Results Baseline audit revealed 40% of patients well enough to get dressed were still in pyjamas at lunchtime. No patient went to the day room to eat. First quarter results to be presented at conference, along with patient and staff feedback.

Conclusion Despite good physio input, the wider hospice teams could do more to increase patient activity and reduce deconditioning. The 'Sit up, get dressed, keep moving' campaign can be/is appropriate for the hospice setting.

Service development, models and collaborative working

P-148 THE MY CARE CO-ORDINATION TEAM

Sarah Myford, Elaine Tolliday. *Keech Hospice Care, Luton, Bedfordshire*

10.1136/bmjspcare-2018-hospiceabs.173

The co-ordination model came about from a Local Implementation Group which involves many different local professionals from the hospital, community, social care and hospice. The aim was to co-ordinate patient care through a 24 hour advice and support line, acting as the centre point that holds patient medical records. Communicating with patients, relatives, health care professionals both in the community and hospitals. Helping to reduce avoidable hospital admissions and enable patients to remain in their preferred place of care.

The team have built strong relationships with the local hospital, paramedics, community services and GPs. Attending regular meetings within all areas including Respiratory, Rare Neurological and Heart failure MDTs. We hold the medical records for all consented patients on our database (SystmOne).

Weekly data is sent to the local hospital, paramedic services and out of hours GPs about who is known to The My Care Co-ordination Team (MCCT). This ensures they have up to date information; included is DNACPR status and Preferred place of care.

The palliative care support workers provide hospital/hospice discharge visits to ensure transition back into the patient's home is as smooth as possible. This has helped reduce the amount of potential hospital 'bounce backs'. Personal care is provided for patients whilst waiting for a care package to start which assists in rapid discharge from hospital.

Some feedback: patients feel their care is well coordinated, MCCT has helped patients to remain in their preferred place of care. *'We were lost, no idea what to do. MCCT enabled us to make the right decision for our palliative patient'*, (Paramedic). Patients known to service: 559 with a population of 2 00 000. Hospital avoidances: 446 year 2017–2018.

The aims for the service in the future are to offer texting services, skyping and a responsive community nursing team to continue to increase hospital avoidances.

P-149 INCREASING RECOGNITION AND SUPPORT FOR ALL IN OR AROUND THE LAST YEAR OF LIFE, AIREDALE'S EXPERIENCE

^{1,2}Linda Wilson, ²Elizabeth Procter. ¹Airedale NHS FT, Steeton, UK; ²Sue Ryder Manorlands, Oxenhope, UK

10.1136/bmjspcare-2018-hospiceabs.174

In Airedale, we have been developing end of life care services at a population level, aiming to identify, offer sensitive conversations, document end of life preferences via an EPaCCS template and coordinate care from a 24/7 hub based at an acute hospital (Gold Line). In 2017/18, 76% of all 'non-sudden' deaths (56% all deaths) were supported by Gold Line (assuming 25% deaths are not preceded by a phase where identification is possible). Training for health professionals in serious illness conversations has been provided, partly via the NHS England Serious Illness Conversation pilot.

Of the patients who were identified as being in the last year (or so) of life, 14% died in hospital, 69% in their usual place of residence and 74% in the preferred place of death. Airedale has the lowest % of all deaths in hospital in England (33.4% cf 46.2%). 78% of patients registered to the service have a non-cancer diagnosis and 76% are NOT known to specialist palliative care services. 42% have a dementia code in their record and 70% are aged 80 or over.

Data from the End of Life Intelligence Network shows that in 2015, 69% of all deaths were on a GP palliative care register and only 4.8% patients who died had three or more acute hospital admissions in the last 90 days of life (England 6.9%). Figures are likely to have improved further since then.

Our service is offering coordinated support 24/7 to a large proportion of people dying who are not being supported by specialist palliative care services. High levels of satisfaction are expressed by patients, their carers and professionals. We believe that the provision of a 24/7 support and advice line, supported by an EPaCCS template is helping to encourage identification and thus improve outcomes for many more patients and their families in line with their expressed preferences and in a cost effective way.

P-150 THE GP'S ROLE IN PALLIATIVE CARE: VIEWS AND EXPERIENCES OF PATIENTS WITH CANCER

¹Emilie Green, ¹Heidi Lempp, ²Jane Naismith, ¹Patrick White. ¹King's College London, London, UK; ²St Joseph's Hospice, London, UK

10.1136/bmjspcare-2018-hospiceabs.175

Background General practitioners (GPs) are a vital component of palliative care, given their expertise in generalist care, their relationships with patients and families, and their knowledge of available community health and social services. Little is known about how patients understand and experience the role of their GP in delivering palliative care in the community.

Aims To explore patients' views and experiences of: (i) The role of the GP in providing palliative care to adult patients with cancer; (ii) The facilitators and barriers to the GP's ability to fulfil this perceived role.

Design Qualitative data were obtained through face-to-face semi-structured interviews. Thematic and discourse analysis were undertaken.

Setting/participants Adults with a cancer diagnosis and palliative care needs known to an inner-city hospice.

Results Fifteen participants reported actual and desired constituents of the GP's role in palliative care provision, such as: