Background Inspected in February 2016 the hospice achieved an outstanding rating for Caring and requires improvement for four other key lines of enquiry, Safe, Effective, Responsive and Well-Led, including three breaches of legislation. A new leadership team had been in place for a short while and had already identified an action plan and programme for improvements.

Aims There was a lack of audit, quality assurance and governance within the organisation. Reporting of incidents was underpinned by a blame culture which acted as a barrier to incidents being reported, leading to a lack of learning and accountability. Longevity of service amongst some clinical staff created an environment that was resistant to change and a lack of recognising the need to improve and monitor practice.

Method A priority was to recruit to key posts including a new Registered Manager and Head of Information and Quality, a team who had the knowledge, skills and ability to engage clinical teams in the change process. Education sessions were carried out to explore how to use incidents as learning experiences to implement changes to practice and improve accountability. A new competency framework was introduced. An audit and research group was set up to facilitate audit becoming routine practice. Quality and data spot checks were carried out monthly. A clinical management team regularly reviewed policies and guidelines in line with legislation and national standards. Improvements were underpinned by improving the patient/carer experience and outcomes: Advance Care Plans, Patient Centred Goals, and Preferred Place of Death. There was investment in workforce wellbeing: clinical supervision, Schwartz Rounds and a representative group.

Outcome Inspection in February 2017 achieved 'Outstanding' in Caring and Responsive, 'good' in Safe, Effective and Well-Led. Overall achieved outstanding, and a delighted workforce. The inspectors noted 'impressive improvements and a learning culture throughout the hospice'.

0-23 FROM CRISIS TO OPPORTUNITY

Gill Horne, Rachael Bryett, Jon Hill, Georgina Walker. *Rowcroft Hospice, Torquay, UK*

10.1136/bmjspcare-2017-hospice.23

Background Rowcroft Hospice delivered community, inpatient, hospice@home and chronic oedema services to a population of 2 80 000 over 300 sqm. By Christmas 2015 it was clear that legacy income was going to fall well short of the budget; a risk we carried for many years was now realised. Our plans had proved unsustainable and the trustees had to make the decision whether to close the hospice or significantly reduce services.

Aims To reduce the hospice's financial deficit and bring financial stability, including replenishing sufficient reserves for Board assurance, whilst retaining 'core' patient and family services and our reputation for outstanding care.

Methods

1. Develop plans to redesign and reduce patient, family and support services to those deemed 'core' within four months.
2. Launch a Crisis appeal for £585 000

3. Establish 'Project Red' including staff and volunteer briefings, a collective consultation, involvement of trade unions, staff empowerment to negotiate savings within teams
4. Develop a transformation plan

Results Plans were developed through collaboration with the local NHS provider and CCG. Our chronic oedema service was taken over by the NHS. We reduced from 17 to 12 inpatient beds – redesigning a bay into a dayroom; reduced staffing of hospice@home and redesigned our community and support services. We have delivered similar service activity to the previous year, although our contacts are fewer. We exceeded our crisis appeal target by £20 000 and gained 500 new regular givers. Our transformation plan has meant closer engagement with our local NHS provider and other partners.

Conclusion Although born out of crisis, the opportunities for learning, redesigning services to fit within a reduced budget, supporting team cohesiveness and a 'one hospice' culture, enhancing our collaborations with the local NHS provider and CCG and in gaining support from the public and partners have all served to secure the hospice's position.

Parallel session 6: Leaning in: transformation and privilege

0-24 VIRTUAL REALITY TRANSFORMING THE LIVES OF TERMINALLY ILL PATIENTS

Katherine Pabla, John Knight, Mandy Motley. *LOROS, Leicester, UK*

10.1136/bmjspcare-2017-hospice.24

We have commissioned and produced a virtual reality film of a local park to give terminally ill patients whose lives have become restricted due to their illness, the chance to see the world from the comfort of their chair or bed. By simply wearing the virtual reality headset, patients are 'virtually transported' to a completely different location, and are then able to discuss and reminisce with friends and families. With patients' wellbeing in mind, the films are an important therapeutic tool, relaxing those that watch as they are 'taken away' to a familiar environment. Research suggests that the brain accepts the virtual world within 20 s after which the experience becomes all absorbing. A patient who has Motor Neuron Disease (MND), was the first patient to try out the experience. 'You soon relax, it's just like you're there, I loved it' he said, as he experienced 'walking through' the park. 'I nearly waved at somebody, as they walked past.' 'Since being diagnosed with MND, we can get out but I can't spend a lot of time out of the wheelchair, so being able to have these experiences through the glasses is really good'. 'It's almost as good as the real thing.' We are now looking at enhancing patients' experiences both regionally and nationally, by partnering with other hospices to commission a portfolio of films, like walking on a beach, or a canal ride for example. These films will be accessible via a bespoke app, allowing multiple patients to access the films at the same time. The app will also allow shared experiences for groups such as in day