

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%**

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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**

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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**

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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