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.

**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 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.

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

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10.1136/bmjspcare-2017-hospice.217

**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): ‘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 care 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).
**P-193** HOSPICE CNS SEVEN-DAY SERVICE: 6/12 PILOT REVIEW

Elizabeth Atwood, St Peter’s Hospice, Bristol, UK

10.1136/bmjspcare-2017-hospice.218

**Background** The hospice community CNS team has piloted a 9–5 service at weekends and bank holidays in response to national guidance and the need for a continuous seven day service for patients with complex palliative care needs at home (NPEoLC Partnership, 2015–2020).

**Aims** To promote preferred place of care/death, avoid inappropriate hospital admission, promote appropriate hospice admission and provide continuity of care for hospice community patients.

**Methods** One CNS working on bank holidays and weekends received 52 urgent referrals from the hospice advice line for interventions associated with uncontrolled symptoms, rapid deterioration, emotional distress, and requests for hospice admission. 47/52 received the service of which 36/47 were visited at home.

**Results**

1. **Promote PPC or PPD**
   - Most patients with complex needs who received this service achieved their preferred place of care, 27/32 or 84%.
   - 2. Avoid inappropriate hospital admission
     - This was achieved as hospital admission was appropriate for 5/5 or 100% who were assessed as requiring treatment from secondary care.
   - 3. Access for appropriate hospice admission
     - Appropriate admission to the hospice was achieved by 10/12 patients but two were not admitted due to lack of beds. Inappropriate hospice admission was avoided for a further seven patients where 5/7 were supported by this service to stay at home and 2/7 were assessed as requiring hospital admission.
   - 4. Provide continuous care in complexity
     - CNSs strongly agreed or agreed that the aims of the referral were met for 43/44 or 98% of patients and families who received this service.

**Conclusions** The results demonstrate positive outcomes of this service in the urgent management of complex symptoms, distress, deterioration and the promotion of PPC. The service criteria is being expanded to address the unmet need of patients who require proactive CNS interventions to sustain palliative care control and avoid crises.

**P-195** SUPPORTING PEOPLE AND FAMILIES AT END OF LIFE TO ENSURE THEY ARE CARED FOR IN THEIR PREFERRED PLACE OF CARE

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10.1136/bmjspcare-2017-hospice.220

The hospice was approached by a Clinical Commissioning Group (CCG) to run a pilot project supporting people in their normal place of residence at end of life.

The CCG felt that too many people were being admitted to hospital and that there were delays in discharge due to lack of co-ordination and personal care.

The aim of this service was to enable people to: die in their preferred place of care; enable rapid discharge from acute care to preferred place of care; avoid unnecessary admission to acute care; provide support to carers/families.

This community service was developed to enhance services already available to support people at end of life.

**Method** A small team was recruited to deliver this service: one band 6 RN to assess, plan care and co-ordinate the service (Monday to Friday 9 am – 5 pm).

Availability of HCAs to deliver personal care from 8 am-8 pm, 7 days a week.

Referrals were made via the hospice assessment and coordination team.

People were managed by this service for a maximum of 5 days, then discharged on to the most appropriate hospice/external service for ongoing support.

Detailed results were kept and reported on.

**Results**

- 99 people were supported in nine months
- 31 died under the care of the service
- 12 were admitted into the hospice