availability of smoothies! User reported outcomes show 93% feel their views are appreciated and want to attend again. The group now takes place on two sites and also includes inpatients, discharged patients and bereaved relatives.

Wasn't that nice!

The success of the Feedback Group has been due to consistent user steer, good inter-service teamwork, leadership and not being disheartened by initial small attendance (e.g. less than 10).

P-204 'WE ARE ALL IN THIS TOGETHER' BUILDING CAPACITY FOR SERVICE USER INVOLVEMENT IN OUR HOSPICE

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10.1136/bmjspcare-2018-hospiceabs.229

Background It is important that we understand what matters to our patients and their families. We cannot overestimate the financial cuts and constant social challenges our patients and their families are facing today. Service User Involvement has become a formal requirement for policy and practice in health and social care. Research has identified a lack of consistency with the way service user involvement is implemented within healthcare. It is acknowledged that our clinical priorities and the increasing pressures of time can lead to staff neglecting the importance of service user involvement.

Aim Marie Curie Hospice West Midlands will recognise the importance and will prioritise service user involvement.

Methods Development of a service user group – consisting of both service users and staff. Development of Service User Champions (SUC) within each professional team at the hospice. Development of formal training sessions to be delivered by service users to our SUCs and hospice management team – highlighting the importance of service user engagement in current service evaluations and future developments. Formal service user involvement in the development of the hospice strategy.

Results We have already formalised our service user group, which meets regularly. Over the next year, we hope to demonstrate that:

- Service user involvement is at the centre of our practice
- Establish formal Service User Champion roles within hospice MDT
- Demonstrate that we both receive and act on pertinent service user feedback by formally evaluating our implementations
- Facilitate the development of partnership working between all stakeholders under the heading 'We are all in this together' in the development of the hospice strategy.

Conclusion Service user involvement needs to be a priority in health and social care. We hope to demonstrate the benefits of implementing formal processes to ensure this remains a priority at our hospice.

P-205 THE CHALLENGES AND PITFALLS OF ALTERING OUTCOMES FOR FRAIL ELDERLY PATIENTS IN RESIDENTIAL CARE

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10.1136/bmjspcare-2018-hospiceabs.230

Aim The main purpose of our project was to assist care home staff with identifying their own residents who may be palliative, opening up ceiling of care/advance care planning discussions, and reducing inappropriate hospital admissions.

Background A survey by BUPA in 2011 found that 72% of new admissions die within 42 months. We were invited by local commissioners to review four nursing home facilities to identify any gaps in meeting their residents' palliative care needs. Despite heavy encouragement from local commissioners two care facilities declined our input at the beginning. The remaining two care home managers agreed to participate and we completed a baseline review/scoping exercise to understand challenges in maintaining residents in their place of choice. From this individualised review we negotiated next steps in assisting with identification of patients who could die in the next 12 months and look at how this is communicated to all relevant parties.

Results Majority hospital admissions due to infection with underlying morbidity of frailty and dementia. Significant variance in quality of documentation and communication with residents, families and primary care teams. Home A has failed to retain two care home managers since project began highlighting issues with leadership and continuity. The enthusiasm, consistent staffing and ownership of project by staff in Home B has been vital to this project moving forward. We have completed seven ceiling of care documents since May 2018 and have commenced GSF like meetings monthly.

Conclusion None of what was revealed is unique or novel but is a timely reminder of barriers to transforming outcomes for this vulnerable population. The commissioner has acted as an intermediary/broker and unclear if this has led to suspicion, fear of financial penalties and then refusal and inertia to be part of the project.

P-206 THE ROLE AND IMPACT OF PHARMACISTS WITHIN A HOSPICE'S CARE HOME SUPPORT TEAM

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10.1136/bmjspcare-2018-hospiceabs.231

The Royal Pharmaceutical Society (2016) reports integrating a pharmacy team in care homes would improve the efficiency, safety, and quality of medicines use for patients; offering immediate support in:

- Polypharmacy
- Antipsychotic prescribing
- Safe transfer of information
- Education, training; and standards
- Palliative and end of life care.

Aims Pharmacists undertake level 3 clinical medication reviews (National Institute for Health and Care Excellence, 2014) aiming to manage and deliver safe, efficient and effective medicines optimisation support to patients, in line with NICE guidelines and local clinical governance (Butterfield & Shah, 2014; Kinley, Froggatt & Bennett, 2013; Swift, 2018).

Methods A Clinical Commissioning Group in South East England employs two full-time pharmacists working in partnership with the local hospice's Care Home Support Team to provide specialist palliative medicines information and advice for the organisation. The project currently covers 16 care homes, including 700 to 900 patients. The pharmacists perform

structured medication reviews to optimise the impact of medicines, minimise the number of medication-related errors and reduce medicines waste. These are carried out in agreement with patient, nurse, family/carer and GP. The pharmacists also offer support to care home staff by reviewing, monitoring and improving medicines-related policies.

Results From January 2017 to January 2018, 574 medication reviews took place, leaving a total of 4997 medicines and 1787 suggested medication changes. Approximately 76% of these changes were agreed and actioned by patients' GPs, savings estimated using CCG costings of £169,986.96. A feedback survey to measure quality outcomes for patients, care homes and GPs is also underway.

Conclusions The introduction of pharmacists to the hospice's care home support team has offered considerable medicines knowledge and support to care home residents, relatives, hospice and care home staff, GPs and other stakeholders. The pharmacy team aspires to expand, develop even further into specialist clinical areas such as dementia and palliative care, and continue improving health outcomes and patient quality of life.

P-207 SCOPING CARE HOMES SUPPORT... WHAT DOES GOOD LOOK LIKE?

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10.1136/bmjspcare-2018-hospiceabs.232

Without expansion of end of life care training for staff in care homes numbers of hospital deaths (of elderly, frail residents with dementia) will increase unsustainably (Bone *et al*, 2017). The challenges to education in care homes of high staff turnover, funding, time, attitudes, GP support and language and cultural differences (Marie Curie, 2017) impede this but there are established programmes, nationally, with evidence showing that, with high 'being present' facilitation supported by multi-layered learning, necessary change in this environment is achievable (Kinley, 2018). Whilst Birmingham St Mary's Hospice (BSMH) is a Regional Centre for Gold Standard Framework (GSF) Care Home Training and provides a substantial education programme, there is an urgent need to explore how to support local care homes better.

Aims Six months of discovery and design to produce an effective service model which facilitates on site education, embedding of sustainable systems and role modelling to local care home staff to improve their competence and confidence.

Methods Palliative Care CNS seconded for six months to:

- Map, scope and identify local and national evidence-based practice
- Design a model
- Test the model
- Collaborate with Birmingham University
- Audit and measure outcomes.

Initial results Preliminary interviews with 23 care homes show:

- Need for additional support (in particular health care assistants and on site)
- Examples of good practice (e.g. regular ANP and GP input)
- Uptake of education programme does not reflect the number of care homes
- Poor out of hours communication
- Poor communication from hospital

- Significant number of homes relying on more than two GP practices
- Some understanding of advance care planning but need to improve communication with families
- only four have embedded use of GSF.

Conclusions Prioritise completion of the Care Homes Project to produce a robust and flexible approach to facilitation. This project will build upon current research to produce innovative strategies in this arena.

P-208 SUPPORTING END OF LIFE CARE IN A CARE HOME SETTING – A HOSPICE APPROACH

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10.1136/bmjspcare-2018-hospiceabs.233

The national picture The NSF for Older People emphasised the need to provide the right care in the right place at the right time. Hospital is not necessarily the best place for older people, unless they are in need of acute medical or surgical intervention (Department of Health, 2001). Admissions are expensive (Department of Health, 2004) and often a frightening experience, particularly for those who are frail and vulnerable; people with advanced dementia are particularly vulnerable and frequently admitted to hospital, often unnecessarily (Department of Health, 2009).

In view of this St Giles Hospice are working with Virgin Care and SES CCG to support care homes in providing end of life care to their residents by providing expert support and implementation of key tools to help identify residents in their last 12 months of life.

Aims and objectives of the service

- Development of a 'Planning Ahead' register of frail patients at risk of admission or likely to be in the last 12 months of life using recognised and evidence based prognostic indicator(s)
- To ensure residents on this register have a care plan and advance care plan where appropriate
- To ensure valid DNACPR is in place for patients
- To ensure a valid RESPECT document is in place (where appropriate)
- To deliver reduction in the number of unplanned emergency admissions to hospital.

Outcomes and the future Currently St Giles Hospice are working with 25 homes providing weekly support sessions and review of the planning ahead register. There has been an increase in people achieving preferred place of death enabling 80% to die in their care home and of all admissions to hospital during this period only one was found to be avoidable. Quarterly reports/evaluations are collated with the aim to increase this service to all care homes within our area.

P-209 COLLABORATION IN PRACTICE – BETTER OUTCOMES FOR MOST

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10.1136/bmjspcare-2018-hospiceabs.234

Background The Care Home Palliative Education Programme is rolled out over 13 Care Homes and addresses: – palliative and end of life care, symptom control, communication skills,