to look at the provision of very end of life care in the last 12 weeks of life. To enable improved use of resources and coordination between services, to deliver care that is truly person-centred. At the end of life, time is precious. Loved ones' feedback is that services often feel uncoordinated, and the numbers of seemingly duplicated visits by different services can be overwhelming.

One Neighbourhood Team has chosen to audit and review the delivery and coordination of end of life services in the last 12 weeks of life, with a view that this will also positively influence closer collaboration and improved outcomes for all people. The poster presentation outlines our work and achievements.

P-218 STAND TOGETHER TO BE OUTSTANDING

Linda Prendergast, Louise Pickford. *Mountbatten, Isle of Wight, UK*

10.1136/bmjspcare-2018-hospiceabs.243

Background With over 120 local care providers, more than a quarter are currently rated by the Care Quality Commission (CQC) as Inadequate or Requires Improvement. Following our own Outstanding inspection we, as the sole provider of specialist end of life care, now have a unique role to play sharing our knowledge and skills.

Aim The key to a successful CQC inspection is to work in partnership with other organisations with the aim of improving or maintaining CQC ratings to 'Good'. A shift in culture and leadership will improve the lives and experiences of some of our most vulnerable people and place them at the centre of their care.

Methods The programme aims to provide information and tools to help the proprietors and managers both produce and take forward robust quality assurance and action plans, focusing on culture and leadership based on the Key Lines of Enquiry, but particularly 'Safe' and 'Well Led'. A five-day classroom based education delivered to four cohorts per year; access to an online 'Share-point' of information for all participating providers; and ongoing support visits to help implement the tools.

Results With a rapidly subscribed programme extending over three years, there is already evidence of improved relationships and communication between Statutory Authorities and providers. Ratings are already improving as we share this hospice's mission, vision and values to support each other.

Conclusion With support and improved CQC inspections there will be fewer closures which result in the local area losing essential care provision. Working in partnership with an open and honest culture is the only sustainable model to ensure the future delivery of high quality care. Highlighting gaps in training and education this project has led to further programmes of training which we are now coordinating as a partnership to ensure the delivery of quality standardised education to all.

P-219 IMPROVING THE EFFECTIVENESS OF HOSPICE NURSING HANDOVERS

Emma Little. *St Catherine's Hospice, Preston, UK*

10.1136/bmjspcare-2018-hospiceabs.244

Introduction The quality of nursing handover is important to ensure safe and effective care of patients and to reduce health

care errors by ensuring patient information is correct and understood. Review of evidence shows a number of models used in clinical practice but none felt to be appropriate for a hospice care environment. Staff comments were sought and identified that a more structured and meaningful approach was needed.

Aims Provide a more structured and consistent approach to nursing handover. To utilise a team approach to change in practice. New approach to be user friendly

Method A fishbone analysis was conducted to provide a systemic perspective of current practice of nursing handover on the in-patient unit. Staff comments and ideas collected through group discussions, ideas shower, observations, interviews, dotting voting and audit.

HOSPICE mnemonic created: H – History; O – Overall care needs; S – Symptoms; P – Psychological needs and support; I – In/Output and Infection prevention; C – Controlled medication; E – Evaluation of care.

Nursing champions within the team identified to facilitate implementation.

Implementation Colourful prompt cards detailing 'HOSPICE' handover mnemonic, provided to all staff. Four-week trial period of using new approach, showed existing handover sheet required review. Documentation changed to match the structure of the 'HOSPICE' mnemonic. Ongoing implementation using new approach.

Evaluation Data will be gathered three months post-implementation and will include staff comments and experience, review of clinical incidents and audit of documentation.

P-220 SOCIAL SUPPORT: DEVELOPING SUPPORT ROLES FROM WITHIN THE WORKFORCE

Helen Birch. *Queenscourt Hospice, Southport, UK*

10.1136/bmjspcare-2018-hospiceabs.245

Background Increasing workload of palliative care social worker recognised. Employed by hospice but funding for post shared by hospice, local authority and Clinical Commissioning Group with responsibility to attend meetings, training and supervision away from hospice base.

Aims In order to facilitate a timely discharge to preferred place of care, we need to be able to respond and meet the demands of the complex and challenging needs of patients and improve the accessibility of social work advice to patients and their families in a timely manner.

Methods Empower existing staff in a developmental role by recognising ambition, skills and knowledge in a current staff member, whilst acknowledging limitations of this and respecting specialist social worker role. Shadowing of palliative care social worker on ward rounds, outpatient clinic and day services; communication skills training undertaken. Developing existing knowledge for application of Continuing Healthcare Funding and placements with further training planned for benefits and welfare advice. Work closely with social work administration support.

Results Access to social work advice from health professional at time suitable to patient and family means no waiting. Discussions and administration around discharge planning can be commenced in a timely way and followed up with specialist input from social worker. Better use of health professional skills; palliative care social worker can undertake joint

discharge planning visits with appropriate members of team allowing patient to tell their story only once, more timely discharge. It releases time to care for RGNs who have social work support team available as resource.

Conclusion By empowering experienced staff member who has a sound knowledge base of palliative care and the introduction of new skills and training, patients have services readily accessible to them. The specialist palliative care social worker is now able to concentrate on complex issues whilst being supported from a more knowledgeable team than before.

P-221 HOW DOES END OF LIFE CARE AND THE VIEWS OF STAKEHOLDERS FIT WITH THE AMBITIONS OF NATIONAL POLICY?

¹Rhiannon Barker, ¹Patricia Wilson, ²Claire Butler. ¹Centre for Health Service Studies, University of Kent, Canterbury, UK; ²University of Kent and Wisdom Hospice, Medway Community Healthcare, Kent, UK

10.1136/bmjspcare-2018-hospiceabs.246

Background Whilst a string of strategy reports (Department of Health, 2008) over the last decade have laid out aspirations for good care, responsive to individual needs and preferences, at the end of life, Care Quality Commission (2016) data reveals huge variability in provision. Inequities relating to geography, age, ethnic group, geographical area and disease/condition are frequently reported (House of Commons Health Committee, 2015).

Aims There are a paucity of studies looking at how national policy in end of life care helps to shape local practice both in relation to allocation of resources and attempts to improve national consistency in end of life provision. This study will ask if national policy is effective in helping to surmount the system challenges confronted in delivering an effective end of life service and whether the aspirations of policy fit with the views of patients, carers, clinicians and managers.

Methods Phase 1: Scoping study. Literature review and semi-structured interviews with a sample of professionals from the statutory and non-statutory sector who have been influential in shaping current policy. The purpose of these interviews is to help identify and map key challenges in end of life care, to shed light on how policy has evolved and how it supports and guides practice. Phase 2: Case studies in three Clinical Commissioning Groups to interrogate how end of life care is rolled out at a local level.

Results This presentation will discuss results of the ongoing scoping study due to be completed by August 2018.

Conclusions It is anticipated that this poster will generate important conversations that will inform the direction of Phase 2 of the PhD. Key recommendations will be provided for professionals and policy makers that will feed into the debate concerning how end of life policy and guidance can contribute to achieving more equitable and consistent end of life care.

P-222 TIMELY SUPPORT FOR CARERS OF PEOPLE AT THE END OF LIFE THROUGH THE ADULT CARER SUPPORT PLAN

Emma Carduff, Susan Swan, Richard Meade. *Marie Curie, Glasgow, UK*

10.1136/bmjspcare-2018-hospiceabs.247

Introduction The Carers (Scotland) Act (2016) places a duty on local authorities to prepare an Adult Carer Support Plan (ACSP) and Young Carer Statement for any carer who requests one, or is identified as such. From 2019, this will be assisted by a fast track process for carers of people in their last six months of life. Timely identification of unpaid carers, assessment and support can; reduce the overwhelming pressure of caregiving, increase competence, confidence, satisfaction and the quality of the care given.

Aim To provide evidence on the supportive needs of carers to inform recommendations regarding the timescale for the creation of fast tracked ACSPs under the Carers (Scotland) Act (2016).

Methods The study triangulated data from a literature review, qualitative secondary analysis (n=19 interviews; three focus groups) and two primary focus groups with bereaved carers (n=11).

Results Themes included; barriers to and triggers for identification and needs including physical support, psychological support, respite, information, communication, co-ordination and competing demands. Additional themes were speed of decline and end of life care.

Conclusion Health and social care professionals need to take a radical, reactive move to presume that every patient has a carer, and ensure they understand their entitlements. Carer identification is everyone's responsibility and it should be the ambition of the Carer (Scotland) Act (2016) that this happens early in the illness trajectory. In so doing, rapid assessment and support can be initiated to help carers navigate and cope with an uncertain, often rapidly deteriorating illness trajectory.

P-223 MODERN MATRON IN PALLIATIVE AND END OF LIFE CARE: LINKING CLINICAL STRATEGY TO DAY-TO-DAY CARE

¹Kim Bonnar, ¹Rachel Ainscough, ²Eleanor Grogan, ³Audrey Rowe, ³Karen Torley, ²Paul Paes. ¹Marie Curie, London, UK; ²Northumbria Healthcare NHS Foundation Trust, Morpeth, UK; ³Marie Curie, Newcastle, UK

10.1136/bmjspcare-2018-hospiceabs.248

Background When first introduced, the Modern Matron role was designed to have authority on leading on clinical strategy and governance, while also being an active presence on wards and in communities (Department of Health, 2000).

Aim As part of a wider partnership that established a multi-site palliative care hospital liaison team and a rapid response service, an innovative NHS Foundation Trust and a leading charity identified that a Modern Matron in Palliative and End of Life Care could support a joint strategy to improve care locally.

Method Several studies indicate variation in how Modern Matron roles are implemented in different areas (Savage & Scott, 2004; Read, Ashman, Scott *et al.*, 2004). As the role is untested within a palliative care context, this work aims to better understand how this role works in practice. To explore this, an in-depth, case study interview was conducted with the Modern Matron in Palliative and End of Life Care.

Results Thematic analysis identified three priorities for the role:

- Linking strategy to day-to-day delivery through clinical leadership
- Creating a seamless service between hospital and community
- Value in partnership working.