understanding of hospice care is lacking in trainee pharmacists due to minimal hospice training. The Experiential-Learning-Trajectory helped improve the trainees' confidence in understanding a pharmacists' contribution to hospice care. Further placements and evaluation using higher levels of Moore's Evaluation Framework is planned.

P-177 **EXPLORATION OF ATTENDANCE ACROSS 28 ECHO PROJECT ECHO NETWORKS IN THE CONTEXT OF EVERYDAY PRACTICE**

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10.1136/spcare-2021-Hospice.193

Introduction Many studies that have included reports of attendance at ECHO sessions have focused on networks that have purposively selected participants to attend. This data may not provide an accurate reflection of participation rates within the constraints of everyday practice.

Aim The aim of this study was to explore attendance patterns across ECHO networks attended by both medical and social care professionals within the confines of normal working practice, and identify the reasons for any observed variations.

Methods Network activity data were collected from 28 ECHO networks to include the number of ECHO sessions delivered within each network and the number attended by each participant. The number of 'low' (attended 1-32% of sessions), 'medium' (attended 34-67% of sessions) and 'high attenders' (attended $\geq 68\%$ of sessions) for each network were calculated. Data were examined and explanations for observed attendance patterns were extracted.

Results The majority of networks delivered nine ECHO sessions held monthly. 1588 participants attended at least once across all 28 networks. Variations in the proportion of low, medium and high attenders were observed across the networks. In 20/28 networks $\geq 50\%$ of participants were 'low' attenders. Reasons for low attendance included competing workplace demands and staff shortages. However, interview data indicated that for several networks with a high proportion of 'low attenders' participation in the network was at service rather than individual level. Impacts at a service level were still identified through qualitative data collection. Networks with a larger proportion of 'medium' or 'high' attenders were characterised by strong leadership and/or a link to wider service developments.

Conclusion It needs to be considered what outcomes are realistic to assess based on levels of attendance and number of ECHO sessions delivered. Qualitative data collection is recommended to unpick reasons for observed attendance patterns and identify any unexpected outcomes.

P-178 **USING THE CONSOLIDATED FRAMEWORK FOR IMPLEMENTATION RESEARCH (CFIR) TO EXPLORE THE USE OF PROJECT ECHO**

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10.1136/spcare-2021-Hospice.194

Introduction The Health and Social Care Board identified Project ECHO as a methodology to implement change. The aim was to develop the knowledge and skills of health and social care professionals, transform service delivery, and ultimately improve patient care. Up to 38 ECHO networks across a variety of settings (e.g. palliative care, ophthalmology) were established between 2018-2020.

Aim The aim of this study was to use the Consolidated Framework for Implementation Research (CFIR) to guide assessment of the outcomes and impacts, and explore the factors which influence success across different contexts.

Methods Qualitative study; key stakeholders including high and low attenders, and hub members were purposively invited to participate in a semi-structured interview; interview schedules guided by the CFIR method utilised for data analysis.

Results 28 stakeholders participated. Network purpose varied across contexts, (i) provision of education and support to isolated practitioners; (ii) support practical implementation of strategies/guidelines across sites, (iii) support cross sector working, (iv) build capacity of GPs to manage patients on waiting lists, (v) transform and provide ongoing governance of a new service. Impacts on participants included increased knowledge of conditions and symptoms, increased confidence to treat patients, and increased capacity to manage patients in primary care. Improvements in relationships between primary and secondary care, and across sectors were also reported e.g. improved understanding of regional strategies, service initiatives and referral pathways. Impacts at service level were reported.

Conclusion Project ECHO is an ideal methodology for not only delivering education and support to health and social care professionals, but also as a mechanism for delivering service change. CFIR is a useful framework for identifying preconditions which should be met before a network is operational to ensure success and sustainability.

P-179 **A JOINT AGENCY APPROACH TO PROMOTING WELLBEING AND RESILIENCE IN CARE HOME STAFF**

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10.1136/spcare-2021-Hospice.195

A regular multi-agency meeting 'The Ethical Task Force Group' was created in response to COVID-19 pandemic. It was recognised that staff, managers and owners of care homes were experiencing unique challenges during the pandemic. The task force comprised the Isle of Wight council, the Isle of Wight-Care Partnership and Mountbatten Hospice. The group met weekly to discuss concerns and issues relevant to all parties in order to respond to the needs of care home staff.

One main concern raised was the emotional impact the pandemic was having on care home staff. Many homes lost multiple residents in a short space of time. Often they had known their residents for many years and described their bereavement as the same as losing a family member. They were unable to acknowledge the death in the usual way and therefore were left coping with the ongoing stress of caring for their residents, whilst unable to access their usual support networks and process their bereavement. Both owners and managers of care homes were keen to access strategies and

services to support their staff. In the early stages of the pandemic there was a plethora of information outlining ways of managing the emotional impact of the pandemic. However, the information was not reaching the staff in an accessible way.

To address this we developed a simple guide to resilience and wellbeing for all staff. This joint project outlined different levels of support from informal peer led support and individual strategies, to formal referrals to bereavement or mental health services.

Outcomes and impact The guide received a national award from Skills for Care as an example of best practice. Following on from this work both Southampton CCG and West Hampshire CCG asked for the same guide to be sent to all care homes in Southampton city and West Hampshire.

P-180 DEMENTIA, STRESS AND DISTRESS – SUPPORTING THE PALLIATIVE CARE WORKFORCE

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10.1136/spcare-2021-Hospice.196

Background Behaviours and psychological symptoms of dementia (BPSD) are prevalent, complex, and distressing for people with dementia and caregivers. They are associated with additional stresses on people and systems, resulting in care packages breaking down, hospitalisations, caregiver burden, cognitive deterioration, psychotropic polypharmacy, and poor quality of life (Brodsky, Connors, Xu, et al., 2015). They are often the result of an unmet need such as pain. People living with dementia are often unable to self-identify or report pain and may express their discomfort through responses perceived as agitation and aggression. The correlation between behaviours and pain is known (Atee, Morris, Macfarlane, et al., 2021), yet more needs to be done to raise awareness with care staff, and to provide practical support as to what works.

Aims To describe the characteristics of referrals to a health technology programme, developed in response to pandemic restrictions, which provides relationship-based support to care staff as they respond to behaviours, stress and distress.

Methods A pilot study evaluated the feasibility of the programme from June-September 2020. Referral data included demographic and clinical characteristics such as age and BPSD. Data were reported as descriptive statistics. All referrals received BPSD assessments using the Neuropsychiatric Inventory-Questionnaire (NPI-Q) (Kaufer, Cummings, Ketchel, et al., 2000).

Results Referral characteristics: Mean age: 84.3 years (SD = 6.7); Female: 67.9%; Alzheimer's disease: 33.9%; Primary cause of behaviour: delirium (32.1%); pain (25.0%); Mean total NPI-Q severity score: 12.8 (SD = 6.5); Mean caregiver distress score: 15.7 (SD = 9.0); Referrals with ≥ 5 neuropsychiatric symptoms: 67.9%; ≥ 9 symptoms: 14.3%; Top three primary behaviours on referral: agitation, physical aggression, anxiety.

Conclusion BPSD were caused primarily by delirium and pain, both of which are prevalent but under-diagnosed in people with dementia (International Psychogeriatric Association, 2012). If care staff can access real-time support to mobilise assets and resources and build capacity, we can reduce the need for more costly health resources and the human costs of personal crisis (Macfarlane, Atee, Morris, et al., 2021).

P-181 HOW TO ENSURE THAT THOSE WHO DELIVER CARE ARE THEMSELVES WELL LOOKED AFTER- THRIVE OR SURVIVE!

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10.1136/spcare-2021-Hospice.197

Background A pilot scheme was delivered during the COVID-19 pandemic to support staff at a local hospital to cope with the unprecedented traumatic situation. This highlighted shortfalls and the need to promote systemic change in wellbeing provision, to encourage a more robust and accessible programme of support for healthcare professionals in multi-disciplinary organisations working with grief, loss, and trauma pre/post bereavement.

Aims To develop multidisciplinary tailor-made support for healthcare professionals, embracing cultural diversity, self-sustaining resilience, and empowerment. This support will incorporate various approaches and will be developed to meet presenting needs. It will aim to improve communication and develop a greater understanding between staff teams and organisations, encouraging working in partnership. It will promote transparency and openness as opportunities for learning and improvement rather than blame and punishment. It will lessen work-related stress and anxiety, create a happier and more compassionate environment, which in turn will improve quality of care.

Methods Review of literature. Feedback analysis. Internal consultation via multidisciplinary steering group meetings. Liaise with wellbeing department to work in collaboration. Consultation with relevant local organisations. Secure premises. Funding application. Recruit staff. Recruit and train specialist volunteers to provide therapeutic support. Continuous service review and evaluation using core assessment outcomes.

Results

- Increased coping strategies, emotional resilience, and mental health, measured by Core 10 psychological assessment.
- Increased peer and multidisciplinary support verified by group activity attendance and staff feedback.
- Improved communication channels.
- Staff training to deliver reflective practice and debriefs.
- Development of a specialist volunteer team
- A programme of workshops and therapeutic groups delivered to meet staff need.

Conclusion Evaluation showed increased awareness of the importance of self-care and peer support amongst healthcare professionals. Greater autonomy of support enabled a willingness to engage in wellbeing provision leading to additional coping strategies and resilience.

182 YOU CAN'T POUR FROM AN EMPTY JUG

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10.1136/spcare-2021-Hospice.198

Background In the earliest stages of the COVID-19 pandemic, Inverclyde was particularly badly impacted. Ardgowan Hospice felt strongly that, as well as supporting the local community, it didn't want those involved in supporting and caring for others during this unprecedented time to be overlooked.