

Methods Support was offered by telephone, face-to-face home visits, in virtual groups or more recently in outpatients. Registered nurses and palliative care support workers hold their own caseloads. The service has provided advice and education for patients and families, enabled access to MDT, reduced social isolation, built relationships and introduced patients to hospice. STAR evolved using patient feedback and review of future model will include stakeholder engagement, cost effectiveness, activity levels, the broader community model and government guidelines.

Results Day hospice attendances, prior to the pandemic were, on average, 128 per month (2019-20) in contrast to 216 patient contacts per month 2020-21. With the same staffing model this provided a reduction in gross costs of over £30 per patient (Scheme 1 £101.16 vs Scheme 2 £70.32). Patient feedback is excellent – one patient stating ‘STAR has been a lifeline in difficult circumstances when people needed to shield and were very isolated’.

Conclusions STAR has provided much needed support during a difficult period. Work is ongoing on the final community model at hospice although, through work so far, we know video training is as effective as face-to-face, patient satisfaction is high and the service is liked by the whole team but lack of peer support/social engagement is missed by patients and use of technology is a barrier for some.

P-89 THE SURPRISINGLY POSITIVE OUTCOMES FOLLOWING THE COVID-19 RESPONSE WITHIN DAY HOSPICE

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10.1136/spcare-2021-Hospice.107

Background Day hospices, along with most other healthcare services changed dramatically in response to the COVID-19 pandemic, this included halting face-to-face services, stopping traditional day hospice models and in this case being left wondering what their role within the provision of specialist palliative care was. There was a period of grieving for what was seen as the loss of the day hospice service by staff members, colleagues, patients and their families. Despite the challenges, there have been some very positive outcomes from these enforced changes.

Aim The discontinuation of face-to-face contact within a traditional day hospice model enabled teams to evaluate their roles and services, leaving a blank canvas to allow development of more accessible and responsive services to meet changing needs during and after COVID-19.

Method The break in service allowed time for obtaining feedback from all users of the day hospice including patients, carers and professionals, enabling the development of user-led systems, processes and services.

Development and growth Feedback enabled the team to develop pilot programmes aimed to help meet the needs of service users. The pilots were then tested using the PDSA cycle, ensuring robust evaluation processes were embedded within each.

Results Pilots included the development of virtual services, a community hub, and MDT outpatient suite. These pilots are currently being evaluated and results pending.

Outcomes

- The opportunity to reflect and re-evaluate service aims.

- A flexible, empowered, and confident team.
- Developing an accessible, user-led specialist palliative care service using a quality improvement approach.
- Robust evaluations in place to measure the impact of pilot services.

P-90 TRANSFORMATION OF THE LIVING WELL SERVICE

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10.1136/spcare-2021-Hospice.108

Background In one week the Living Well team completely changed the way they worked with patients and carers, from face-to-face to virtual support working from home (except essential home visits and essential reviews on the inpatient unit). Individual roles were adapted to meet the needs of patients and support of other hospice departments.

Aim(s)

- The Living Well stepped model of care needed to continue to meet the needs of the patients and carers.
- To provide choice and empower patients to manage their own illness.

Methods

- 8 – 12 weeks virtual therapeutic programme via video or telephone call
- Virtual outpatient clinics via video call or telephone call.
- A wide range of therapeutic Living Well zoom courses including Men's Space, adapted Tai Chi, breathlessness, fatigue management.
- A wide range of drop-in groups via Zoom including nature therapy, art club and relaxation.
- 10 weeks empowerment webinar series including sleep hygiene, journaling, and self-care through bereavement.
- All patients had access to the Living Well virtual services leaflet and website resource page.

Results Attendances increased by 173% to 2,209 comprising; Therapeutic programme 442, Living well 413, clinics 677, Social/information groups 677.

Conclusions We will offer a hybrid model of care (virtual and face-to-face) going forward, utilising the new space ‘The Green’. This will enable the living well team to offer more choice and flexibility to patients and carers and empower patients, at any stage of their illness, to live well.

P-91 POST COVID-19 COLLABORATIVE APPROACH TO SERVICE ADAPTATION BY THERAPY AND COMMUNITY DEVELOPMENT TEAMS

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10.1136/spcare-2021-Hospice.109

Background Our service supports patients and carers to manage the challenges of living with a life-limiting condition; helps maintain independence and enhance quality of life, and gives patients the confidence to live as well as possible. Prior to COVID-19, we offered one-to-one therapy assessments, personalised programmes, group therapies and open-ended general wellbeing activities; our Compassionate Neighbours