

P-168 LIVING BETTER, DYING WELL – A COORDINATED APPROACH: A SPOONFUL OF CARE HELPS MANY IN OUR TOWNS

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10.1136/bmjspcare-2018-hospiceabs.193

Background The nation has an ageing population and our local demographic is approximately five years ahead of the curve in relation to this. It is projected that our 65+ population will increase by 18 000 and the 85+ population will increase by 6500 by 2039.

Aims Our new coordination centre will mean 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 are not smothered in a blanket of care and become ‘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 will range from light touch support, including access to our 24/7 support line, social programme and rapid response service, to CNS involvement. Our vision is that more people will fit in to the criteria of the former, enabling a planned approach, with patient’s wishes achieved and stress and anxiety managed.

Results Although the project is still in its infancy we have already seen significant positive outcomes from this new way of working. This includes callers able to talk to an expert no matter when they phone, call backs and checking in with people who might otherwise be missed, a heightened awareness of the number of people that will be requiring our services as we move forward and admission avoidance.

Conclusion Accepting referrals for people in the last five years of life is innovative and bold, a brave new model that we believe is necessary to meet the changing needs of our community. #therightdose.

P-169 DEVELOPING A NEW INNOVATIVE SERVICE: SUPPORTING WOMEN IN LIVING WELL WITH AND AFTER CANCER

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10.1136/bmjspcare-2018-hospiceabs.194

The initiative Living with cancer is challenging in a stretched healthcare system. Research indicates there are unmet needs affecting women with cancer due to the uniqueness of their issues (Cheng, Wong & Koh, 2016). Over a period of 12 months, St Giles Hospice, in partnership with Breast Friends have developed this new innovative service based on research and feedback. Feedback highlighted a clear need to support women who have had body changing surgery, chemotherapy, radiotherapy and continue with long term medications, which have left them with low self-esteem, self-worth and issues with their sexuality and relationships. The service offers day, evening or weekend appointments over three days.

The goals

- Improve the wellbeing of women living with cancer and the adverse effects of its treatments
- Empower women to take control and self-manage a range of problems impacting on their body image, sexuality and wellbeing

- Re-connecting relationships, enabling them to discuss their concerns relating to how cancer and its treatments may impact upon their relationship.

Why the service is unique and innovative

- Empower women to self-refer – in their own time, leading to self-management
- Time to talk openly about concerns with a nurse in a relaxed, safe, confidential and welcoming environment
- Support via ongoing sessions for not only the woman but her partner and family as required
- Easy access to other specialist services via onward referrals or signposting
- A supportive care service that other healthcare professionals can refer/signpost to.

The future Evaluation will be collated over the next 12 months by measuring the success of the intervention on confidence, motivation, anxieties and general state of mind. Questionnaires pre- and post interventions will be gathered and will enable St Giles Hospice to lead and provide evidence based practice to other healthcare professionals which will benefit further women living with cancer and the adverse effects of its treatment.

P-170 THE EAPC CORE DOMAINS FOR DEMENTIA – BENCHMARKING ADMIRAL NURSING

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10.1136/bmjspcare-2018-hospiceabs.195

There are over 850 000 people living with dementia in the UK, with numbers projected to triple by 2050. Dementia prevalence increases with age, affecting 6% of those aged 75–79 years and a third of people over the age of 95 (Knapp & Privette, 2007).

Increasing numbers of people will die with dementia and in 2015 dementia became the commonest cause of death in men and women over the age of 80 years (Office for National Statistics, 2017). Deaths due to dementia will increase to around 220,000 deaths per year by 2040 leading to an increased need for palliative care (Etkind, Bone, Gomes *et al.*, 2017). Identifying when people with dementia are reaching the end of their life can be challenging and some studies have attempted to identify prognostic indicators to guide clinicians to adopt a palliative care approach. However, these tools are more reliable at identifying people with dementia at low risk of dying rather than those at higher risk of death (van der Steen, Ooms, van der Wal *et al.*, 2005). So what does palliative care for people with dementia ‘look like’?

Definitions of palliative care share a common philosophy, which is an holistic approach, valuing autonomy of patients and families, focussing on dignity, collaborative relationships between healthcare professionals, patients and their families, good communication, and a central goal to maintain quality of life. The European Association for Palliative Care (EAPC) surveyed experts in the field using a Delphi process and published a consensus statement defining the principles of practice for palliative care in dementia (van der Steen, Radbruch, Hertogh *et al.*, 2014). Around this time Dementia UK developed its ‘hospice model’ of Admiral Nursing, of which services are growing. This paper will describe benchmarking of the

Admiral Nurse palliative care approach against the domains and recommendations as set out in the EAPC white paper.

P-171 CARING HEARTS: TRANSFORMING PALLIATIVE CARE FOR PATIENTS WITH HEART FAILURE

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10.1136/bmjspcare-2018-hospiceabs.196

Over half a million people in the UK are currently living with heart failure (Hospice UK, 2017). It is a chronic condition characterised by frequent distressing symptoms and an unsure disease trajectory. People with heart failure, and those family and friends who care for them, have a high burden of unmet palliative care needs, but have poor access to hospice services (Hospice UK, 2017).

It is recognised that providing timely and effective care for those with heart failure is challenging. 'Looking after end-stage heart failure is not rocket science. It is much more difficult. The trajectory of a rocket is predictable: the course of heart failure is not. Patients are not made of metal, and it matters what happens to them' (Johnson, Lehman & Hogg, 2015).

During 2017/2018 a large acute trust in the West Midlands, along with a palliative and end of life care provider, worked together to develop an innovative project to improve the lives of people living with heart failure. Funding was secured from St James's Place Charitable Foundation and the project commenced in January 2018.

The project aims to develop collaborative and creative approaches to delivering care and support for those with heart failure across the locality, and thus transform care for this group of patients and their families. This paper explores the approach taken (drawing on the work of Ind & Watt, 2004, regarding harnessing staff potential), discusses the key phases within the project and presents some initial findings and insights from the project. These early outcomes focus primarily on referrals, patients' experiences of care and professional development. We also reflect on the learning which can be applied to any project involving collaboration within and across professional and organisational boundaries and consider the need for such approaches given the wider challenges facing health and social care.

P-172 INTEGRATION OF PALLIATIVE CARE IN THE MANAGEMENT OF ADVANCED LIVER DISEASE

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10.1136/bmjspcare-2018-hospiceabs.197

Background Between 1970 and 2010 the mortality rate for people dying with liver disease increased by 400%. It is now the third most common cause of death in working-aged adults (18–65 years). This has resulted in a significant pressure on acute hospital services. Most patients with decompensated cirrhosis rarely receive palliative care intervention despite the significant symptom burden. It has been recognised that palliative care intervention improves symptoms, mood and quality of life in patients with advanced liver disease.

Aim To improve local access to palliative care services for patients with advanced non-malignant liver disease.

Method In early 2017 collaborative working between the hospice-based Consultant in Palliative Care and the acute hospital-based Consultant Gastroenterologist commenced. In October 2017 a combined liver clinic was commenced at the hospice with patients being reviewed by both gastroenterology and palliative care.

Results Although the monthly liver clinic is still in a very early phase our SystemOne data has demonstrated:

- Three patients with advanced non-malignant liver disease were referred for our palliative care services in the two years 2015–2016
- 15 patients with advanced non-malignant liver disease referred for our palliative care services for the two years 2017–2018 (still six months to go).

The majority of these referrals have been for outpatient clinic, however, direct referrals to the inpatient unit have increased as well.

Conclusion The increase in our referral numbers correlates with the start of our collaboration with the acute gastroenterology team. The need to improve end of life care for patients with liver disease has been recognised internationally. The huge symptom burden that these patients experience needs specialist palliative care input. We hope that our local collaboration will continue to help to address the inequality of access to our services for this group of patients.

P-173 HOSPICE VOLUNTEERS SUPPORTING THOSE WITH NEUROLOGICAL CONDITIONS AND COGNITIVE CHANGE

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10.1136/bmjspcare-2018-hospiceabs.198

The EVOLVE project was set up following a high number of referrals of patients with the dual diagnosis of MND and frontotemporal dementia. It was found that existing services did not adequately meet their needs. The EVOLVE project was made possible through funding from St James Place Charitable Foundation managed by Hospice UK to provide rehabilitative palliative care over a period of 18 months.

The project aimed to recruit and train volunteers, with a background in healthcare, to support patients with complex needs. Specially trained volunteers supported patients with a dual diagnosis of a neurological condition and cognitive change to work towards their own goals during regular home visits. At the same time these visits would provide respite for carers who were encouraged to use this time to attend to their own priorities.

Preliminary findings have shown that the calibre of volunteers recruited for the project has been very high with a high level of experience in caring. This has provided former carers with a volunteering role which they have enjoyed carrying out. Goal setting with patients proved difficult due to the cognitive changes patients experience, however, meaningful relationships were built up and social advantages were seen as significant. Carers seem to have benefitted most from this project through having an additional source of support, dedicated to their loved one's specific needs, who provided practical and emotional support. This project has enhanced client-centred care as the volunteers provided an additional support