clinical and non-clinical skills after completing specialty training and the support available during the transition from trainee to consultant.

Method An online survey, using previous literature, pilot tested on multi-specialty consultants to test functionality. A five-point Likert scale to record various aspects of preparedness was used. The survey was distributed via the Association for Palliative Medicine email and social media. Ethics approval was obtained.

Results Forty-eight consultants completed the survey; 80% were female. 40% were in a consultant post for 1 year, 50% worked across multiple settings, 46% worked as a specialty doctor before training. The majority felt very or extremely prepared in clinical skills (71%), audit (84%), interaction with other colleagues (70%), time management (64%) and self-management (64%). 50% felt moderately prepared in Human Resources, 68% in organisation structure and 52% in leadership. The majority (70%) were not at all or slightly prepared in financial management. 50% reported being moderately and 43% slightly or not at all prepared in complaint management. Attendance at management and leadership course (68%) and management meetings (55%) were most useful to gain management experience. The majority (75%) found departmental colleagues gave the most support in stressful situations but only 7% had a formal mentor.

Conclusion Palliative Medicine consultants may require support with the non-clinical aspects of their role, such as management of complaints, finances and mentorship. This is consistent with findings from other specialties. Future research should identify how trainees should be supported in these areas, especially with changes to speciality training; 'Shape of training'.

39 DID YOU KNOW YOU COULD GIVE THE GIFT OF EYESIGHT? AN AUDIT OF CORNEAL DONATION DISCUSSION AT A PALLIATIVE CARE HOSPICE

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Background Currently in the United Kingdom there is a shortage of 500 corneal donors per year with a waiting list of 2 years. To address this, Sue Ryder St John's Hospice actively encourages all of its doctors to discuss with patients their views on corneal donation.

Aim The aim of the audit was to assess if all new inpatient admissions to the hospice were considered eligible for a discussion about corneal donation. A standard was also set for these discussions to occur within 72 hours of admission.

Method A review of electronic patient records for all admissions between January 1st 2022 to March 31st 2022.

Results There were 34 admissions to the hospice in this time. All admissions were considered for corneal donation discussion. Discussions were had with 79.4% (27/34) patients, all within the target time frame of 72 hours. Those not had were due to reasons such as confusion or rapid deterioration. Out of the discussions that occurred, 96.3% (26/27) of them were held by GP trainees. As a result of this developing trend, a concurrent survey was sent to all the GP trainees in February to indicate their confidence levels in this topic. Of the responses, 100% (4/4) of trainees had never had such discussions before with only 50% (2/4) of them having heard about corneal donations prior to their palliative care placement. The change implemented was the creation of an informational leaflet about corneal donation which was distributed in March. This educational resource was also incorporated into the induction pack for future trainees. The leaflet was well received and data continued to be promising.

Conclusion This local hospice demonstrated a high rate of discussions about corneal donation. Fostering an awareness among all staff, like the GP trainees, was key to promoting this.

40 PHASE OF ILLNESS SURVEY

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10.1136/spcare-2023-PCC.60

Background Phase of Illness (POI) describes the current stage in the patient's illness and are classified according to the care needs of the patient. The phases are stable, unstable, deteriorating, and dying. POI are useful to prioritise interventions, manage caseloads and in handovers. POI is documented at every clinical contact by a range of healthcare professionals (HCP); therefore, consistency of assessment is important.

Aim To assess whether there is consistency across the organisation and clinical areas as to how to POI is being used and interpreted.

Method Clinical staff across the organisation were asked to complete two questionnaires. Two fictional patient scenarios were devised for the surveys. HCPs were asked to choose which POI best represented the patient's condition, which evolved over time, at each clinical contact by an HCP.

Results Thirty-five HCPs completed scenario 1, 29 completed scenario 2. The range of HCPs included nurses, doctors, physiotherapists, occupational therapists and patient and family services. Majority agreement across all POI assessments in scenario 1. Five of the seven questions having agreement of the phase by over 70%. Less agreement across the POI assessments of scenario 2. Only 2 questions showing agreement by over 70% of the respondents. This was in part due to disagreement when to change from unstable to another POI.

Conclusion POI assessments give a useful description of the patient and families' current care needs and whether an effective care plan is in place. This survey shows that there is mostly agreement of POI assessment across the multidisciplinary team. More work in terms of staff training and support is required to ensure the consistency of POI assessment across the hospice. The results of the survey have been disseminated to the hospice HCPs with a focus on when to change a POI.

41 FORTY YEARS OF PALLIATIVE AND END OF LIFE CARE TEACHING: A RETROSPECTIVE AND AN UPDATE

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10.1136/spcare-2023-PCC.61

Background Palliative and end of life care (PEOLC) is now a core competency for all UK graduating medical students. In 1983, a UK-wide survey investigated how PEOLC was being taught in medical schools. A similar survey has been

conducted every decade since, in 1994, 2000, 2013, and now 2021. This paper presents 2021 survey data, providing an overview of current national practice and historical comparison over the last forty years.

Method An anonymised web-based 46-item questionnaire was sent to the PEOLC Teaching Lead(s) at 35 UK medical schools. Results were compared between all previous surveys.

Results Responses received from 32 schools. Time allocated to PEOLC teaching continues to increase, with mean hours (1983, 1994, 2000, 2013 and 2021) being 6-h, 13-h, 20-h, 36-h, and 39-h respectively. There is greater focus on clinical experience than before (in 1983 hospice visits were usually optional and rarely offered), with medical students spending more time in relevant clinical environments. However, in 38% of schools students are allocated less than one week (average 2 days) in total to attend clinical areas relating to PEOLC. The number of PEOLC teaching topics addressed in each survey has increased (respectively 8, 15, 19, 21, and 29 topics) and are reported to be covered in greater detail. Assessment of PEOLC teaching has evolved from informal student feedback to the use of formal examination (respectively 0%, 22%, 58%, 83%, and 91%).

Conclusion PEOLC has grown to become a mandated subject with its own widening curriculum. The quantity and quality of medical school PEOLC teaching has increased over the last forty years, with students spending more time meeting patients with palliative care needs. There is however great variability in what is provided, and recent literature on the preparedness of new doctors suggests that there is still considerable room for improvement.

42 PALLIATIVE AND END OF LIFE CARE TEACHING DURING THE COVID-19 PANDEMIC – WHAT CAN WE LEARN?

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10.1136/spcare-2023-PCC.62

Background The COVID-19 pandemic caused far-reaching disruption and medical education had to rapidly adapt to overcome the many challenges. Palliative and end of life care (PEOLC) is a core competency for all UK graduating medical students, and may involve emotionally confronting topics requiring great care during teaching sessions, which is potentially difficult in a virtual environment. The ability of medical schools to foster experiential PEOLC learning may also have been impacted. However, the pandemic may have been a catalyst for some positive changes in PEOLC teaching too. Questions relating to the pandemic were included as part of a larger national survey of PEOLC teaching.

Method An anonymised web-based 46-item questionnaire was sent to the PEOLC Teaching Lead(s) at 35 UK medical schools. 12 items related to adaptations to teaching during the COVID-19 pandemic.

Results Responses received from 31 schools. Previously popular teaching methods, such as lectures and seminars/small group discussions, were newly introduced in an online format in 94% and 87% of medical schools respectively. Utilisation of e-learning increased from 59% to 84%. Other newly introduced teaching methods included: telemedicine, podcasts, augmented reality, virtual reality, and virtual ward rounds. Use of experience in clinical areas as a teaching method decreased from 100% to 68% of medical schools. In 30% of schools, assessments were no longer in-person. 40% of participants declared that they had developed novel teaching methods or resources during the pandemic, mostly relating to technology enhanced learning or simulation. Many participants shared the opinion that the increased use of online resources and pre-recorded sessions will persist after the pandemic.

Conclusion The COVID-19 pandemic necessitated PEOLC teaching to rapidly transition online and the use of novel approaches to facilitate clinical experience, however a number of medical schools intend to continue utilising skills and resources developed during this time.

43 FOUNDATION TRAINEE DELIVERY OF PALLIATIVE CARE: A QUALITY IMPROVEMENT PROJECT AIMING AT ANALYSING AND IMPROVING CONFIDENCE IN FOUNDATION DOCTORS VIA MEDICAL EDUCATION

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Background The aim was to determine confidence levels of Foundation Year 1 and 2 trainees in managing palliative care patients, intervene to provide further support in highlighted areas and measure the impact of this support. Literature reviews demonstrate junior doctors from a range of specialties feeling 'unprepared and unsupported in providing palliative care'.[1]

Methods Confidence levels were measured using a questionnaire prior to intervention at the beginning of the foundation year completed by 37 foundation trainees across various specialties. A teaching intervention was created from these results, of which 31 foundation trainees attended, and the same questionnaire completed for comparison.

Results The 'Before Intervention' questionnaire showed that a high proportion of trainees were 'uncertain' or 'very uncertain' in a range of palliative skills. 45% ranked this regarding who to ask for palliative care advice, 29% for how to have end of life conversations with NOK/family, 19% for advance care planning conversations, 35% for rationalizing medications and 61% for syringe driver commencement.

After the teaching intervention, only 4% of foundation doctors said they felt uncertain seeking palliative care advice. There was a large increase in confidence for talking to patients and relatives about dying. The proportion who felt 'confident' increased by 49%, and those who felt 'uncertain-very uncertain' decreased by 25%. Advance care planning conversations were deemed more achievable – those in the uncertain category decreased by 15.5%. Uncertainty about syringe driver commencing decreased to 12%.

Conclusions Medical education has an important role in palliative care and has demonstrated to have a positive impact on the foundation doctor's confidence in delivering care. The aim will be to re-measure confidence levels after a period of clinical practice to determine long term impact of teaching, identify further areas to support the foundation doctors and employing appropriate education methods for the the wider multidisciplinary team.

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