Introduction The role of Assistant Practitioner (AP) was first formally defined in 2002 and is widely considered a pioneering role able to work semi-autonomously across various health and social care settings. Although not registered to a formal body, an AP’s accountability comes through locally agreed and defined protocols. Health Care Assistants (HCA) can progress to AP by successfully completing a 2-year Foundation Degree in Health and Social Care. In 2015 Marie Curie Hospice Liverpool introduced the role of AP to work across all patient-facing areas and two individuals were identified to attend university one day a week while spending 4 days per week in practice developing new skills.

Methods Due to the role being new to the charity, there was opportunity for the AP to co-create the job specification and identify, with the help of the wider multi-disciplinary team (MDT), tasks which would be beneficial to the team for the AP to carry out. The AP would continue to carry out many of the tasks usually delegated to the HCA, while also developing new skills to support the registered nurse.

Results Both APs successfully completed the Foundation Degree and continued to develop the role and their skills. New opportunities to develop the role are continuously sought although there have been some barriers to development due to not being registered to a formal body; mainly around medication checking and administration. Nevertheless, venepuncture, assessing new patients, handover of patients to the MDT and assisting in the application of topical medications have become key skills within the role of AP.

Conclusion Although the introduction and implementation of the role has been somewhat successful, there are areas of the journey of the development of the role that have been identified that could have been improved on and role distinction is still unclear to a certain degree.

Introduction High-flow nasal oxygen (HFNO) is increasingly used as part of ward-based treatment, especially for oncology patients with respiratory failure that is either directly due to the underlying malignancy or secondary to anti-cancer drugs or radiotherapy-induced pneumonitis. Patient selection is paramount to its success, as unsuitable selection can result in delays in appropriate palliation, leading to unrealistic expectations for relatives.

Methods We performed a retrospective audit of 40 patients across both Gloucester Royal and Cheltenham General Hospitals, who received HFNO on the respiratory wards over July–December 2019.

Results The average age for patients receiving HFNO was 74 years with mortality rates being the highest at 80% in the 80–89 years age group. Interestingly, 81% of patients with HFNO as their ceiling of treatment died and only 10% of patients deemed for full escalation of treatment died. The majority of referrals were from medical specialties, closely followed by oncology. The oncology patients did show the highest mortality rates. The majority of patients referred for...