

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?**

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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**

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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**

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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.