

in response, this hospice has set up a Volunteer Discharge Buddy Service to help alleviate these feelings, to maintain patient safety and restore confidence on returning home.

Aims The service aims to support patients and families with practical tasks during and following discharge. The Buddies offer support on the day of discharge and make follow-up visits for up to five weeks. They liaise with community services and signpost carers and families to other services as needed.

Methods To recruit Buddies, there is a rigorous selection process and intensive two-day training programme, which includes issues around working with palliative care patients; lone working policy; safeguarding and other relevant topics. The Discharge Coordinator allocates patients to Buddies, who meet each other prior to discharge; more complex patients are allocated two Buddies. All visits are recorded in the electronic patient notes. We hold monthly supervision sessions where the Buddies discuss their experiences and bring new ideas to develop the service. We find these invaluable.

Results An evaluation form is sent to each patient. Feedback indicates that patients and families feel very reassured by the service we provide. Feedback from colleagues has also been positive. In response to considerable interest from other hospices, we have developed an information pack to assist them in setting up their own service. Colleagues from other hospices have also visited.

Conclusion Uptake has been excellent and we are planning to recruit more Buddies and extend the service to include a 'sitting' service. Additionally, we have supported the community care teams by relieving them of the simpler issues that patients frequently raise following discharge and prevented possible re-admissions when patients or their families panicked when faced with the reality of being at home.

P-178 CAN WE GIVE DYING HOSPITAL PATIENTS BETTER CARE?

¹Keri Thomas, ¹Julie Armstrong Wilson, ²Collette Clifford. ¹Gold Standards Framework Centre C.I.C. Shrewsbury, UK; ²Birmingham University, Birmingham, UK

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Aims A third of hospital patients are in their last year of life, almost 50% of people die in hospital, and most do not die where they choose. Poor end of life care in UK hospitals has received much recent attention and is recognised as a key area for improvement. With earlier recognition and a more proactive approach, more might receive better care, be discharged home earlier, with fewer hospital deaths.

The Gold Standards Framework (GSF) is a quality improvement programme delivering proactive person-centred population-based care for people in the last years of life in all settings. We report on the introduction and impact of the first eight years of the GSF Acute Hospitals Programme, with findings from the first GSF Accredited wards.

Method The structured two-year GSF Hospital training programme includes training, tools, support and evaluation at organisational, patient and staff level, including measures of progress and attainment and some independent evaluations. GSF encourages teams to identify patients earlier (aiming for the 30% figure where appropriate), assess their needs (offering

all initial advance care planning discussions) and proactively planning care aligned to preferences, enabling more to die at home.

Results Evaluations indicate significant progress in several key areas in many hospitals and a 'culture change' on the wards. GSF Accredited wards show embedded good practice including earlier identification (average 35%), more proactive needs-based approach, more offered advance care planning discussions (75%–95%), better communication with GPs, reduced hospitalisation and improved more appropriate referrals to palliative care specialists.

Conclusions Findings from the first phases of GSF trained hospitals and the first accredited wards show significant changes, with proactive, better coordinated, person-centred care. A key factor is earlier recognition which is increasingly being attained.

P-179 IMPROVING CARE FOR PATIENTS WHO MAY BE IN THEIR LAST MONTHS OF LIFE: THE LENS OF ACUTE ADMISSIONS

¹Susanna Shouls, ²Vince Connolly, ²Gavin Eyres, ¹Lesley Goodburn, ¹Anita Hayes, ¹Paul Hayes, ¹Claire Henry. ¹The National Council For Palliative Care, London, UK; ²Emergency Care Improvement Programme, NHS Improvement, London, UK

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Background The aim is to improve the quality of care for patients who may be in their last three months of life who attend or are admitted to hospital in an emergency. Hospitals are an important provider of care for this group of people (Clark et al., 2014). An emergency admission may indicate underlying clinical decline. Quality of experience of care varies (Office for National Statistics., 2015). Acute admission processes are not generally designed to manage care for this group (Bailey et al., 2010). This may result in unwanted inpatient stays and/or treatments (Cardona-Morrell et al., 2016) that affect the person's quality of (their remaining) life. Detail is important: 'sometimes, it's the little things that matter, and that is what you remember' (NHS Improving Quality., 2014). This is in the background of increasing demographic related demand for palliative care (Public Health England., 2015) and associated pressure on services (Lowthian et al., 2010).

Method Four acute hospital Trusts formed a quality improvement collaborative in 2016 with expert clinical, quality improvement and patient experience advice. The methods to diagnose underlying problems and facilitate acute physician engagement included: a 'patient/relative' experience walk-through, a case file review and analysis of activity data and building on existing plans for improvement/known issues. The Trusts set their own priorities for improvement.

Results The 'walkthrough' highlighted areas for improvement, eg information, signage and mortuary visiting environments. The casefile review facilitated acute physician engagement in three Trusts. These highlighted some excellent practice, which was not consistent. Recognition of dying (69% – average three Trusts); recognition clinical uncertainty of recovery (53% average 3 Trusts); non-beneficial treatment (65% average two Trusts). 60% patients who died in hospital had a prior visit to that Trust (three months) – potential missed opportunity to plan.

Conclusions This is an important topic. Results are still emerging including an independent evaluation due in September 2017. Improvements in clinical processes (quality and reliability) depend on good engagement with acute clinicians. Quality improvement methods helped, but other enablers are often required.

P-180 COLLABORATION, COMMUNITY AND CREATIVITY

Lynn Kelly. *St Catherine's Hospice, Preston, UK*

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Background A key objective of the newly formed Knowledge Exchange Directorate in 2015 was to collaborate with other organisations to support the achievement of St Catherine's Hospice's (SCH) aim 'To help more people have quality of life to the end of life'. A formal collaboration with Higher Education was a high priority and in late 2015 discussions began with the University of Central Lancashire (UCLan) to explore a more formal relationship.

Aim of the Collaboration To work together to explore opportunities for the joint development of: the expertise residing in UCLan and SCH for the benefit of local people and the local economy; educational opportunities through potential collaborative provision research and academic projects, including academic updating and sharing of good practice links within their respective industries to provide students with hands-on practical experience; joint bids for external funding to support the above.

Methods A formal three-year Memorandum of Understanding was signed with UCLan to lay out the objectives of the partnership and the principles of collaboration alongside statements on intellectual property and confidentiality.

Results Include

- New opportunities for students from the College of Health and Wellbeing and Medical School to support understanding end of life care. SCH to be included in the pilot of the Physician's Associate role
- Support to help SCH develop its communications strategy including a project by MBA students and a facilitated planning day delivered by the Leadership Hub
- Joint bid for research project on the use of communications technology in end of life care.
- Exploring potential for placements from events, communications and creative/design students.

Conclusion The whole is greater than the sum of each part. SCH has to offer real world issues, experience, and community involvement; UCLan offers research, evidence-based knowledge and developing talent; together there is innovation, thought leadership and impact through social change.

P-181 PREPARED TO CARE? WHAT ARE MENTAL HEALTH AND PALLIATIVE CARE PROFESSIONALS' EXPERIENCE OF COLLABORATING TOGETHER WHEN SUPPORTING PATIENTS WITH SEVERE PERSISTENT MENTAL ILLNESS AND PALLIATIVE CARE NEEDS?

¹Nicky Wood, ²Steve Iwasky, ³Sue Bailey, ⁴May Pheasant. ¹Isabel Hospice, Welwyn Garden City, UK; ²MH Raid team; ³Garden House Hospice, Letchworth Garden City, UK; ⁴Lister Hospital, Stevenage, UK

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Background Much has been written in the past year about inequalities in palliative care. Patients with severe mental illness often present late with an advanced diagnosis for which palliative care is the only option (Ellison, 2008). Research in this area is lacking, no statistical evidence exists as to numbers of patients requiring collaboration from both specialties (Addington-Hall, 2000). A recent American study highlighted barriers present when caring for mental health patients with palliative care needs; as a result this study called for greater collaboration between palliative care and mental health specialties (Morgan, 2016). However, there is very little research to highlight the experience of collaboration between these two specialties.

Aim As a result this scoping session aims to examine the working relationships between mental health and palliative care health care professionals (HCPs) when caring for patients with severe mental illness and also a palliative care diagnosis. The session wants to understand both positive and negative experiences of collaboration in order to highlight the support these patients receive.

Method A scoping session is due to take place on 22 June. 15 HCPs from various palliative care settings and 15 HCPs from mental health settings having been invited. On arrival all participants will be asked to fill in a questionnaire. Following presentations from both specialties there will be mixed group work. Facilitators within the groups will gather information through various means to add weight to the questionnaire.

Conclusion Everyone has a right to high standards of palliative care. This scoping session aims to explore how collaboration is working and if there are gaps or barriers which prevent cohesive working. This session aims to be responsive to issues highlighted and to provide recommendation for improved future collaborative practice, with the ultimate goal of reducing inequalities in care experienced by this group of patients.

P-182 THE DEVELOPMENT OF A CHILDREN'S HOSPICE NEONATAL LINK TO IMPROVE PERINATAL PALLIATIVE CARE

Katrina Williams. *Claire House Children's Hospice, Merseyside, UK*

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Background Perinatal palliative care (PPC) is an evolving specialty committed to providing care for foetuses/babies with a life-limiting condition diagnosed in the antenatal/neonatal period, as well as supporting the parents and extended family. However, the number of referrals for hospice support was few and far between.

Aim(s) Increase awareness of hospice services amongst tertiary centres within Cheshire and Merseyside

Create consistency to families of a choice of place of care and death; hospital, hospice or home

Provide specialist palliative care through diagnosis, birth, child's life, and death.

Methods Links have been developed in two neonatal units within the hospice catchment area. This included regular presence on ward rounds and education about hospice services, thus creating good collaborative working between hospital, hospice and families.

Results Since the initial development of links in 2014, referrals (aged 0–1 years) accepted for hospice care have increased by 216%. This has had a dramatic impact on all services offered