- Link with voluntary services in local communities – e.g. Age UK, Macmillan Cancer Information.

Conclusion Consideration of role to support Primary Carer Networks and facilitate earlier discussions for people affected by a life limiting diagnosis.

P-180 IDENTIFYING 'WHAT MATTERS?': AN ACT-BASED GROUP PROGRAMME FOR PEOPLE WITH CANCER

¹Angie Arnold, ¹Jo Poyner, ¹Rhiannon Lewis, ²Diane Playford, ²Carolyn Gordon, ²Georgina Slatter. ¹The Shakespeare Hospice, Stratford upon Avon, UK; ²South Warwickshire Foundation Trust, Warwick, UK

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Cancer and its treatment brings many challenges for patients and their families, not least physical and psychological recovery, and a return to work and/or activities of daily living (reintegration). Whilst developments in cancer treatment and a rise in survival rates has led to increased chances of people returning to work or other vocational/occupational activities, people with cancer continue to live with the long-term effects of the disease and/or its treatment. As a result, survivors may require some support to return to a more active life post-treatment, and evidence suggests that multi-disciplinary programmes, informed by CBT and Third Wave approaches are an appropriate intervention in this respect.

The poster will describe a collaborative project, undertaken by hospice and NHS services, which aimed to develop an ACT-based group programme. The poster will briefly outline the background to, and rationale for, the project before describing the development of a six-week programme, informed by Acceptance and Commitment Therapy (ACT). The group protocol was designed to support participants' identification of their core values, which some felt had been compromised because of cancer and treatment.

Subsequent content and activities enabled participants to take up, or return to, significant activities that were in line with, or a 'step towards', their values. The programme was delivered on three occasions to small groups and in total ten participants, referred from both hospice and NHS settings completed the full programme. Participant feedback and facilitators' reflections on the programme suggest it was a supportive process, leading to an increase in functioning and sense of self-efficacy and a small data set is available which supports this. The results of the group evaluation will be discussed, and recommendations and conclusions made.

P-181 DEMENTIA TOGETHER – A LOCAL SERVICE EVALUATION

¹Ruth Strudwick, ¹Katie Tyrell, ¹Andreea Tocca, ²Jo Marshall, ²Alana Page, ²Sharon Barber. ¹University of Suffolk, Ipswich, UK; ²Sue Ryder, Ipswich, UK

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Background The Dementia Together Service was launched in April 2017 and by the end of December 2018 had registered and supported 2,202 people - both people living with dementia and their carers living across Suffolk. The service consists of a helpline and staff who visit people living with dementia and their carers, providing support and signposting them to other services.

Aim The service is led by Sue Ryder working with a number of local organisations in service delivery. Despite a comprehensive range of services across Suffolk, people living with dementia were overwhelmed by varying offers which disabled them from accessing the most appropriate services to meet their needs.

Methods A service evaluation was undertaken, based on the views of people living with dementia, their carers, Dementia Together staff and external stakeholders. Questionnaires and focus groups were utilised to obtain both quantitative and qualitative data. Purposive sampling was utilised for the focus groups with people living with dementia and carers, and all staff were included in their focus group. Data from all methods were analysed and triangulated.

Results During Phase 1 of the evaluation, 133 questionnaire responses were gathered from people living with dementia, their carers, Dementia Together staff and external stakeholders. Focus groups were carried out with 18 people living with dementia, carers and navigators.

In phase 2, further focus groups with 20 people living with dementia, carers and navigators were conducted along with three case study interviews ($n=3$) and telephone/email interviews with eight stakeholders. Existing data from meetings and other reports were also analysed.

Conclusions The Dementia Together service has made a significant positive difference to people living with dementia, their families and carers across Suffolk.

P-182 DEVELOPING A SUSTAINABLE MODEL OF CARE FOR PATIENTS WITH END-STAGE HEART FAILURE

¹Wendy Sturt, ¹Gill Horne, ²Jo Sykes, ²Tim Chester. ¹Rowcroft Hospice, Torquay, UK; ²Torbay and South Devon NHS Foundation Trust, Torbay, UK

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Aims and objectives This 18-month project aimed to enhance the opportunities for patients with end-stage heart failure (HF) and families to benefit from hospice and supportive care services to help them plan and experience better end-of-life care.

Method The HF service, care of older people, primary care, hospital palliative care, patients and families and hospice representatives, worked alongside a project lead designing a model of care and pathway for people with end-stage HF. A new Supportive and Palliative Care in Heart Failure MDT was established, providing an interdisciplinary forum for identification of those at the end-of-life, and aiding referral to specialist palliative care services. A patient information leaflet was designed and printed. Education was also provided for the HF Team on palliative/end-of-life care and end-stage HF management for the specialist palliative care services.

Outcomes/impact There is now an established pathway for patients, improved understanding and communications between the HF and specialist palliative care teams. The MDT meeting is held twice monthly and specialist palliative care referrals have more than doubled during the project. Patients and their families have access to core information about hospice and other end-of-life care services in their locality. Documentation audits of advance care planning discussion demonstrate that 64% of patients reviewed at the MDT had discussions about their wishes. However, more

work is required as less than half of the patients had entries on the Electronic Palliative Care Coordination System and only 6% had documented evidence of their wishes. Feedback - such as *'All care and treatment have been excellent.'* (Patient) and *'Much better links between heart failure team and palliative care team with great benefits for patients'* (Staff) - indicates that this collaborative project has been a positive experience, enabling more patients and families to access hospice and other end-of-life care services in their locality.

P-183 ADDRESSING INEQUALITY IN PALLIATIVE CARE PROVISION IN HEART FAILURE

¹Karen Chumbley, ¹Beata Kasznicka, ¹Sue O'Neill, ²Wendy West, ²Ness Andrews. ¹St Helena, Colchester, UK; ²Anglian Community Enterprise, Colchester, UK

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Background There is an urgent need to address the inequality in palliative care provision for people living with heart failure.

North East Essex has a changing demographic, with a predicted 25% increase in the population over 76 years old (Joint Strategic Needs Assessment North East Essex, 2013). Heart failure is a common life limiting condition affecting more than 10% of those over 75 years (Mosterd, Hoes, de Bruyne, Deckers *et al.*, 1999). Therefore the number of people living with heart failure in our community is likely to rise significantly. People with heart failure are under-represented on palliative care registers (Gadoud, Kane, Macleod, Ansell *et al.*, 2014). Only 4% of referrals to St Helena in 2016/17 were for people with heart failure.

Aim To begin to address the inequity of palliative care provision to local people living with advanced heart failure by: increasing referrals to the hospice for people with heart failure; improving access to the local electronic palliative care coordination system (EPaCCS); delivering a coordinated approach between community heart failure services and the hospice and improving knowledge of palliative care in heart failure across both services.

Method We allocated medical time to heart failure service coordination and created a day centre group specifically for people with heart failure. We created a heart failure link nurse role and hosted shared education events on heart failure and palliative care between the hospital, community and hospice services. We developed an inpatient diuresis protocol and audit and created a heart failure and advance care planning animation.

Results Referrals to the hospice increased from 86 to 142 per year, the number of people with heart disease on EPaCCs increased from 136 to 323 and the number of inpatient admissions for people with heart failure increased from 11 to 21.

Conclusion A collaborative focus on a population with a specific diagnosis can begin to address inequality in palliative care provision.

P-184 INITIATING A HOSPICE INPATIENT DIURESIS SERVICE

Beata Kasznicka, Karen Chumbley, Emma Tempest. St Helena, Colchester, UK

10.1136/bmjspcare-2019-HUKNC.206

Background Heart failure is a progressive, highly symptomatic condition (McIlvennan & Allen, 2016), characterised by weakening of the heart muscle, resulting in the inability to maintain an adequate cardiac output. The impact of heart failure is significant with both patients and families requiring much support. One of the typical symptoms is peripheral and pulmonary oedema, which has huge impact on quality of life. This can be managed via parenteral administration of diuretics.

The need for a service offering diuresis in a non-acute setting was identified via multidisciplinary team meetings involving the hospice and the community heart failure team.

Aim To create a safe and effective diuresis service within the hospice inpatient unit for people with advanced heart failure.

Method The diuresis service was commenced after reviewing current literature and exploring already established services. We developed a policy and procedure for the administration of subcutaneous Furosemide within the hospice setting. This was then reviewed by the medical and nursing team within the hospice to ensure it was both safe and feasible.

Results Since the inception of this service in July 2018, St Helena has offered diuresis to 19 patients. An audit showed that we are following our guideline.

Conclusion It is feasible to establish a diuresis service using the administration of subcutaneous Furosemide in a hospice setting. The introduction of this hospice-led service has extended the possibility of diuresis for patients who are not fit for hospital admission and offered the choice of place of care for patients diagnosed with advanced heart failure. The next step is to evaluate the input of this service on patients' symptoms and quality of life.

P-185 INTEGRATED PALLIATIVE HEART FAILURE SERVICE PILOT

Alison Bacon. St Catherine's Hospice, Preston, UK

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Background Patients with heart failure are as likely to be symptomatic with advance care planning needs, however, on average make up only 4% of hospice and palliative care teams' caseload. An application for a grant for a pilot service was made to St James's Place Charitable Foundation.

Aims

- To provide integrated assessments of patients with a primary diagnosis of heart failure who were felt to be in the last year of life;
- Focus on advance care planning and symptom management;
- Provide clinical education on heart failure and palliative care.

Method Through meetings with relevant staff including hospice, local community and hospital NHS Trusts, we developed a service plan, referral criteria-protocol for a targeted, joint (palliative care physician and Heart Failure Clinical Nurse Specialist) intervention with appropriate onward referral and a 'Palliative Care in Heart Failure' conference.

Results The clinical service ran for 13 months: 41 referrals and completed 35 first assessments. 77% were seen at home (home or nursing/residential home) reflecting the poor functional status of many of these patients. 86% of patients had medication changes made at the first assessment. Of the patients seen 85% had a Preferred Place of Care/Preferred