MONEY, MONEY, MONEY: SUPPORTING THE FINANCIAL WELFARE OF HOSPICE PATIENTS

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Background Reports show that finances are one of the top concerns for patients, their families and carers. On average a person is £570 per month worse off when diagnosed with cancer, with almost half of them not receiving any advice regarding their financial concerns from their healthcare professional.

Aim To establish a dedicated hospice welfare service. The specialist service to include, (but not exclusive to), advocacy and advice on welfare benefits, grants, tax, insurances, pensions, wills, power of attorney, probate, funeral costs, council tax, housing, utility bills, immigration, employment rights, carers rights and nursing home fees.

Method Recruitment of an experienced specialist adviser to help establish the welfare service. Where other advice services are age, location or illness specific, hospice patients now receive tailored advice and support on a range of welfare/financial issues from hospice referral to bereavement and beyond.

Engagement with the welfare service enables patients to:

- Afford additional costs associated with illness
- Lessens the impact from loss of earnings through unemployment or reduced hours
- Reduce the need to draw on savings
- Plan finances for those left behind
- Positively impacts on wellbeing of patient, families and carers
- Carers able to concentrate on their primary function
- Bereaved able to address financial and legal issues, and ready to move onto counselling.

Conclusion The provision of a hospice welfare service complements the healthcare patients receive and enables healthcare staff to concentrate on the patient’s medical needs. By addressing patient, family and carer financial concerns the welfare service enables patients to concentrate on their health and for families to have quality time with loved ones rather than worry about financial matters. It has the potential to increase the possibility that patients, family and carers will give greater consideration to donating to the hospice rather than other well-known national charities.

INTEGRATED TAMESIDE EMERGENCY DEPARTMENT COACHING FROM THE SIDE-LINES: CO-DEVELOPING A ‘COMPASSIONATE COMMUNITY’ SUPPORT GROUP

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Background Adapting the principle that ‘care for one another at times of crisis and loss is not simply a task solely for health and social services but is everyone’s responsibility’ (Kellehear, 2015) and a need to find cost effective methods of delivering more support to more people; an innovative model of ‘drop in support’ was developed.

Aims of the Model A ‘light touch’, coaching style of group facilitation has been developed to enable anyone affected by the diagnosis of a life-limiting illness to develop coping strategies and in turn support others.

To provide a safe setting for anyone affected by the diagnosis of a life-limiting illness to meet weekly in a supported and facilitated environment

Attendance will be open to any individual who is affected by a life-limiting illness, be they a ‘patient’, ‘carer’ or someone bereaved.

Results People with lived experience of illness, caring and grieving are supporting one another with compassion, requiring little ‘professional’ intervention. The cost to facilitate these sessions to such large numbers is a fraction of those usually associated with a traditional hospice day care. Attendance every week is in excess of over 40 people and three new groups have been set up in two new centres to meet increasing demand. Outside of the ‘group’ setting, self-sustaining local support networks have been established and shared, decreasing reliance on traditional public services. The model of coaching, empowerment and self-sustainability can be demonstrated by the addition of a new volunteer facilitator who originally joined the group two years ago as a bereaved widow.

Conclusion By creating a safe space and nurturing a compassionate community approach, people are creating their own networks of support and in turn decreasing their reliance on the health and social care system.

INTEGRATED TAMESIDE EMERGENCY DEPARTMENT AND WILLOW WOOD START PROJECT: TRANSFORMING SPECIALIST CARE

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Background Our Integrated Care Organisation acknowledges that there are patients with life-limiting illnesses who attend the Emergency Department (ED) requiring symptom control without requiring admission to hospital. Our hospice day services have undergone modernisation to provide flexible specialist palliative care. The START Clinic at the hospice can support a timely discharge for those patients wishing to not be admitted to hospital who can be supported in the community. Patients with long term or potential life-limiting illness, including patients with dementia, can be referred.

Aims To provide rapid access to specialist palliative care including medical assessment

To support the patient and family to understand their disease progression/symptom management in order to plan their own care and treatment and potentially reduce the incidence of crisis management and unnecessary re-admission to ED.

To provide support to patients living with dementia and their families in a home or care home setting

To reduce the need for crisis interventions

To reduce the need for unnecessary re-admission and potential admission to a busy acute hospital environment.

Methods The patient is deemed medically stable and does not require acute inpatient treatment for their condition. Integrated. Assessing clinician in ED rings through referral to START clinic. START clinic contacts patient at earliest opportunity or confirms patient is coming to START from ED if appropriate. Patient assessed in START by appropriate clinicians and treatment plan agreed with patient and carer. Links to community agencies made including telemedicine, social care etc.
Abstracts

Results The project is about to be launched and will be fully evaluated by patient outcomes, changes in patterns of attendance at ED and collecting patient narratives to look at trends in those using the integrated service.

Conclusion Working in partnership we hope to reduce emergency admissions and improve the pathway for patients.

P-223 ALL ABOUT ME: THIS DOCUMENT WILL HELP US SUPPORT YOU IN AN UNFAMILIAR PLACE
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‘This document is intended to provide staff with information about the person being cared for as an individual. This will enhance the care and support given while patients are in an unfamiliar environment. It is not a medical document. It is about the person at the time the document is completed and may need to be updated if necessary. It can be completed by the person themselves or with help from their carer. It has been adapted from a similar document titled ‘This is me’ produced by the Royal College of Nursing and the Alzheimer’s Society.’ The ‘This is me’ document has been adapted to remove references to dementia and tailor the questions more to the individual needs of patients within the hospice environment. The idea was to get away from the electronic computer system of recording patient care and interactions, to have a document that represented the patient as an individual with individual wishes, hopes, fears and desires. The Hospice ethos is to have patient-centred, family-focused care and I believe this document encourages this from first contact with a family. Questions such as: ‘The kind of things that help me feel at peace are...’; ‘My home and family, things that are important to me...’; ‘I like to relax by...’ are specific questions which help our Spiritual Care Team form closer bonds with patients and their carers. Other prompts help clarify issues for members of our multi-disciplinary team such as questions regarding ‘My Mobility’ are designed to help assessments for the physiotherapy team. All of the questions have value to teams and the information is considered vital for holistic, patient-centred care. We also aim to help patients and relatives celebrate special events or wishes whenever possible as identified in this document.

P-224 THEMATIC ANALYSIS OF REFERRAL CONTROL UPON THE NATURE OF COMMUNITY SERVICE RESPONSE VISITS
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Aims To determine whether the introduction of refined referral limitations, including daily triage, influenced the nature of the response visits undertaken by the community ‘Hospice at Home’ team, with particular attention being paid to the type of care requested and provided and the condition of the patient.

Methods The research was conducted in the form of a thematic analysis (see Braun & Clarke, 2006; Seal, 2016) using the community clinical records which documented the community service response visits. A sample of three groups was selected from patients who had requested and received response visits in June, September and December of 2016, with June acting as the pre-change control group. The encounter records were then fed through a predetermined coding matrix, focusing upon the source of the request, the reason for the request, the condition in which the attended patient was found to be in, the emotional state of the family or carers and the actions undertaken.

Results It was found that while the introduction of refined referral parameters and daily triage meetings did not influence the need for supplementary tasks, such as personal care or psychological support for the patient or family/carers, or the documented levels of distress amongst family or carers, several transitional themes became apparent. Increased restrictions to referral acceptance amplified the ratio presence of patients who were at the very end of life, with activities subsequently becoming more focused upon those associated with end of life care and reducing the presence of actions less associated with palliative conditions.

Conclusions The evidence compiled suggests that, whilst more refined referral criteria may at first assessment risk a detrimental impact upon response visits in the community, greater control over the referral process helps with prioritisation and improves responsiveness towards patients with more urgent palliative needs.

P-225 INNOVATING A WHOLE TEAM APPROACH TO COMMUNITY PALLIATIVE CARE
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Background How often have you heard comments from colleagues about time pressures and unmanageable workloads? In order to redress this situation with a focus on effectiveness, efficiency and quality we took the decision to innovate the way in which our Community Palliative Care Team (CPCT) delivered supportive end of life care.

Aims This is a work in progress, with the aim of becoming one team, facilitating further integration of approach in delivering and responding to patients and healthcare care professionals.

Methods A review of working hours was undertaken, facilitating long days as well as traditional 9–5 and annualised hours for one CNS; with 9–5 worked on call at weekends. Specific roles were designated to cover triage, routine telephone contacts and a CNS as emergency responder: all roles were shared. Visits are scheduled by CNSs across the team, on the days people are working. No individualised case loads. Initially, the service was split into two areas to embed the new working routine and allow for any issues to be identified. Electronic patient records and iPads facilitate remote working negating the need to return to base across the day.

Results The new mode of operandi has had a significant impact across the community service. Team case loads have resulted in a 15% increase in routine visits across the day/evening, with improvement in responsiveness to urgent visits, average increases in telephone contacts with patients up 40% and to HCP up 19%. The team self support and manage their work with a marked reduction in working late, absence and improvement in morale. A shared team approach has reduced patient dependency on individuals, patients are reassured that...