upskilling a member of school staff to support these children, whilst also identifying children who need specialised support with access to our trained counsellors.

Aims Targeting all children affected by grief and loss: providing education and support to school staff, the parents and families, alongside counselling and therapy programmes for pupils. Giving help closer to home, via a trusted school staff member, and helping kids keep some semblance of 'normality' in their lives, when everything else might feel as though it is falling apart. Training a link worker in every primary/secondary school with our service and offering guidance around bereavement and significant loss. Teachers are on the frontline when it comes to the emotional wellbeing of pupils, they are the crucial element in providing that stability for children struggling with loss.

Method Model of training a link worker with ongoing support from the coordinator, within each school is both cost effective but also upskilling staff.

Results Started with 46 schools, now 74, and plan to expand.

Conclusion Providing teachers with extra skills they can steer a child through even the most challenging situations. Additional support from the schools link service has dramatically changed the way youngsters are helped. Many of these children would drop out of education for a time: with our schools link service, they stay in.

0-7 THE IMPLEMENTATION OF PALLIATIVE AND END OF LIFE CARE STANDARDS IN SCOTTISH PRISONS

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10.1136/bmjspcare-2017-hospice.7

Background The Scottish Government's Strategic Framework for Action on Palliative and End of Life Care shares a vision where palliative and end of life care is available to all. With an ageing prison population, the Scottish Prison Service has to deal with more foreseeable deaths from terminal and incurable illnesses than ever before. This brings new challenges for both prison regimes and prison facilities in providing quality palliative and end of life care for those prisoners.

Aims This two-year project aims to implement palliative and end of life care standards within a prison context to ensure access to an equitable quality service.

Initial Aims of Project Introduction visits to meet with prison service and NHS staff to discuss role and introduce them to the standards of care. Objectives for each prison based on a gap analysis and identification of education and training requirements. Identify members of staff as palliative care champions. Work collaboratively with each prison to identify their palliative population.

Results All Scottish prisons have been visited and preliminary work of introduction completed with identification of key sites for implementation of tests of change. Delivered sessions on 'What is palliative and end of life care?' Developed Palliative and Supportive Care registers to support the identification of those who may benefit from palliative care. Support new multidisciplinary prison palliative care meetings. Delivery of Anticipatory Care Planning training to prison and NHS staff. Process mapping of palliative and end of life service provision in key establishment to bench mark against standards of care and evaluate further areas of change.

Next Steps

- Evaluate first year of project.
- Develop training for prisoners
- Develop an education and support platform for Palliative Care Prison champions.
- Focused engagement with other stakeholders i.e., specialist palliative care and third sector organisations.

0-8 PROACTIVE COLLABORATION WITH LOCAL PRISON SERVICES

Helen Knowles, Tina Turner. *Wakefield Hospice, Wakefield, UK*

10.1136/bmjspcare-2017-hospice.8

The Wakefield Hospice in common with many others, is looking to diversify its income generation strategies in order to bring in an even greater financial contribution, and to bridge the growing gap between statutory funding and the ongoing and increasing costs of service provision. In developing this collaborative project with HMPs New Hall and Wakefield, the aim is to bring about benefits for both organisations and therefore for their specific 'populations': providing useful occupation for the residents of both prisons, facilitating access to affordable clothing and improved self-esteem, and providing an opportunity for a vulnerable group to make a positive contribution to the community, specifically those requiring the care of the hospice teams. The project has begun with the establishment of a 'hospice shop' within HMP New Hall and staffed by residents, and there are plans to extend our collaborative relationship with the development of a furniture upcycling initiative at HMP Wakefield, and the production in both settings of a range of saleable items. Benefits for the hospice are clearly financial, with shop sales already in excess of those anticipated, and estimated to increase significantly when the furniture scheme is bedded in: relationships between the organisations are now excellent, and this venture has facilitated new and important links with a community group previously not in communication with the hospice. The intention is to continue to build on the early successes, and possibly use the developing source of saleable products to reach out to other hospices with an offer of sales expansion.

Parallel session 3: Real world practice: referrals, access and partnerships

0-9 PRIORITISING REFERRALS TO A SPECIALIST PALLIATIVE CARE SERVICE

Margaret Clifford, Carl Stanborough, Thomas Osborne. *St Joseph's Hospice, London, UK*

10.1136/bmjspcare-2017-hospice.9

Introduction With increasing referrals to specialist palliative care (SPC) services at a time of limited resources, effective triage systems are essential. This community SPC service uses a 'RAG' triage system, whereby a multidisciplinary team (MDT) decides daily if referrals should be categorised as 'Red' (seen within 24 hours), 'Amber' (3 days), or 'Green' (10 days).

Aims To assess if the MDT correctly prioritises referrals according to palliative care need.

Methods Referrals between 1/1/16 and 12/5/16 were examined retrospectively. Patients were RAG rated at referral. The Integrated Palliative Care Outcome Scale (iPOS) and phase of illness (POI) were recorded at the first visit. Higher iPOS scores, 'Unstable/deteriorating/dying' POI or shorter time between first and second contacts were taken as proxies of greater palliative care need, with lower iPOS scores, 'Stable' POI or longer time between contacts indicating lower need. One way ANOVA compared RAG to total iPOS scores and time between contacts. Chi-Square tested the association between RAG and POI ('stable' versus 'unstable/deteriorating/dying').

Results 296 patients received a RAG rating. Of these, 217 had an iPOS and 207 had a POI completed at the first visit. Red patients had a mean iPOS score of 21, Amber 18 and Green 15 ($p=0.001$). The mean number of days between initial contacts was 3 for Red, 8 for Amber and 11 for Green ($p=0.001$). There was a significant association between RAG triage category and POI (Chi-Square=36.9, $p=0.000$). This was in the expected direction with 67% of patients triaged as Green assessed as 'Stable' at the first visit, compared with 46% of Ambers and 3% of Reds. 97% of Red patients were 'unstable/deteriorating/dying' at first visit, compared with 54% of Ambers and 33% of Greens.

Conclusions These findings support the RAG triage system as a way of prioritising new referrals to a SPC service.

0-10 COLLABORATIVE MULTIDISCIPLINARY CLINICS INCREASE ACCESS TO PATIENTS WITH NON-MALIGNANT DISEASE

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10.1136/bmjspcare-2017-hospice.10

Background Few patients with non-malignant disease access hospice care despite having similar care and support needs to cancer patients.

Aims To increase access to hospice care and advance care planning for patients with non-malignant diseases, and to enable choice in end of life care and improved carer support.

Methods Separate hospice-based multi-disciplinary clinics were established for patients with advanced heart failure; respiratory and Parkinson's disease; and end-stage renal failure. The four clinics are staffed by a disease-specific physician, a palliative medicine physician, a hospice-based multidisciplinary staff and volunteer team and NHS-based disease specific clinical nurse specialists. Clinical assessments focus on quality of life, advance care planning and carer support, making onward referrals to other services as required. We report four years' experience of this new model of care.

Results Between April 2013 and March 2017, a total of 435 patients attended the clinics, with 1036 attendances. Patients with heart failure were the largest group (30%); with 29% being respiratory patients; 23% Parkinson's disease and 18% renal failure. 318 patients (73%) engaged in advance care planning discussions, with 66 patients completing formal advance statements and 28 completing advance decisions to

refuse treatment. 289 (66%) patients have made decisions to refuse cardiopulmonary resuscitation. 67 (15%) of patients had died by the end of March 2017, of whom 52 (78%) were supported to enable death in community settings (home 39%; hospice 22%; care homes 13%; other 9%). Only 12 patients (18%) died in hospital. Clinic patients and carers report improved quality of life and accessed multiple hospice and community based services as a result of initial clinic review.

Conclusions Collaboration between hospice, acute hospital and community trust health professionals has enabled mutual support and learning and provided a popular care model for patients with non-malignant diseases.

0-11 THE CHALLENGES OF A MODERN NURSE-LED PALLIATIVE AND END OF LIFE CARE UNIT

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10.1136/bmjspcare-2017-hospice.11

Background This innovative project has brought together the knowledge and expertise of providing palliative nursing care from an NHS Trust with a local charity dedicated to ensuring patients have choice within their local area.

Aims From its inception at a public meeting to providing care to patients in a purpose-built six-bed unit, this project aims to provide quality care in a non-institutionalised setting. Its innovative approach comes from the nurse-led model where the patient's own local GP retains oversight and leadership of the medical care. It has been provided within a specified financial envelope, utilising the valuable skills of volunteers to support the care provided by nursing and support.

Methods The team has overcome and embraced a range of challenges. These have included:

- Ensuring positive engagement with local GPs – this includes raising awareness of a new service to encourage referrals, and engagement about offering a different approach to palliative and end of life care
- positive engagement with other referrers – the team has worked hard to establish their presence in the local community, even visiting every single ward of a neighbouring hospital to encourage engagement and referrals
- continuing healthcare resources – balancing the ethos of supporting patient choice with the availability of other health resources in the community through other care providers
- a bespoke staffing model, which meets financial efficiencies while ensuring an effective response to local needs. This has also given autonomy to Band 6 nursing staff and development opportunities for students.

Results Our innovative model has supported:

- increased patient choice in the locality good
- engagement with other professionals
- an equal balance between physical and spiritual care.

Conclusions The project has proved the innovative concept of a nurse-led model can effectively support greater patient choice and improve experience in a community setting.