network to the patient and their carer and were able to bridge the gap between healthcare services and families. Carers of those with neurological conditions benefitted from having a dedicated person who understands the changing needs of their loved one and can provide them with some respite from caring responsibilities. Recommendations from the final report, available from August 2018, will be included in the poster.

P-174 THE DEVELOPMENT OF AN MND CO-ORDINATOR ROLE AN EVALUATION OF THE FIRST YEAR

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The development of an MND co-ordinator role, an evaluation of the first year, the impact of the role for patients, carers and the extended multidisciplinary team.

Motor Neurone Disease (MND) is a rare neurological condition that is always fatal. It is a devastating and cruel illness, which affects seven in 100,000 people, for which there is no effective treatment. The quality of life of people living with MND can be dramatically improved through an effective model of co-ordinated care.

Farleigh is one of a handful of hospices in the UK to have a dedicated MND professional. This unique role was created to coordinate care and provide support within the community for those affected by MND within Mid Essex.

- The post-holder started October 2017, introducing patients early to the palliative MDT
- Providing a single point of contact within the community from diagnosis
- Working with patients, carers and health providers ensuring the needs for equipment, adaptations, therapy, information and support are met in a timely, cost efficient and effective way
- Patients and their families supported whilst navigating a vast array of health and social care services
- Peer support gym group for patients and carers
- Partnership working within local Hospital Trust, Regional MND Care and Research Centre, community based health and social care professionals and charitable organisations including the MND Association.

In 2016/17 there were 330 bed days attributed to those with MND in the local Acute Trust (approximately 25 patients). If we assume that the bed day cost on average is £400, then the total cost for the number of bed days occupied by MND patients in 2016/17 in Mid Essex was around £132,000. A key function of the role is to reduce reliance on secondary care input helping patients feel confident to remain in their own homes where appropriate.

P-175 THE NEUROLOGICAL HUB

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Background Living with a neurological condition greatly impacts on quality of life (Cella, Nowinski, Peterman *et al.*, 2011). 70% of respondents in the 2016 Neurology Patient Experience Survey identify that living with a neurological

condition frequently restricted engagement in activities ('Falling short: how has neurology patient experience changed since 2014?', Neurological Alliance, 2017; 'Parity of esteem for people affected by neurological conditions...', Neurological Alliance, 2017). The Neurological Alliance ('Parity of esteem for people affected by neurological conditions...', 2017) identifies significant gaps in neuropsychological and neuropsychiatric services.

Aims To develop a patient-centred, supportive 'hub' for those living with complex neurological conditions. To meet physical, mental, social, psychological and spiritual needs to enhance quality of life to live and die well.

Method Increasing demands for neurological palliative rehabilitation presented an opportunity to develop neurological services. A two-hour once a week group was piloted to develop a central 'hub' for patients and their families to access holistic support throughout the patient journey. Funded by charity.

The programme includes components that endorse self-management strategies, increase function and support wellbeing (Tiberini & Richardson, 2015). Rehabilitation for those with palliative neurological conditions focuses on a multi-disciplinary holistic approach to enhance quality of life for patients and their families (Tiberini & Richardson, 2015; National Institute for Health and Care Excellence, 2016). Therefore, group work and one-to-one therapies including mindfulness, exercise, art therapies, complementary therapies and social support are offered. Advance care planning and referrals to external supportive services are addressed.

Standardised quantitative outcome measures from The Outcome Assessment and Complexity Collaborative (Witt, Murtagh, de Wolf-Linder *et al.*, 2016) are implemented. Qualitative word clouds are also collated to illustrate benefits to patients and their families.

Results The hub has been established for ten months with an average of 17 patients plus a family member attending weekly. Word clouds identify that patients and families feel; relaxed, positive, valued, supported and inspired. In addition to finding the hub friendly, social, helpful and calm.

Conclusion The neurological hub offers unique coordinated services to the patient life journey and beyond. The intention is to create a yearly programme offering increased opportunities and knowledge to patients and families.

P-176 IMPROVING CARE COORDINATION FOR PEOPLE LIVING WITH MOTOR NEURONE DISEASE (MND) IN THE BRADFORD AREA

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Background People living with Motor Neurone Disease (MND) frequently have care delivered by a high number of professionals. In the Bradford area, it was recognised that people living with MND did not have a single point of access for care. This was felt to lead to lower quality care through poor coordination and inequity in access to services.

Aim An MND Care Coordinator was appointed at a local hospice, with the aim of establishing a single point of access for patients and families. Additionally, the role aims to increase understanding of MND amongst professionals locally and support the running of the hospice multidisciplinary team clinics.

Methods This work presents findings from the formative evaluation, which utilised in-depth interviews, service data analysis and time-log methods.

Results All new patients have been contacted by the coordinator within two weeks of receipt of referral, with the aim of establishing themselves as their single point of access.

- The ability to have more frequent caseload review has allowed for the identification of care needs in a timelier way
- Conversations about care for people with MND can be emotive. Due to their clinical experience as a senior nurse, the coordinator has provided appropriate psychological support in conjunction with coordinating care
- The coordinator co-organised a professionals MND study day, as well as completing informal MND training to hospice staff and has made improvements to the Multi-Disciplinary Team clinics to encourage a person-centred approach.

Conclusion Evidence to date suggests structures have been put in place to establish the coordinator as a single point of access locally, as well as to support patients, families and other professionals alike. Future evaluation will assess the extent this may have had an impact for people living with MND and their families.

P-177 EVALUATION OF JOINT WORKING BETWEEN THE RENAL AND PALLIATIVE CARE TEAMS IN A HOSPITAL AT EAST LONDON

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Introduction Identifying dialysis patients who are deteriorating and require a palliative care approach is challenging. Few have advance care planning (ACP) discussions and the majority die in hospital (Elliott & Gessert, 2016; Davison, 2010). Joint working between the dialysis team and the Specialist Palliative Care team (SPC) was introduced following the recommendations of the UK End of Life Care Strategy (NHS Kidney Care, 2009). Dialysis patients likely to be in the last year of life according to the Gold Standards Framework (GSF) prognostic criteria were added to a 'Cause for Concern' register and discussed at a monthly renal/palliative care Multi-Disciplinary Meeting (MDM) attended by the hospital and community SPC teams. We aim to evaluate the impact of renal/SPC joint working.

Methods Firstly, we reviewed records of all dialysis patients three months before and 15 months after the joint working began. Secondly, we reviewed records of dialysis patients who died over a one-year-period before and after the introduction of the joint working. Statistical tests were performed to compare the situation pre- and post- introduction of the joint working. Thirdly, semi-structured interviews were conducted with renal staff and the data analysed using thematic analysis.

Results The proportion of dialysis patients being offered an ACP discussion increased by five-fold ($p=8.4E-04$), ACP discussion documentation increased from zero to 3.5% ($p=3.7E-03$) and proportion with Coordinate My Care (CMC) increased from zero to 3.14% ($p=7.4E-03$). The staff

interviewed ($n=8$) highlighted the benefits of working alongside the SPC team, especially on symptom management and community support.

Conclusion Introduction of the joint working appears to have improved ACP and delivery of palliative care to dialysis patients. It is hoped that further embedding routine screening with GSF prognostic criteria, MDM discussions and renal-SPC collaboration will continue to improve palliative care for dialysis patients.

P-178 COST-EFFECTIVE INNOVATIONS FOR INTEGRATION OF PALLIATIVE CARE AND RESPIRATORY SERVICES

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Background It is recognised that chronic respiratory patients benefit from palliative care due to their burden of symptoms and risk of inappropriate medical interventions at end of life (Joshi, Joshi, & Bartter, 2012; Taylor & Murray, 2018). However, respiratory referrals to our palliative care services have remained low. Research has shown that patients and staff can equate palliative care with 'giving up' (Smallwood, Gaffrey, Gorelik *et al.*, 2018) when exacerbations are potentially reversible, resulting in patients dying in hospital, whilst undergoing active medical management.

Aims Understand the needs of chronic respiratory patients. Increase respiratory referrals to hospice services. Increase knowledge and skills for healthcare professionals in managing palliative respiratory patients.

Methods Using contacts from the community specialist nurses and hospital palliative care team, a quarterly meeting at the hospice was set up for interested healthcare professionals from the hospice, community and hospital involved in working with chronic respiratory patients. By sharing information on the services available and discussing complex respiratory cases, new ways of working together were identified. These included:

- Respiratory nurses observing consultant ward rounds at the hospice
- The hospital oxygen clinic being held at the hospice
- The Interstitial Lung Disease support group moving to the hospice
- Developing a respiratory breakfast club at the hospital for palliative and respiratory staff to discuss the management of hospital and community respiratory patients
- Hosting a regional conference on interstitial lung disease at the hospice
- Joint home visits with the respiratory and palliative care teams.

Results Anecdotal evidence so far has shown an increase in referrals of respiratory patients to Hospice services and these patients have benefitted from palliative care. Quantifiable data will be available by November 2018.

Conclusions It is possible to increase referrals from respiratory to palliative care without expensive or time-consuming interventions. Developing relationships and improving understanding between the teams has helped to break down barriers and led to further collaborative working.