concluded this is safe and effective.\textsuperscript{3,4} For patients using high doses of around-the-clock opioid it is hypothesised that proportional dosing may prevent dropout of participants during titration, due to lack of confidence of efficacy before maximal dose has been achieved.\textsuperscript{3}

Methods We performed a systematic review of the literature for pharmacological and non-pharmacological management of breakthrough cancer pain. A survey of healthcare professionals working in specialist palliative care and multi-centre case-note review were performed analysing current management of breakthrough cancer pain.

Results 94 Healthcare professionals (HCP’s) responded covering community, hospice and hospital settings. 57\% prescribe transmucosal Fentanyl, with most initiating transmucosal Fentanyl every 2–3 months. The main benefits are its short duration of action and rapid onset of action. 73\% found the greatest barrier is the titration schedule. 90\% found heat and cold packs helpful. Davies\textsuperscript{5} also concluded heat, rest and positional change were most beneficial non-pharmacological options. 179 patient case notes were analysed. 56\% of those prescribed transmucosal Fentanyl were using equivalent to 60mg morphine as background opioid, 34\% were using less than equivalent 60mg morphine. 65\% of cases had pain assessed using a tool, 74\% of these used the Numeric rating scale. In 84\% of patients the titration schedule was used. 83\% of patients initiated on transmucosal Fentanyl continued to use it, discontinuation was most common due to entering the dying phase.

Conclusion Regional standards and guidelines have been updated following this review. There was consensus that under specialist palliative care guidance where patients are using the equivalent or higher than 60mg Morphine per 24 hours it might be appropriate to consider starting transmucosal Fentanyl at higher doses than manufacturer recommendation.

REFERENCES
Abstracts

Design Retrospective case note analysis and prospective interventional quality improvement study.

Setting A 16 bedded specialist palliative care inpatient unit.

Population Hospice inpatients with an ECOG performance score of zero to three who had been prescribed opioids.

Intervention Three Plan-Do-Study-Act (PDSA) cycles were performed. Firstly, the issue was discussed in the daily multidisciplinary team meeting (MDT) to raise awareness, secondly a prompt was added to a pre-existing clerking proforma. Finally, a reminder poster was placed in the ward office to promote discussion prior to discharge.

Outcome Measures Primary measures were the proportion of patients with the presence of documented driving status, and the presence of a documented discussion surrounding driving and opioids.

Results Baseline data found that 11.5% of patients had a documented driving status and 11.5% had a documented discussion surrounding driving and opioids. Over the course of the study the proportion improved to 65.2% and 60.9% respectively.

Conclusion Use of Quality improvement change methods have resulted in the successful integration of new interventions to increase discussions around driving when prescribed opioids. A previously overlooked issue in this facility, thus improving clinical and patient information sharing, and patient empowerment to take charge of their own health.

Poster Nos 85–89: Psychosocial

85 THE PREVALENCE AND IMPACT OF CHRONIC BREATHELESSNESS IN AN OLDER, FRAIL POPULATION IN PRIMARY CARE

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Background Chronic breathlessness is a debilitating symptom with major adverse impact on those involved. Little is known about prevalence and impact of breathlessness in community-dwelling older, frail adults.

Methods Mixed-methods study. Cross-sectional survey of 249 adults at risk of severe frailty (living in own homes; >65 years, eFrailty Index >0.36) to determine i) prevalence (self-reported breathlessness most days/past month), ii) impact of chronic breathlessness (questions about mental health, activities, care from healthcare practitioners (HCPs), and iii) associated clinical factors. Qualitative interviews explored psychological impact and experiences of breathlessness care in primary care for: patients (n=20), carers (n=5), and HCPs (n=10). Quantitative analysis used descriptive and inferential statistics (odds ratios); qualitative data were subjected to thematic analysis. Findings were synthesised using modified Critical Interpretative Synthesis.

Results 99/249 (40%) participants (median age 80 years, 61% women) reported chronic breathlessness. Breathlessness was associated with worse psychological outcomes: higher odds of anxiety (OR 2.2; 95%CI 1.29–3.85), family anxiety (OR 2.0; 95%CI 1.20–3.41), and depression (OR 1.9; 95%CI 1.12–3.39) (measured on Integrated Palliative care Outcome Scale), and poorer quality of life (QoL): higher odds of significant problems with usual activities (OR 1.78; 95% CI 1.06–2.96) (measured on EQ-5D-5L). People with chronic breathlessness give up activities because of their breathlessness which they conflate with underlying disease. Breathlessness is ‘one of many’ symptoms and in context of ‘one appointment, one problem’, is not recognised as therapeutic target by patients or HCPs, remaining invisible and unmanaged. HCPs can feel helpless and do not routinely ask about impact of breathlessness.

Conclusion Over one-third of older, frail adults live with chronic breathlessness with major detrimental impact. Lack of routine assessment in primary care means they may not access evidence-based symptom-targeted interventions. Systematic identification, assessment, and management in primary care may help improve psychological health, QoL, and overall wellbeing.