promoting patient choice to provide a greater experience of care for all involved. Active discharge planning is encouraged with a 'step down' facility of telephone support.

Methods Gateway makes the first telephone contact and undertakes an expert assessment of need, ensuring patients and families are fully involved in their care through informed decision making in order to live well and die well. Gateway can provide an urgent home assessment to support appropriate admission to the inpatient unit if needed. Gateway provides specialist advice for patients and families to manage their condition promoting resilience and empowerment.

Results Patients and families receive true holistic assessment of need to identify and pre-empt potential problems with compassionate care through competent professionals who are committed to excellent communication. This service has proved to be cost effective and efficient whilst being highly effective. Economic evaluation provides evidence of significant reallocation of costs up to £423 000 per year across the hospice, enabling appropriate resources to be deployed to those most in need.

Conclusion Through leading change to effect a new culture of practice, current feedback identifies better allocation of resources at a cost saving, whilst enhancing excellent individualised care provision to patients and families referred for hospice support.

P-235 USING A PROJECT MANAGEMENT APPROACH TO DEVELOP AND IMPROVE PATIENT SERVICES

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Background Project Management focuses on benefits and outcomes, providing a proven and effective way of using resources and managing risks to undertake service development and improve patient services. Project management harnesses and shares knowledge, improves organisational engagement, communication and reflective learning. A trial of this approach was used to develop a Fatigue and Breathlessness service. Fatigue and breathlessness (FAB) are common and distressing symptoms for many people living with a life-limiting illness. Supporting patients to self-manage these symptoms is a key component of the rehabilitative palliative care agenda (Hospice UK, 2015).

Project

Aims To scope, develop, pilot and evaluate a community-based outreach service for patients experiencing fatigue and/or breathlessness within seven months.

Methods A small scale project management approach based on the principles of 'Prince2' (Prince2, 2009) was used to plan, implement, monitor and evaluate the development of this new service. A cross-functional project team with clear roles and responsibilities was established from the start. Regular team meetings, a succinct project brief and an ambitious but realistic project plan were all utilised to ensure successful completion of the project's objectives. Following a period of research, a six week FAB programme was developed incorporating education, self-management strategies, exercise and relaxation. Patient outcomes were measured using a modified MYMOP2 (Measure Yourself Medical Outcome Profile, University of Bristol), alongside participant evaluation forms.

Results Project management supported effective and resource efficient service development on time and within budget. Four groups were delivered during the pilot stage of this project in a range of community venues. Nineteen attendees completed outcome forms, with improvements made in all domains:

- Fatigue, 13%
- Breathlessness, 14%
- Chosen activity, 7%
- Wellbeing, 2%
- Knowledge, 19%
- Confidence in self-management, 17%

Conclusions Project Management supported significant patient and organisational benefits including:

- Risk management
- Patient safety
- Improved communication
- Team development and learning.

P-236 CHILDREN AND ADULT HOSPICE PROVISION FOR YOUNG ADULTS WITH LIFE-LIMITING CONDITIONS: A UK SURVEY

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Background Over 55 000 young adults aged 18–40 years old in England are living with life-limiting conditions (LLCs). This number is increasing. There is evidence of poor continuity of care for these young adults after transition to adult services, including the lack of short breaks/respite care. This lack of continuity for young adults and their family can ultimately result in carer burnout for families and deterioration in the young adult's health.

Aim To gather the views of staff from children's and adult hospices on the availability and challenges of providing services for young adults with LLCs.

Method An online survey was sent to children's and adult hospices across the UK with support from Hospice UK and Together for Short Lives to gather information about challenges around transition, and the current and future provision for young adults. Ethical approval was granted by the Faculty of Health and Social Care Research Ethics Committee. The study was funded by Liverpool Clinical Commissioning Group.

Results Thirteen children's hospices and 63 adult hospices responded (n=76); estimated response rates of 25% and 37% respectively. Findings indicate clear gaps and challenges in provision: lack of funding and capacity to develop services; lack of existing developmentally-appropriate services; perceived lack of a skilled and confident adult hospice workforce to support young adults who have complex care needs; and the need for better integrated working between children's and adult hospices, and other services. Findings also revealed excellent examples of hospice provision and integrated working.

Conclusions Improved communication and integration is vital to the development of hospice provision that meets the needs of young adults with LLCs and their families. There is also the need to gain young adults' perceptions and opinions on their wishes for care and services.

P-237 UNDERSTANDING THE NEED FOR RESPITE CARE AT DOVE HOUSE HOSPICE: A RETROSPECTIVE AUDIT

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Background UK policy and guidance frequently refers to respite care as a key factor in supporting carers. (NICE, 2004; Department of Health, 2005) However, little is known about respite care in palliative and end of life care and the role of hospices in providing respite care. (Wolkowski & Carr, 2017; Vandepitte et al., 2016; Wolkowski et al., 2010). Dove House Hospice (DHH) in Hull provides respite care. Our observation is that the needs of both the patient and carer are frequently complex and patients are often highly dependent, with a high level of nursing and sometimes medical needs.
Aims To increase our understanding of the characteristics of respite care patients and carers with a view to articulating the need for hospice respite care, its benefits and potential benefits.
Methods A retrospective audit of records of respite care patients (2015–2016) was carried out. A simple data collection tool, organised on a Microsoft Excel spread sheet was used to extract and analyse data. Data collected included demographic and patient characteristics, diagnosis and condition background, referral/admission details, living arrangements and outcome of admission.
Results The majority of the 90 patients admitted for respite care were male (58%). Complex neurological disorders were the leading background diagnosis (28%) among the 16 diagnosis groups identified. Most referrals were from the community services or from patients and their families. Although most patients, 80%, were discharged home after respite, about 12% died during the course of the respite. As this was a retrospective audit, we could not examine quality of care or impact of the intervention on patients or carers because the information was not available.
Conclusion The audit has enhanced our understanding of respite care patients and their carers. Results from this audit will provide a platform for further enquiry helping to guide and improve service provision.

P-238 STAFF NURSE ROTATION INPATIENT TO COMMUNITY – BREAKING THE BARRIERS TO CARE SETTINGS

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10.1136/bmjspcare-2017-hospice.263

Background Palliative care teams have historically worked in isolation from other services. St Giles has revolutionised their workforce by incorporating staff nurse rotation between community and palliative care services.
Aim To provide seamless patient care, St Giles Hospice has incorporated rotation of staff nurses between community and inpatient palliative care services. The aim of this is to streamline patient journeys between services, increase staff knowledge between departments, maintain clinical skills and offer career development for staff.
Methods Staff nurses between departments were identified to be part of the pilot rotation, timeframes were set for rotation with evaluations at the beginning and end to evaluate the pilot and the benefits it had had. Patient feedback was also evaluated for any reference to the rotational role.
Results The initial rotation timeframe was too short, feedback from the nurses was that six months in each department would be more efficient and enable embedding into practice. Clinical skills in the community have been maintained with nurses able to perform more clinical tasks (bloods, medications etc) with increased confidence and competence. In addition the handover of care to inpatient settings has been improved with patients having a familiar face when they enter an unfamiliar setting. Due to the success this has now been rolled out to all staff nurses in the community with recruitment underway for their rotational counterparts.
Conclusion To date the rotation has been a success. We now have a rotation of CNS and Sister between departments and also rotation between staff nurses as well. As patients do not see barriers between services neither should staff. A greater understanding of each department enables better outcomes for patients and also staff with greater appreciation of roles.

P-239 THE INSIDE OUT HOSPICE PROJECT – ARDGOWAN HOSPICE

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Introduction Ardgowan Hospice has delivered specialist palliative care services to the people of Inverclyde for the past 35 years. Potential recipients of the services have had to travel to our hospice buildings, this coupled with the need for professional referral has limited the range of people who could benefit from much needed support. Traditionally we have offered support through in-patient stays, day services including therapy, bereavement, family and child support along with home care services. This model has been unchanged since the hospice opened.
Aims With the support of the Big Lottery we will transform the services that are offered to the people of Inverclyde. To make them more accessible, more inclusive and reaching deeper and wider into communities, in essence being able to offer our support where, when and how they want, services delivered.
Method Through a consultation across communities and in collaboration with partners we have an understanding of the current view of what the hospice provides and the view of how care should be delivered in the future. This engagement was via online survey and hardcopy format distributed across Inverclyde. 21 focus groups and six open groups were held where participants were guided by the questionnaire in an open discussion.
Results Response to the survey was 41%. Over 500 comments were received over the course of the consultation from both individual responses and group settings. The analysis of the needs and wishes is now being carried out, this will determine how we will transform the services to meet the needs.
Conclusion On completion of the analysis Ardgowan Hospice will work collaboratively with communities and partners to develop appropriate responses and implement the necessary changes to achieve the project goals, reviewing delivery across the four year term to ensure that services continue to meet needs.