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)

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### Abstracts

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

Debbie Sevant, Farleigh Hospice, Chelmsford, UK

10.1136/bmjspcare-2019-HUKNC.223

**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 24 hours 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

Sarah Fradsham, Dominic Bray, Ruth Pryce, Colette Parfitt, Emma Kirk, Clare Carr, Lorraine Howard, Anne Howard, Marie Cune Hospice, Liverpool, UK

10.1136/bmjspcare-2019-HUKNC.224

**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...
improved both in terms of its productivity and its person-centredness.

Aim The aim of the project was to:
- Review our current inpatient MDT, recognising the strengths and weaknesses of it;
- Devise a new innovative model to be trialled and evaluated in the unit.

Method A multidisciplinary task and finish group was set up and the following aspects of the MDT meeting were considered:
- The team – membership, dynamics, contributions, culture;
- Infrastructure – environment and the role of technology;
- Meeting organisation;
- Person-centred decision making – is the patient’s voice represented?
- Governance – outcome measures.

Prior to commencing the project a survey was carried out of all professionals attending the MDT to determine the effectiveness of the meeting in its current format, along with the value professionals felt was given to their contributions and role. MDT meetings in other organisations were also observed to help develop ideas for the new model.

Results The majority of staff surveyed felt the MDT could be improved significantly in its format and productiveness. A number of members of the MDT felt their role was not valued.

Through the project a new model for working has been developed which is currently being trialled prior to evaluation. This model is thought to be a better representation of the patient voice along with acknowledging and reaffirming the value of all members of the MDT.

Conclusions The new MDT model is currently under evaluation. A research project has also been designed with the following aims:
- To investigate what are the patient-centred goals set at a weekly hospice inpatient MDT meeting?
- Are these goals being achieved?

P-203 TRIAGING REFERRALS TO SPECIALIST PALLIATIVE CARE – AN AUDIT AND IMPROVEMENT ACTIVITY

Katie Jeram, Heather Paterson, Rowans Hospice, Portsmouth, UK; Solent Specialist Palliative Care Team, Portsmouth, UK

Background Changes to staffing levels and concerns within the Specialist Palliative Care Team (SPCT) about inconsistent triage methods led to a review of the triage process: an audit with a service review of patients seen once and discharged was completed, triage operating procedure updated and a re-audit completed.

Aim To ensure a consistent and equitable triage process to allow Solent patients referred to the SPCT to be appropriately seen in a timely manner.

Conclusions
- Changing the triage process has led to a more streamlined and consistent approach;
- Restarting Early Palliative Care clinic has allowed for a more responsive service (self and re-referrals are encouraged) to a wider range of patients;
- The percentage of patients triaged and subsequently not seen, and of those breaching target date once triaged have decreased – this could be due to improved staffing levels, improved triage process and the restart of the Early Palliative Care clinic.

Learning points
- A detailed triage process allows for a patient-focused and responsive service;
- A consistent approach allows for teams to continue to provide a good quality service even when under pressure.

P-204 PALLIATIVE CARE REFERRALS CENTRE

Liz Kennedy, Peace Hospice Care, Watford, UK

Background Service inequity identified within palliative care community services and access to inpatient unit beds across the locality.

Palliative care referrals were triaged through each organisation. This often resulted in multiple referrals for each person to multiple organisations and service providers.

GP population 610,000 people; 72 surgeries. Clinical Commissioning Group (CCG) – commissioners.

Aims The ‘Ambitions for Palliative and End of Life Care’ include: ‘Care is coordinated’; ‘each person gets fair access to care’ and ‘each person is seen as an individual’ (National Palliative and End of Life Care Partnership, 2015).

Specialist Palliative Care (SPC) providers and CCG worked together implementing single point referral to:
- Provide equitable access to services across the locality;
- Reduce duplication of referrals to multiple services;
- Increase access to SPC;
- Improve timely intervention on referral;
- Ensure patient wishes recorded: Electronic Palliative Care Co-ordination System (EPaCCs).

Methods
- Eligibility criteria;
- Priority tool and response times;
- Agreed monthly data collection and reporting;
- Management of EPaCCs data;
- 2-year CCG funding – set up, admin costs;
- Agreed resources from each organisation providing 5-day nurse triage cover;
- One agreed host centre;
- Community service lead meetings;
- Commissioned report at end of 18-month period;
- Online professionals survey feedback;
- Staff interviews – working within or managing service feedback.

Results Report findings (18-month evaluation report):
- Monthly average – 255 referrals;
- Systems and processes reported more streamlined;
- Greater awareness of services across providers;
- 26.8% monthly average referrals were P1 & P2 (Emergency/Urgent);
- 72.6% monthly average referrals were P3 & P4 (Responsive/Planned).