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

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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

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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

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10.1136/bmjspcare-2019-HUKNC.207

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

Place of Death recorded following assessment and 65% achieved this. Further qualitative evaluation by a local university will provide more detailed information regarding benefit.

The 'Palliative Care in Heart Failure' conference was held on 15 November 2018 with 51 attendees. There were speakers on a range of relevant topics (including external experts) and 98% of attendees rated it highly.

Conclusion This pilot has increased the number of patients with heart failure accessing hospice services, and by raising awareness of the needs of these patients will continue to do so.

P-186 EVOLUTION – ADAPTING A FATIGUE AND BREATHLESSNESS COURSE FOR HEART FAILURE PATIENTS IN THE COMMUNITY

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Background and aim As part of a project to 'bridge the gap' between cardiology and palliative services for heart failure patients. The Living Well services in two partner hospices collaborated to design and deliver a heart failure specific fatigue and breathlessness course, aiming to educate patients to manage symptoms and improve quality of life through earlier engagement with hospice services. Led by two physiotherapists and supported by a Heart Failure Nurse Specialist, the course consisted of weekly tailored exercise (Taylor, 2019; NICE (NG106), 2018) an informative education session, relaxation and directed peer support.

Methods The course was modelled on the original Fatigue and Breathlessness courses (FAB) run at the hospices with exercises and education specifically modified for patients with heart failure. Education sessions addressed goal-setting and self-management, fatigue, breathlessness, eating, exercise, relaxation, advance care planning and living with heart failure. Attendees completed an IPOS assessment pre- and post- course as well as a Views on Care questionnaire. Therefore, quantitative and qualitative data was collected.

Results There were 25 referrals to the courses, 16 patients attended. There was an increase in the overall rating of quality of life post-attendance. 100% of respondents reported that the course gave them 'a lot of benefit' or 'some benefit'.

Qualitative data: what aspects of the course went well?

- Exercise circuit, good company
- Social side of the course. Learning breathing techniques
- Exercise information and meeting similar people
- Everything
- Exercise
- All of them.

Conclusions After attending the course, patients were equipped with the knowledge to manage their symptoms better. The patients reported enjoying the exercise and interaction with others. They now had the skills and confidence to exercise in the community and at home. At the end of the course many of the patients participated in further exercise and relaxation sessions within the hospices and the wider community.

P-187 A REVOLUTION IN THE CARE OF HEART FAILURE PATIENTS

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10.1136/bmjspcare-2019-HUKNC.209

Background Nearly a million people in the UK live with heart failure (HF) (Hospice UK, 2017). 30–40% of patients die within a year of diagnosis, yet despite a high symptom burden they make up only around 4% of those receiving specialist palliative care services (Hospice UK, 2017).

Two hospices working collaboratively received a grant from Hospice UK to bridge the gap between their care and the local NHS hospital trust cardiology team.

Aims To improve care for heart failure patients by:

- Providing a joined-up service for HF patients
- Developing a regional HF referral pathway
- Increasing hospice referrals
- Upskilling and educating the cardiology, specialist palliative care (SPC) and community healthcare teams
- Providing fatigue and breathlessness (FAB) courses.

Actions A consultant from one hospice and CNSs from the other hospice attended weekly hospital HF clinics and monthly multidisciplinary team meetings.

Hospices ran off-site, HF specific FAB courses.

A regional referral pathway between cardiology and SPC was developed.

Hospices held educational events for GPs and community healthcare professionals on HF management and palliation.

Outcomes Development of strong links between cardiology and SPC, increasing collaboration and knowledge within SPC and cardiology teams about the others roles.

HF referrals to the hospices doubled, with twice the national average of HF patients receiving hospice care. Patients accessed increased palliative support, holistic symptom management, advance care planning and family support.

Patient reported improvements in breathlessness, fatigue, weakness and quality of life following HF FAB courses.

Excellent feedback following community healthcare professionals' HF management and palliation education events.

Conclusion This collaborative project revolutionised the ongoing ability of cardiology and SPC to jointly manage HF patients' palliative care needs, resulting in a doubling in hospice referrals for HF patients. SPC support, including hospice referral and FAB courses, reduced HF patients' reported symptom burden. Community professionals' knowledge of the importance of SPC for HF patients was increased, supported by a comprehensive new referral pathway.

P-188 IMPROVING ACCESS TO HOSPICE ENABLED CARE FOR HEART FAILURE PATIENTS – A SERVICE EVALUATION

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In November 2017, following a successful application to St James's Place Charitable Foundation for funding, Nightingale House Hospice in partnership with Betsi Cadwaladr University Health Board, commenced an 18 month project to integrate