

Abstract P-52 Figure 1 Results

		Totals	Total Referrals	% Admitted	Bed Occupancy	Length of Stay (days)	Throughput
2018/19	Admitted	165	236	69.9%	81.2%	16.77	1.4
	Not-admitted	71					
2019/20	Admitted	156	246	63.4%	84.6%	19.4	1.3
	Not-admitted	90					
2020/21	Admitted	195	240	81.3%	80.5%	21.3	1.1
	Not-admitted	45					

Conclusion Despite increasing bed capacity in April 2020 (10-18 beds) until July 2020 and remained at 14-15 beds until June 2021, the number of referrals to IPU remained the same. Due to increased capacity, more patients were admitted (81.3%) which supported the theory that IPU should permanently increase bed capacity. However, length of stay for the last 3 years is above national average (15 days) (Hospice UK, 2016) and throughput below national average (1.5). Case reviews are required for patients with a prolonged length of stay to evaluate the effectiveness of discharge planning, management plans and patient/carer expectations. Before considering increasing in-patient capacity, effective case management needs to be established minimising length of stay and maximising throughput to ensure that all patients referred to the IPU have equitable access to care (National Palliative and End of Life Care Partnership, 2021).

Innovation Evaluation of the implementation of nurse-led end of life beds within an established hospice in-patient unit to meet unmet need within the East Lancashire locality.

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ARE THERE DIFFERENCES BETWEEN ADMISSIONS TO A HOSPICE IN-PATIENT UNIT BETWEEN PEOPLE WITH MALIGNANT AND NON-MALIGNANT DISEASE?

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Background Non-malignant disease accounts for approximately 3 in 4 deaths in England and Wales (Office for National Statistics, 2021) yet hospice care continues to be skewed in favour of supporting people with malignant disease (Hospice UK, 2021). The Health Select Committee report (2004) identified a lack of palliative care provision for people with non-malignant disease as a major inequity, with fewer than 10% of hospice beds being devoted to non-malignant disease. Different disease trajectories and patient/carer expectations were identified as perceived barriers to increasing this proportion.

Griffin and Conway (2008. *Int J Palliat Nurs.* 14:616) compared non-malignant and malignant admissions to a Scottish hospice between 2003 and 2006 found no significant difference between length of stay, reason for admission and outcome. Despite this, malignant disease continues to be over-represented in hospice referrals and admissions for end-of-life care (Tobin, Rogers, Winterburn, et al., 2021. *BMJ Support Palliat Care.*). Despite the audit published by Griffin and Conway (2008) suggesting there is no difference in length of stay, our recent experience has led us to question whether this is the case in our hospice.

Aim(s) The primary aim is to compare in-patient admissions for malignant and non-malignant disease, focusing on a) length of inpatient stay, b) primary reason for admission, and c) outcome of admission. The secondary aim is to identify causes of discharge delays, and whether this differs between malignant and non-malignant disease.

Methods A retrospective audit from April 2022, of the most recent 30 consecutive patients in each disease group (malignant vs non-malignant primary diagnosis) to the in-patient unit of a hospice in England. Primary diagnosis defined as the life-limiting condition which demanded the most resources during the patient's stay. Data collected from electronic hospice records.

Results We hope that our anticipated results will provide insight into whether these groups differ in their admission lengths and outcomes to help us understand some of the challenges of providing in-patient palliative care in non-malignant disease.

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USE OF STRUCTURED CASE REVIEW TO IMPROVE CARE USING INFORMATION FROM PATIENTS WHO DIE BEFORE ASSESSMENT

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In the NHS structured judgement case note reviews have been used to assess the quality of a variety of hospital based care processes and are now widely used for mortality reviews (Royal College of Physicians, National Mortality Case Record Review Programme).

At Trinity, we wanted to use information from our mortality data across different areas of the hospice to maximise any learning and potential improvement for patients and their loved ones. As a starting point we decided to consider all patients who had been referred to our community services but who had died before being seen. Our approach involves monthly meetings of the same team members who consider each case in detail using a structured approach.

Specific stages of the referral process are reviewed including:

- Referral form (including urgency).
- Communication with referrer.
- Communication with patient +/- family +/- care home staff.
- Triage.
- First contact (including time to contact).
- Communication around death.

For each phase a score is given from 1-5 as below (if the phase is not applicable to the case it is given the score 0).

1. Very poor.
2. Poor.
3. Adequate.
4. Good.
5. Excellent.

Comments are also logged for each case if it is felt that anything could have been done differently.

From the analysis of individual cases we have already found several areas where small changes in practice have led to improvements for patients and their families including:

- Bereavement calls to the loved ones of all those referred not only those who have been seen.
- Changes to how we support nursing homes to ensure immediate support is provided for patients.
- More efficient processes for different members of the workforce.
- Not delaying patient contact whilst waiting for additional clinical information from referrers.

It is hoped that we will be able to continue this work in other areas of the hospice.

P-55 FOR WHAT IT'S WORTH – REVIEWING WELFARE SERVICE DATA

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Background Accessing benefits for the terminally ill has been a controversial topic in recent years (Marie Curie, 2022; Marie Curie, 2019). Our Welfare Service helps hospice patients, families, and carers with their benefit entitlements. Combining the technical expertise of a colleague with support from volunteers, enables us to help more patients. COVID-19 restrictions forced us to change our way of working, giving us the opportunity to review the collection and use of our data.

Aims

- Review paper-based processes of collecting and sharing data.
- Show that terminally ill patients are often entitled to more than just Attendance Allowance or Personal Independence Payment.
- Improve outcome reports to executive and multi-disciplinary teams.
- Bolster our message to sponsors and supporters.

Method

- Identify which data are important for measuring the impact of the service.
- Make use of technology to improve the quantity and quality of the data we capture.
- Develop shared spreadsheets and electronic files so that referrals are not missed or delayed.
- Change data capture to current financial year instead of on file closure.
- Create calculations of average life expectancy to demonstrate monetary value of benefits accessed.

Results The Welfare Service now provides data on:

- Referrals: annual/monthly/quarterly; by source; and by age.

- Statistics in real-time.
- Analyse benefits entitlements, showing we helped more patients during COVID-19 restrictions, with a value of £28104.00 in 2021/22.

Demonstrate successes including

- Outstanding benefit payment to patient of £7230.00, and ongoing award of £62.00pw due to a DWP error.
- £792.00 pw for a couple who had spent their savings on rent and were threatened with eviction.

Conclusion Our new normal is an improvement. Research shows that terminal illness is detrimental to health and wealth. Specialist welfare advice is an important part of end-of-life care, making a difference to patients' wellbeing. Our Welfare Service supplements existing healthcare provision to holistically improve patient outcomes.

P-56 ESTABLISHING A RESEARCH PROGRAMME IN AN INDEPENDENT HOSPICE

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Background Integrating research into the work of a hospice 'enables good quality care to be provided, described, evaluated and shared' (Hospice UK. Research and outcomes. [Internet]). Independent hospices act outside usual NHS research processes but remain subject to HRA stipulations (Health Research Authority, 2018). We report the establishment of a research programme in an independent hospice.

Aims To describe the process of developing and integrating a research programme in an independent hospice in the North of England.

Methods Over a five-year period, the hospice appointed a research lead, developed a research strategy, formed a research committee with board representation and established a governance process which reflects HRA requirements. Alongside these processes, the research lead captured existing research activity and outputs in a register, formed relationships with local and regional academic units, engaged with external studies and obtained funding for stand-alone projects.

Results Since beginning this programme, the hospice has a portfolio of research including 16 external studies we have supported as a recruitment site, ranging from small staff surveys/interviews to studies of patients/service users. We have also developed and led three studies, whilst the research lead has been a co-applicant on a further two. Hospice staff have published 11 papers in peer-reviewed journals and have generated 14 other outputs including dissertations, posters and oral presentations. The research lead is an active member of a University research group. Looking to future ambitions, we are planning on hosting a conference and are developing a 'flagship' project for submission to NIHR.

Conclusion The integration of research into hospice culture requires engagement at all levels of the organisation. Capturing existing activity, engaging with external research projects, forming relationships with academic centres and establishing governance procedures are important first steps. These processes form the foundation for an independent hospice to generate research and source external funding.