P-179 **COORDINATED END OF LIFE CARE (EOLC) FOR BIRMINGHAM AND SOLIHULL (BSOL) WORKING PARTY**

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In September 2017 we called together individuals from across the city, who are currently delivering or receiving end of life care services. Discussion ensued about how services could be improved. All agreed to collaborate to develop a more coordinated approach. The working party membership developed a clear vision and associated mission statements, as well as an outline plan for a new system wide model of coordinated care delivery.

Vision To create a better experience at the end of life (EOL) for everyone in Birmingham and Solihull.

Mission statements By bringing together providers with a common purpose, to shape EOL service development and improvement we will:

- Create a central coordination system for all EOL services that will ensure:
 - Early identification of those in need of end of life care
 - Improved patient-centred care, designed according to individuals' priorities, including promoting choice of place of care and reducing inappropriate hospital admissions
 - Equitable access to services
 - Fewer gaps in care provision
 - Increased information sharing to enhance patient safety.
- Promote a compassionate community ethos, working with the diverse communities in BSOL to design and deliver end of life care
- Ensure end of life education is delivered in a coordinated way, to best enable everyone to care
- Collaborate to design services that are delivered efficiently and are sustainable by sharing intelligence, eliminating duplication of provision and holding each other to account
- Evaluate evidence concerning new models of care critically to inform the activities of the Working Group
- Undertake evaluation research to determine the impact of the new BSOL end of life care system/model.

Achievements The Vision and mission statements have been integrated into a re-draft of the Birmingham and Solihull Sustainability and Transformation Partnership Strategy, as new priorities for end of life care. The working party will be represented at an STP EOLC oversight group, which will drive the implementation of these priorities and will report into the STP portfolio board.

P-180 **FINALLY, FULLY, FUSED!: THE END OF THE LONG ROAD TO COMPLETE SPECIALIST PALLIATIVE CARE SERVICES INTEGRATION**

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Background Specialist palliative care services (SPCS) often develop within organisations providing care in community, hospital and hospice. Even in their own geographical area, patients may meet at least three separate specialist teams – all working slightly differently, with individual telephone numbers

and sets of guidelines – in addition to tertiary centre specialist teams.

Aim To provide a single, seamless, SPCS for patients, families and their associated health professionals.

Method A recent community services tendering process had threatened to destroy at a stroke, a successful, longstanding plan to keep community and hospital SPCS integrated through five local health service reorganisations/TUPE transfers. Negotiation, opportunity and creativity allowed the final pieces of the jigsaw to slot into place. Palliative care nurse specialists (PCNS), admin staff and consultants (NHS contract retained) transferred under TUPE arrangements, enabling the formation of a single integrated SPCS working across all settings.

Results A single telephone number, Hospice Central Access Hub, takes all clinical calls from patients registered with the integrated SPCS, their families and health professionals – manned 7/7, from 9–5. A full service operates during the week, and a doctor, PCNS, Transform facilitator and admin support share weekend work across all settings. At night clinical calls are directed to the inpatient unit who access the doctor on call if required.

Conclusion Wholly integrated services means patients have ONE – number to ring, team to speak to, joined up service, set of guidelines and bereavement service. The team receive the SAME – development training, uniform, support, and access to assistance. ONE single multidisciplinary team meeting discusses all new referrals to the whole service, documented on ONE single electronic patient record with mobile access for clinical staff with no duplication. There is much to do and many ideas for further development, but with a new improved road to travel.

P-181 **INTEGRATED PALLIATIVE AND END OF LIFE CARE ON A SMALL ISLAND**

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Background The integrated care concept is being implemented world-wide but is often considered setting-specific. Small islands are one of these settings which face particular issues. Hospice Isle of Man is taking a measured approach, from which we hope that others might be able to benefit.

Aim To develop a strategy for integrated palliative and end of life care on a small island.

Methods

- Create connections and networks to support the planning, implementation and evaluation stages of the work
- Identify, via a needs assessment, what works, what gaps need filled and what matters to the population and professionals
- Identify particular issues facing small islands and ensure that any recommendations for change lead to solutions which are sustainable in the longer term.

Results to date Hospice Isle of Man formed relationships with the International Foundation for Integrated Care (IFIC) and IFIC Scotland who facilitated two face-to-face stakeholder meetings in 2017 and 2018. Using an example of a patient journey, areas that could be improved were identified. As a result, Hospice Isle of Man, public health care providers and

charities meet bi-monthly to discuss the progress of the needs assessment and consider how to work more closely together. Engagement activities for the needs assessment have included members of the public, patients and carers, schoolchildren, community groups, public and private health care providers, nursing home staff and residents with their families.

Conclusions Many of the issues encountered are similar to those in other settings and proximity does not always lead to closeness although personal connections are an advantage. There is some consistency so far in the views of participants that we aim for the right care, in the right place at the right time, although the small island setting presents some unique challenges.

P-182 USING THE MODEL FOR IMPROVEMENT TO REDESIGN DAY THERAPY SERVICES

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Background A review of Day Therapy (DT) services was required due to the challenges of increasing numbers of people with complex multi-morbidity needing services over a longer time period (Commission into the Future of Hospice Care, 2013). A need to provide more diverse and flexible services, able to meet the needs of a wider range of people was identified through service evaluation and user feedback. Transformational changes to services can be challenging to embed and maintain and the use of a framework can enable effective and sustainable service improvement (NHS England Sustainable Improvement and Horizon's Team, 2018).

Aims

- To evaluate the current model of day therapy
- To identify changes required to ensure services remain appropriate for our current and future patient population
- To use a service improvement framework to ensure changes are embedded effectively and sustained.

Methods The Model for Improvement (ACT Academy, 2018), was used by the DT staff team as a basis for redesigning and implementing the changes required. This model starts with three key questions, including 'what are we trying to accomplish?', followed by a Plan, Do, Study, Act (PDSA) cycle, allowing for continual analysis and improvement. The 'Fresh eyes' redesign tool was also used to facilitate viewing the redesign from the perspective of people using the service.

Results

- Evaluation of current service completed – identified elements that work well and those that are less effective
- Identified shared purpose for DT services: 'To provide a range of rehabilitative, holistic outpatient services to those with a variety of life-limiting conditions in a format that is individualised and flexible.'
- Identified proposed service changes, including outcome measurement and used PDSA cycle to implement
- Studied impact of changes using OACC data, attendance figures, user feedback.

Conclusion The Model for Improvement was an effective tool for planning and implementing change within the DT setting. It ensured focused planning and careful study which led to successful implementation of service improvement.

P-183 USING IPOS TO EVALUATE THE IMPACT OF DAY THERAPY SERVICES

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Background Outcome measures are designed to capture changes in health status as a consequence of clinical interventions (Witt, de Wolf-Linder, Dawkins *et al.*, 2015). Measuring outcomes in palliative care can be challenging due to the progressive nature of the diseases people accessing services have. The OACC suite of outcome measures (Witt, de Wolf-Linder, Dawkins *et al.*, 2015) has been in use in Day Therapy since 2015, in particular the Integrated Palliative Care Outcome Scale (IPOS) (<https://pos-pal.org/>).

Aims To audit the use of IPOS outcome measures in a day therapy setting. To assess the differences in reported IPOS scores between cancer and non-cancer patients. To evaluate any changes in IPOS scores between the beginning and end of Day Therapy sessions.

Methods A retrospective audit of the data all patients attending day therapy between March 2017 and January 2018 was completed and the following data was extracted from an electronic patient record database:

- Patient age
- Diagnosis
- Gender
- IPOS scores recorded for all Day Therapy attendances
- Dates of all Day Therapy attendances.

These data were then analysed using Excel spreadsheets.

Results Between March 2017 and January 2018:

- 600 IPOS measures were completed by 112 different patients
- 53% of patients had a non-cancer diagnosis
- 28% of IPOS had one or more values missing
- The mean total IPOS score for cancer patients was 22.9
- The mean total IPOS score for non-cancer patients was 29.1
- Improvements were seen over time in all psychosocial, spiritual and practical domains of the IPOS
- Scores on the physical domains were maintained over time.

Conclusion A significant proportion of IPOS were not fully completed. Non-cancer patients scored on average higher than the cancer patients. Day Therapy appears to have a positive impact on psychosocial domains and maintains physical symptoms, which may be surprising given the progressive nature of the diseases those attending have. Methods to ensure completion of IPOS need to be identified.

P-184 CREATIVE GROUP LEGACY PROJECT

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Background Previous creative groups had been focused on creative exploration and distraction, however, it was decided that the focus of the creative groups should be more therapeutic, utilising the skills of the Occupational Therapists (OTs) and enabling patients to explore memories, thoughts and feelings. A new six-week legacy project was developed to enable patients to do this.