Methods We designed a voluntary educational intervention for medical students interested in palliative care centred around two fictional hospital inpatients discussed in a virtual MDT. A multi-professional team was recruited (chaplain, clinical nurse specialist, occupational therapist, physiotherapist, clinician) led by a chair. Cases were designed to highlight MDT roles and reduce focus on the physician, with opportunities for questions. A practice session was conducted pre-event. Learning points included attributes and benefits of effective MDTs and understanding roles. Pre and post online surveys were distributed.
Results 6 participants attended this 60-minute pilot session with 83% (n=5) completing both pre and post surveys. Post-survey feedback indicated greater understanding of MDT roles (including that of the physician) with 100% (n=5) identifying they understood each professional's role (agree/strongly agree). Students cited features of an effective MDT including teamwork, communication, respect, structure. A better understanding of chaplaincy role was particularly valued.
Conclusion The intervention was time and resource intensive, reliant on technology adequacy – although this did facilitate remote attendance. Intervention timing (evening) likely impacted attendance. Although a small sample size, the intervention was well-received. Objectives of showcasing teamwork and adequate communication were met, despite online delivery. This virtual model could feasibly be delivered on a larger scale. There may be value in showcasing to other healthcare professionals. The option to record could further expand audience and convenience of access.

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P-43 DEVELOPING A POSITIVE PALLIATIVE CARE RESEARCH CULTURE WITH A BESPOKE ONLINE INTER-PROFESSIONAL RESEARCH TEACHING PROGRAMME

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Background Palliative Medicine is increasingly developing as an evidence-based specialty. However, research experience during training is not uniform for all disciplines involved. In a tertiary referral Cancer centre, palliative care clinical staff (N=30) reported a lack of confidence in the language and understanding of research and critical appraisal, inhibiting research engagement.
Aim To create a bespoke research teaching skills course which builds confidence and capacity in a multi-disciplinary team thereby fostering a positive research culture.
Method A virtual programme was developed with 10 live sessions which were recorded for offline access. The programme was based on learners' needs and included terminology, audit vs. research, statistics, quantitative vs. qualitative and how to appraise research papers. It employed a range of teaching aids including interactive quizzes and games. Responses from pre- and post-programme questionnaires plus individual session feedback were compared to assess changes in confidence and enthusiasm for research engagement.
Results The pre-course survey highlighted a lack of confidence. On a scale of 1–10 (10 most confident), scores ≤5 were reported for 50% of staff regarding research methods and evaluating journal articles, 60% for research language and 70% for statistics. Feedback for individual sessions demonstrated improved confidence, with 85% reporting this for statistics. The post-course survey highlighted a global improvement in confidence and knowledge with 100% of respondents rating the course a minimum of 8/10.
Conclusion This research teaching programme has improved confidence and encouraged a more positive research culture amongst clinical staff, opening doors for further research and education opportunities.

P-44 GEORGE FLOYD AND THE DEVELOPMENT OF THE ASSOCIATION FOR PALLIATIVE MEDICINE (APM) RACE EQUITY COMMITTEE

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Background Racial prejudice and discrimination are increasing in healthcare and towards healthcare professionals. Studies show increased rates of poor mental and physical illness among the minority ethnic ageing population compared with the majority population.[1] Research and GMC data also demonstrate disparities according to ethnicity in medical workforce outcomes across all measures of training and career progression, as well as GMC investigations and sanctions.[2]
Race Equity in Palliative Care Within palliative care there is evidence of poor access and outcomes for minority ethnic groups. This has commonly been attributed to deficits within minority ethnic communities such as lack of awareness and misconceptions of services, religious and cultural preferences, a reluctance to engage in advance care planning and language barriers. Little serious consideration has been given to structural disadvantage.[3]
Race Equity Committee Following the death of George Floyd and the Black Lives Matter demonstrations of 2020, the APM supported the creation of a Race Equity Committee, led by a group of trainees and consultants working within the specialty from minority ethnic backgrounds. The Committee has been supported by members of the APM executive team. The Committee aims to:

1. Create a safe space for members from minority ethnic backgrounds to share experiences and views on how to address racial and ethnic inequity.
2. Understand the experiences of staff working within palliative care of racial and ethnicity-based prejudice and discrimination.
3. Support the development of an anti-racism strategy within the APM.

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Progress:

1. The committee have valued peer support and aim to expand membership so others can benefit from a safe space for minority ethnic staff within palliative care. Safe spaces for allies will also be supported.
2. A staff survey to explore experiences of racism within palliative care is due for release.
3. A commitment to being better representative of the minority ethnic people it champions.

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P-45 BEGINNING TO CHANGE PRACTICE? – EXPERIENCES OF VIRTUAL BREAKING BAD NEWS TEACHING FOR FOUNDATION YEAR 1 DOCTORS

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Background Breaking Bad News and having conversations at the end of life is an important skill needed for Foundation Doctors. Every year all our Foundation Year 1 (FY1) doctors undertake this teaching. Due to COVID-19 we quickly changed our traditional face-to face teaching day, to a virtual session. We wanted to understand if this virtual teaching was valuable for participants and what impact it may have on their clinical practice.

Methods During the academic year of 2020–2021 we conducted 6 virtual teaching sessions around end-of-life conversations, resuscitation decisions and breaking bad news. These sessions were undertaken by FY1 doctors. Each student completed an eLearning module then attended the teaching session. Teaching sessions involved mixed educational modalities including didactic sessions, role plays and group reflective discussions over the course of 1 day. Each session involved up to 20–25 participants per session. They only needed to attend 1 session over the year. Approximately 6–8 weeks later attendees were invited to fill in an evaluation to understand the impact of the teaching for them.

Results Approximately 120 FY1 doctors attended one of the 6 sessions from September 2020 to March 2021. 34 attendees completed the delayed evaluation. 62% found they were looking after dying patients weekly, with 30% having conversations with either patients or relatives about dying most weeks. 70% felt the virtual teaching had changed the way they had conversations with dying patients and their relatives. Examples included feeling empowered to start these conversations, how to pace the information given and the importance of using the word die in the conversation.

Conclusion This first year of doing these sessions virtually has been overall positive, with some significant clinical impact for these junior doctors. These challenging topics are still educationally impactful despite being taught virtually.

P-46 TIME CRITICAL TELEPHONE CONVERSATIONS IN THE EMERGENCY DEPARTMENT – CHANGING CLINICAL PRACTICE THROUGH SIMULATED TELEPHONE CALLS FOR BREAKING BAD NEWS SITUATIONS

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Background In many countries the COVID-19 pandemic has resulted in restricted hospital visiting by relatives. Staff have been forced to deliver unwelcome news over the telephone. There are few training resources around how to do this. We created a bespoke training package consisting of a 15-minute eLearning session and a 1-hour facilitated role-play session. We wanted to see if this could help improve conversations over the phone and if this could potentially impact clinical practice when doing this.

Methods A blended learning package was created. This consisted of a bespoke 15-minute eLearning session and a 1-hour facilitated role-play session. Two simulated telephone calls to a professional actor, posing as the relative were undertaken. The calls simulated realistic time critical telephone conversations including obtaining crucial medical information, conveying news of an acutely unstable patient. A second call to the relative involved breaking the news that the patient had died. Following this the actor gave feedback to the caller focusing on the experience of a relative during these conversations with. Participants were asked for evaluation 4–6 weeks later after attending the session.

Results 240 staff received this session over 12 months, from May 2020- May 2021. Participants were nurses and doctors of all grades. 98 participants (40%) completed the delayed evaluation. 70% of participants used the knowledge from these sessions in their clinical practice. With themes of the importance of checking where the relative was, being empowered to use the phrase died over the phone, and how tone of voice is crucial. 85% feel these sessions have changed how they now practice.

Conclusion The unique opportunity to practice these new skills and using the feedback from an actor in this format has influenced clinical practice. Further work and training are needed to understand this more.

P-47 DEVELOPING A FRAMEWORK FOR COMMUNICATING TIME CRITICAL TELEPHONE CONVERSATIONS IN THE EMERGENCY DEPARTMENT

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10.1136/spcare-2022-SCPSC.68

Background The COVID-19 pandemic has resulted in restricted hospital visiting by relatives. Staff have been forced to deliver unwelcome news over the telephone. There are few training resources around how to do this. We created a bespoke training package consisting of a 15-minute eLearning session and a 1-hour facilitated role-play session using an actor. As these conversations can be often challenging, we

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