

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

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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

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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).

Conclusion Evaluation data and feedback demonstrated benefits to patients, referrers and increased awareness of services. Single point of referral enabled accurate data gathering and efficient use of service resources.

Demonstrated effective collaborative working. We learnt increased GP awareness across the locality may increase earlier referrals and clear feedback was required to referrers regarding priority of triage.

P-205 WORKING AT SCALE... NOT TIPPING THE SCALES

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Background The Mountbatten Coordination Centre is central to our strategy moving forward. It is becoming the catalyst for working in different ways to future proof services, supporting people at scale with the services they need.

Aims Our coordination centre referral criteria of anyone with a life limiting disease or within their last five years of life, means we can reach more of our population earlier, preventing inappropriate admissions to the acute setting and enabling a planned approach to care. Our desire is to give the correct dose of care to each person at the right time, meaning our finite resources are used effectively and people aren't smothered in a blanket of care becoming 'a patient'.

Method The criterion for referral into our coordination centre is the last five years of life. All people referred are assessed and a plan put in place. The plan can range from light touch support, including access to our 24/7 support line, social programme and rapid response service, to the assignment of a specialist nurse. Our vision is that more people will fit in to the criteria of the former, enabling a planned approach, with patients' wishes achieved and stress and anxiety managed.

Results We have recently undertaken an evaluation of the Coordination Centre, this has resulted in some interesting findings. There is some evidence that it has had a positive impact on primary care with the amount of contacts decreasing after referral to the Coordination Centre. There have also been many pieces of anecdotal feedback from patients, family and professionals.

Conclusion We are using our limited resource to reach more people, when they need us; an increase of 50% in the past year. Helping them wherever, whenever and however is appropriate, to make the final years of their lives as rewarding as possible, giving all hope.

P-206 CONTINUING HEALTHCARE FAST TRACK PROJECT – ONE YEAR ON

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Background In April 2018, the hospice was commissioned to deliver care packages to patients who qualified for continuing healthcare (CHC) funding under fast track provision. Initially the project offered five virtual beds which enabled patients with a deteriorating and life limiting illness to remain at home by preventing avoidable admissions to hospital and

facilitating early discharge from in-patient care, either hospital or hospice.

Aims of the service

- Ability to provide rapid discharge from acute sector;
- To deliver a comprehensive fast track CHC service for service users with palliative and end of life care needs based on their clinical need rather than diagnosis;
- To support people to live and die in their preferred place of care especially where this is identified as their own home;
- To prevent avoidable admission to hospital.

Method Commenced provision of five virtual beds in April 2018 and the level of care was based upon clinical need rather than being time specific. Care was provided by Health Care Assistants (HCAs) with the necessary skills to support this vulnerable group of people with specialist assessment being carried out by Registered Nurses. Care was offered up to a maximum of four times per day and was personalised and tailored to meet the needs of patients.

Results

- The ability to be responsive to patients' preferred place of care/death;
- The ability to support Community Teams;
- feedback from both patients and carers has been overwhelmingly positive;
- The smooth transition between hospice services including in-patient and day service.

Conclusion Following evaluation of the service and the positive feedback received from both staff, patients and relatives, the CCG have commissioned a further five virtual beds.

As of the 1 April 2019 the service can now provide care for 10 patients with a maximum of four visits per day.

P-207 FAST TRACK IMPROVEMENT PROJECT: SIX MONTH REPORT (SEPT 2018 – MARCH 2019)

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Introduction Fast Track Continuing Healthcare (CHC) is a care package, funded and arranged by the NHS when a person is identified as having a 'rapidly deteriorating condition that may be entering a terminal phase of life' (National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care, 2018).

Methodology Various initiatives were developed and implemented to provide guidance and improve the process:

- Direct electronic referral to CHC;
- Fast Track Operational guidelines detailing roles and responsibilities of staff;
- Integrated Discharge Team accountable for Fast Track referrals and discharge;
- Patient information leaflet;
- *End of Life care: a guide* – a booklet for people in the final stages of life and their carers (Macmillan Cancer Support and Mare Curie, 2015);
- Community services leaflet with contact telephone numbers;
- Discharge toolkit on the hospital intranet;
- Discharge prompt stickers for medical notes;
- End of life care facilitator attendance at daily ward board rounds;