

## 118 HOSPITAL SPECIALIST PALLIATIVE CARE AND CARDIOLOGY COLLABORATION – ‘A BREATH OF FRESH AIR’

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**Introduction** Symptom burden, including breathlessness, in patients with advanced heart failure is very severe. How best to address these needs in a hospital population is not yet fully addressed. We describe a novel approach to proactive palliative care in this population.

**Method** University Hospital Southampton has appointed a palliative care consultant with a third of his time dedicated to work proactively with the inpatient heart failure team. In the first year of the post, we have conducted a survey of the heart failure team to ascertain their confidence in management of breathlessness in advanced heart failure.

**Results** At the time of writing, we had 16 responses (6 consultant, 4 registrar and 6 clinical nurse specialist). NYHA classification was universally used for breathlessness measurement. 45% had no non-pharmacological methods for management with 50% suggesting a fan and far fewer any other methods. Oral and intravenous diuretics were widely used whilst only one said they would use subcutaneous diuretic. 70% use opioids and 45% benzodiazepines. Very few (12.5%) felt confident in management with the majority feeling ‘somewhat confident’ (50%) or ‘not so confident’ (37.5%). In answer to the question ‘when would you consider referral to palliative care and how would you do this?’ the answers ranged from ‘don’t know’ to naming the specific palliative care consultant. The main themes centred on end of life care and symptoms beyond the managing team’s confidence.

Conclusion and further work

The cardiology team demonstrates confidence in managing breathlessness in the modalities they are used to (oral or IV diuretics) but appear to lack confidence in alternative routes or non-pharmacological methods. We will take the results of this survey to proactively target teaching to the cardiology teams, to increase their confidence in breathlessness management but also to raise the profile of palliative care within this patient population.

## 119 RESULTS THROUGH RELATIONSHIPS: IMPROVING PERSONALISED CARE TOWARDS THE END OF LIFE

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**Background** In spring 2018, NHS England invited Dorset to be a demonstrator site for improving personalised care towards the end of life. Our purpose: ‘In my last year of life, help me to live well until I die’.

**Method** We seized the opportunity to take a different approach, understanding what people really needed, what mattered to them, and crucially, why. We developed six core capabilities and compared them with what actually happened, by bringing together services to map experiences of people and their families in detail, and observing interactions as they happened.

We triangulated this with quantitative data including measures of informal support; advance care planning,

investigations, treatments, admissions, length of stay, contacts with services in the last year of life, and place of death.

**Results** We identified previously hidden assumptions about the way the work worked, and themes started to emerge, such as a tendency for:

- viewing people in isolation, rather than through their relationships and context, and recording facts rather than stories;
- focusing on interventions, services and organisations rather than relationships and community;
- assessing, diagnosing and reacting to what’s happened, rather than thinking and learning together, developing shared understanding and anticipating and planning ahead.

**Conclusions** A paradigm shift is needed in the way we think about the work and the people we support. This approach highlights implicit assumptions in the way systems currently work, and provides opportunities for shared sense-making and fundamental change.

**Collaborators** Dorset CCG, Poole North, Dorset End of Life Care Partnership, NHS England

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## 120 WHO DOES SINGLEPOINT SERVE?

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All patients should have equitable access to palliative care services according to need. A service evaluation to determine who is using a 24 hour single point of access helpline.

**Background** Many palliative care services have systems to improve care co-ordination and access to palliative care and end of life support. St Helena Hospice developed a single point of access (SinglePoint), rapid response nursing service and an Electronic Palliative Care Coordination System (EPaCCS) called the ‘My Care Choices Register’.

We evaluated if this service is accessed by the population hospices traditionally serve or it widens access for those with previously unmet need.

**Aim** To assess if the demographics of service users reflect those of the population it serves and thus identify groups under utilising the service.

**Design** A service evaluation looking retrospectively at calls to SinglePoint in September 2016.

**Setting/participants:** Calls to SinglePoint in September 2016 related to 321 individuals.

**Results** 19% of calls concerned patients under 65 years old, 23% were 65–74, 35% were 75–84 and 23% were 85 or over. 54% of calls concerned female patients. 44% of calls were from Colchester district, 51% from Tendring district and 5% from Mid Essex district. 73% of calls concerned patients with a cancer diagnosis. 15% of patients were living in care homes. 49% of patients were already known to the hospice.

**Conclusion** Key groups under using the service included people with non-cancer diagnoses and those from areas of deprivation. Further work about care home residents and the elderly is needed to define why their utilisation of the service is low. Undertaking a service evaluation of this sort is helpful in guiding future efforts to target areas of unmet need.