Wheatfields hospice. We conducted 4 focus groups with six service users and 17 professionals involved in palliative care. We analysed these using thematic analysis with two independent coders.

**Findings** We found several major themes. Service users identified access to their GP as a major barrier. Service users and healthcare professionals also identified discrimination and lack of trust in professionals. Healthcare professionals identified a lack of experience and education in caring for this group, but stated they were keen to develop this. Service users also identified education around what palliative care is as a major barrier to accessing services. Despite these themes both professionals and service users described their real life experience as positive.

**Conclusion** Although the experience of both service users and professionals in the context of palliative care in this community has been positive we have identified barriers to developing these services further. Flexible services are required to ensure holistic, and culturally sensitive care. This requires collaboration between services, with access to GPs being identified as a crucial area to start.

**164 COMPASSIONATE COMMUNITIES': A QUALITATIVE STUDY EXPLORING THE VIEWS OF GENERAL PRACTITIONERS**

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**Introduction** General Practitioners (GPs) face challenges when providing palliative care, including an ageing, multimorbid population, falling GP numbers and increasing demand. A ‘public health palliative care’ (PHPC) approach is gaining momentum, and is defined as ‘working with communities to improve people’s experience of death, dying and Bereavement’. ‘Compassionate communities’ is one example, supporting patients by linking professional health carers and community networks. Primary care is central to the approach, which has been incorporated into General Practice Dafodil Standards, however there is little evidence of GP perspectives of these approaches. Our aim, therefore, was to explore GP perceptions of PHPC and ‘compassionate communities’.

**Methods** Using snowball sampling, GPs were recruited through university teaching and research networks. Additionally, purposive sampling ensured widespread representation of gender, level of experience and practice populations. Following informed consent, semi-structured, digitally audio-recorded interviews were conducted. Interviews were transcribed verbatim, and thematic analysis was undertaken. Interviews continued until data saturation was reached.

**Results** Nine GPs were interviewed. Most were unfamiliar with ‘compassionate communities’, but recognised examples within their practice. Three themes identified perceived benefits of the model: ‘increasing awareness of community services’; ‘combating taboo’; and ‘embracing health outside of healthcare’. Three themes identified perceived barriers: ‘limited time and funding’; ‘patient safety concerns’; and ‘integration with current care’. Some GPs perceived the PHPC approach as a distinct social issue outside of ‘proper’ palliative care and General Practice. Others envisaged a GP ‘signpost’ role, supporting a community-led system.

**Conclusion** GPs recognised the importance of the wider community in caring for palliative care patients, but had differing views regarding the application of ‘compassionate communities’ and their position within this. Understanding more about the model’s practical implementation and exploring potential service-users’ views would help establish the feasibility of ‘compassionate communities’ in practice.

**165 EXISTENTIAL SUFFERING IN THE DAY-TO-DAY LIVES OF THOSE LIVING WITH PALLIATIVE CARE NEEDS ARISING FROM CHRONIC OBSTRUCTIVE PULMONARY DISEASE**

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COPD is predicted to become the 3rd biggest cause of death worldwide by 2030, placing palliative care provision a high
priority. COPD palliative care provision currently focuses upon physical symptom management with less attention paid to the holistic ethos of palliation. A integrative review of existing literature across twelve databases was undertaken to explore the presence of existential suffering for those living with COPD and associated palliative care needs. 35 papers were included within the review of both qualitative and quantitative underpinnings. Thematic analysis was completed, identifying key themes explaining the impact of existential suffering:

1. ‘Liminality’ Patients are unsure of who they currently are and who they will become throughout disease progression.
2. ‘Lamented Life’ Feelings of life ceasing to exist, fuelled by grief of former life prior to illness.
3. ‘Loss of Personal Liberty’ – Frustration that they couldn’t do activities/hobbies they once could.
4. ‘Existential Isolation’ Becoming isolated throughout disease progression from social and personal/family relationships. Feelings of being misunderstood had a significant impact upon low feelings of self-worth.
5. ‘Life Meaning’ Some patients were able to identify some life meaning and purpose, through adapting hobbies and interests to within their physical capabilities.

This integrative review has given good insight into how existential suffering manifests within this patient population. Furthermore, it has identified the need for further research to explore how life meaning and purpose is found within their daily lives, alongside the need to adapt current palliative care policy to encompass addressing existential suffering.

**Background**
Patients with end stage renal failure on dialysis have high a symptom burden (1) and survival on dialysis can be comparable to some cancers. (2) Increasingly it is recognised that patients with advancing age and comorbidities may benefit from a conservative approach rather than dialysis. (3) Patients with non-malignant disease often receive palliative services late or not at all. (4)

**Aims**
Development of a monthly Renal Palliative MDT meeting alongside a Supportive Care Register (SCR) with the aim to improve renal palliative integration, education and support for patients with End Stage Renal Failure (ESRF), particularly focusing on haemodialysis (HD).

**Results**
Data from 2018/19 collected and analysed. All deaths in patients on haemodialysis were analysed. In 2019 increasing amounts of haemodialysis patients who died had been identified and placed on SCR (48% versus 70%). Numbers of deaths in those not on SCR or discussed at MDT reducing each year, suggesting we are missing less of the patients who are likely to die. Some HD deaths will be in chronic patients who we could not predict would die suddenly. The referrals have been appropriate and controlled in number. The majority of patients on SCR and discussed died out of hospital in a community setting. A greater understanding of the population we support and mutual education has resulted in closer working relationships and increased referrals. Further development of a joint Nephrology/Palliative clinic is planned. A focus group to identify patient and carer needs and experiences is planned.