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

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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

project will be run as a three year pilot funded by the Issa Medical Group.

Method CNS is based at the practice hub. Referrals are now taken directly from primary care staff to the CNS. CNS has access to practices' electronic systems to streamline communication and ensure timely treatment and prescribing. CNS maintains place in week-end rota, line management, clinical supervision and multi-disciplinary team input from the hospice.

Results Challenges we encountered were:

- I.T.; ensuring access to two electronic patient records in two locations;
- Establishing working relationships within a large two-centred practice;
- Adapting prescribing policy and practice to that used by the Group;
- Changing practice to enable greater flexibility and responsiveness;
- Acquiring enhanced skills, such as verification of death.

Initial benefits

- Joint ward rounds held at large nursing homes;
- Waiting time now less than 48hrs compared to the current CNSs wait of 4 weeks;
- Wider referral criteria, including early intervention. 23 patients seen who would not have been seen in the old model of which 14 were for end of life care;
- GPs appreciate being able to see entries put directly onto EMIS rather than in traditional letter format;
- Cancer care reviews undertaken on palliative patients.

P-219 LIVING WELL PROGRAMME: SUPPORTING OUR COMMUNITY TO LIVE INDEPENDENT AND HEALTHIER LIVES

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10.1136/bmjspcare-2019-HUKNC.241

Background As part of our aim to support our wider community and help people live independent and healthier lives, we worked with a local GP surgery to provide a Living Well Programme for identified patients with long term health conditions.

Aims

- Improve overall health, wellbeing and independence;
- Help participants' flexibility and muscle strength;
- Increase access to supportive advice and information;
- Provide social opportunities.

Method The Living Well Programme comprises 13 sessions. During Session One we complete baseline physical assessments: balance test, gait speed, sit to stand and grip strength. These were repeated at the end of the programme.

All other sessions began with a 45 minute seated exercise class, followed by a short break to socialise, then 45 minutes from a speaker. Speakers covered a variety of topics including assistive technology, dementia awareness, personal safety, nutrition, benefits advice and advance care planning. Client feedback was sought at regular intervals throughout the programme.

Results

- Physical assessments increased on average by 1.83 points;
- Grip test scores increased on average by 2.85 kg (left hand) and 2.4 kg (right hand);
- Participants reported new friendships made and told us that they 'learnt something new' during the course.

Client feedback *'I had knee surgery 18 months ago and it's not been right, but it's feeling stronger. I'm doing exercises at home too'.*

'You have a good chat with the friends that you've made. I really look forward to coming'.

'It's been interesting. I enjoyed the talk on being prepared for when you 'fall off the twig' - putting everything in order for those left behind'.

Conclusion Our assessments and client feedback demonstrate that wellbeing programmes improve the health, wellbeing and social connectedness of participants. The course has been replicated at several locations within our locality with similar results.

P-220 A NOVEL APPROACH TO GSF MEETINGS – CAN VIDEOCONFERENCING TRANSFORM COLLABORATIVE WORKING?

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10.1136/bmjspcare-2019-HUKNC.242

Hospice UK identified in 2017 as a key strategic aim, the need to open up hospice care so that it could be delivered in any setting. A collaborative approach with local GP surgeries has identified the need to revisit how we undertake GSF meetings. These can often be poorly attended and involve increased travel time for participants resulting in reduced patient visits and a poorly represented GSF.

To overcome this St Giles Hospice and GPs within the Tamworth and Lichfield locality are trialling videoconferencing to liaise with GP Practices for GSF meetings thereby avoiding the long commute to different GPs by Clinical Nurses who are now freed up to see more patients or attend more meetings within the same time frame.

Freeing up travelling and parking time means GSF meetings can be held more often and at quick notice. Also palliative care consultant input can be provided if needed to the GSF meeting resulting in a tiered approach to specialist palliative care and enabling advice and support more efficiently and effectively. With time this can be expanded to include other members of the multi-disciplinary team such as district nurses, allied health professionals, social services and patients.

The first meeting was conducted on 27/03/2019 between Trinity Surgery and St Giles Hospice. This saved more than one hour of travelling and parking time for the clinical nurse specialists. There are 15 practices within the Tamworth and Lichfield area alone. This equates to 60 GSF meetings a year between St Giles Hospice and GP practices. Undertaking GSF meetings in this way could save more than a week of the nurses' time each year increasing the number of patients that can be supported and resulting in better attendance and representation at the GSF meetings by all involved.