

P-185 **WHOLE SYSTEM END OF LIFE STRATEGY**Alison Stevens, Eva Lew. *Farleigh Hospice, Chelmsford, UK*

10.1136/bmjspcare-2017-hospice.210

Our hospice leads the End of Life Locality Group within our Clinical Commissioning Group (CCG) area. The CCG End of Life Strategy (EOL) was due for renewal so it was agreed to develop a 'whole system' strategy led by the hospice including the CCG, all providers with a key responsibility in delivering end of life care and service users. The aim of this was to adopt a consistent approach to meeting local need, pooling resource and sharing best practice, resulting in a better end of life experience for people within the locality.

A project planning group was set up and looked at local needs as well as national drivers. The group decided to adopt the national Ambitions for Palliative and End of Life Care as the overarching framework for the strategy.

The locality group hosted four 'Transforming End of Life Care' whole system workshops with 193 attendees across all providers to identify gaps in service delivery and areas of best practice. Knowledge gleaned from these workshops fed into the local actions that were allocated to each ambition and a high level action plan was embedded within the strategy.

This strategy and high level action plan now drives the actions of five locally based workstreams, each with a lower level action plan, clearly identified outcomes and measurements to ensure the overall strategy is delivered. Ongoing evaluation is undertaken by the Locality group.

During the strategy planning phase there were a number of external changes that occurred including the decision by NHS England to introduce the 'Success regime' to Essex. The group used this as an opportunity to share the strategy with the other CCGs involved and it was adapted and used as the framework across a wider area to influence good practice and improve experiences for patients and their families.

P-186 **CALDERDALE END OF LIFE NETWORK – A COLLABORATIVE APPROACH**¹Tracey Wilcocks, ¹Karen Hagreen, ²Rachael Ross, ³Kirsty Dutton. ¹*Overgate Hospice*; ²*Skills for Care*; ³*Calderdale Council*

10.1136/bmjspcare-2017-hospice.211

Overgate Hospice provides specialist palliative care, but acknowledges that many patients receiving end of life care will have some or all of their care delivered by generalist practitioners in other 'care' settings including patients' own homes. The recognition that care is comprised of many strands of multi-disciplinary work, strongly influenced the vision of a multi-agency network, underpinned by highly effective education and training. The potential benefits of one collaborative group were explored, clearly identified and became our driving force with one clear aim; to work cohesively to improve end of life care across the locality.

The project began with an initial expression of interest; inviting key organisations to engage with a mapping exercise; tracking a fictional patient's journey from diagnosis of illness to end of life. This map formed the basis for network membership and has since been shared as a guide for professionals. The exercise was thought-provoking. We had found mapping

the journey confusing, with many overlaps and potential gaps in the road; an experience we feared would be echoed by patients and families.

Collaboratively, we refined our aims and formalised our terms of reference.

The Network offers opportunities to:

- Share best practice, new ideas and innovations
- Learn from each other
- Discuss and seek resolution for practical issues
- Access learning opportunities.

Membership includes:

- Community specialist palliative care nurses
- Care home staff
- Supported living staff
- Learning disability nurses
- District nurses
- Community matrons
- Workforce development staff
- Hospice staff
- Skills for Care Locality Manager
- End of life social workers
- Domiciliary care workers
- End of life educators
- Marie Curie nurses
- End of life doulas.

2016/17 has seen the exciting inauguration of the Network, where positive relationships have been formed across service boundaries. By extending our membership and the continued attendance and contribution of attendees, we have connected many services, improving the experience of patients and families in keeping with our initial aims.

P-187 **CREATIVITY THROUGH PARTNERSHIP WORKING TO IMPROVE OUTCOMES**Zoe Holman. *St Margaret's Hospice, Taunton, UK*

10.1136/bmjspcare-2017-hospice.212

Background The Association of Palliative Care Social Workers highlights the importance of having 'Social Care Champions' to work with social care colleagues and promote good practice. The hospice and local authority Adult Social Care Service are working in partnership to jointly employ two specialist palliative care social workers and two specialist palliative care occupational therapists (OTs). They work across the adult social care and hospice settings to support service users, their carers and families to live and die in the place of their choosing where possible.

Aims Using the Care Act (2014) they work to promote well-being and quality of life for the people they work with using services from both statutory and voluntary agencies. Sitting within the multi-disciplinary team (MDT) at the hospice as well as within adult social care teams avoids delay, enables better multi-agency working and positive outcomes for service users. It enables creativity, using skills and knowledge of specialist palliative care and social care systems and resources to quickly put things in place for people. It also provides advice to the MDT within the hospice around social care issues including Safeguarding, DOLS and Social Care services. These specialist palliative care social workers and OTs provide