

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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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

heart failure patients within the specialist palliative care services at the hospice.

The service had six core aims:

1. To establish a heart failure clinic at the hospice;
2. To develop a heart failure monthly meeting focusing on reablement and including planned sessions on fatigue management, breathlessness management etc;
3. To develop a new service planning focus group of heart failure patients and carers co-designing and co-producing future services to meet their identified needs;
4. To support the heart failure team to develop and run a heart failure multi-disciplinary team meeting in partnership with palliative care colleagues;
5. To further develop peer learning between heart failure specialist and specialist palliative care teams;
6. To establish a conversational training programme for primary and secondary health care colleagues focusing on advance care planning and prognostication in heart failure.

The project achieved five of our six objectives during the 18 month period. In addition it produced resources as a legacy to the project including patient designed leaflets for individuals being referred to the hospice, patient designed leaflets for their family and carers about allowing them to try things independently even if it takes longer to complete a task and a DVD on mastering breathlessness.

Both quantitative and qualitative data demonstrated positive outcomes, which have resulted in substantive funding from the hospice to continue the service.

The project team were invited to present the work orally at the 9th Annual Heart Failure Conference in Glasgow in March 2019, generating national interest in this partnership working.

P-189 DOES CHANGE ACTUALLY MEAN CHANGE? HOW DID A NON-PALLIATIVE SERVICE REVIEW INFLUENCE AND BENEFIT THE PALLIATIVE LYMPHOEDEMA SERVICE?

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In January 2018 Dorothy House Hospice Care commenced a service cost project to establish baseline figures and activity that would influence the future negotiations with the Non-Palliative Lymphoedema service. This exercise highlighted that the non-palliative service was not cost effective and was ineffective in being responsive to new referrals and follow-ups.

Due to ineffective diary management, lack of clinics and lack of time to engage with external referrers both the Non Palliative and Palliative Service were affected and response to referrals were poor.

Benefits of service review

- Opportunity to fully cost out a non-palliative service and ensure the service model is cost effective and ensure transparency with contracting and costings;
- Opportunity to redesign services to enable quality improvement to be part of continuous improvement of services;
- Opportunity to integrate Palliative and Non Palliative Services together to utilise fully the skills of the wider team;

- Provide a more responsive and consultative model of care to palliative patients.

Issues

- Conflict of historic model of care and changing processes within provider and commissioning service;
- Withdrawal of non-palliative contract meant reduction in team numbers and staff consultation proceeded;
- Historic expectations of hospice providing services based on thought and not need;
- Conflict about care provision to palliative vs non-palliative patients;
- Loss of experienced staff;
- Lack of non-palliative contract knowledge by external team members created uncertainty within core palliative services.

The future Through valuation and redesign/cost modelling of the non-palliative contract we have been able to fully cost out and design a service that is responsive, safe and provides quality care in a holistic manner. Through remodelling of the service we have been able to create additional time to support existing staff within the hospice to understand palliative lymphoedema and provide support and guidance to the patients etc. based on the lymphoedema service.

P-190 IMPLEMENTING A BESPOKE AND DEDICATED TRIAGE PROCESS FOR REFERRALS TO A HOSPICE LYMPHOEDEMA CLINIC

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Aim To improve the patient experience for anyone diagnosed with cancer or a life limiting illness who has been referred to the hospice for lymphoedema treatment.

To provide a more personalised, responsive service, allowing patients a more appropriate appointment in their preferred clinic location to reassure them and provide education at an earlier time point.

Description The team developed a bespoke triage process and improved the patient experience by mapping the existing lymphoedema service referral process and developing clear aims, objectives and key performance indicators.

A new process and criteria was designed, tested, implemented and evaluated with the aim of improving the response of the first contact. We provide patients with an earlier opportunity to access other hospice services to improve their whole experience.

All referrals are triaged by a lymphoedema specialist by telephone within one week of receiving the referral and a bespoke template is then used to identify the level of need and to determine the priority of care required.

Evaluation The results have shown this change in service delivery has dramatically improved the process of referrals and has had a positive benefit to the patient and carer experience by addressing all forms of physical and emotional distress as demonstrated in our Service Quality Health Survey.

This has reduced the number of inappropriate referrals and the team has been able to signpost patients to other hospice services in a more timely way, thereby reducing waiting time, multiple telephone contacts and unnecessary visits and enabling a more personalised and responsive service.