showed a range of visits and complexity of care. RGHC staff provided 19% of the care at a cost of £3295; district nurses 13%, cost £2005; and formal carers 55% at a cost of £1344. 23 GPs visits comprised 4% of all visits but 15% of total costs. Macmillan/Marie Curie nurses accounted for just 2% of visits but 19% of cost as they stayed overnight. The entire cost of 177 days of care for 17 patients at end of life was £11,814; i.e. £66.7 per day as care was not needed every day of each diary period. The average length of the diaries was 10.4 days.

Conclusions The cost of home care seems acceptable, compared to the national average cost of a day in an inpatient specialist palliative care bed at £397–£400 (Data.Gov.UK 2015).

P-154 EMERGENCY ADMISSIONS TO A HOSPICE: CAN HOSPICE AT HOME SERVICES REDUCE THESE?

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10.1136/bmjspcare-2018-hospiceabs.179

Background Hospice at Home (H@H) services aim to provide at-home care whilst dying, but these services are not universal and although studies have examined whether such services can prevent acute hospital admission, it is unclear whether they can prevent emergency hospice admissions (Buck, Webb, Moth *et al.*, 2018; Ward, Graham & Sixsmith, 2017).

Aim To investigate whether the introduction of a H@H service would reduce emergency hospice admissions, by analysing the needs of patients admitted as an emergency to a hospice inpatient unit.

Method All patients admitted as an emergency to this hospice, which does not currently offer a H@H service, are reviewed by the multi-disciplinary team at Mortality and Morbidity (M and M) meetings. The data from this evaluation was collected between September 2016 and August 2017.

Results 190 emergency admissions took place during the above period. 93 patients (48.9%) were admitted for complex symptom control, 52 patients (27.4%) were admitted for end of life care, and 27 (14.2%) were admitted for both complex symptom control and end of life care. Eleven patients (5.8%) were admitted for multiple reasons including complex symptom control, end of life care, complex social situation and psychological distress. Seven patients (3.7%) were admitted because of social crisis. At the M and M review it was agreed that a H@H service would not have prevented 122 admissions (64.2%) but may have prevented 58 admissions (30.5%). In 10 cases (5.3%) it was unclear if H@H could have prevented admission.

Conclusion Most emergency admissions were for symptom control or multiple reasons, not end of life care alone; this may explain why only 30.5% of admissions could have been prevented with a H@H service. Patients choosing the hospice as their preferred place of death, or who were not imminently dying, will also affect the number of preventable admissions. This information on the needs of patients requiring emergency admission may help in the future development of a H@H service.

P-155 INTRODUCING RAPID RESPONSE FOR COMMUNITY PALLIATIVE CARE, CLINICAL NURSE SPECIALISTS (CNS) TEAMS

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10.1136/bmjspcare-2018-hospiceabs.180

Background There is a national drive to support patients in their preferred place of choice and a need to reduce the number of unnecessary hospital admissions (Department of Health, 2008; National Palliative and End of Life Care Partnership, 2015). The community teams received over 1600 referrals last year. The triage team perform a telephone assessment, prioritising patients on need and transferring them to community clinical nurse specialists (CNSs). There was no formal pathway to respond to urgent needs of new and existing patients. It was unclear where to escalate urgent calls if all CNSs were occupied with planned visits. We decided to introduce a designated daily rapid response CNS into each of the teams to respond to the urgent referrals and reduce the number of patients who died before assessment.

Aims To introduce changes in working practices to respond to patients in a timely manner, with the intention to provide palliative care to more patients at home, thus supporting them in their preferred place of care (Calanzani, Higginson, Gomes, 2013).

Results The role of the rapid response CNS was defined and introduced into the three borough teams – each team identifies a rapid response CNS each day on the off duty. They are the first point of contact for the triage team and community administrators who frequently take calls from patients. The rapid response CNSs minimise planned visits for that day to ensure they have time to respond to urgent patient need.

Conclusion This was a challenge to traditional ways of working (Leary, Crouch, Lezard *et al.*, 2008), however, involving the CNSs in developing the structure of the role and the pathway helped to develop a sense of ownership of the project. Although it is too early to formally evaluate there is a feeling of confidence and security for staff in the knowledge that their responsibilities are clearly defined. For the future we will examine responsiveness by introducing new activity codes to support data collection.

P-156 URGENT RESPONSE: MEETING NEED, CHANGING CULTURE

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10.1136/bmjspcare-2018-hospiceabs.181

Background A Pilot Urgent Response Service was launched by the Hospice @ Home team due to it being identified that the nature of care needs for patients in the community were changing. More people required an urgent response for care crisis, symptom management, emotional distress and end of life care.

Aim The service aimed to support the Clinical Nurse Specialist and Primary Care Team in managing patients with urgent palliative care needs by coordinating a visit within two hours of a referral. The service was available to any patient already known to the Community Palliative Care Team (CNS, Hospice @ Home and Day Hospice).

Approach To ensure the service was responsive and effective the Duty CNS, who provides a first response telephone service, and the Urgent Response Nurse would work closely together. The majority of Urgent Response referrals were from the Duty CNS following an identified need. The Hospice @ Home service allocates a Band 5/6 nurse each day to carry out Urgent Response visits. Each visit involves a holistic assessment and management of urgent concerns and problems. **Outcome** Following a three month pilot an audit of the 30 patients referred was carried out. 95% of the visits were carried out within two hours of referral. The service:

- Supported patients in crisis to remain at home
- Assessed and managed symptoms
- Identified patients with palliative care emergencies and facilitated admission
- Supported patients and families in emotional distress
- Carried out urgent assessment/review.

Direct feedback from patients, relatives and colleagues was extremely positive highlighting that the service provided timely, effective and supportive care.

Conclusion Due to the audit results and positive impact of the service the pilot was extended and the service continues. In addition the service facilitated more effective working relationships and team integration between H@H and the CNS team.

P-157 CINDERELLA SERVICE – IMPROVING CARE AT HOME WITH THE GSF DOMICILIARY CARE PROGRAMME

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10.1136/bmjspcare-2018-hospiceabs.182

Aim Domiciliary care workers play an important but often unrecognised role in supporting people to remain at home as they near the end of life, especially those with dementia and frailty. Despite this, few receive specific training in end of life care. Focussed training enables home care workers to improve the quality of care for such people who choose to remain in their homes, and contribute to better coordinated cross boundary care.

Method The fully revised GSF Domiciliary Care training programme focuses on enabling generalist frontline staff in end of life competencies. The Train-the-Trainer cascade programme works with Domiciliary Care Agency Trainers; using action based, interactive learning and reflective practice in six modules, with support from the virtual learning Zone/DVD, and resources. Comparative before and after qualitative and quantitative evaluation is intrinsic and includes frontline care worker confidence self-assessments, supportive care analyses and organisational competency questionnaires.

Results Homecare workers in various areas of the country show improvements in:

- Confidence and competence of home care staff
- Communication, working relationships and collaboration with primary care
- More advance care planning discussions, with service users keen to be involved in these discussions
- Encouragement and empowerment of staff to advocate for their service users leading to improved communications with other professionals
- Increased awareness of the knowledge they already possessed and future training needs.

Conclusion This highlights the important role that domiciliary care workers play, and the importance of empowering care staff that interact with the service users on a daily basis. The GSF Domiciliary Care Training Programme boosts the confidence and competence of care workers, improves collaboration and coordination with others and helps to improve care for more people nearing the end of life at home – which is for most the best place to be.

P-158 INCREASING THE RESPONSIVENESS OF THE COMMUNITY CLINICAL NURSE SPECIALIST TEAM

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10.1136/bmjspcare-2018-hospiceabs.183

Background Referrals to the community team are increasing and demand for community palliative care services has led to a longer community waiting list. Consequently, the hospice is struggling to respond quickly to referrals for community assessment. In 2016/2017, 200 patients died whilst waiting to be seen.

Aims To reduce the time from referral to initial palliative care assessment for patients who have un-managed symptoms at the point of referral. To reduce the number of patients who die before being seen by specialist palliative care. To reduce unnecessary emergency hospital admissions. To support earlier discharge from hospital. To facilitate appropriate hospice IPU admissions in a timelier manner. To reduce the need to contact the GP or district nurse (DN). To reduce on-going distress of the patient/family member/carer. To create a positive experience for the patient/family member/carer.

Methods The new way of working involved creating capacity in order that a Clinical Nurse Specialist was able to respond in a timely way to patients who have been deemed to need an urgent response due to un-managed symptoms or an expected short prognosis. The urgent response role was intended to have minimal caseload responsibilities, having the capacity to be responsive.

Results The project data extracted was in three phases: (1). 12 weeks pre-project; (2). 12 weeks with an additional 1.0 WTE working as an urgent response nurse; (3). 12 weeks without additional capacity having a substantive CNS working in an urgent response way. The results showed that the different way of working increased the number of assessments completed and the numbers of patients that died before being seen reduced considerably, whilst increasing the number of active patients on caseloads. The project produced positive data that working in a different way could improve responsiveness, but additional capacity improved outcomes even further.

P-159 USING EXISTING RESOURCES TO ENHANCE COMMUNITY PALLIATIVE CARE: 30 MINUTES TO MAKE A DIFFERENCE

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10.1136/bmjspcare-2018-hospiceabs.184

Background Bolton NHS Foundation Trust serves a population of approximately 260,000. Specialist palliative care services are integrated between hospital, community and