

classified as resource-constrained but identified as a positive mutual need. Results were divided into these groups accordingly for comparison.

All of the health links had been initiated by an individual with a passion for the work and some respondents asked for anonymity in their interviews. Overall, the benefits of these health links have been shown to be of mutual learning and respect and were personally transformative where positive professional relationships developed. Participants were clear they would like a national coordination system for resources, sharing information and to promote engagement in this work to avoid 'reinventing the wheel'. There was concern about longer term sustainability of the work and concern for international equity of care for patients.

Participants had clear advice for those hospices wishing to develop active health links in the future. The key suggestions were for research prior to establishing the health link, clear aims and objectives and making the right connections for the health link.

'Do not leave those suffering behind' (Worldwide Hospice Palliative Care Association, 2014)

#### P-200 ST MARY'S LIVING WELL CENTRE – WORKING COLLABORATIVELY TO MAKE A DIFFERENCE EARLIER

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Barrow-in-Furness residents die 10 years earlier than local peers, 61% over 65 live with disability and the town rates high in fiscal and health deprivation. Despite the town's level of need, in 2018 only half the expected GSF 1% used hospice services. This project is based on the belief that we need to reach more people but cannot allow this to mean ever spiralling costs. We set a target of 70 more people for each of five years.

Our work with partners lets us engage earlier with more people, particularly those who may not previously have considered hospice services as being for them. A side benefit of working with partners is the development of smoother referral pathways. Working through others' resources keeps costs sustainable and relatively constant.

The clinical service is delivered from a building shared with our furniture warehouse to keep costs low and increase public visibility. We actively sought centre partners who were already working with our target client groups and also approached those holding community wellbeing assets (such as art, craft and exercise) offering opportunities to meet their own targets by providing no cost services to our centre users.

From November 2018 to May 2019 monthly footfall rose to 250, through engagement with those living with advancing lung disease, dementia, neurological conditions and stroke. Classes provided by Adult Education and the local leisure centre which start in the Summer should increase this to nearer 330. Our local ICCs are part of our Steering Group and now planning to include cardiac conditions.

As our hospice is continually pressed by limited income, increased aging and the need to reach hard to reach groups, we are finding this centre has addressed those issues at minimal cost whilst enhancing the profile we have with local funders and supporters.

#### P-201 STRATEGIC SUCCESS OF A WHOLE SYSTEM APPROACH TO END OF LIFE CARE

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**Context** A system wide review of end of life care services identified a number of gaps in service provision. A Hospice Enhanced End of Life Care project was commissioned to;

- Extend availability of hospice advice line from 8 to 8, 7 days a week.
- An enhanced hospice at home (H@H) service including:
  - An increase in availability of H@H within the community/ care homes from 8 to 8, 7 days a week;
  - Introduction of community rapid response service 8 to 8, 7 days a week;
  - Introduction of a specialist palliative care In-Reach Service to coordinate rapid end of life care discharges from hospital.

#### Key achievements

**Service user feedback:** *'Without your help and support my husband would have died in hospital. You provided and arranged rapid discharge so my husband could come home. We are very grateful for everything you have done.'*

**Professional's feedback:** *'Very friendly, helpful and quick to respond. Had very good feedback from patients and relatives. Have really helped make getting patients where they want to be so much easier and quicker which is greatly appreciated.'*

- Referrals increased by 24.09% (target 9%);
- Calls to the hospice advice line increased by 23% (target 17%);
- Preferred place of death achieved 100% to 88% (the target was 88% and in some months the target was over achieved and met up to 100%);
- Increase in hospital ward referrals, improving time taken from referral to assessment by less than 24hours in most cases;
- Average 25 referrals monthly;
- The average 24-hour response time increased by 23%.

#### Key strategic success

- Demonstrated impact of a whole systems approach to end of life care;
- Working in partnership with local hospital, community providers and Clinical Commissioning Group;
- Raised the profile of end of life care within the acute setting;
- Relationship building between partners creating a 'bridge' engendering a genuine 'can do attitude';
- Fast track provision appropriately targeted with a regular review of the patient's needs to optimise the use of resources;
- Allows a more flexible delivery of individualised care according to changing needs for people.

#### P-202 IT'S ALL ABOUT YOU . . . A PERSON CENTRED MDT DEVELOPMENT PROJECT

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**Background** Our specialist palliative care unit is currently undertaking a project to improve the 'person-centredness' of the care it provides. It was recognised that the MDT (multi-disciplinary team) meeting for our 26 inpatient beds could be