champion support was available for all shifts for the first two weeks following this date. Standard Operating procedures for downtime were put in place and communicated.

Results A very successful implementation of a significant cultural change with no resistance from the team which has achieved the aims.

Conclusions Support and protected time was key, alongside involving the team and listening to their ideas and fears from the outset. By providing champions to work alongside staff they felt secure and protected in their learning

P-243 DRIVING CHANGE IN HOSPICE CARE – REFLECTING ON THE SUCCESSES AND THE SCARS

Jan Noble, Heather Richardson, Rob George, Penny Hansford, Ruth Sheridan, Jan Thirkettle. *St Christopher's Hospice, London, UK*

10.1136/bmjspcare-2017-hospice.268

Aim A hospice in South East London has been engaged in a major programme of change to support its new strategic priorities. This presentation will provide an overview of the change management programme.

Methods The hospice recruited a senior manager to work as service development and transformation lead. Her focus was on change that would allow the hospice to reach more people using an increasingly finite resource of people and money.

Results Over the last two years the post-holder has been engaged in projects focused on:

- establishing the new Single Point of Contact
- designing and utilising a case management approach to guide the allocation of our resources (staff, skills and services)
- improving clinical decision making and related communications between professionals
- introducing a new electronic patient records system
- redesigning clinical administration services to better support clinical professionals.

Working closely with the different clinical directors she has adopted an approach broadly reflective of the PDSA cycle to design and implement change. The work has been overseen by a change board. Much of the change planned has been implemented relatively quickly and results are impressive. However, some resistance exists within the workforce, the impact on staff has been significant and further work is required to embed the changes and ensure new ways of working are sustained.

Conclusion Major change is possible within a hospice context, but it is challenging to implement. Dedicated and senior leadership is required to do this successfully; whilst careful attention to engaging staff in building a vision for something different prior to requiring them to change behaviours is a vital step.

P-244 ASPIRING TO BE THE BEST WE CAN BE – A HOSPICE JOURNEY

Elizabeth Arnold. *Earl Mountbatten Hospice, Newport, UK*

10.1136/bmjspcare-2017-hospice.269

The Care Quality Commission's (CQC) model of inspection changed in 2014 using a framework encompassing five key questions; is the service safe, effective, responsive, caring and well-led? The hospice planned for the inspection over many months, working with staff, volunteers and trustees to highlight areas of good practice and identify areas that required improving. The whole organisation engaged in workshops and interactive sessions together, fostering recognition that everyone has a responsibility to improve the quality of the services provided and the experiences of people who use our services.

Over 150 staff, trustees and volunteers came together periodically over the course of 18 months and informed us of their perceptions of the organisation's strengths and weaknesses. Through a process of engagement, listening and information gathering we formed a detailed picture of the hospice's position against the CQC's five domains. A detailed action plan was created together with files of 'evidence' for the CQC. The hospice received a rating of 'Outstanding'. It is without question that this achievement was wholly as a result of working together, collective leadership, trust and pride. A number of key themes emerged through this process which may be useful for other providers to replicate:

- What is the best that we can be? – developing a culture where people really believe in the values; these appeared essential to greater levels of engagement
- Leadership is about yourself – every person from 'ward to board' took personal responsibility and were supported to take the initiative and innovate
- Celebration and stories – the promotion of stories was seen as vital to emphasise the impact of what hospices do; one volunteer carried a photograph of an owl 'visiting' a patient to show the CQC should she be working when CQC visited!
- Our challenge is to be 'outstanding' across our entire organisation, every day and always.

P-245 NOW WHERE IS THAT POLICY ON ...

Paula Powell, Daniel Monnery, Susan Schofield, Charles Hyland, Debbie Jones. *Willowbrook Hospice, Merseyside, UK*

10.1136/bmjspcare-2017-hospice.270

Most specialist palliative care units have clinical policies to support best practice. In addition multiple resources are available to clinical staff as books, clinical guidelines and apps. Our experience at Willowbrook Hospice was that staff would refer to guidelines and formats they were most familiar with even if newer versions were available. Equally comprehensive policies were not referred to because staff could not recall how to find them or when found the pertinent information was not easily accessible.

This represents a risk to patients and the organisation.

This poster describes the work that the medical and nursing teams carried out to develop hospice specific 'quick reference guidelines' for important policies and procedures that distilled the information into an accessible form, usually flow charts. Examples are – hypercalcaemia management, commencing ketamine, recognition and management of delirium and sepsis.

Over a year this has developed into a comprehensive but easily accessible practice guide that staff know is easily available on their desktops and in paper format in a ward folder. As new policies are updated a 'quick reference' guide is created and added to the resource.

This change has been supported by education as each topic is added so all staff are aware of changes to clinical practice and how to access the most up to date information.

P-246 NEW METHOD FOR CLINICAL RISK MANAGEMENT

Jayne Dingemans, Sarah Bell, Steve Mellish, Susan Plummer. *Garden House Hospice Care, Letchworth Garden City, UK*

10.1136/bmjspcare-2017-hospice.271

Background We recently reviewed and revised our methodology for risk management. The existing process was not intuitive or informative; did not demonstrate the seriousness of some risks or how much work had been invested in mitigating them. Critically, risks faced and the levels at which they were being managed were not well understood or appreciated by the Board of Trustees.

Aim To revise the methodology and format for recording clinical risks and controls, so allowing an improved understanding of the risks and enhance clarity around existing controls. To augment identification of areas where controls require enhancement and record the actions taken to allow this.

Method After agreeing the new format for the risk register and risk presentation, all existing risks were reviewed. This produced a clearer understanding of the new terms of 'gross risk', defining the level of risk with no controls in place and 'net risk', defining the level of risk with mitigation actions in place. The register additionally documented the controls in place to mitigate risks and the probability and potential impact of each risk.

Results Key risks were accurately and clearly highlighted, based on causes and consequences, to both the clinical team and Board of Trustees. This resulted in a better understanding of organisational risk appetite. The effect of existing controls was clearly evidenced and areas where further controls were required was demonstrated.

Conclusion This process has significantly enhanced our understanding of the risks faced by the hospice clinical team, clarified the work already undertaken to mitigate risks and identified areas where further controls are required. Improving our risk management process has put us in a better position to justify future investments. As a consequence of success with this new clinical risk management approach, all other institutional risks registers are to be put into this format.

P-247 HOW CAN FUNDRAISERS FUNDRAISE EFFECTIVELY IF THEY DON'T KNOW WHAT WE DO?

Sarah Wells, Lyn Wood. *Marie Curie Hospice West Midlands, Solihull, UK*

10.1136/bmjspcare-2017-hospice.272

Background Fundraisers are key to the livelihood of our hospices. Their voice within the community represents the work that we do and the patients that we care for. The fundraising team at our hospice have become actively involved in Schwartz rounds, both as panellists and audience members. As

a facilitator responsible for preparing panellists, it became apparent that the fundraisers did not have a clear idea of the work that the clinicians were involved in.

Methods Following discussion with the Fundraising manager, a programme of immersion in clinical activities for the fundraising team was planned. This included attending the in-patient unit and day services during the induction period as well as established fundraisers attending ward rounds and day services to understand the complex care that is being delivered by our staff.

Results 90% of the fundraising team have now attended a ward round. The result has been incredibly positive:

- They have felt enlightened on the extent of care being delivered
- They feel more connected with the clinical team
- Increased connexion with patients
- It has been very emotional and at times difficult for them but still wholeheartedly welcomed
- They feel that they are able to give a much clearer and emotive description of the care we are providing while out in the community.
- We plan to continue this programme and extend to attending day services.

P-248 CARE TOWARDS THE END OF LIFE COURSE FOR CARERS 'HOW PEOPLE DIE REMAINS IN THE MEMORY OF THOSE WHO LIVE ON', DAME CICELY SAUNDERS

Claire Hewitt, Sharon Kelly. *The Hospice of St Francis, Berkhamsted, UK*

10.1136/bmjspcare-2017-hospice.273

Background It has been evidenced 'By improving communication about the medical, practical, psychosocial, and religious/spiritual issues that surround death and dying will lead to caregivers being better prepared for the death and, as a result, improve their well-being' Herbert RS et al. (2009). Locally from completing the Carer Support Needs Assessment Tool (CSNAT) (Ewing & Grande, 2013), we are finding that the most common domain identified by carers and needing additional support is 'knowing what to expect in the future.' Therefore, in collaboration with carers in Hertfordshire and the Peace Hospice in 2013 the 'Care towards the End of Life Course for Carers' was developed to be run across both hospices.

The Aim of the Course To provide a safe forum to educate carers and provide support for those in a similar position. To share experiences and build on their confidence, particularly in having difficult conversations.

Methods A six-week programme is delivered twice a year covering a range of relevant topics, each one developed further from feedback. We aim to have 12 people attend.

Results Forty-nine carers have attended the courses. 92% of carers were very satisfied with the content and delivery. Carers' feedback: 'The knowledge of understanding of what's to come'; 'That it is never too early but can be too late'; 'Reaffirmed that I am doing the right things and planning correctly.'

Conclusions The impact of the carer journey can significantly influence the bereavement process. The feedback supports the need of the course in providing information and support to carers who are who are caring for a person who is approaching their end of life. We have been contacted by other