mindfulness was particularly popular and the Spiritual Co-ordinator has piloted an eight-week programme. Group members have discovered for themselves what therapies they benefit from and therefore might incorporate into their lives. Three group members went onto enrol on a complementary therapy course. Clients say the group experience generates fantastic positive “energy”.

## Social Media, Communication and Technology

**P-209 COMMUNICATION – HOW TO MAKE IT CLEARER**

Elizabeth Bailey, Denise Williams. *East Lancashire Hospice, Blackburn, UK*

10.1136/bmjspcare-2016-001245.230

**The Issue** We needed cost effective in-house communication skills education to suit all levels of staff and volunteers to ensure they had the knowledge, skills and confidence to communicate effectively with patients, their families and with each other.

**Why it is important** All of our staff and volunteers will at some time be supporting people in distress. Clinical staff often have ‘big’ conversations with their patients – breaking bad news etc. They can only do this if they have the right communication skills and the confidence to use them.

**What was done** We developed a three- tier programme of interactive communication skills workshops called CLEARER.