Aim Crises are frightening especially near the end of life. Primary care teams are pivotal in caring for patients in the final years of life, enabling more to live well and die where they choose, and reduce inappropriate crises and hospitalisation. With increasing pressures from the ageing population, rising mortality and limited resources, a more proactive approach to meeting these challenges is required.

The Gold Standards Framework (GSF) Quality Improvement Programme has been influential in EOLC since 2000 with most UK general practitioners using GSF foundation principles. We report on the findings of the first 17 GP practices undertaking GSF Going for Gold training and accreditation with some reaccredited three years later, demonstrating what is possible to achieve.

Method Primary care teams undertake a practice-based distance-learning GSF Gold programme with optional interactive workshops over 6–12 months. Evaluations before and after in preparation for accreditation include key outcome ratios, on-line After Death Analysis plus submission of a portfolio of evidence and assessment interview.

Results Cumulated findings for the accredited practices show significant improvements, including some reaccredited three years later demonstrating long-term sustainability. Practices demonstrate enhanced proactive end-of-life care, with earlier identification of over 60% of their patients who died, offering ACP discussions to over 65%, leading to more home deaths and improved outcomes for patients and carers.

Conclusion Improving care for people in their last year of life in GP Practices with proactive person-centred care is pivotal to meeting the challenges of the ageing population, and making best use of limited resources. The GSF Gold programme reported here, is an example of a practical, well-received evidence-based quality improvement, leading to more proactive planned care in line with peoples' preferences, meeting the increasing needs of the ageing population.

P-272 SUCCESSFUL SHARING OF MEDICAL EXPERTISE

^{1,2}Debbie Talbot, ^{1,2}Sarah Mimmack. ¹Birmingham St Mary's Hospice, Birmingham, UK; ²John Taylor Hospice, Birmingham, UK

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Background Two hospice organisations, serving the majority of the population of a major UK city (Hospice A and B). Hospice B has been unsuccessful over several years, at recruiting into a substantive Consultant role. Medical staffing, was therefore identified as a potential area for joint working, that would improve patient experience and promote collaboration.

Aim Both organisations agreed that the Medical Director at Hospice A, would provide some clinical leadership to Hospice B.

Methods Medical Director job plan split between the two units (with backfill funded by Hospice B)

Initial objectives agreed:

- Review existing medical staffing and make recommendations around future workforce planning, including how to optimise chances of recruitment into consultant post(s)
- Identify opportunities for the hospices to work together more, especially around shared job roles and clinical redesign projects
- Lead a joint hospice initiative, to effect system -wide change for EOLC across the city.

Achievement against these objectives will be assessed at appraisal.

Results Recommendations around Hospice B medical staffing, included formally linking the Consultant post with Hospice A, making optimal use of peer support and existing CPD opportunities. Consultant body agreed to amalgamate second on-call services, for more efficient out of hours working. Revised job description approved by RCP – recruitment pending. Joint clinical working provoked wider sharing of resources such as policies, guidelines, education material etc and heightened efficiency around clinical governance. Both organisations are now scoping joint working around support functions such as IT. Combined senior clinical staff away day, identified priorities for influencing at regional and national level. Future EOLC stakeholder events scheduled.

Conclusions Good example of a joint clinical role, becoming a conduit for greater cooperation between neighbouring organisations. There have been benefits to both, including reputational. Most notably, however, patient care has been positively impacted, with less staff time being expended on duplicating efforts.

P-273 MORE EFFECTIVE TOGETHER: PUTTING OUR HEADS TOGETHER TO INNOVATE AND LEAD

Karen Causton, Nicola Button, Laura Shukla, Kathryn Davies. *St Helena Hospice, Colchester, UK*

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Background The clinical heads of departments within our hospice had traditionally been located with their own teams, working in relative isolation. Budgets were managed individually, and often relatively small amounts of money were left unutilised. Clinical Heads did not always have a business background or expertise in this area.

Aims To share best practice, move away from silo working, utilise resources and encourage greater collaboration between the departmental heads.

Approach Help the Hospices' (2013) 'Future ambitions for hospice care; our mission and our opportunity' document recommends that hospices will be stronger in the future if attention is given to succession planning and developing leaders for the future. Furthermore, Hospice UK (2017) recommends that best practice is valued and shared, by combining expertise with business intelligence. One of the identified ways to achieve this, was to relocate the clinical heads of departments into an office together where they were joined by the newly appointed Head of Business, to facilitate coordinated working across teams. Positive feedback from members of our respective teams, our directors and visiting clinical heads from other hospices, has led us to believe that the approach is an innovative one.

Outcomes Joining the forces of clinical expertise and business acumen has provided collaborative leadership across Patient and Family Services and has generated the following benefits: joint strategic planning, inter-departmental budget setting, sharing of resources, joint KPI setting and performance monitoring. An example of this, is that combining left-over budgets from the three teams, which would otherwise have been left unspent, allowed a social worker to be employed to work across the organisation.