improve quality of life (Booth. Prog Palliat Care. 2013; 21:4). They have not been developed or evaluated in the palliative day therapy setting.

**Aims** To explore the feasibility of implementing a breathlessness programme and evaluate patient experiences and outcomes.

**Method** The Cambridge Breathlessness Intervention Service study day was attended by a specialist palliative care physiotherapist and occupational therapist, to consolidate existing knowledge and understand the Breathing, Thinking, Functioning model (Spathis, Booth, Moffat, et al. Prim Care Resp Med. 2017; 27(1):27). A six-week group programme was designed and implemented covering breathing techniques, staying active, stress and anxiety, fatigue management, living well whilst planning for the future and guided relaxation. This took place weekly, in four hour sessions. The programme was delivered by a physiotherapist and occupational therapist, with support from nursing and medical colleagues. Demographic data and patient feedback were collected, with the Chronic Respiratory Questionnaire- Self Reported (CRQ-SR), (Williams, Singh, Sewell, et al. Thorax. 2001; 56(12): 954–9) completed at weeks one and six.

**Results** 44 patients were referred to the programme. 47% had a cancer diagnosis, 30% a respiratory condition, 10% cardiac failure and 13% a mixed cancer/respiratory pathology. 14 patients attended the group, over three different cohorts. 7 patients completed the entire programme and completed the PROMs. 9 patients died after referral, 4 after starting the group. The 21 referrals who did not start a group either declined the group or were not appropriate for a variety of reasons. The mean number of sessions attended was 3.5. Of those that completed the programme, CRQ-SR score had a mean improvement of 10.7 points, with the Mastery domain demonstrating a mean improvement of 3.28, where 2.0 is considered significant (Morgan. Respiratory Med. 1991; 85:23–24).

**Conclusion** An informal group in a day therapy setting can be an effective, acceptable and feasible method of delivering a breathlessness and fatigue management programme. This project can offer learning to those in similar settings.

**P-166 THE CREATION OF A HOSPICE BASED PALLIATIVE BREATHLESSNESS REHABILITATION GROUP: ‘TAKE A BREATH’**

Sarah Sharp. Sue Ryder: Leckhampton Court Hospice, Cheltenham, UK

10.1136/spcare-2023-HUNC.187

**Background** Respiratory disease affects 1 in 5 people and is the third biggest cause of death in England. Both British Thoracic Society (BTS, 2013) and NICE guidelines advocate the use of pulmonary rehabilitation. However, research shows that those people with advanced disease struggle to complete pulmonary rehabilitation despite evidence confirming significant benefits. The Breathlessness Service at this hospice regularly encountered patients with end stage disease who either declined or were unable to access NHS pulmonary rehabilitation. Despite a high symptom burden, patients with respiratory disease remain under-represented in palliative care. Research suggests that by integrating pulmonary rehabilitation with palliative care, symptom burden can effectively be addressed in a holistic, patient centered manner.

**Aim** To set up a hospice-based breathlessness rehabilitation service which will provide patients with advanced disease a supportive environment in which to exercise and learn self-management techniques.

**Methods** A literature search was conducted confirming the evidence base for a palliative pulmonary rehabilitation group. Using BTS and NICE guidance, a 6 week programme of 2 hour sessions was devised consisting of circuit based exercises, education topics and relaxation sessions. Using an existing cohort of patients, a pilot group was formed, completing the first ‘Take a Breath’ course in February.

**Results** Patients demonstrated improvements both subjectively and objectively. Data was collected using a modified Chronic Respiratory Questionnaire (CRQ), Phase of Illness, Karnofsky Performance Scale, Timed Up and Go and a patient feedback questionnaire.

**Conclusions** This course is an effective example of rehabilitative palliative care, and also importantly provides an introduction and route into hospice care. For many of these patients, ‘Take a Breath’ has been their first experience of hospice care and has allowed them to go and make further links with the wider hospice MDT. Further audit into the longer term benefits would be beneficial, in terms of symptom control, self-management and also ongoing engagement with palliative care services.

**P-167 POST PANDEMIC IMPLEMENTATION OF A HOSPICE-BASED REHABILITATION PROGRAMME**

Nikki Reed, Sophie Boyle, Lisa Shymalan. Marie Curie Hospice West Midlands, Solihull, UK

10.1136/spcare-2023-HUNC.188

**Background** In March 2020 the community focused day services at our hospice were stopped overnight as the UK went into national lockdown due to the pandemic. In April 2022 it was acknowledged, that whilst still balancing Infection Prevention & Control measures (IPC), it was important to re-establish community focused day services within the hospice.

A literature review highlighted:

1. Rehabilitative palliative care has the potential to reduce disability and reduce dependence on families, health, and social care services.
2. Prolonged periods of social isolation reduce quality of life.

**Aim** To implement a rehabilitation programme at our hospice.

**Methods** A small project group generated: Inclusion/exclusion criteria; Standard Operating Procedure; Project management documentation; Risk assessments; Agreed validated outcome measures.

An eight-week rehabilitation programme was commenced in April 2022. Initial assessment with both a physiotherapist and occupational therapist, to consolidate existing knowledge and understand the Breathing, Thinking, Functioning model (Spathis, Booth, Moffat, et al. Prim Care Resp Med. 2017; 27(1):27). A six-week group programme was designed and implemented covering breathing techniques, staying active, stress and anxiety, fatigue management, living well whilst planning for the future and guided relaxation. This took place weekly, in four hour sessions. The programme was delivered by a physiotherapist and occupational therapist, with support from nursing and medical colleagues. Demographic data and patient feedback were collected, with the Chronic Respiratory Questionnaire- Self Reported (CRQ-SR), (Williams, Singh, Sewell, et al. Thorax. 2001; 56(12): 954–9) completed at weeks one and six.

**Results** 44 patients were referred to the programme. 47% had a cancer diagnosis, 30% a respiratory condition, 10% cardiac failure and 13% a mixed cancer/respiratory pathology. 14 patients attended the group, over three different cohorts. 7 patients completed the entire programme and completed the PROMs. 9 patients died after referral, 4 after starting the group. The 21 referrals who did not start a group either declined the group or were not appropriate for a variety of reasons. The mean number of sessions attended was 3.5. Of those that completed the programme, CRQ-SR score had a mean improvement of 10.7 points, with the Mastery domain demonstrating a mean improvement of 3.28, where 2.0 is considered significant (Morgan. Respiratory Med. 1991; 85:23–24).

**Conclusion** An informal group in a day therapy setting can be an effective, acceptable and feasible method of delivering a breathlessness and fatigue management programme. This project can offer learning to those in similar settings.
3. Completion of validated outcome measures were sporadic.

Following this review the priorities generated are:
1. Significant focus on the promotion of this service to external community and hospital stakeholders, aiming to receive earlier patient referrals.
2. The programme is now offered as a ‘rolling’ programme.
3. Outcome measures were reviewed and refined – acknowledgement that specific training around these will be necessary for professionals involved.

This rehabilitation programme and its project plan could be reproducible at other hospices.

**Conclusion** Rehabilitation in palliative care improves the quality of life for patients. It reduces disability and a group approach aims to address the social isolation that our patient cohort experience.

**Abstracts**

**P-169 FOREST BATHING AS A THERAPEUTIC HEALTH INTERVENTION FOR THOSE ACCESSING HOSPICE SERVICES: A COLLABORATIVE PILOT STUDY**

1. Julie Waite, 2Rachel Norman, 2Rachel Norman. 1Treetops Hospice, Risley, UK; 2Nottingham Trent University, Nottingham, UK

**Background**


**Aim(s)** Evaluate whether spending time immersed in nature had a positive effect on wellbeing for people who access hospice services. Measure any contrast in results, if any, between guided and unguided Forest Bathing. Study the correlation between nature and impact on wellbeing.

Understand how this therapeutic intervention could enhance service provision.

**Methods**

- 17 participants.
- 60 minutes immersed in nature.
- Heart rate variability (HRV) measurement.
- Data analysed using analysis of variance and the reliable change index for both psychometric measures and HRV.

**Results** Improved HRV in both guided and unguided conditions, more improvement in guided condition. Improved Wellbeing and Inclusion in nature scores in both conditions after Forest Bathing, but greater in guided condition. This was a small pilot study, but data suggests that offering Guided Forest Bathing alongside more traditional therapeutic interventions may improve wellbeing, feelings of inclusion in nature and Heart Rate Variability.

**Conclusions** The study was to test if a nature-based concept could offer a therapeutic intervention alongside standardised care at the hospice. The results show strong evidence that