

Outcomes

- Hospice staff attend prison palliative care meeting
- Prisoners with complex needs referred to specialist service
- Plans in development to access out of hours nursing care and medication
- Commitment to ongoing development work
- Hospice staff supportive and confident to look after prisoners
- Partnership with prison viewed by charity as an opportunity not a threat.

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THE DYING WELL IN CUSTODY CHARTER: EXPERIENCE OF HMP LITTLEHEY AS A PILOT SITE

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Background The number of prisoners over 50 years old has nearly trebled in the past 15 years, leading to an inevitable increase in natural deaths in prisons. The number of expected deaths has more than doubled (Prisons and Probation Ombudsman, 2017). The *Dying Well in Custody Charter Self Assessment Tool* was launched in March 2018 to promote good practice in palliative and end of life care in prisons (Community of Practice for Prisons Steering Group, 2018). It includes eight ambition statements, each with quality statements and evidence guides and is backed by NHS England Ambitions for Palliative and End of Life Care Partnership (Community of Practice for Prisons Steering Group, 2018).

HMP Littlehey is a Category C prison. With approximately 1220 residents, it is one of England's largest older age prisons: 35.5% aged over 50 years and 6.6% over 70. The prison has no 24 hour healthcare but has developed close links with its local palliative care team and hospice.

Aims To promote quality palliative care for prisoners by piloting the *Dying Well in Custody Charter* and sharing the experience.

Methods A multi-disciplinary group of a nurse, a governor and a palliative medicine consultant used the *Self Assessment Tool* to review current work.

Results The tool enabled a review of current practice and establishment of standards including:

- Identification of patients using the SPICT for All tool (University of Edinburgh, 2018)
- All patients enabled to do Advance Care Planning
- All patients having a Family Liaison Officer and keyworker
- Establishment of Palliative Care MDT
- Controlled Drugs available via locked box in cell subject to risk assessment
- Timely application for compassionate release
- Timely assessment by specialist palliative care
- Healthcare input into risk assessments on restraint.

Conclusions The *Self Assessment Tool* is a helpful way to evidence existing good practice. It may also be useful where change is required, or palliative care is infrequent in demonstrating the standards expected in the prison service and which can be achieved.

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COLLABORATIVE SPECIALIST PALLIATIVE CARE BEDS

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Background Our hospice covers a geographical area with a high elderly population in both affluent and deprived areas (Sleeman, Davies, Verne *et al.*, 2016). Residents living in deprivation are less likely to have access to palliative care services (Care Quality Commission, 2016). Local data shows that 16% of patients in 2017 choose hospice as their preferred place of care (PPC) but only 4.5% of annual deaths in our locality occur in the hospice.

Aims Tendring residents theoretically have equal access to hospice beds but local data demonstrates that they are half as likely to die in a hospice than residents in Colchester. This suggests an inequality in provision and unmet need in the Tendring area (Help the Hospices, 2013). In order to address this shortfall, our hospice and the local community provider have worked in collaboration to provide additional specialist end of life care beds.

Method Patients are admitted to the community hospital nurse-led unit where we aim to provide high quality, holistic care. Patients are admitted either from the community or transferred from the local acute hospital. Day to day care provision is provided by the nursing staff on the ward with support being provided daily by hospice clinical nurse specialists (CNSs). By working in collaboration residents are offered the choice of a local community hospital as their PPC to allow them to be cared for closer to home. The CNSs have also provided formal training to the multidisciplinary team.

Results Since September 2017 53 patients have benefitted from this service which has provided additional access to local community beds with support from a specialist palliative care team. Collaborative working has enabled adequate symptom control, appropriately supported discharges or a peaceful death to achieve their PPC.

Conclusion This collaborative service has enabled access to additional specialist palliative care beds and supported patients to achieve their preferred place of care.

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ACCESS TO SPECIALIST PALLIATIVE CARE – A HEALTH EQUITY AUDIT

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Provision of palliative care based solely on need is the core business of all specialist palliative care (SPC) services. This audit aims to identify inequities in access to hospice-based SPC in a deprived and ethnically diverse borough of London. Characteristics of those who died between 2010 and 2015 who were known to the hospice were compared with population deaths over the same period. Between 2010 and 2015, the number of deaths remained stable (av. 1013) while the number of residents who used SPC services increased from 359 to 525. Only 11% male/16% female deaths known to