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

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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 (SysmOne).

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

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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

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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:

prescription management; home visits; care coordination; and emotional support. Multiple perceived facilitators and barriers were identified, relating to: accessibility; continuity; GP's attitude and interpersonal skills; time and staffing levels; GP's involvement in diagnosis; and communication between primary and secondary care.

Discussion This study explored patients' views and experiences of the GP's role, and the perceived potential facilitators and barriers to its fulfilment. Further work is required to characterise a realistic model of continuous and accessible community palliative care.

P-151 THE VALUE OF A NIGHT SERVICE FOR HOSPICE-AT-HOME: REASONS FOR MAKING CONTACT AT NIGHT

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10.1136/bmjspcare-2018-hospiceabs.176

Background People approaching the end of their lives have physical and psychological needs that should be met in a timely way, at any point during the night or day, and met in a way which addresses their needs and preferences. Crises at any time require prompt, safe and effective urgent care (NICE 2011).

Methods Rennie Grove Hospice Care (RGHC) provides 24/7 care, with a night service available from 9.15 pm to 7.15am. RGHC conducted an independent study to identify the value of the service, including reasons people make contact at night and how many calls could be settled without a visit. Over the study period (145 nights) each call was charted with demographic details, reason for call and outcome.

Results 550 calls were received, resulting in 335 visits. On seven nights there were no visits, the highest number in a night was nine, with an average 3.79 visits per night. Only those consenting to participate were analysed, reducing eligibility to 351 calls and 208 visits. Of these, reasons for a night visit included symptom control (64%), carer support (19%), death (13%), death verified by night team (9%), message (7.5%), planned visit (7%) and 'other' (4%). Major symptoms included pain (42%), anxiety (32%), nausea (17%) and a small number with chest problems, bowel issues, pyrexia, syringe pumps. In 143 cases a visit was not necessary due to telephone reassurance (55%), another service being more suitable (12%), the team were too busy (8%), and 12% were handed to the next shift.

Conclusions The night team plays a vital role in 24/7 care, with 40% of calls being managed without a visit. Visits were, in the main, for symptoms or problems concerning support. Death, for a Hospice at Home service also becomes a significant issue requiring a prompt and caring response.

P-152 DOES A 24/7 HOSPICE AT HOME SERVICE PREVENT OR POSTPONE ACUTE HOSPITAL ADMISSIONS?

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10.1136/bmjspcare-2018-hospiceabs.177

Background Most people wish to die at home but in England almost 50% die in hospital, suggesting that more can be done

to keep people at home. Some studies have shown this may be possible, especially with adequate support and good pain control.

Methods Rennie Grove Hospice Care (RGHC) carried out an independent study to identify the value of their night team in providing 24/7 care over a period of 145 nights. The study considered whether the provision of overnight care affected decisions to make hospital admissions. Data from a night nurse template recording all overnight visits, a review of 42 patient/carer records of those who had called the night team, a carer questionnaire (n=87), carer interviews (n=18) and staff interviews (n=9), were analysed.

Results The night nurse template recorded five overnight admissions made during the study period, all for acute reasons and considered unavoidable. Review of 42 patient records showed 23 hospital/hospice admissions occurred, most during the daytime (18 to hospital, five to a hospice) of which only three were considered avoidable. The carer questionnaires showed 13 (16%) of their cared-for persons had been admitted to hospital in the last few weeks of life, with most reporting the admission was necessary. Staff interviews identified a pride in supporting patients to stay at home, while information from carers gave a clear indication that RGHC nurses enabled their cared-for individual to remain at home; that contact with the night team helped prevent or postpone an admission; and without RGHC their alternative would have been 111/999, district nurse or out-of-hours GP.

Conclusions There are occasions when hospital admission is appropriate. However, there was clear evidence showing support from the night team could prevent or postpone hospital admissions.

P-153 THE COST OF THE OVERNIGHT SERVICE AT RENNIE GROVE HOSPICE CARE VERSUS THE COST OF AN ACUTE ADMISSION

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10.1136/bmjspcare-2018-hospiceabs.178

Background Rennie Grove Hospice Care (RGHC) runs a Hospice at Home service providing 24/7 care. An independent study calculated the cost of a RGHC visit and the total community cost of home care, including all health care professional (HCP), carer, and family member visits.

Methods Over a period of 145 days, 550 calls and 335 visits made to/by the night team were recorded, averaging 3.79 per night. The salary cost per hour for each nurse, plus organisational add-on costs, was calculated. To derive a total community cost, 35 families, considered by the nursing team to be able to consent, kept a diary for up to two-weeks, recording all HCP, carer and family support visits and duration of each visit. Seventeen diaries were returned. Descriptive analysis was used with the Statistical Package for the Social Sciences (SPSS v22). Costs were taken for HCPs and social care services from the Personal Social Services Research Unit data 2015/16.

Results For 3.79 visits per night the cost per visit was £195 (taking into consideration that RGHC nurses travel in pairs). The 17 patient diaries covered a total of 177 days and