used to identify the number of non-elective hospital admissions, reason and length of admission.

Results In JOPCC there were 45 non-elective hospital admissions compared to 70 admissions in SOC. The main reason for admission in both groups was for new complications of diagnosis: JOPCC 84.4%; SOC 85.5%. Complications of treatment were more common in the SOC patients; JOPCC 10.5%; SOC 26.7%. The average length of admission was significantly shorter ($p=0.0015$) in the JOPCC (4.8 days).

Conclusions JOPCC appear to reduce both the number and length of non-elective admissions. This may be partly attributed to fewer patients actually receiving treatment or having previous access to palliative care teams; resulting in fewer admissions. Further research comparing non-elective admissions within 12 months from first consultation with a larger sample size, confining data to a single site-specific cancer diagnosis will allow further conclusions to be made.

P-227 COMBINED ONCOLOGY AND PALLIATIVE CARE CLINICS; PATIENT PLACE OF DEATH

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10.1136/bmjspcare-2019-HUKNC.249

Background Combined oncology and palliative care clinics (COPCC) have developed in Cornwall to enable early palliative medicine input into the care of cancer patients. The evidence suggests referrals to palliative care are usually late (Bennett, Ziegler, Allsop, Daniel *et al.*, 2016), despite growing evidence that earlier palliative care reviews enhance patient quality of life and in some cases survival (Temel, Greer, Muzikansky, Gallagher *et al.*, 2010). The majority of patients express a preference to die either in their own home or the hospice (Gomes, Higginson, Calanzani, Cohen *et al.*, 2012; Gao, Ho, Verne, Glickman *et al.*, 2013; Gomes, Calanzani, Gysels, Hall *et al.*, 2013), yet unfortunately most die in acute hospitals (Cohen, Pivodic, Miccinesi, Onwuteaka-Philipsen *et al.*, 2015). The aim of this review was to determine the place of dying phase of care for patients reviewed in the COPCC.

Method A retrospective database review identified place of death for 675 consecutive patients seen in COPCC between 2012 and 2017.

Results 45% died at home or nursing home, 26% died in the hospice and 29% died in hospital (21% acute, 8% community). In comparison nationally, 37% of patients with cancer died at home or nursing home, 17% died in palliative care institutions (i.e. hospice) and 44% died in hospital.

Conclusions COPCC aim to provide holistic palliative care to control symptoms, address information needs, help with psychological distress and guide advance care planning. COPCC allow patients with advanced cancer to be referred earlier to the community palliative care teams or hospice services. Patients who are reviewed in COPCC appear to be more likely to die at home, nursing home or hospice and less likely to die in an acute hospital compared to national data for patients with a cancer diagnosis. COPCC may help patients to die in their preferred place of death. Patients with non-cancer diagnoses such as end stage heart failure may also benefit from combined clinics with palliative care. Further work is needed to explore this.

P-228 LINKING HOSPITAL TO HOME AT END OF LIFE

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10.1136/bmjspcare-2019-HUKNC.250

Background No Occupational Therapists (OTs) previously in Hospital Palliative Care Team (HPCT) and lack of continuity for patients and their families from leaving hospital to being at home for end of life care (EOLC).

- It was recognised that OTs were needed as an essential part of the HPCT;
- Needed to improve upon patient and family's experiences of EOLC in the John Radcliffe Hospital.

Aim(s)

- To provide support and continuity of care for patients and families throughout patient's EOLC journey from hospital to home;
- To provide education and support to hospital staff in regards to palliative and EOLC;
- To promote role of OT in palliative care within the trust and nationally.

Methods

- Networking with other OTs working in palliative care and sharing ideas;
- Qualitative data collected – formally from staff using an anonymous form and informally from patients and relatives;
- Planning on initiating a qualitative research project using a research assistant to interview families and loved ones.

Results

- 237 patients seen in the first year;
- 100% of staff agreed that input from the palliative care OTs improved the quality of EOLC for palliative patients;
- Excellent informal feedback from patients, relatives and staff across the hospital and in the community.

Conclusions Project demonstrated that OTs in the HPCT have a positive impact on the EOLC received by patients in the trust and into the community. We are one of the only OT teams that follow patients through their entire journey from hospital to home. The findings of our project supports ambition 4 of the *Ambitions for Palliative and End of Life Care* - ensuring care is co-ordinated.

This project will be of interest to palliative care professionals across the country as it is displaying innovative practice and has so far achieved excellent results and feedback.

P-229 DOROTHY HOUSE HOSPICE CARE AND ROYAL UNITED HOSPITAL – COMPASSIONATE COMPANIONS HOSPITAL END OF LIFE CARE

Sadie Hall, Wendy Meilton. Dorothy House Hospice Care, Bath, UK

10.1136/bmjspcare-2019-HUKNC.251

The Compassionate Companions Service is a new service that provides specially-trained volunteers who offer support, compassionate listening, comfort and companionship to patients in their last days of life at the hospital, who do not want to die alone. They will also provide respite companionship support for patients' families so that loved ones can recuperate during what is a psychologically and physically exhausting time.

The Dorothy House Hospice Care RUH Compassionate Companions service is a joint partnership between Dorothy House Hospice Care and the Royal United Hospitals Bath NHS Foundation Trust (RUH) Palliative Care and End of Life Team. This inspiring and progressive approach to caring for people was launched on 15 May 2019 with the support from the RUH Forever Friends Appeal and funding from the Sperling Trust for three years.

- To support the provision of compassionate and dignified care at the end of life for those dying in hospital, whilst aiming to improve carer outcomes reported through the bereavement feedback questionnaire;
- The service will supplement the quality nursing care that patients require in their final days or hours of life. Being able to spend time sitting with a dying patient, talking to them and their family and listening can be an enormous comfort at an emotionally challenging time for patient, family and ward staff;
- To provide a 7 day service that meets the needs of patients, carers and their families throughout the hospital. Volunteers work up to three-hour shifts from 9 am – 9 pm;
- Provide extra care and support for patients who are thought to be in the last 48 hours of life, are inpatients at RUH, and have limited or no family support or have family that would benefit from respite;
- The service is starting with three wards and will expand to cover the whole hospital.

P-230

COMPASSIONATE COMPANIONS: QUEENSCOURT VOLUNTEERS IN HOSPITAL

Helen Birch, Julie Davidson, Louise Charnock. *Queenscourt Hospice, Southport, UK*

10.1136/bmjspcare-2019-HUKNC.252

Background It was recognised there was a gap in companionship and empathic support for certain patients in hospital approaching end of life.

Aim Queenscourt in Hospital, an extension of Queenscourt Outside Volunteer Service, is launched to provide comfort and companionship for patients in hospital who are in the last hours to days of life, and whose families are absent or need support to take a short break.

Method Volunteers are recruited with previous health and social care experience and who are available at very short notice to respond to patient's changing condition. Volunteers are aligned with the hospice's vision and values. A bespoke training programme was put in place to prepare, educate and allay any potential anxieties and fears.

Results Patients eligible to benefit from service are identified by members of the Queenscourt Supportive and Specialist Palliative Care Services working in hospital. Volunteers may read quietly, provide gentle hand massage or may just simply be present. Volunteers may escalate a patient's needs and concerns to the ward staff if unsettled. Volunteers are fully debriefed following each shift and consequently report feeling empowered and valued for having made a difference. Challenges around hospital policies and procedures were overcome by liaising between HR departments, and open communication.

Conclusion Queenscourt delivers compassionate and emotional support to patients and their families across all settings. Our

new volunteers in hospital are an integral part of this. By enlisting the support of volunteers, patients in hospital who are reaching the end of their lives have an empathic presence and companion by their side. We aim to support more people dying in hospital and communicate with secondary care colleagues ensuring all professional boundaries are respected. Training and support of volunteers ensures retention and continuation of a worthwhile service.

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USING VOLUNTEERS FOR BEDSIDE COMPANIONS TO SUPPORT THE CONCEPT OF 'BEING THERE' AT END OF LIFE

Jenny Butler. *Oakhaven Hospice, Lymington, UK*

10.1136/bmjspcare-2019-HUKNC.253

Background 'Being with' dying people is an integral part of nursing (Tornøe, Danbolt, Kvigne, Sorlie, 2014), with hospices best placed to holistically achieve this (Gomes & Higginson, 2008). However, an increasing demand of patients with complex end of life care and support needs, without requisite increase in funding, means the future challenges facing hospices are considerable (Commission into the Future of Hospice Care, 2012). The value of volunteers supporting people at end of life has now been widely recognised as a response to these challenges (Commission into the Future of Hospice Care, 2012; Radbruch & Payne, 2009). As hospice nurses identify less availability to sit with dying patients and their families, support was sought from a successfully established volunteer-led bedside companion scheme.

Aim To deliver innovative experience-led training to hospice volunteers: giving them confidence to visit and support patients in the hospice inpatient unit, particularly at end of life. Service will be closely monitored and evaluated to inspire future expansion.

Methods

- May 2018: met with Volunteer Communications Tutor for initial consultation and model planning;
- June 2018: Scoping for volunteers;
- July 2018: Focus group with hospice multidisciplinary staff;
- Aug–Oct 2018: Final volunteer recruitment;
- Sept 2018: Staff awareness sessions;
- Nov 2018: volunteer training delivered by Volunteer Communications Tutor. Volunteers visit local established bedside companion scheme to 'shadow';
- Jan 2019: Service begins, comprising of mostly rostered scheduled sessions with a written summary recorded and reviewed by ward Sister. Six-weekly debriefing/supportive sessions between volunteers and staff are on-going.

Results

- 8 volunteers recruited. Pilot from January – end April 2019;
- 81 shifts;
- 257 visits;
- 41 patients;
- Taking 114 hours;
- Positive qualitative data collected from volunteers, inpatient staff and patients.

Conclusion Oakhaven's response to the challenges of a changing health and social care landscape by empowering volunteers with the skills to 'be with' hospice patients, as suggested by literature, has shown to be supportive to inpatient staff and