

patients. Future training sessions will widen the scope of available bedside companion support.

P-232 BEFORE WE CHANGE, LET US UNDERSTAND: A PROSPECTIVE CHARACTERISATION OF HOSPICE INPATIENTS

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Background Hospice service redesign aims to achieve the greatest impact for the greatest number of people within limited resources. The strategic direction within the NHS is towards care as close to home as possible, reducing avoidable admissions and improving patient experience of end of life care. However, there is little published evidence describing patient use of a specialist palliative care inpatient service, despite this significant resource.

Aim To enhance the understanding of why patients are admitted to two hospice inpatient units within one Health Board area, to describe the characteristics of patients admitted and to explore their needs and wishes in this process.

Method We are conducting a prospective mixed methods evaluation. Using case note review, we are collecting data on approximately 250 hospice inpatient admissions over a four month period. In addition, we are conducting up to 40 interviews with patients and carers to explore expectations and feelings around the admission; and seek feedback from the referrer and the receiving staff about appropriateness of admission and alternatives to admission.

Results We will present preliminary data on the reasons for referral to the hospice inpatient services, describe characteristics of patients referred including Adapted Karnofsky Performance Score, Phase of Illness and iPOS at time of referral; along with preliminary qualitative findings regarding patient and carer perspectives about hospice inpatient admission.

Our findings will inform our understanding of the use of hospice inpatient services and how resources can be most effectively allocated to meet patient and family needs and preferences within a locality. This will allow meaningful service redesign, ensuring the patient experience informs change.

P-233 DYING TO WORK TOGETHER – PARTNERSHIP AND POTENTIAL

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'The path to successful partnerships is littered with many attempts that have failed' (Mitchell & Karoff, 2015).

Over a period of more than a decade, the hospice had an in-reach specialist palliative care team working in the local hospital, during which time the hospital developed its own end of life care team. Both teams worked in isolation, challenged by different structures, values and approaches. It

became clear that expectations regarding leadership, goals, roles, processes and responsibilities of partnership working differed significantly. The concept of the two teams working collaboratively was strong, but many challenges soon emerged. Joining forces to make a difference was not going to be an easy prospect. We had not aligned our values and as a result, became disconnected in our day-to-day interactions to such an extent that it was on the threshold of being unsustainable.

In October 2018, the Trust appointed a Clinical Director for End of Life Care and this was the beginning of the integration of the two teams. Together with the Director of Nursing from the hospice, leadership of this team is based on trust in each other's ability to lead effectively and with integrity. One of the early pieces of work we commenced together was to acknowledge the two organisations values, missions and operating principles and collectively agree our operational values and behaviours moving forward.

For this partnership to be successful, it will require strong leadership, common understanding, a shared vision and purpose, mutual understanding and an acceptance of differences. It will require resilience in the face of inherent tensions and inevitable conflict. Partners frustrate each other; partners will let each other down – if we can accept these challenges and work with them, together we have a much better chance of making a difference.

P-234 SPIRITUAL CARE SUPPORT WITHOUT WALLS AT ROWCROFT HOSPICE

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Background Spirituality is a hugely important part of the end of a person's life: what matters to them most, who they are; their story; their friends/family; those that care for them. When the hospice's existing Anglican Chaplain retired after 17 years, an opportunity arose for us to review our provision of spiritual care, moving away from a traditional chaplaincy model to support our ever-changing communities. Evidence, identified as part of the process, highlighted the gaps in the care we already provide.

Aim To create an updated model for spiritual care, led by a newly appointed Spiritual Care Specialist, achieving inclusive support for all that come in to contact with Rowcroft regardless of religion, beliefs, faith, or no-faith.

Method September 2018 – Jan 2019: we conducted a service evaluation, set up a Task and Finish Group which consisted of core representation across the organisation; different nurses from the ward attended each group, undertook a literature review, contacted other hospices, hospitals and Healthwatch Torbay, developed a Spiritual Care Model and gained Senior Management Board and Trustees buy-in.

Results A Spiritual Care Specialist was appointed. The existing on-site Chapel was de-registered and renamed The Sanctuary. Marriages, celebrations and other events for all (regardless of faiths, beliefs, religions) can take place in the space, also providing a 'quiet' space. There are seven further recommendations within the new model that will now be progressed to fully achieve the desired outcomes with the help of a Spiritual Care 'Custodian' Group.

Conclusion Challenging the traditional ‘chaplaincy’ role, creating a new model of care to match the changes in the local communities and across the country, has been a huge transformation within the organisation. Our new Spiritual Care Specialist will ensure our organisation is fully inclusive, meeting the needs of all Rowcroft patients, relatives, carers, staff and volunteers.

P-235 EVOLUTION IN THE TEAM, REVOLUTION IN THE SERVICE

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Background We are a family support team of 4.68 WTE paid staff made up of counsellors, a social worker, spiritual care co-ordinator, administrator and 25 volunteers. A new manager was appointed in late 2017 and found a team struggling under a long waiting list. Feedback from other teams in the hospice was frustration that family support was slow and unresponsive.

Aims Following a team away day in January 2018 we decided to re-focus our work to be:

- timely and appropriate;
- rehabilitative and empowering;
- efficiently supported and evaluated.

We had no specific numeric goals at this point, only to reduce our waiting list and become more responsive.

Method Taking a whole-system approach devised a plan which included major changes to:

- Team ethos;
- Assessment and referral processes;
- Communication and roles;
- Our counselling/service model;
- Recruitment and training;
- Evaluation and data collection.

Results After a year we achieved and have maintained:

- The elimination of our waiting list; clients are now allocated within days of being assessed unless they have very limited available time slots;
- Response to tasks and requests within two working days, usually within 24 hours;
- Positive outcomes demonstrated in self-reported evaluation and improved Core 10 scores.

Conclusion

- A whole team/whole system approach fostered a commitment to our aims and acceptance of the changes we needed to make, even when they were difficult;
- A short-term counselling model is appropriate in a hospice setting if supported by theoretical and practical training in how to deliver counselling in this way;
- The no-waiting approach means that the intervention is made when it is needed and can be most effective, and our outcome results show this;
- Our willingness to be flexible in the way we work with individual cases where specific need is demonstrated provides the team with confidence that we remain client centred within a rehabilitative model.

P-236 WIRRAL HOSPICE ST JOHN'S TEMPORARY VOLUNTEER BENEFITS ADVISOR SERVICE

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Background The Wirral Hospice understands the need for expert benefits advice and guidance to assist and support patients and carers to maximise income and reduce hardship. We set up and audited a volunteer benefits advisor service at the hospice and its effectiveness over an 18-month period.

Aim The audit of a new temporary volunteers benefits advisor service (unpaid specialist advisor) via appointments with patients/carers and to assess benefit of specialist intervention.

Method Quantitative data collection. Via referrals, intervention and outcomes measures -Benefits correct, Benefits gain and Benefits overpayment, use of DS1500, and referral to third party agencies. The average number of referrals were 3–4 patients/carers PW during an 18 month period. Over 110+ patients took part.

Results

- The evidence showed that the service prompted a financial gain for many patients and carers, which was around 64%;
- Financial gain is not the only measure in value – patients/carers found reassurance that their benefit was correct. It gave the opportunity for some families to discuss future financial position if a person dies;
- The timely use of DS1500 was very important to avoid people missing out on their entitlement. 21% of patients were issued a DS1500 as they met criteria and were not receiving higher/enhanced rates of disability payment;
- 10% of patients/carer were referred on for complex issues requiring paid skilled benefit advisors.

Conclusion It was established that the benefit to patient/carers were considerable based on audit. The service needs to grow and move to a day time provision which would allow for the provision of benefits awareness sessions for staff and volunteers. We have agreed a four-hour weekly CAB provision at the hospice to start September 2019.

P-237 A SURVEY OF PSYCHOLOGICAL SUPPORT SERVICES IN UK HOSPICES: WHO, WHAT, WHERE AND HOW?

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Background People receiving end-of-life care and their family carers can experience significant psychological distress (Wilson, Chochinov, Graham Skirko, Allard *et al.*, 2007; Galfin & Watkins, 2012; Braun, Mikulincer, Rydall, Walsh *et al.*, 2007; Grov, Dahl, Moum, Fosså, 2005). Psychological support is a fundamental aspect of the holistic care provided by hospices (NHS. Hospice care [Internet], 2017; NHS England, 2019). However, there are limited clinical guidelines in the UK on how hospices should deliver psychological support services (National Institute for Health and Care Excellence, 2017). No recent research has explored how psychological services are delivered in UK hospices on a national level. A nationwide