

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**

Helen Chapman. *Isabel Hospice, Welwyn Garden City, UK*

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**

H Lucy Thomas, Helen Cooper. *Isabel Hospice, Welwyn Garden City, UK*

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): '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).

**P-193 HOSPICE CNS SEVEN-DAY SERVICE: 6/12 PILOT REVIEW**Elizabeth Attwood. *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-194 REACHING OUT: VOLUNTEER OUTSIDE SERVICE**Helen Birch, Susan Williams, Karen Groves. *Queenscourt Hospice, Southport, UK*

10.1136/bmjspcare-2017-hospice.219

**Aim** Volunteers ensure high quality experience for hospice attendees. Building on existing practice and promoting future excellence, a volunteer workforce was trained to support patients and families in end of life (EoL) choices, in own home/hospital, particularly if alone. Volunteers, aligned to hospice vision and values, complement and 'fill gaps' in existing services.

**Approach** A review of day/'at home' patients, revealed those 'well enough' for discharge from specialist palliative care (SPC) input, who would still benefit from regular hospice support for self/family. A willing, confident, flexible, health and social care experienced, volunteer team, able to respond to

changing demand, recruited to work unsupervised in people's homes. A bespoke training programme, addressed expressed anxieties, role clarity, boundaries and communication skills. Volunteer Outside Service (VOS) co-ordinated by Hospice at Home, ideally placed to promote initiative whilst identifying/assessing potential patients. Patients seamlessly allocated volunteer visits and SPC as condition dictates. Uniformed volunteers, with lone worker devices, start and finish from hospice, with current patient information to avoid 'surprises' on arrival at patients' home, undertake light household duties; provide listening ear/read; make meals; not expected to undertake personal/clinical care; have clear guidelines to follow if encounter difficulties and appropriately debriefed on return.

**Results** 10–14 volunteers made 500 home/hospital VOS visits. Volunteers report feeling valued and fulfilled, privileged to be involved in lives of people at an important time and proud of making a difference. Hospice staff report, that despite required time and support, they have integrated well into existing team providing companionship and practical support.

**Conclusion** Volunteers, integral to package of care, meet complex and challenging patient and family needs. Younger volunteers are needed, due to the demographic profile of the current volunteer workforce. The plan is to support more people dying in hospital and we continue to communicate with secondary care colleagues to ensure professional boundaries are respected. Volunteer training and retention, ensures continuity of a reportedly worthwhile valuable service.

**P-195 SUPPORTING PEOPLE AND FAMILIES AT END OF LIFE TO ENSURE THEY ARE CARED FOR IN THEIR PREFERRED PLACE OF CARE**Alison McCarthy. *Greenwich and Bexley Community Hospice, London, UK*

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