Abstracts

9 STAFF WELLBEING IN CHILDREN’S HOSPICES (SWiCH): A MIXED-METHODS STUDY
Johanna Taylor, Andrew Papworth, Jan Aldridge, Lorna Fraser, Suzanne Mukherjee, Byony Bereford, University of York, Martin House Hospice
10.1136/spcare-2020-PCC.9

Background Staff shortages in children’s palliative care and uncertainty about how to promote the wellbeing of staff who work in the sector are increasing concerns. The SWiCH (Staff Wellbeing in Children’s Hospices) study aims to increase understanding about the work-related stressors and rewards experienced by staff working in children’s hospices, and identify the staff support systems and organisational practices that offer potential to enhance wellbeing at work.

Methods This mixed methods study has two phases. The first consists of a systematic review to identify factors associated with work-related wellbeing of staff in hospice settings, and the development of work-related stressors and rewards scales for children’s hospice staff. The second phase is a cross-sectional survey of UK children’s hospice organisations and their care staff.

Results Findings from this ongoing study will be presented. The systematic review included 20 studies that identified personal, role and organisational factors associated with wellbeing. The scale development adapted measures for paediatric oncology through survey feedback, focus groups and cognitive interviews with 60 staff from five children’s hospices. New stressor and rewards were identified, including: providing complex medical care; supporting families through end of life and Bereavement; and the challenges of liaising with non-hospice services. The national survey will examine levels of staff wellbeing (including burnout) and use regression models to identify the associated organisational features.

Conclusions This study will provide important evidence about wellbeing and burnout in children’s hospice staff, and increase knowledge about organisational and staff support features that enhance wellbeing. The children’s hospice sector has welcomed the opportunity to be involved in this research, and the development work has already shed light on the distinct stressors and rewards experienced by staff.

Free papers 10 – 12: service evaluation

10 ENHANCED SENIOR 7 DAY SPECIALIST PALLIATIVE CARE SERVICES ACROSS THE HOSPITAL AND COMMUNITY TEAMS IN SALFORD
Katie A Hobson, Tim Jackson, Alison Roberts, Angela Kelly, Debra Morris, Jennifer Forsyth, Kathryn Waiganjo, David Waterman, Anne-Marie Raftery, Louise Lawrence. Salford Royal NHS Foundation Trust, St Ann’s Hospice, Greater Manchester and Eastern Cheshire Strategic Clinical Network, Greater Manchester Cancer, Macmillan Cancer Care
10.1136/spcare-2020-PCC.10

Background A 21 month Macmillan Funded Programme has been undertaken to transform weekend and bank holiday Specialist Palliative Care (SPC) provision in Salford. This has tested the proposed APM model, increasing the level of 7 day working staff from the minimum to Level 1 with elements of Level 2.

Method In addition to the established Senior Clinical Nurse Specialist (SCNS) rotas in hospital and community, new Advanced Clinical Nurse Specialists (ACNS) with enhanced clinical skills have delivered senior SPC face to face reviews across care settings. For 50% of weekends, medical consultant face to face review has also been available. Outcome measures have been developed.

Results Over 600 complex patients have had senior SPC review at the weekend, across care settings in the initial 10 months. Average hospital weekend referrals have increased by 37% (from 16.9 to 23.1) with improvement in hospital weekend response times (81.2% Vs 69.6% seen within 24hrs).

Conclusion This model has demonstrated patient, carer, staff and cost benefits as well as addressing issues with inequity of service delivery and capacity across care settings.

11 HOW IS ANTICIPATORY PRESCRIBING IN COMMUNITY END OF LIFE CARE GOVERNED IN THE UK? A CONTENT ANALYSIS OF NATIONAL AND LOCAL GUIDANCE DOCUMENTS
Richella Ryan, Ben Bowers, Anna Spathis, Stephen Barclay, University of Cambridge
10.1136/spcare-2020-PCC.11

Introduction Anticipatory prescribing (AP) in end of life care is a complex process consisting of at least 5 sequential phases: 1) decision to prescribe, 2) prescribing and dispensing, 3) set-up, storage and monitoring, 4) assessment and administration, and 5) post-death procedures. Little is known about how this process is governed across the UK. We aimed to investigate the scope and content of UK AP governance documents.

Methods Stakeholders from a stratified random sample of 55 CCG areas in England and all health board (or equivalent) areas of Scotland (n=14), Wales (n=7) and Northern Ireland (n=5) were asked to supply their AP governance documents. Qualitative and quantitative content analysis was conducted using the 5 phases of AP as an analytical framework. A typology of approach to AP governance was developed.

Results 49 sets of documents, 5 national (representing all 4 countries) and 44 local (33 English, 11 Scottish) were analysed. Two predominant types of approaches to AP governance were identified. Type 1 ‘Last Days of Life Care’: AP guidance
is embedded within ‘last days of life’ symptom management guidelines and is usually limited to the prescribing and administration phases (predominant in England and NI). Type 2 ‘Anticipatory Care’: AP guidance covers more than the ‘last days of life’ period and documents specifically address all 5 phases of the AP process (predominant in Scotland). National frameworks supporting both approaches exist in Wales. Significant guidance gaps were identified with the type 1 approach, particularly in relation to: 1) timing of the decision to prescribe, 2) transition from prescription to administration, and 3) drug disposal.

Conclusions Despite its complexity, AP is often treated as a simple component of ‘last days of life’ within governance documents, resulting in important guidance gaps. National guidance development work is underway to address these gaps.

12 A SERVICE EVALUATION OF HOSPICE ADMISSIONS FOR PATIENTS WITH MOTOR NEURONE DISEASE AND DUCHENNE’S MUSCULAR DYSTROPHY AND BARRIERS TO THEIR TRANSITION AND ADMISSION
Rachel Taylor, Mike Macalafane, Tracey Willis, Derek Willis, Hannah Fox. Severn Hospice

Background and introduction With DMD patients now living in to their 30’s, there is a greater need for them to transition into adult services. Given their needs are often similar to MND patients, looking at barriers to hospice admissions for both these groups could help provide indicators for service development.

Methods All UK hospices were contacted with the following survey either in person, telephone, email or using the enquiry form on their webpage:

- Do you take Motor Neurone Disease Patients?
- What are the barriers to admitting such patients?
- Do you take patients with Duchenne’s Muscular Dystrophy?
- What are the barriers to admitting these patients?
- Do you take patients on NIV?
- What training do staff have on using NIV?

Results 78 responses from 191 hospices. 98.7% admitted MND patients and 93.6% would admit DMD patients; however 51.3% had not had any referrals for DMD.

Barriers were identified as challenges rather than barriers. The top four for each group were:

MND
1. Staffing levels and high dependency
2. NIV
3a. Bed availability
3b. Difficulty managing their needs

DMD
1. Patients remaining under children’s services/difficulty with transition
2. Difficulties managing their needs
3a. Not being referred
3b. No respite in adult hospices

93.6% of hospices would admit patients on NIV, but most of them often found this challenging and wouldn’t start NIV or amend the settings; staff of only 23% had formal training on NIV.

Conclusions While it’s difficult to provide answers for wider service issues like staffing and bed availability, we need to be providing increased services for transitioning DMD patients into adult care. Commonly hospice’s were worried about the complexity of care that these patients require, including familiarity with equipment and use of NIV. Going forward, it is necessary to work with children’s services to develop learning packages for adult hospices to feel more comfortable with these admissions.

Free papers 13 – 15: integration

13 PRACTICES, ISSUES AND POSSIBILITIES AT THE INTERFACE BETWEEN GERIATRICS AND PALLIATIVE CARE WITHIN THE HOSPITAL: AN EXPLORATORY STUDY (INGAP)
E Borgstrom, S Khan, R Schiff, E Hindley, D Thayabaran, E Savage, N Gough, R Holti. The Open University, Palliative Care Department Guy’s and St Thomas’ NHS Foundation Trust, Department of Aging and Health Guy’s and St Thomas’ NHS Foundation Trust

Introduction With the expansion of palliative care into non-malignant conditions, there is an increasing emphasis on interdisciplinary working between extended geriatric teams and palliative care. This inter-disciplinary working has evolved organically and more needs to be known about current working practices. This is of policy and clinical interest as the elderly patient population continues to grow.

Methods An exploratory case study was undertaken of end-of-life care for older in-patients in a London hospital. Staff from all grades and roles within palliative care and geriatric medical/nursing teams, patients and carers were invited to be interviewed, according to a protocol approved by HRA. 30 semi-structured qualitative interviews were conducted with staff, two with patients and five with carers. Questions covered: recent examples where teams worked together; staff perceptions of collaboration, working practices and issues; patient and carer perceptions of clarity as to who was providing care. Interviews were transcribed and thematically analysed focusing on: examples of successful collaboration; areas of tension, duplication or confusion about responsibilities; suggestions for future practice.

Results Participants were overwhelmingly positive about collaboration between the teams. Examples of what currently works well were: the referral process to the palliative care team; inter-team communication and use of face-to-face handovers; unity between the teams when communicating with patients and families. Areas of concern and for future development were: improving collaboration between palliative care and physiotherapy and occupation health; the need for continual on-ward education given rotation of junior medical staff; embedding palliative care within multidisciplinary team meetings within the ward. Patients and carers did not generally distinguish between the teams and presumed collaborative working practices.

Conclusions A commitment to working together was important. The findings are also relevant to understanding good practice between older persons ward teams and other specialisms.