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

SPC were aged 85+, while 20% male/27% female overall deaths were aged 85+.

Place of birth on death certification compared with SPC users' ethnicity showed similar proportions from Bangladeshi/other Asian groups (20%/19.6%) and Black groups (5%/5%). Fewer White British groups used SPC (53.5%) compared to the proportion of deaths of people born in the UK and Ireland (65.6%).

55% of SPC users had cancer, which caused 30% of all deaths. There was low use amongst people with circulatory (3%) and respiratory disease (5%) although these combined cause 40% of deaths. Data was not routinely recorded for groups for whom there is evidence of poor quality palliative care (learning disability, mental illness, homelessness and substance misuse).

These findings suggest the hospice has a reasonable reach across ethnic groups, although may be under-accessing the oldest old. People who died from cancer were more likely to have accessed SPC. Joint working with non-cancer specialist services is currently underway to try to address this. The hospice's information team are exploring routine recording of protected characteristics such as learning disability and homelessness so that these can be part of future health equity audits.

P-47 TACKLING INEQUALITIES IN END OF LIFE CARE FOR SPECIFIC MINORITY GROUPS

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Background In 2016 the Care Quality Commission published a review of end of life care which heard from people who may be less likely to receive good care – whether because of diagnosis, age, ethnic background, sexual orientation, gender identity, disability or social circumstances – and found that this may be because their specific needs are not always understood or fully considered by providers and commissioners. Later in 2016 the Government announced six commitments to end variation in end of life care in England by 2020 (Department of Health, 2016).

Aim/s This project explored what the six point commitment on end of life care means for three groups identified by the CQC's review; Gypsies and Travellers, LGBT people and people experiencing homelessness. It sought to understand the particular needs of these groups in making the commitments a reality and to share evidence and personalised end of life care examples.

Methods The project was guided by an advisory steering group and informed by a literature review plus focus group and stakeholder consultation. Case studies of emerging practice and innovation were sought through the group's networks and wider communication channels.

Results Five principles for delivering personalised end of life care for children, young people and adults were identified; including enabling strategic level partnership working; good communication to support informed decision making;

workforce training and support. A practical guide has been produced for commissioners, service providers and care professionals.

Conclusions In identifying work to improve personalised end of life care for the three groups, the project also found a need for more evidence and research. Equitable end of life care needs to be a local priority and better data about needs and access to services is required.

This project was funded as part of the national Voluntary Community and Social Enterprise Health and Wellbeing Alliance.

P-48 DEATH: A SOCIAL DISADVANTAGE? SUPPORTING UNDER-REPRESENTED GROUPS IN END OF LIFE CARE

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Woking and Sam Beare Hospices provide specialist palliative care services to North West Surrey; an ethnically diverse population. With a substantial Muslim community, 10.1% of people in Woking report English as second language. Supporting an aging population, there was an 18% increase in people over 60 between 2001 and 2011 (Joint Strategic Needs Assessment, 2018). There are 36 000 carers; with incidence of dementia expected to rise by 25% by 2025. The catchment area has two prisons, with homelessness estimated to have quadrupled in the last five years.

With this in mind and the launch of a new five year hospice strategy, an Equalities Steering Group was established to promote an improved organisation-wide approach to understanding the cultural and societal differences in accepting and accessing hospice care, plus identify and remove barriers to supporting our community.

Aims (i) Establish closer working relationships through hospice representation and involvement with local community groups, agencies and organisations (ii) Raise awareness of hospice services to under-represented groups and enhance access to care.

Method Over three years the programme of work identifies priority areas, exploring the intersectionality between groups and embedding the approach into practice. Year 1 focused on dementia, learning disability and carers; Year 2 – LGBTQ+, Gypsy Romany Traveller Community and BAME; Year 3 – Homelessness, Prisoners and Ex-offenders.

Initial actions identified hospice champions to promote awareness among staff and sit on local action groups (Dementia Action Alliance, Action for Carers Surrey and Learning Disabilities partnership board).

Delivered programme of events with national awareness weeks, including in-house training, access to e-learning and social media publications.

Expected results Year 1 will culminate in an 'equality' themed conference; hospice teams and stakeholders will come together to share progress, identify further needs and celebrate successes, establishing the foundations upon which future events will be held, opening up hospice services for all.