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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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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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 SystmOne 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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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

network to the patient and their carer and were able to bridge the gap between healthcare services and families. Carers of those with neurological conditions benefitted from having a dedicated person who understands the changing needs of their loved one and can provide them with some respite from caring responsibilities. Recommendations from the final report, available from August 2018, will be included in the poster.

P-174 THE DEVELOPMENT OF AN MND CO-ORDINATOR ROLE AN EVALUATION OF THE FIRST YEAR

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The development of an MND co-ordinator role, an evaluation of the first year, the impact of the role for patients, carers and the extended multidisciplinary team.

Motor Neurone Disease (MND) is a rare neurological condition that is always fatal. It is a devastating and cruel illness, which affects seven in 100,000 people, for which there is no effective treatment. The quality of life of people living with MND can be dramatically improved through an effective model of co-ordinated care.

Farleigh is one of a handful of hospices in the UK to have a dedicated MND professional. This unique role was created to coordinate care and provide support within the community for those affected by MND within Mid Essex.

- The post-holder started October 2017, introducing patients early to the palliative MDT
- Providing a single point of contact within the community from diagnosis
- Working with patients, carers and health providers ensuring the needs for equipment, adaptations, therapy, information and support are met in a timely, cost efficient and effective way
- Patients and their families supported whilst navigating a vast array of health and social care services
- Peer support gym group for patients and carers
- Partnership working within local Hospital Trust, Regional MND Care and Research Centre, community based health and social care professionals and charitable organisations including the MND Association.

In 2016/17 there were 330 bed days attributed to those with MND in the local Acute Trust (approximately 25 patients). If we assume that the bed day cost on average is £400, then the total cost for the number of bed days occupied by MND patients in 2016/17 in Mid Essex was around £132,000. A key function of the role is to reduce reliance on secondary care input helping patients feel confident to remain in their own homes where appropriate.

P-175 THE NEUROLOGICAL HUB

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Background Living with a neurological condition greatly impacts on quality of life (Cella, Nowinski, Peterman *et al.*, 2011). 70% of respondents in the 2016 Neurology Patient Experience Survey identify that living with a neurological

condition frequently restricted engagement in activities ('Falling short: how has neurology patient experience changed since 2014?', Neurological Alliance, 2017; 'Parity of esteem for people affected by neurological conditions...', Neurological Alliance, 2017). The Neurological Alliance ('Parity of esteem for people affected by neurological conditions...', 2017) identifies significant gaps in neuropsychological and neuropsychiatric services.

Aims To develop a patient-centred, supportive 'hub' for those living with complex neurological conditions. To meet physical, mental, social, psychological and spiritual needs to enhance quality of life to live and die well.

Method Increasing demands for neurological palliative rehabilitation presented an opportunity to develop neurological services. A two-hour once a week group was piloted to develop a central 'hub' for patients and their families to access holistic support throughout the patient journey. Funded by charity.

The programme includes components that endorse self-management strategies, increase function and support wellbeing (Tiberini & Richardson, 2015). Rehabilitation for those with palliative neurological conditions focuses on a multi-disciplinary holistic approach to enhance quality of life for patients and their families (Tiberini & Richardson, 2015; National Institute for Health and Care Excellence, 2016). Therefore, group work and one-to-one therapies including mindfulness, exercise, art therapies, complementary therapies and social support are offered. Advance care planning and referrals to external supportive services are addressed.

Standardised quantitative outcome measures from The Outcome Assessment and Complexity Collaborative (Witt, Murtagh, de Wolf-Linder *et al.*, 2016) are implemented. Qualitative word clouds are also collated to illustrate benefits to patients and their families.

Results The hub has been established for ten months with an average of 17 patients plus a family member attending weekly. Word clouds identify that patients and families feel; relaxed, positive, valued, supported and inspired. In addition to finding the hub friendly, social, helpful and calm.

Conclusion The neurological hub offers unique coordinated services to the patient life journey and beyond. The intention is to create a yearly programme offering increased opportunities and knowledge to patients and families.

P-176 IMPROVING CARE COORDINATION FOR PEOPLE LIVING WITH MOTOR NEURONE DISEASE (MND) IN THE BRADFORD AREA

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Background People living with Motor Neurone Disease (MND) frequently have care delivered by a high number of professionals. In the Bradford area, it was recognised that people living with MND did not have a single point of access for care. This was felt to lead to lower quality care through poor coordination and inequity in access to services.

Aim An MND Care Coordinator was appointed at a local hospice, with the aim of establishing a single point of access for patients and families. Additionally, the role aims to increase understanding of MND amongst professionals locally and support the running of the hospice multidisciplinary team clinics.