upskilling a member of school staff to support these children, whilst also identifying children who need specialised support with access to our trained counsellors.

Aims Targeting all children affected by grief and loss: providing education and support to school staff, the parents and families, alongside counselling and therapy programmes for pupils. Giving help closer to home, via a trusted school staff member, and helping kids keep some semblance of ‘normality’ in their lives, when everything else might feel as though it is falling apart. Training a link worker in every primary/secondary school with our service and offering guidance around bereavement and significant loss. Teachers are on the forefront when it comes to the emotional wellbeing of pupils, they are the crucial element in providing that stability for children struggling with loss.

Method Model of training a link worker with ongoing support from the coordinator, within each school is both cost effective but also upskilling staff.

Results Started with 46 schools, now 74, and plan to expand.

Conclusion Providing teachers with extra skills they can steer a child through even the most challenging situations. Additional support from the schools link service has dramatically changed the way youngsters are helped. Many of these children would drop out of education for a time: with our schools link service, they stay in.

Parallel session 3: Real world practice: referrals, access and partnerships

0-9 PRIORITYING REFERRALS TO A SPECIALIST PALLIATIVE CARE SERVICE
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Introduction With increasing referrals to specialist palliative care (SPC) services at a time of limited resources, effective triage systems are essential. This community SPC service uses a ‘RAG’ triage system, whereby a multidisciplinary team (MDT) decides daily if referrals should be categorised as ‘Red’ (seen within 24 hours), ‘Amber’ (3 days), or ‘Green’ (10 days).

Aims To assess if the MDT correctly prioritises referrals according to palliative care need.
Abstracts

**Methods** Referrals between 1/1/16 and 12/5/16 were examined retrospectively. Patients were RAG rated at referral. The Integrated Palliative Care Outcome Scale (iPOS) and phase of illness (POI) were recorded at the first visit. Higher iPOS scores, ‘Unstable/deteriorating/dying’ POI or shorter time between first and second contacts were taken as proxies of greater palliative care need, with lower iPOS scores, ‘Stable’ POI or longer time between contacts indicating lower need. One way ANOVA compared RAG to total iPOS scores and time between contacts. Chi-Square tested the association between RAG and POI (stable versus ‘unstable/deteriorating/dying’).

**Results** 296 patients received a RAG rating. Of these, 217 had an iPOS and 207 had a POI completed at the first visit. Red patients had a mean iPOS score of 21, Amber 18 and Green 15 (p=0.001). The mean number of days between initial contacts was 3 for Red, 8 for Amber and 11 for Green (p=0.001). There was a significant association between RAG triage category and POI (Chi-Square=36.9, p=0.000). This was in the expected direction with 67% of patients triaged as Green assessed as ‘Stable’ at the first visit, compared with 46% of Ambers and 3% of Reds. 97% of Red patients were ‘unstable/deteriorating/dying’ at first visit, compared with 54% of Ambers and 33% of Greens.

**Conclusions** These findings support the RAG triage system as a way of prioritising new referrals to a SPC service.

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**0-10** COLLABORATIVE MULTIDISCIPLINARY CLINICS INCREASE ACCESS TO PATIENTS WITH NON-MALIGNANT DISEASE

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**Background** Few patients with non-malignant disease access hospice care despite having similar care and support needs to cancer patients.

**Aims** To increase access to hospice care and advance care planning for patients with non-malignant diseases, and to enable choice in end of life care and improved carer support.

**Methods** Separate hospice-based multi-disciplinary clinics were established for patients with advanced heart failure; respiratory and Parkinson’s disease; and end-stage renal failure. The four clinics are staffed by a disease-specific physician, a palliative medicine physician, a hospice-based multidisciplinary staff and volunteer team and NHS-based disease specific clinical nurse specialists. Clinical assessments focus on quality of life, advance care planning and carer support, making onward referrals to other services as required. We report four years’ experience of this new model of care.

**Results** Between April 2013 and March 2017, a total of 435 patients attended the clinics, with 1036 attendances. Patients with heart failure were the largest group (30%); with 29% being respiratory patients; 23% Parkinson’s disease and 18% renal failure. 318 patients (73%) engaged in advance care planning discussions, with 66 patients completing formal advance statements and 28 completing advance decisions to refuse treatment. 289 (66%) patients have made decisions to refuse cardiopulmonary resuscitation. 67 (15%) of patients had died by the end of March 2017, of whom 52 (78%) were supported to enable death in community settings (home 39%; hospice 22%; care homes 13%; other 9%). Only 12 patients (18%) died in hospital. Clinic patients and carers report improved quality of life and accessed multiple hospice and community based services as a result of initial clinic review.

**Conclusions** Collaboration between hospice, acute hospital and community trust health professionals has enabled mutual support and learning and provided a popular care model for patients with non-malignant diseases.