

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.