skills of the workforce, liaising with key referrers and securing funding.

Throughout the first complete month the service made 200 visits, half of these provided emotional support. The team have been called by patients who previously frequently called 999 when they were anxious or distressed, hence now freeing up a much more costly service.

45 of the visits were to provide continence care to patients, one relative said *'my father would have suffered through the night as I struggle to clean him myself'*.

The current Hospice at Home service is a limited resource providing care to people in the last days of life. Carers are satisfied with a short visit from the Hospice Night Support Team when a whole Hospice at Home shift is unavailable. This is an excellent way of supporting family and patients in their preferred place of care while efficiently using resources.

P-213 WILLEN AT HOME AN INTEGRATED COMMUNITY SERVICE

Anita Connolly, Jackie Meissner. *Willen Hospice, Milton Keynes, UK*

10.1136/bmjspcare-2019-HUKNC.235

Background The Department of Health End of Life Care Strategy (2008) identified an increasing need for good end of life care in the community. The planning and reorganisation of this new community service has been developed to meet the demands of managing patients with more complex disease trajectories in an ever growing local population.

The new team Willen at Home is a new integrated community service, which combines the original Hospice at Home and Clinical Nurse Specialist Teams (CNSs). The Willen at Home team was established in January 2019. The vision for this new team was to provide a holistic and responsive service using the combined skills of a multidisciplinary team. Patients are triaged according to their Phase of Illness and Performance Status (AKPS, 2005), and care is provided by the skill mix of professionals appropriate to their needs. Unwell, unstable or dying patients are triaged, ensuring a timely response as their condition changes. The integrated team comprises: Community Lead Nurse, CNS, Community Senior Nurse, Registered Nurses, Healthcare Assistants, Doctors.

Each day, staff are assigned to core roles:

- Telephone triage;
- Visiting;
- Monitoring.

This enables prompt assessment, prescribing, delivery of care and liaison with secondary care.

Impact of the new team In the new team, staff have a designated role for the day, ensuring that triage, assessment, visiting, prescribing and care planning are carried out in a personalised and timely way. As a result of this: Multidisciplinary team working means the patient's care is tailored to their needs on the day. Clinical staff work collaboratively with allied services such as Social Work, Psychology and Patient and Family services. Nurse prescribers provide timely access to specialist medications. Patients can be reviewed on the day by a specialist doctor. More patients receive specialist care at home and are enabled to die in their own surroundings, avoiding unwanted or crisis admissions.

P-214 HOSPICE AT HOME RESPITE SERVICE

Debby Varnam. *St. Giles Hospice, Lichfield, UK*

10.1136/bmjspcare-2019-HUKNC.236

Recently the organisation has been looking at how to improve support for our patients and their families in the community. Our already well established Hospice at Home service offers personal care, respite support and night sits for patients in their last few weeks of life. However, the organisation recognised that there was still more needed to enable families and patients to feel supported at home. After speaking to families, patients and community health-care professionals, including GPs and District Nurses, the organisation identified a gap in service provision for respite care. Consequently, in January this year we launched our new respite service.

The aim of this new service is to provide support to patients and carers in the last 12 months of life by providing respite care within the home setting. The service aims to support family members caring for relatives with a life limiting illness which can result in physical and emotional problems directly related to the stress and demands of daily care. By offering much needed respite the aim is that this will enable patients to remain at home longer and avoid unwanted admissions to other health care settings.

Everyone needs some time for themselves, even more so when they care for someone else. Respite has traditionally been offered as residential, however by offering respite care in the home this causes minimal disruption to the patient and provides the carer with a much needed break. The service aims to be as flexible as possible offering visits during the morning, afternoon or early evening, seven days per week. This gives carers the opportunity to attend appointments, have a much needed rest, or time out to enjoy social activities.

We continually evaluate the service by gathering feedback from our service user surveys. The feedback we have received has been extremely positive and reflects how much this service is needed.

P-215 DEVELOPING A LIVING SUPPORT GROUP – LEARNING FROM PATIENT FEEDBACK

Dympna Jones, Katherine Rugen, Kate McIntegart. *Woodlands Hospice, Liverpool, UK*

10.1136/bmjspcare-2019-HUKNC.237

Background Woodlands Hospice has run a 'Supportive Living Programme' aiming to enable patients to live as well as they can, for as long as they can, for several years. This is a 10 week rolling programme of clinician-led sessions on varied topics relating to patient wellbeing, which is well attended and receives positive feedback. Following completion of this programme, patients are encouraged to attend an informal peer support group where they can share experiences, make friends and grow in confidence. Over time it became apparent that attendance at this group was diminishing and feedback from the patients was that they missed the clinical support they had enjoyed in the 10 week programme.

Aims The hospice was keen to ensure ongoing appropriate support and enable patients to feel safe in the knowledge

that their individual clinical needs would continue to be met by the healthcare professionals they had come to know and trust, avoiding a crisis situation or potential hospital admission.

Method Patient feedback was reviewed and discussions held between patients and healthcare professionals following which the 'Living Support Group' was re-launched alongside a nurse-led clinic. Feedback from patients following this re-launch was then sought and attendance evaluated.

Results Since its re-launch there has been an increase in attendance by 35% over the course of a year. Feedback from patients and carers indicates that knowing they have access to clinical support encourages them to attend and enables them to enjoy time with other patients in a peer support setting.

Conclusion Patients find peer support, friendship and experience-sharing very beneficial to their overall wellbeing. Having individual clinical support available to them in the 'Living Support Group' encourages attendance and thereby promotes patient wellbeing in both clinical and non-clinical attributes.

P-216 PILGRIMS 'THINK TALK ACT' MODEL-PROACTIVE IDENTIFICATION, TRIAGE AND ASSESSMENT OF THE 1%

Wendy Hills. *Pilgrims Hospices in East Kent, Canterbury, UK*

10.1136/bmjspcare-2019-HUKNC.238

There is a growing body of evidence to support the need for better identification of people in their last year of life, followed by appropriate care planning and support. We also believe the longer the relationship we, as a hospice, have with the family, in the last year, the better the overall experience and outcome will be for all those involved. With this in mind we have developed the Pilgrim's 'Think, Talk, Act' pilot.

We are working with four GP surgeries to proactively identify patients, utilising a software programme, who are at risk of dying in the next year and offer them access to information via a socially prescribed workshop in the community. The aim is to enable earlier engagement with healthcare professionals to actively make advance care plans. This is the THINK part of the model.

Patients will be categorised into those who have symptoms that could benefit from our Pilgrims Therapy services. These patients will be invited into the practice to TALK about their condition. To help tailor the referral, the patient will be asked to complete an IPOS form to identify any concerns or symptoms they currently have. Patients who are identified and categorised as severely frail will be ACTed upon and, if required, referred directly to Pilgrims Hospices for full service support.

The aims are to

- Increase the percentage of people identified as likely to be in their last year of life – DH mandate.
- Increase the percentage of people who have died who have been offered the opportunity for personalised care and support planning – UPC Target.
- Work alongside primary care colleagues to help identify and support relevant patients. We will introduce proactive and personalised care planning for everyone identified as being in their last year of life – NHS Long term plan.

P-217 IMPROVING END OF LIFE CARE IN KIRKLEES AT A PRIMARY CARE NETWORK LEVEL

¹Sadaf Adnan, ²Dil Ashraf, ¹Michael Crowther. ¹Kirkwood Hospice, Huddersfield, UK; ²The Valleys Health and Social Care Network, Huddersfield, UK

10.1136/bmjspcare-2019-HUKNC.239

The formation of Primary Care Networks provides a real opportunity to influence and improve the care and support provided to people with a life limiting illness within Kirklees.

Following formation, the next phase is an integration of community care with the overall vision for integrated services provided by place-based primary, community and social care organisations.

Kirkwood Hospice has been a key partner in a number of emerging networks, most notably with The Valleys Health and Social Care Network. This network is made up of partners from Kirklees Council, Locala CIC, My Health Huddersfield GP federation and six practices with a combined patient population of 54,000.

This focus on end of life care has provided a tangible and meaningful way of developing integration between the network partners. Network funding is supporting a range of activity, including the development of a link worker role, dedicated training and education and support to practices in undertaking QOF Quality Improvement activity.

With support from CCG Data Quality teams, a data summary has been created to identify current activity and areas for improvement. This captures key themes and areas for improvement including numbers on palliative care registers, EPaCCS (Electronic Palliative Care Co-ordination Systems) care home activity and numbers with Advance Care Plans.

A network-wide training and education event was held in June 2019, with over 50 attendees representing GPs, practice managers, practice and community nurses, adult social work assessors and Kirkwood staff. The event reiterated the agreed network approach to meet the following aims, which are continuing to be progressed by a dedicated Project Task and Finish group:

- Increase numbers of patients identified as being within the last year of life;
- Increase the proportion of people on EPaCCS;
- Promote Advance Care Planning;
- Improve training and education across our network in order to achieve people's preferred place of care.

P-218 MOVING IN TOGETHER

¹Suzanne Holt, ¹Claire Capewell, ²Brenda Vernon. ¹St Catherine's Hospice, Preston, UK; ²Issa Medical Group, Preston, UK

10.1136/bmjspcare-2019-HUKNC.240

Overview Pilot study to embed a Clinical Nurse Specialist (CNS) into a large GP group practice whilst maintaining supervision under hospice framework.

Background Based at the hospice traditionally each member of our Community CNS team is linked to 5–8 GP practices within a geographical area. Issa, a large inner-city G.P. practice, approached the hospice with a proposal to fund a St Catherine's CNS working solely with Issa patients (list size 30,000). The project commenced in November 2018. This