P-177 EVOLUTION AND REVOLUTION IN CARE HOMES; FRAILITY PROJECT ONE YEAR ON

Jane Baumeister, Maddie Kinnar, Sue Phillipo. *Garden House Hospice Care, Letchworth, UK*

10.1136/bmjspcare-2019-HUKNC.199

Background Our geographical area was identified as having a higher proportion of care home beds than average which results in a disproportionately high workload for primary care. A report in 2008 (Joseph Rowntree Foundation) noted that patients in UK care homes received nearly twice as many GP contacts as similar aged patients in the community. The Frailty Community Nurse Specialist service was implemented in April 2018 and has been funded for two years to support GP workload in care homes.

Aims of the service

- To support primary care;
- To initiate advance care planning and escalation plans;
- To review residents within 48 hours of admission;
- To improve confidence of care home staff through education and therefore reduce primary care contacts;
- To provide triage for minor illness/signpost care home staff to alternatives to GP by use of flowchart.

Method Initial scoping exercise of care home admissions, education needs and end of life care planning undertaken to develop clearer understanding of needs of care homes, patients and GPs. The visibility of the CNSs has ensured that they are the point of contact for advice and input/signposting, liaison with relatives regarding advance care planning including DNACPR (Do Not Attempt Cardio-pulmonary Resuscitation) and treatment escalation plans.

Results Feedback from both GP practices and care homes has been positive with the service seeing over 1000 residents within the first year. This has significantly improved both patient, carer and family experience as patients are able to remain within care homes with the support of the Frailty CNSs for end of life care.

Conclusion Initial results from the first year of service demonstrate a positive impact on GP workload, a reduction in A&E admissions and an increase in achievement of preferred place of care/death.

P-178 WIDENING ACCESS TO HOSPICE CARE – SUPPORTING END OF LIFE CARE IN CARE HOMES

¹Helen Reeves, ¹Katie Taroni, ²Joe Potts, ²Jeanette McCartney. ¹St Giles Hospice, Whittington, UK; ²Douglas Macmillan Hospice, Blurton, UK

10.1136/bmjspcare-2019-HUKNC.200

Background 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 to 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 and Douglas Macmillan Hospice are working with South East Staffordshire + Seisdon Peninsula Clinical Commissioning Group 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.

St Giles and Douglas Macmillan Hospice are supporting care homes throughout their localities by providing a specialist palliative care nurse to help support the home in identifying patients who may be in the 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 resuscitation status is reviewed for patients and that support is provided for these discussions;
- To deliver reduction in the number of avoidable emergency admissions to hospital.

Outcomes and the future Currently St Giles Hospice and Douglas Macmillan Hospice are working with 46 homes providing weekly support sessions and review of the planning ahead register. Data is collated quarterly, with results due the beginning of July 2019.

P-179 HOW CAN I LIVE WELL WHEN I'M DYING?

Karen Tudge. *Dorothy House Hospice Care, Winsley, UK*

10.1136/bmjspcare-2019-HUKNC.201

Background The Live Well Partnership Coordinator (Band 4 Role) is an innovative and collaborative post. Run in partnership with Macmillan Cancer Support and the Royal United Hospital Bath, it brings together three organisations to identify and provide support and guidance to patients who are newly diagnosed with a metastatic condition or reoccurrence of their primary cancer. The post is based on the principles of supporting patients and families who are newly diagnosed with a metastatic illness and are 'living well'.

Previously the feedback demonstrated that this group of patients would have been seen by the acute teams for treatment and then sent home under the care of their GP. Feedback gained highlighted that patients and their families rarely sought support for anything related to their ability to live well and therefore any life enhancing and supportive services were not picked up until the problem became a crisis or the patient's condition deteriorated and they were referred to targeted palliative and hospice care.

Method and results Since the post started in May 2018 we have engaged in opportunities to highlight the importance of palliative care and how it can enhance and support life and not just support dying. Through working with; specialist nurses, palliative care teams, Emergency Department and medical teams we have been able to break down misconceptions about the role of hospice care and promote to professionals and patients the benefits of early engagement with hospice services, including:

- Information about planning ahead and advance care planning;
- Emotional support – re difficult conversations;
- Link with Dorothy House Community Services, e.g. Nurse led clinic, Coffee Club, COPE (Self-management course), carers support and young person's support;

- Link with voluntary services in local communities – e.g. Age UK, Macmillan Cancer Information.

Conclusion Consideration of role to support Primary Carer Networks and facilitate earlier discussions for people affected by a life limiting diagnosis.

P-180 IDENTIFYING 'WHAT MATTERS?': AN ACT-BASED GROUP PROGRAMME FOR PEOPLE WITH CANCER

¹Angie Arnold, ¹Jo Poyner, ¹Rhiannon Lewis, ²Diane Playford, ²Carolyn Gordon, ²Georgina Slatter. ¹The Shakespeare Hospice, Stratford upon Avon, UK; ²South Warwickshire Foundation Trust, Warwick, UK

10.1136/bmjspcare-2019-HUKNC.202

Cancer and its treatment brings many challenges for patients and their families, not least physical and psychological recovery, and a return to work and/or activities of daily living (reintegration). Whilst developments in cancer treatment and a rise in survival rates has led to increased chances of people returning to work or other vocational/occupational activities, people with cancer continue to live with the long-term effects of the disease and/or its treatment. As a result, survivors may require some support to return to a more active life post-treatment, and evidence suggests that multi-disciplinary programmes, informed by CBT and Third Wave approaches are an appropriate intervention in this respect.

The poster will describe a collaborative project, undertaken by hospice and NHS services, which aimed to develop an ACT-based group programme. The poster will briefly outline the background to, and rationale for, the project before describing the development of a six-week programme, informed by Acceptance and Commitment Therapy (ACT). The group protocol was designed to support participants' identification of their core values, which some felt had been compromised because of cancer and treatment.

Subsequent content and activities enabled participants to take up, or return to, significant activities that were in line with, or a 'step towards', their values. The programme was delivered on three occasions to small groups and in total ten participants, referred from both hospice and NHS settings completed the full programme. Participant feedback and facilitators' reflections on the programme suggest it was a supportive process, leading to an increase in functioning and sense of self-efficacy and a small data set is available which supports this. The results of the group evaluation will be discussed, and recommendations and conclusions made.

P-181 DEMENTIA TOGETHER – A LOCAL SERVICE EVALUATION

¹Ruth Strudwick, ¹Katie Tyrell, ¹Andreea Tocca, ²Jo Marshall, ²Alana Page, ²Sharon Barber. ¹University of Suffolk, Ipswich, UK; ²Sue Ryder, Ipswich, UK

10.1136/bmjspcare-2019-HUKNC.203

Background The Dementia Together Service was launched in April 2017 and by the end of December 2018 had registered and supported 2,202 people - both people living with dementia and their carers living across Suffolk. The service consists of a helpline and staff who visit people living with dementia and their carers, providing support and signposting them to other services.

Aim The service is led by Sue Ryder working with a number of local organisations in service delivery. Despite a comprehensive range of services across Suffolk, people living with dementia were overwhelmed by varying offers which disabled them from accessing the most appropriate services to meet their needs.

Methods A service evaluation was undertaken, based on the views of people living with dementia, their carers, Dementia Together staff and external stakeholders. Questionnaires and focus groups were utilised to obtain both quantitative and qualitative data. Purposive sampling was utilised for the focus groups with people living with dementia and carers, and all staff were included in their focus group. Data from all methods were analysed and triangulated.

Results During Phase 1 of the evaluation, 133 questionnaire responses were gathered from people living with dementia, their carers, Dementia Together staff and external stakeholders. Focus groups were carried out with 18 people living with dementia, carers and navigators.

In phase 2, further focus groups with 20 people living with dementia, carers and navigators were conducted along with three case study interviews ($n=3$) and telephone/email interviews with eight stakeholders. Existing data from meetings and other reports were also analysed.

Conclusions The Dementia Together service has made a significant positive difference to people living with dementia, their families and carers across Suffolk.

P-182 DEVELOPING A SUSTAINABLE MODEL OF CARE FOR PATIENTS WITH END-STAGE HEART FAILURE

¹Wendy Sturt, ¹Gill Horne, ²Jo Sykes, ²Tim Chester. ¹Rowcroft Hospice, Torquay, UK; ²Torbay and South Devon NHS Foundation Trust, Torbay, UK

10.1136/bmjspcare-2019-HUKNC.204

Aims and objectives This 18-month project aimed to enhance the opportunities for patients with end-stage heart failure (HF) and families to benefit from hospice and supportive care services to help them plan and experience better end-of-life care.

Method The HF service, care of older people, primary care, hospital palliative care, patients and families and hospice representatives, worked alongside a project lead designing a model of care and pathway for people with end-stage HF. A new Supportive and Palliative Care in Heart Failure MDT was established, providing an interdisciplinary forum for identification of those at the end-of-life, and aiding referral to specialist palliative care services. A patient information leaflet was designed and printed. Education was also provided for the HF Team on palliative/end-of-life care and end-stage HF management for the specialist palliative care services.

Outcomes/impact There is now an established pathway for patients, improved understanding and communications between the HF and specialist palliative care teams. The MDT meeting is held twice monthly and specialist palliative care referrals have more than doubled during the project. Patients and their families have access to core information about hospice and other end-of-life care services in their locality. Documentation audits of advance care planning discussion demonstrate that 64% of patients reviewed at the MDT had discussions about their wishes. However, more