therapy or with loved ones. This project was funded by the generosity of the TS Shipman Trust.

0-25 THE PRESSURE AND PRIVILEGE OF PROVIDING PALLIATIVE CARE PROFESSIONALLY TO FRIENDS, FAMILY AND COLLEAGUES

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Background Previous research has found that palliative care staff find it distressing when patients with whom they have grown close die. Hospice staff at units serving geographically remote populations are likely to provide palliative care frequently for friends, family and colleagues.

Aims This mixed methods study was designed to (i) determine whether levels of burnout were higher in hospice staff who had provided care for a greater number of people they knew personally and (ii) explore professionals' experiences of providing this care.

Methods Fifty nine participants from two hospice units completed the Maslach Burnout Inventory and reported the number of patients they had cared for over the last year who were friends, family or colleagues. They also reported stressors they perceived as causing and protecting against burnout. Eight participants then took part in focus groups to explore their experiences of providing palliative care for people they knew personally.

Results >75% of participants had provided care for people they knew personally in the last year (Mean=4.4). Burnout scores were low and there was no relationship between burnout and the number of patients staff had known personally over the last year. While participants reported stressful aspects of caring for people they knew, particularly pressure to 'get it right', time pressures and team conflict were more consistently implicated in burnout. Factors such as sense of privilege, self-care, and support from colleagues acted as a buffer against burnout.

Conclusions Levels of burnout in staff providing end of life care are low. Where burnout does occur, it is more likely to be caused by organisational issues rather than any aspect of caring for patients. The emotional toll and pressure of providing palliative care to family, friends and colleagues is mitigated by a range of protective factors. By drawing on coping strategies, this is often an intensely rewarding experience.

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0-26 DEALING WITH THE 'DIFFICULT STUFF', WORKING IN A NON-CLINICAL TEAM IN A UK HOSPICE

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Negotiating the changing health and social care environment has required hospices to recruit individuals to carry out specific roles which are not formed around clinical and caring responsibilities (Hospice UK, 2017). An individual joining a hospice may have expertise in digital marketing and social media but is unlikely to have detailed knowledge of end of life care. Whilst their role may require that they engage with

and represent the day to day work of a hospice, unlike those performing clinical and caring roles, the individuals and the team at the centre of this study carried out their day to day work away from day centres or inpatient units. Whilst several studies have illuminated the work and challenges of clinical and care workers at hospices, little is known about the experiences of these other individuals and teams working away from patients and families but who together with clinical teams comprise and at times embody a modern hospice (Baughner, 2015; Bennet & Barkensjo, 2005; Cain, 2012). Based on a three-month ethnographic study of a marketing team in a UK hospice which included participant observation and interviews, this study is important for trustees, senior leadership and clinical teams detailing the experiences of those working in hospices but away from patients and families. This study considers how individuals in a marketing team came to understand and find their own way to engage with the 'difficult stuff' (Georgia, 2015) at the heart of a hospice. At times understanding the challenging work of their hospice through BBC dramas such as 'The C Word' (Lucy, 2015) or their own families' experiences of hospice care the team were also concerned that those on the clinical side might regard their team as 'sitting in a cosy ivory tower' (Nina, 2015). Emerging themes from this study consider how a non-clinical team makes sense of a UK hospice.

0-27 REHABILITATION PROVISION ACROSS UK HOSPICE SERVICES

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Background Rehabilitation is a key component of multi-professional palliative care. The provision of rehabilitation across hospice services falls outside national audit and is under-researched and therefore poorly understood.

Aim To describe the therapy input and interventions provided to patients attending UK hospice rehabilitation services, across inpatient and outpatient settings.

Methods Adults with advanced progressive disease were recruited to a multisite observational study examining the use of goal setting in routine rehabilitation practice, across 10 nationally representative hospices. Baseline demographics, allied health professional (AHP) involvement and therapy interventions were recorded, then compared according to setting using chi-squared or Mann Whitney U tests as appropriate. Therapy interventions were ranked for each setting.

Results 239 patients (46% male, mean (SD) age 68 (15) years) from outpatient (n=141) and inpatient (n=98) settings took part. The majority (72%) had a primary cancer diagnosis and a stable phase of illness (70%). Inpatients received more therapy input compared to outpatients with a greater number of AHPs involved (median [IQR] 2 [1-3] vs. 1 [1-2], p<0.001), more frequent involvement from occupational therapists (56% vs. 27%, p<0.001) and rehabilitation assistants (51% vs. 30%, p=0.001), and more therapy interventions being provided during an episode of care (median [IQR] 4 [2-6] vs. 2 [1-4], p<0.001). The type of therapy intervention(s) also differed according to setting (Table 1).