and Relationships *online*). Working closely with local NHS commissioners ensures that services meet the needs of the local population and provides opportunities to influence development of healthcare services (NHS England: NHS Commissioning *online*).

Aims Effectively engage with our local CCG Commissioner to create and maintain robust relationships ensuring palliative and end of life care remains a CCG priority.

Methods By reaching out to our lead commissioner we established a more cohesive working relationship, in line with our organisation's values. Our open and honest approach was well received, as was our ability to adapt to an ever-changing healthcare landscape. The commissioner works from the hospice regularly and is on first-name terms with many staff there. Communication with the CCG has vastly improved and the hospice is more widely recognised as the experts in palliative/end of life care.

Results We have been formally recognised by the CCG for our progress over recent years and were asked to collaborate with the lead commissioner to jointly design and deliver an innovative pilot to support patients' preferences at end of life. We received a significant investment from the CCG to support this, and produce monthly KPIs to evidence outcomes and improvement.

Conclusions Having an open and honest relationship with the commissioner has helped us to grow and expand hospice services. Embedding the commissioner within the hospice has helped to place palliative and end of life care firmly at the heart of the commissioning agenda. This hugely positive relationship has ultimately benefitted patient care.

P-191 IN-PATIENT CARE BEING MIRRORED INTO THE COMMUNITY

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10.1136/bmjspcare-2017-hospice.216

Background In November 2016 the in-patient unit (IPU) was temporarily closed and relocated to a nursing home to allow essential demolition work. This meant a reduction from 12 to 5 IPU beds. An Enhanced Hospice at Home (EHAH) service was developed to mirror the care we deliver in IPU and support the reduction in beds.

Aim Our organisation wanted to ensure that patients' needs and wishes continued to be met. To enable this, the service supports four patients in their own home environment for end of life care or complex symptom control issues. It is enabling us to bring our in-patient care out into the community.

Methods A team of experienced registered nurses and health care assistants offer up to four visits a day to provide personal care, symptom management and emotional support. Specialist hospice doctors provide daily visits depending on the patient's clinical needs. Care in the community still involves our wider multidisciplinary team including therapists, family support and benefit advice.

Results During the project data has shown 93% of patients' PPDs that have been home have been met. Combined IPU and EHAH admissions are higher than previous IPU admissions alone. Staff costs have been unchanged by splitting the service.

Feedback Includes 'I felt the team were excellent and it was obvious they were very experienced as they knew exactly how to advise myself and my brother with all aspect of our mother's care.'

'My family felt the care we received was invaluable, it enabled my husband to pass from this world with dignity. It would be wonderful to think that all people could receive this special care in the last days of their lives.'

Conclusion This EHAH has not only helped us provide holistic specialist care to our patients and families but it has also given us the opportunity to build working relationships with GPs and district nurses and be able to share our knowledge and skills.

P-192 TAKING INPATIENT UNIT LEVEL CARE INTO THE HOME: AUTO-ETHNOGRAPHIC REFLECTIONS OF TWO HOSPICE DOCTORS

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Background In November 2016, building work required us to temporarily reduce the number of our hospice inpatient beds and modify our model of care. We transitioned from having a 12-bed inpatient unit (IPU), to five inpatient beds complemented by four 'enhanced hospice at home' beds providing inpatient-level care to end of life patients with complex needs in their own homes. This included providing up to one medical home visit a day as part of a multidisciplinary team.

Aim In this presentation, we reflect on the impact on our doctoring role of shifting the location of complex end-of-life care from the professional setting to the intimacy of the patient's home.

Methods We used an auto-ethnographic (Chang, 2016) approach to create and analyse written reflections on caring for six patients in the IPU and enhanced hospice at home setting. Based on our analyses, we will present our findings as an illustrative story of caring for one patient and their family.

Results We identified four key themes: Fulfilling the promise to provide continuity of care (Leadership Alliance for the Care of Dying People, 2014): 'We'll be there for you until the end [and I mean it].' Dissolving professional boundaries within the multidisciplinary team (Hospice UK, 2015): 'Working together, side by side.' Supporting rather than supplanting existing care (Janssen & MacLeod, 2012): 'Thank you for helping *us* care for him.' Shifting the boundaries between care-giver and care-receiver (Janssen & MacLeod, 2012): 'Would you like a cup of tea doctor? You must find it difficult dealing with all this loss'

Conclusions Changing location from a professional setting in which we deliver care, to a home setting into which we are invited as *co-carers* has the potential to redefine our relationships with our patients, their families and our colleagues. It can enable us to support, rather than supplant reciprocal caring relationships (Janssen & MacLeod, 2012), embrace national palliative care initiatives (Leadership Alliance for the Care of Dying People, 2014; Thomas et al., 2016), and through increased job satisfaction build our professional resilience (Hospice UK, 2015).