Men's Sheds can be successful in the hospice context or how they can benefit members.
Aim The aim of this project was to identify features for the success of a hospice-based Men's Shed group and use this learning to contribute to the development of further Men Shed groups across other hospices.
Method Non-participant observations and semi-structured interviews were undertaken with 12 members/stakeholders of a Men's Shed. Thematic analysis was used to identify key factors affecting success. A Delphi approach involving key stakeholders was used to develop draft recommendations for expanding the service to other hospices. These were then piloted at a second hospice and lessons learnt used to provide final recommendations.
Findings This study identified three key benefit themes: A space for emotional support, practical activities, and social opportunities. We also found that factors affecting the success of the Men's Shed, included: clear governance structures, a connection with the hospice, a dedicated physical space for the group, a supportive space, and having volunteers to lead the group who had experienced loss. The health benefits of attending gender specific support were described by participants as improving their physical, psychological, spiritual and social health.
Conclusion Shared experiences in hospice and palliative care environment were crucial for Men's Shed members to develop supportive and confiding relationships. Participants described the Men's Shed as an "*essential part of the bereavement service*".
Recommendations The study developed recommendations, successfully piloted at a second site. These were written up as part of a 'toolkit for setting up a Men's Shed'.

P-59 RE-IMAGINING THE HOSPICE INPATIENT UNIT THROUGH INTEGRATION OF SERVICES, LEADERSHIP RE-STRUCTURE AND USE OF PHYSICAL SPACE

Sarah Burns, Angela Harrison, Laura Chapman, Lucy Williams, Sarah Stanley. *Marie Curie Hospice, Liverpool, Liverpool, UK*

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Background Evidence suggests that the needs of palliative care service users are changing (van Langen-Datta, Driscoll, Fleming, et al. Compromised connections: The impact and implications of COVID-19 on hospice care in the West Midlands and nationally. 2022). The COVID-19 pandemic has seen many hospices reduce their inpatient capacity and find innovative ways of using telehealth to manage palliative patients in the community (Etkind, Bone, Lovell, et al. J Pain Symptom Manage. 2020; 60(1): e31-e40). We re-designed our hospice inpatient unit space to reflect these changing needs.
Aims Our aims were to re-design our hospice inpatient unit (IPU) to improve palliative care services for both hospice inpatients and those in the community.
Methods We took a multi-professional innovative approach to reviewing how leadership re-structure and integration of teams could help us to re-design our hospice inpatient unit by:

1. Developing a flexible staffing model in which the nurse manager oversees both IPU and day services, promoting an integration of these services. An increased number of Band 6 roles were created to promote nurse-led services within the IPU and to provide senior support for junior staff across all shifts.
2. Reducing admissions by offering medical or nurse-led outpatient clinics for patients requiring symptom management and ambulatory services, for example paracentesis or blood transfusion.
3. Re-designing our IPU space to incorporate day patient beds, a nurse-led clinic room, paracentesis room, family area, children's bereavement room and research hub.

Results The results have been positive for both patients and staff, and space is being well utilised. Patients are experiencing a more streamlined flow of care through hospice services and can access treatment as a day case, outpatient or experience a shorter admission. Nursing staff have reported feeling more valued and recognised in their specialist roles which has led to staff career progression, leading to increased retention and recruitment.
Conclusions By re-imagining services within the hospice space, and up-skilling staff, we believe that patients have quicker access to palliative care services and inappropriate IPU admissions are prevented.

P-60 DOES THE ADVANCED NURSE PRACTITIONER ENHANCE THE MEDICAL SERVICE IN THE IN-PATIENT UNIT OF A HOSPICE?

Janet Bilton, Emma Frampton, Alison Llewellyn. *Dorothy House Hospice, Bath, UK*

10.1136/spcare-2023-HUNC.81

Background The medical services at Dorothy House Hospice were reconfigured with an aim to extend the medical capacity in the community. Two Advanced Nurse Practitioners (ANPs) were recruited to the inpatient unit. Full integration of ANPs into a medical team was innovative and it was important to evaluate this new service.
Aim(s) To evaluate the impact ANPs have had on the service. To understand from a multidisciplinary team (MDT) perspective the impact. To evaluate whether the introduction of the role has improved patient access to the inpatient unit.
Methods Qualitative methodology using in-depth interviews (eight in total) were conducted to a purposeful sample of a cross-section of the hospice MDT. Thematic analysis was used to analyse the data and identify themes for further discussion. Comparative data analysed activity in and times of admissions.
Results The ANP role has overwhelmingly been considered a success throughout the MDT. Key themes were identified following thematic analysis. The role was perceived to enhance team working across all teams, and in particular the medical team. There is evidence that the ANP role has increased flexibility for admissions. One area identified by several interviewees was the need to enable the ANP role to certify death in the future.
Conclusions The ANP role has enhanced the medical service in the inpatient unit of the hospice. This study provided evidence to base further integration of nurses using advanced skills to be recruited into the hospice and to be clinically supported and supervised by senior medical colleagues. The predicted national increase of people with complex multicomorbidities and the anticipated rise in the death rate will add to the existing strain on medical services. Nurses with

advanced clinical practice skills can be part of a wider clinical solution.

P-61 ADVANCED LIVER DISEASE – WORKING COLLABORATIVELY TO IMPROVE PATIENT CARE

[1,2]Nikki Reed, [2]Nikita Salmon, [2]Alison Wickham, [1,2]Claire Ferguson, [2]Alexandra Daley. *[1]Marie Curie Hospice West Midlands, Solihull, UK; [2]University Hospitals of Birmingham NHS Trust, Birmingham, UK*

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Background Advanced liver disease is the second leading cause of premature mortality. With high symptom burden, frequent hospital admissions and poor quality of life, this patient cohort has substantial palliative care needs. Early provision of palliative care can lead to improvements in physical and psychological symptom burden and reduced health-care use. Prior to March 2020 a joint (Palliative Care/Gastroenterology) monthly advanced liver clinic existed at our hospice.

Aim To provide early specialist palliative care (SPC) intervention for patients with advanced liver disease.

Method The pandemic forced a natural temporary closure of this face-to-face clinic. Review of data from this clinic demonstrated: Late referral to the SPC team; High non-attendance rates; Lack of flexibility regarding SPC clinical review. This led to the need for a different approach to support this patient cohort. Between 2020–2022 direct referrals to the SPC community medical team increased and specialist liaison was supported by the new IT developments that we all witnessed in the pandemic. In 2023 an advanced liver disease MDT was established between the hospital-based gastroenterology team and the SPC team at the hospice. Currently bi-weekly virtual meetings discuss new referrals to SPC, obtain patient management advice from the specialist colleagues and update on shared-care patients.

Results This service development has so far:

1. Facilitated regular meetings and additional liaison between the two specialties.
2. Increased referral rates to SPC.
3. Improved referral process into SPC services.
4. Decreased the waiting time from referral to clinical review by SPC teams.
5. Supports recent NICE guidance – mandatory to discuss the consideration of an indwelling peritoneal catheter (pleurX) at an MDT.

Conclusion Symptom burden in advanced liver disease is high. An advanced liver disease MDT provides opportunity to identify and discuss the supportive care needs of patients, establish reasonable ceilings of care, and clarify management plans.

P-62 NEURONETWORK – THE LAUNCH OF THE NEUROLOGICAL COORDINATOR ROLE

Jenny Warren, Louise Greenaway, Kayleigh Beardsmore. *Compton Care, Wolverhampton, UK*

10.1136/spcare-2023-HUNC.83

An estimated 1 in 6 of the population is either affected by or diagnosed with a neurological condition at some point in their lifetime. The complex needs of these patients need a comprehensive approach to care that addresses the physical and psychosocial needs, often this group of patients are supported through Living Well or Day Therapy Units. As we returned to a new normal after the pandemic, several support groups locally had discontinued. In response to this local gap in services, we recruited a Neurological Conditions Coordinator and launched the NeuroNetwork. The role was developed to bring together healthcare professionals to help facilitate an integrated holistic approach to supporting those with complex needs. Key specialist nurses now join monthly to network and share knowledge. The initial relationship building further impacted on positive MDT working, and early identification of patients who may benefit from our services.

With around 800,000 hospital admissions resulting from the effects of living with neurological conditions, we further expanded with a Clinical Nurse Specialist with a specialist interest recruited into our specialist palliative care team to not only support complex symptom management but also conversations around advance care planning.

We have also started a support group for patients which empowers those with a neurological condition to get involved with physical activities, in addition to keeping minds active and giving the opportunity to meet new people. Often this group provides an initial introduction to Compton Care in a safe social environment. The coordinator's role can range from signposting and supporting patients to achieve their goals, which could be anything – from supporting one of our transition patients going to college, to finding a job, to working with a patient with Parkinson's Disease in feeling more confident with enjoying trips out.

P-63 LIVING WITH A PROGRESSIVE NEUROLOGICAL CONDITION – THE DEVELOPMENT OF A THERAPEUTIC GROUP

Laura Janowski, Anne Edwards. *St Christopher's Hospice, London, UK*

10.1136/spcare-2023-HUNC.84

Background Prior to COVID-19, St Christopher's Hospice operated under a hospice day care model. The need to develop a therapeutic approach for individuals with Progressive Neurological Conditions (PNCs) became evident based on feedback from day centre visitors. A number of individuals with PNCs attended the centre on a regular basis and had multiple referrals within the hospice. These individuals could not traditionally be discharged from the hospice and expressed the lack of peer support and isolation within the community.

Aims Provide a therapeutic programme with peer support. Focus on the individual, rather than condition. Empower and enable individuals and carers to live fully. Facilitate discussions between 'patient' and 'carer', exploring roles and identities.

Methods During lockdown, a programme was developed by the MDT offering all therapeutic services the hospice has to offer. This was conducted via Zoom, offering professional therapeutic intervention, combined with social activities. The last session of the programme ended with feedback and discussion to enable the future development of the programme.