

P-210 **MAN SHED – EXTENDING THE REACH AND ENGAGING THE COMMUNITY**

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Background Historically certain groups of people have been less likely to access hospice support, for example of every three women accessing bereavement support only one man did. Men's Sheds have grown in popularity but only one hospice had a shed specifically for people affected by life-limiting illnesses.

Aims

- To provide alternative support for patients, carers and bereaved relatives
- To diversify volunteering roles
- To demystify hospice care by engaging the local community.

Methods A cross-organisational steering group of staff, volunteers and users was formed and a fundraising project launched which exceeded £112 000. Plans were agreed and a 12.5 m × 5.5 m structure was built by contractors to accommodate a fully functioning wood workshop and social area designed and fitted out by volunteers. Health and Safety, Facilities, Volunteering and Education teams supported induction processes, development of risk assessments and training.

Results

- Cross-organisational project brought together clinical and non-clinical staff and volunteers
- New roles have been created for volunteers
- New links have been forged with businesses and the local community donating wood and consumables

During the first nine months:

- six volunteers have been recruited and trained to lead sessions
- one volunteer provides administrative support, one volunteer ambassador sources equipment and consumables
- Opens three days a week
- 53 'shedders' have been referred, resulting in 357 attendances.
- Patients, carers and bereaved relatives have attended woodworking sessions
- A basic computer literacy course has taken place
- Feedback is positive and the service valued by people who would not have accessed traditional services
- Items produced have raised funds to sustain the project
- A local woodcarving group also uses the building.

Conclusions The Man Shed has created opportunities for people to be offered 'shoulder-to-shoulder' support while engaging in practical activities. This informal approach has helped to break down pre-conceived barriers and misconceptions about hospice care. A number of other hospices are now planning their own sheds.

P-211 **THE NURSE LED MODEL OF HOSPICE INPATIENT CARE – 7 YEARS ON**

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Hospices across the UK are having to re-examine the way their services are run as pressure on funding is becoming increasingly problematic in a nation that has fiscal uncertainty. In Wales statutory funding for hospices is arrived at by a formula and St Kentigern Hospice receives 18% of its funding from the Welsh Office.

The hospice hit financial crisis in 2010 and took drastic measures with swingeing cuts to services, including the decision to make the medical director and sole doctor redundant. A decision was made that St Kentigern Hospice would become a nurse-led unit in the faint hope that this would save the hospice. This was entirely a reactive decision and could only be made because the hospice had a prescribing Advanced Clinical Practitioner, who had been practising for 18 months in that role.

One year later in 2011, the hospice was fully operational in both its inpatient and day therapies services and £1,000,000 credit in the bank. This is the story of innovation in practice where the advanced nurse practitioner role in palliative care has been extended to an autonomous level not practised anywhere else in the UK. From adversity this eight-bedded IPU and day therapies hospice now has a service that is economically robust and has been approved and recognised by the Welsh peer review process. Such is the success of the model that the hospice is undergoing a major new build, and expansion of services, funded entirely from its own resources, responding further to our communities' palliative care needs.

The model and its sustainability along with challenges will be discussed. Change in practice, innovation and leadership for nursing within a hospice setting will be explored.

P-212 **IMPROVING THE PATIENT'S JOURNEY BY DESIGNING AND IMPLEMENTING A BESPOKE, DEDICATED TRIAGE SERVICE**

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Background A comprehensive review was carried out in 2013/2014 with the support of Macmillan Cancer Support focusing on workforce development for the Palliative Care Specialist Nurse team working in the community. It recommended the provision of a more responsive and accessible service for patients, carers and health care professionals by developing a bespoke, dedicated Triage and 24/7 Advice Line.

Aims To analyse and explore the most effective referral process to deliver a more responsive and accessible service for all patients who are referred to the Palliative Care Specialist Nurse team.

Method In September 2016 a two-year project commenced which involved four phases:

- Understanding current practices
- Analysis of the literature, audits and clinical practice in other hospices
- The transformational phase which included the development of a bespoke robust model, implementation of systems and processes ready for Test and Launch
- Evaluation of the model, impact analysis on the organisation, patient and carer outcomes.

Results The results of the test in May 2017 demonstrated a clear need for a dedicated Triage referral service Monday to

Friday staffed by experienced nurse specialists and administration support. The focus during this period was on defining patient need and priority, response, team capacity, ability to give specialist symptom management advice and support, referring and signposting to other appropriate services, reduction in hospital admission, patient, carer and health care professional satisfaction and improved caseload management. These initial service outcomes have shown significant increase in responsiveness and improved assessment of patient need and priority. The process was robust and is transferrable across other internal services at the hospice which could impact on time and cost effectiveness.

Conclusion The dedicated Triage Service will launch 26 June 2017 followed by the launch of the dedicated Advice Line in October 2017.

P-213 WIDENING ACCESS TO HOSPICE BEDS USING A NURSE-LED MODEL OF END OF LIFE CARE

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Background Nationally, it is recommended that dying patients have choice in where they spend their final days nominating a preferred place of death (PPD) (Department of Health, 2008; NICE, 2015). Where patients choose hospice, they may be ineligible due to lack of complex symptoms required to meet specialist palliative care eligibility criteria. Responding to identified need, we developed a nurse-led service offering end of life care (EOLC) to dying patients with generalist palliative care needs within a hospice environment.

Aims This project aimed to widen access to hospice beds enabling patients without specialist needs to die in their PPD.

Methods

- Innovating for Improvement award from the Health Foundation enabled project pilot
- Nurse Consultant appointed as project lead
- Nurse Consultant accountable for total patient care supported by a team of nurses trained in non-medical prescribing. This innovative approach is unique in an in-patient setting.
- Steering group of local stakeholders formed to direct the project
- Operational group formed to develop and drive the project
- Four beds within existing IPU designated EOLC beds
- Outcome measures identified to enable project evaluation
- VOICES survey adapted for carer feedback.

Results To date, 115 patients have achieved their PPD and would not previously have had this option. Median length of stay is four days.

We have:

- widened access, particularly to non-cancer patients (42%) and elderly (mean age 88)
- successfully tested a safe, effective model which is now a permanent service
- received positive feedback from patients, relatives and referrers
- increased bed occupancy maximising use of hospice beds
- reduced in-hospital deaths
- developed nurses' skills, knowledge and confidence.

Conclusions This project has enabled us to widen access for end of life care to a greater number of patients, particularly non-cancer patients and the elderly known to be disadvantaged in terms of access to hospice care (Health Select Committee, 2015). We have developed and sustained a successful and replicable model of end of life care.

P-214 PALLIATIVE CARE OUTPATIENTS IN THE HEART OF THE COMMUNITY

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Background The hospice is based in a large urban community with a diverse population. Traditional hospice CNS first assessment was in the person's home. The hospice designed a primary care clinic pilot based in GP surgeries to work alongside this model.

Aims

- Increase referrals from low-referring communities
- Provide choice of service in the patients' locality
- Provide efficiencies in CNS working in mileage and time.

Method

- Engagement with communities, referrers and primary care to scope and design the model with continued engagement
- Three weekly clinics piloted; two in GP Practice and one at the hospice, all in areas with diverse demography
- Referrals assessed as appropriate for clinic at first contact
- Mobile working enabled on remote site
- Use of IPOS for assessment and follow up.

How do we measure outcomes?

- Patient experience questionnaires
- Use of integrated palliative care outcome scale (IPOS) for assessment and monitoring
- A steering group of GP, patient representative, clinical leads and fundraising monitor progress and outcomes

Results

- 71 new patients seen across three clinics in 10 months
- 94 follow-up appointments
- 165 total consultations at clinic.

This is approximately 8% of total caseload.

Mileage costs and time are reduced. Mobile IT enables efficiencies and access to records. Clinics have created choice for those who do not wish to be seen at home. The hospice clinic has created an opportunity to experience the hospice environment. Complex holistic care can be managed in a clinic setting. Questionnaire feedback demonstrates; appreciation of choice and improved quality of life.

'We are feeling more positive with the future and understand that we are not alone. Thank you'

Conclusion CNS Outpatient clinics can lead to efficiencies in CNS working and improved primary care relationships. Clinics are a useful option to have alongside usual home assessment. Future plans are to increase clinic sites and develop integrated team working at sites.