Abstracts

**Aims** The aims were to:
- map the extent of hospice community volunteering services
- gather information about services already in place
- identify barriers to developing services
- inform the development of resources for hospices interested in establishing community volunteering services.

**Methods** A 40-item online questionnaire was developed, reviewed by the project reference group, piloted and revised. Comprising multiple choice and open-ended questions, it was circulated to the full membership of Hospice UK; 225 hospices including 14 combined adult and children’s services and 25 children’s hospices. Quantitative analysis was undertaken using both the online survey data output and Excel. Qualitative data were analysed using a framework approach. Children’s hospice data were analysed and reported separately.

**Findings from adult hospices**
- 113 adult hospices responded
- 70% had community volunteering services (CVS)
- 61% of hospices without CVS were keen to develop these
- the majority of hospice CVS were staff-led.

**Benefits included:**
- improved wellbeing for patients, families and volunteers
- respite for families/carers
- improved access to a range of services for patients and families
- improved quality of care
- staff having greater understanding of patients’ and family needs
- staff skills and time more effectively used
- increased service provision.

**Barriers to development included:**
- lack of resources (including funding, staff, volunteers and time)
- concern over lone-working, safeguarding and insurance.

Respondents indicated that they would find materials to guide development helpful.

**Conclusions** Hospice community volunteering services appear to be widespread and growing. There are clear benefits for patients, families, volunteers, organisations and staff.

**Aims** To move from a ‘specialist’ DT model towards a mixed model, including a range of out-patient opportunities and more ‘light touch’ services. To evaluate services including attendance figures, OACC (Outcome Assessment and Complexity Collaborative) and other outcome measures and user feedback.

**Methods** Some existing services maintained, alongside new services:
- Therapeutic group work for those with complex physical, emotional, social and spiritual needs, including nursing assessment and involvement of MDT as appropriate
- Rehabilitative and psychoeducational groups encouraging self-management
- Increased outpatient services
- Social drop-in groups, including café style and creative social groups, delivered by a therapy assistant and volunteer.

**Results** Due to routine overbooking, between 96%–120% of available sessions were booked with attendance ranging from 46% to 101%. Drop-in sessions were particularly successful, with 92%–101% attendance. Around 70% of people accessing services have a non-cancer diagnosis. User feedback has been positive for sessions, including quotes such as ‘supportive’ and ‘something to get out of bed for’. OACC data have demonstrated that people have complex, multidimensional needs. De Jong Gierveld Loneliness Scale outcomes have improved in social groups and have highlighted individuals’ social needs.

**Conclusion** People accessing Day Therapy services have a complex mixture of physical, psychological and social needs and services need to be designed to meet these in appropriate and cost-effective ways.

**O-21 HOW DO HOSPICES FACILITATE SOCIAL SUPPORT?**

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**Background** Social isolation is increasing, with negative consequences for both physical and mental health. People with life-limiting illness and their carers are at risk of inadequate social support and loneliness. Hospices support social wellbeing with services including traditional day care, support groups, befriending, multi-component interventions, and community activities. Existing research suggests that access to social support is highly valued. However, models of support used in practice are poorly documented and outcomes difficult to ascertain. The significance of social support in palliative care is under-researched.

**Aim** To establish an overview of hospice service models that facilitate social support for adults living in the community with life-limiting illness.

**Method** An online survey was developed, piloted, and disseminated to adult hospices in the UK and ROI. Questions include hospice characteristics, provision of services facilitating social support, access issues, use of patient outcomes, and availability of cost data.

**Results** 107 hospices responded to the survey (c. 50% of eligible hospices). A diverse range of service models were identified. Results include descriptive statistics of the sample, categories of services identified, and salient access issues. Implications of findings for research and economic evaluation are discussed.
Conclusion This survey demonstrates hospices to be interested and active in facilitating social support. It is possible that increasingly diverse approaches used in practice may improve issues regarding access to and awareness of hospice care. More work is needed to share best practice, document outcomes, and consider cost-effectiveness.

Background A current concern is the number of people dying in hospital who have no medical need, or wish, to be there (Marie Curie Cancer Care, 2012). 72% of people would prefer to die at home (ComRes, 2014), yet just 23% do so, with 50% dying in hospital (Gomes, Calanzani, Higginson, 2011). Instinctively, hospice-led initiatives play an important role in minimising inappropriate hospital usage at the end of life, but there is a lack of robust data.

Aim To establish the impact of different hospice led innovations on a) reducing the number of hospital beds days during the last 90 days of life, b) place of death and other secondary outcome measures: the number of emergency and inpatient admissions and discharges to a hospice in the last 90 days of life.

Method Mixed methods study with a quantitative quasi-experimental longitudinal design employing a ‘difference of difference’ analysis of HES data to assess the impact on hospital utilisation in the last 90 days of life. Any encountered differences are compared to control cohorts. Stakeholders were qualitatively interviewed through open-ended, semi-structured and structured interviews followed by narrative, framework and content analysis respectively.

Results Quantitative: ongoing, however, we anticipate data showing a reduction in the number of hospital beds days in the last 90 days of life, within the locality of the intervention hospice. Qualitative: interviewed 188 people, including 24 patients and carers, across 27 interventions at 25 sites providing 31 recurrent topics of which the five most relatively frequent were the process of development, collaboration, the number of hospital beds days, inpatient admissions and discharges to a hospice in the last 90 days of life.

Conclusions Qualitative evaluation of these innovations shows benefit to the patient experience and factors critical to success and replicability. Quantitative data will show the impact on NHS resources, and together the findings will enable better evidence-based commissioning, supporting service redesign at a local level. Final report due Sept. 2018.

Abstracts

Patient and public involvement (PPI) is an established component of high quality palliative care research. The way patients and public are involved in research differs between and across research studies, however the range of contributions and different models of working are not well documented in palliative care.

Aim The aim is to document the range and scope of activities of a service user advisory panel – the Palliative Care Studies Advisory Group (PCSAG), established at The University of Sheffield in 2009.

Methods A narrative summary of PPI activities, documenting the range and scope of contributions to research over the nine years since the PCSAG was established.

Results Since they were established the group have contributed to 34 research projects and funding applications in the area of palliative and end of life care. These have ranged from substantial multi-million pound international research studies to PhD studies and student projects. In the main, researchers attended facilitated group discussions to request advice on aspects of their research projects, however, other models of working have emerged in more recent years. These include group members sitting on project steering committees as co-applicants, contributing to data analysis and presenting at conferences, and developing on-line methods of providing PPI input.

Discussion The Palliative Care Studies Advisory Group have made a substantial contribution to palliative and end of life care research. The scope and depth of PPI involvement has increased over the years, as researchers and service users have gained confidence in working together. Models of co-working which involve service users as co-applicants have more recently become commonplace as the PPI movement has become more embedded in research. However, little guidance is available to support researchers working with service users in palliative and end of life care, and further research could address this gap.

Introduction A prudent approach to provide quality end of life care (EoLC) advocates for active participations of the patients in designing the service (Wynne, n.d.). Patients and carers demand for improvements in decision-making at the EoLC (Sinuff et al, 2013). But there is a lack of evidence on understanding of people’s attitudes towards EoLC and shared decision-making (Hajizadeh, Uhler, Herman, et al., 2016).

Aim To increase understanding of people’s views, feelings and preferences around EoLC and decision making.

Method An online survey was conducted using an electronic survey tool. Descriptive statistics and thematic analysis were used to perform data analysis.

Results 2210 people (Age: Mean ±SD: 55±14 years) participated in the survey, 43% of those were members of the public, 29% were patients/carers, and 23% were health professionals. 49% of respondents thought that available EoLC and palliative care was inadequate and only 31% believed that people could access these facilities. More than 60%