Results suggest that the greatest value in having Clinical Psychology onsite is in relation to the indirect clinical work that is provided. Respondents spoke about the importance of having Clinical Psychology present at MDTs as well as being able to approach the Clinical Psychologist for ad-hoc consultation. Themes also reflected perceived benefits in relation to the service’s safety, responsiveness, equitability and patient-centeredness. These qualitative findings are complemented by quantitative data from routine audit.

**Potential impact** In highlighting the benefits of having access to an onsite Clinical Psychologist, as perceived by the healthcare professionals who interface with the service, this project can inform future service developments locally as well as offering support for the adoption of similar provisions elsewhere.

Diagnosis of terminal illness and subsequent transition into palliative care can cause fear and uncertainty, resulting in distress and decreased quality of life (Murray et al, 2007).
Difficulty and distress when negotiating this transition can also be a barrier for patients and their families in engaging with the process of advanced or anticipatory care planning (Lund, Richardson & May, 2015). Acceptance and Commitment Therapy (ACT; Hayes, Strosahl & Wilson, 2011) is a promising but under-researched psychological intervention for supporting terminally-ill cancer patients (Arch & Mitchell, 2015). We developed and are pilot-testing a brief ACT-based intervention to improve quality of life and psychological acceptance for this group. A multiple baseline, single-case, non-controlled design is used. Ten participants have been recruited. Each receives five sessions with an ACT-trained facilitator, in the hospice setting. Quality of life, distress, and ACT-process changes are self-reported, weekly. Psychological flexibility and overall health are measured daily. The attrition rate is 60%. One participant demonstrated measurement floor and ceiling effects, but small increases in psychological acceptance. Two participants demonstrated small changes in quality of life and psychological flexibility, with some level of distress reduction. Finally, one participant shows tentative improvements in psychological distress and complex future care planning. Nutrition and weight loss are predictors of survival (Leigh et al, 2006). It is important that the option to have gastrostomy be an integral part of the MDT in managing often rapidly progressive symptoms, psychological distress and complex future care planning. Nutrition and weight loss are predictors of survival (Leigh et al, 2003) and often relate to progressive dysphagia (Heffernan et al, 2004).

Gastrostomy can be used to administer nutrition with studies suggesting this can both prolong survival and improve quality of life (Mazzini et al, 1995; Ganzini, 2006). It is important that the option to have gastrostomy is discussed at an early stage taking the patient’s personal preferences into account (MND association, 2019). Patients with MND often have other interventions to try and optimise QOL such as Non-Invasive Ventilation (NIV). Recent literature describes the withdrawal of NIV at the request of patients with MND (LeBon & Fisher, 2011; Messer et al, 2019) and the APM (2016) has issued guidance which considers the legal and ethical implications of this. However, a