P-224 EAST SUFFOLK PREFERRED PLACE OF CARE PILOT

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In East Suffolk, our local End of Life (EOL) strategy priority is to support more people to achieve their preferred place of care and to deliver a reduction in the number of deaths in an acute setting. We have a shared local ambition between all partners to reduce in-hospital deaths by 50% over five years.

From January 2018 a new community based model of EOL care has been piloted in East Suffolk resourced by iBCF funding over 18 months. This model has built on the role of the local hospice, St Elizabeth Hospice, as a co-ordinating 'hub' to support patients, families and carers in their final stage of life and to support patients to die in their preferred place of care. Elements of the service model include:

- Increasing palliative care capacity in the system to include more health care assistants to provide in-reach service to the hospital and proactive care, coordinated by the hospice, in partnership with other providers;
- Expansion of the existing 'One Call' advice phone line to establish a care co-ordination centre;
- Developing a range of care homes accredited and actively supported by the local hospice to provide alternatives for direct admission as an alternative to hospital.

The interim pilot evaluation has demonstrated:

- A 10% reduction in number of hospital deaths;
- Calls to the advice line increasing from 1,300 to 1,900;
- Proactive working – to support admission avoidance and discharge from hospital;
- St Elizabeth Hospice Community nurse specialist team – there has been a 31% rise in demand for planned and reactive visits during 2018;
- 10 care homes have signed up to a scheme to be end of life accredited care homes.

The pilot has been extended for a further three months funded by the CCG and a final evaluation of the pilot is to be completed later this year.

P-225 DEVELOPING A NEW 'DROP-IN' SERVICE ON THURSDAYS AT OVERGATE DAY HOSPICE

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It has been identified that to meet future requirements for hospices they need to review their services, beginning with placing patients' goals for living at the centre of holistic support. Hospices need to create a culture of enablement and provide patients with greater choice, independence and dignity in advancing illness. They need to respond to ever increasing demand for palliative and end of life care within the demands of financial restraint (Hospice UK, 2017).

The aim of changing current service to 'Drop-in' is to provide a supportive nurse-led environment for adults and their carers living with a life-limiting illness. Promote a sense of wellbeing and a positive approach to living with their illness.

The services/support we provide:

- Patient centred: 'pick and mix' – attend as often or little as needed. No appointment required;
- Goal-orientated;
- Workshops e.g. Breathlessness management/falls prevention/fatigue management/mindfulness/nutrition/advance care planning;
- Physiotherapy;
- Complementary therapy;
- Counselling;
- Chaplaincy;
- Social work;
- Peer support;
- Creative activities;
- Patient/Carer/Staff Meetings to ensure we are providing what patients/carers want.

Findings since service developed Patients and carers attending Day Hospice have increased dramatically - increased by 250% on the 'Drop-in' day.

- Some patients are very ill – 'fear of the hospice' feeling that it is a 'place to die', however, when patients and carers are shown around the hospice and advised about the services/support we offer, they feel reassured that the hospice is here for many reasons;
- Increased awareness of the service from Acute Trust/Specialist Nurses who advise patients to attend;
- We network very closely with Primary Healthcare Team and signpost patients and carers to other services;
- Reduced costs – less staff required/do not provide transport or meals.

The service has evaluated very well. Patients have quoted 'fantastic service'; 'Didn't know where to go - thank you I feel so much better'.

P-226 REDUCING HOSPITAL ADMISSIONS IN PATIENTS WITH CANCER: CAN JOINT PALLIATIVE CARE CLINICS HELP?

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Hypothesis The use of joint oncology and palliative care clinics (JOPCC) to introduce palliative care early in the disease trajectory will reduce the number and length of subsequent non-elective hospital admissions in patients with cancer.

Rationale Patients with cancer are often admitted to hospital to gain symptom control or for management of acute complications (Numico, Cristofano, Mozzicafreddo, Cursio *et al.*, 2015). Previous research has shown the early intervention of palliative care can improve patient quality of life (Temel, Greer, Muzikansky, Gallagher *et al.*, 2010) and reduce hospital admissions (Hui, Kim, Roquemoore, Dev *et al.*, 2014). For the past 20 years, Royal Cornwall Hospital Trust (RCHT) have aimed to achieve this by allowing the two specialties to run in parallel (Benham, Broadbent, Mader, Palmer *et al.*, 2017).

Methods Data were collected from 54 patients seen in JOPCC and 59 patients seen in control standard oncology clinics (SOC) throughout 2016. Patients diagnosed with breast, prostate, upper and lower gastrointestinal cancers were included. Patients admitted electively (e.g. for planned chemotherapy or transfusion) were excluded. Patient electronic records were

used to identify the number of non-elective hospital admissions, reason and length of admission.

Results In JOPCC there were 45 non-elective hospital admissions compared to 70 admissions in SOC. The main reason for admission in both groups was for new complications of diagnosis: JOPCC 84.4%; SOC 85.5%. Complications of treatment were more common in the SOC patients; JOPCC 10.5%; SOC 26.7%. The average length of admission was significantly shorter ($p=0.0015$) in the JOPCC (4.8 days).

Conclusions JOPCC appear to reduce both the number and length of non-elective admissions. This may be partly attributed to fewer patients actually receiving treatment or having previous access to palliative care teams; resulting in fewer admissions. Further research comparing non-elective admissions within 12 months from first consultation with a larger sample size, confining data to a single site-specific cancer diagnosis will allow further conclusions to be made.

P-227 COMBINED ONCOLOGY AND PALLIATIVE CARE CLINICS; PATIENT PLACE OF DEATH

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Background Combined oncology and palliative care clinics (COPCC) have developed in Cornwall to enable early palliative medicine input into the care of cancer patients. The evidence suggests referrals to palliative care are usually late (Bennett, Ziegler, Allsop, Daniel *et al.*, 2016), despite growing evidence that earlier palliative care reviews enhance patient quality of life and in some cases survival (Temel, Greer, Muzikansky, Gallagher *et al.*, 2010). The majority of patients express a preference to die either in their own home or the hospice (Gomes, Higginson, Calanzani, Cohen *et al.*, 2012; Gao, Ho, Verne, Glickman *et al.*, 2013; Gomes, Calanzani, Gysels, Hall *et al.*, 2013), yet unfortunately most die in acute hospitals (Cohen, Pivodic, Miccinesi, Onwuteaka-Philipsen *et al.*, 2015). The aim of this review was to determine the place of dying phase of care for patients reviewed in the COPCC.

Method A retrospective database review identified place of death for 675 consecutive patients seen in COPCC between 2012 and 2017.

Results 45% died at home or nursing home, 26% died in the hospice and 29% died in hospital (21% acute, 8% community). In comparison nationally, 37% of patients with cancer died at home or nursing home, 17% died in palliative care institutions (i.e. hospice) and 44% died in hospital.

Conclusions COPCC aim to provide holistic palliative care to control symptoms, address information needs, help with psychological distress and guide advance care planning. COPCC allow patients with advanced cancer to be referred earlier to the community palliative care teams or hospice services. Patients who are reviewed in COPCC appear to be more likely to die at home, nursing home or hospice and less likely to die in an acute hospital compared to national data for patients with a cancer diagnosis. COPCC may help patients to die in their preferred place of death. Patients with non-cancer diagnoses such as end stage heart failure may also benefit from combined clinics with palliative care. Further work is needed to explore this.

P-228 LINKING HOSPITAL TO HOME AT END OF LIFE

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Background No Occupational Therapists (OTs) previously in Hospital Palliative Care Team (HPCT) and lack of continuity for patients and their families from leaving hospital to being at home for end of life care (EOLC).

- It was recognised that OTs were needed as an essential part of the HPCT;
- Needed to improve upon patient and family's experiences of EOLC in the John Radcliffe Hospital.

Aim(s)

- To provide support and continuity of care for patients and families throughout patient's EOLC journey from hospital to home;
- To provide education and support to hospital staff in regards to palliative and EOLC;
- To promote role of OT in palliative care within the trust and nationally.

Methods

- Networking with other OTs working in palliative care and sharing ideas;
- Qualitative data collected – formally from staff using an anonymous form and informally from patients and relatives;
- Planning on initiating a qualitative research project using a research assistant to interview families and loved ones.

Results

- 237 patients seen in the first year;
- 100% of staff agreed that input from the palliative care OTs improved the quality of EOLC for palliative patients;
- Excellent informal feedback from patients, relatives and staff across the hospital and in the community.

Conclusions Project demonstrated that OTs in the HPCT have a positive impact on the EOLC received by patients in the trust and into the community. We are one of the only OT teams that follow patients through their entire journey from hospital to home. The findings of our project supports ambition 4 of the *Ambitions for Palliative and End of Life Care* - ensuring care is co-ordinated.

This project will be of interest to palliative care professionals across the country as it is displaying innovative practice and has so far achieved excellent results and feedback.

P-229 DOROTHY HOUSE HOSPICE CARE AND ROYAL UNITED HOSPITAL – COMPASSIONATE COMPANIONS HOSPITAL END OF LIFE CARE

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The Compassionate Companions Service is a new service that provides specially-trained volunteers who offer support, compassionate listening, comfort and companionship to patients in their last days of life at the hospital, who do not want to die alone. They will also provide respite companionship support for patients' families so that loved ones can recuperate during what is a psychologically and physically exhausting time.