

9 WHAT IS THE COMMUNITY PHARMACIST'S ROLE IN PALLIATIVE CARE: VIEWS OF HEALTHCARE PROFESSIONALS WITHIN A UK CITY

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10.1136/bmjspcare-2018-ASPabstracts.9

Background Changes in population demographics and greater demand for palliative care are placing increased pressure on general practitioners (GPs) to support patients and families near the end of life. There is little research on how community pharmacists (CPs) contribute and collaborate in the care of palliative care patients in the primary healthcare team. The aim of this study was to determine views of healthcare professionals on the CPs' role in palliative care.

Methods In-depth qualitative semi-structured interviews with a purposive sample of 16 community healthcare professionals. Participants were recruited through e-bulletins, email, team leaders and hospice team within Sheffield. Interviews were audio-recorded, transcribed verbatim and analysed using the Framework method following an inductive and iterative thematic process. Ethical approval was obtained from the University of Bradford.

Results 5 CPs, 3 GPs, 5 community nurses, 2 palliative care team members, and 1 intermediate care team member consented to interview. Two main themes emerged: timely access to palliative medicines and the CP's role in palliative care. There was poor understanding of the CP's professional role and pharmacy services of potential benefit to palliative care patients with nurses and GPs holding a traditional view of CPs in the dispensing and safe supply of medication. The CP's role was limited due to reluctance from other healthcare professionals to share information, poor access to patient records and a lack of integration into the primary healthcare team.

Conclusion Despite the national direction to increase the CPs involvement in palliative care, they remain a largely untapped resource for supporting patients and families towards the end of life due to a lack of integration into primary healthcare teams.

Acknowledgements This research was funded by Pharmacy Research UK (Grant reference GA10). The views expressed are those of the authors and not necessarily those of Pharmacy Research UK.

Free papers 10–12 | Developing approaches to palliative care

10 BARRIERS TO PALLIATIVE CARE IN RESOURCE-LIMITED SETTINGS: A QUALITATIVE STUDY IN KAZAKHSTAN

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10.1136/bmjspcare-2018-ASPabstracts.10

Background Palliative care (PC) improves the quality of life of patients and their families facing life-threatening illness through relief of physical, emotional, and psychological suffering and pain. Identification of modifiable determinants of obstacles to universal quality PC in resource-poor settings like

Kazakhstan can represent an example for other countries with similar challenges in PC provision. The 2015 Quality of Death Index, which evaluates global distribution of availability and effectiveness of PC, places Kazakhstan 50th out of 80 countries assessed. The Association of Palliative Care of Kazakhstan reports a substantial unmet demand for increased accessibility to pain relief medications, increased numbers of PC facilities, and training courses for medical care professionals. These improvements are supported by legislation and national policies.

Specific Aims to identify specific determinants of obstacles to provision of PC in a resource-limited developing country including drug availability, opportunities for healthcare professionals to receive training in palliative medicine and policy development process, as well as to evaluate the status and cost-effectiveness of PC provision in Kazakhstan.

Methods The study employs qualitative research in form of purposive recruiting with content analysis, semi-structured in-depth interviews until targeted participant numbers are completed or saturation is achieved. Consent was provided by participants. The data is then translated into English, coded and analysed. With the new study findings, supplemented by published literature and government documents, the best practices within the socio-cultural context of Kazakhstan are systematically determined.

Preliminary results The determinants of barriers to palliative care provision in Kazakhstan are associated with the limited availability of opioids, lack of specialist training and insufficient public awareness concerning palliation.

11 DO WE PREPARE PATIENTS FOR THEIR DIGITAL LEGACY? A SURVEY OF HEALTHCARE PROFESSIONALS IN THE WEST MIDLANDS

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10.1136/bmjspcare-2018-ASPabstracts.11

Background Social media is becoming a more prominent part of our everyday lives. As a consequence we will be leaving a digital legacy after death. Digital legacy is the digital information that is available about someone following their death, which may include website or blog listings, social media profiles, photos, videos and gaming profiles. Many will find it a comfort that their legacy remains on social media but there can also be negative consequences in relation to death, dying and bereavement. This survey was carried out to establish whether we prepare patients for their digital legacy within the West Midlands.

Methods An online survey was sent to 11 hospices within the West Midlands over a 6 week period with an initial email and then a reminder at 3 weeks. The survey was circulated by the hospices to the doctors, nurses and social workers.

Results 210 responses were collected (35% response rate). The majority of respondents were from nurses (77%). Doctors accounted for 22% of the responses and 7% were from social workers. 96% had never discussed digital legacy with patients. Reasons for not having such discussions largely related to it not being considered, lack of knowledge about digital legacy or it not being felt to be appropriate or important.

Discussion This survey of health and social care professionals shows that we do not discuss digital legacy with patients. There is a potential unmet need that we are not addressing

for patients. There is an education need across the region to raise awareness and confidence of digital legacy, which the undertaking authors will be addressing.

12 IS SIMULATION AN EFFECTIVE WAY TO TEACH PALLIATIVE MEDICAL EMERGENCIES TO SPECIALIST TRAINEES?

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10.1136/bmjspcare-2018-ASPabstracts.12

Background Simulation is increasingly being used to train those in 'acute' medical specialties, offering the chance to practice in a safe environment, without compromising patient safety. It lends itself particularly to infrequently occurring situations which are potentially life-threatening. Its use in palliative medicine is mainly limited to advanced communication skills – there is little published work regarding its use for acute clinical skills.

Methods A simulation day was arranged for eleven palliative medicine specialist trainees in the East Midlands. This covered five scenarios (hypoglycaemia, opioid toxicity, acute left ventricular failure, massive haemorrhage and anaphylaxis) from the specialty training curriculum for palliative medicine. In each scenario trainees took part in pairs, the 'patient' being an actor, or the 'SimMan' manikin. There was a nurse and HCA present in each, and an actor playing a relative was present in three of the scenarios. Each was observed by the consultant present. The trainees not taking part watched events unfold via video-link. Feedback was led by the consultant present, with input from an acute medic. There was group discussion with all trainees present. The consultant completed 'mini-CEXs' for each trainee in the scenario.

Results Pre and post-simulation day feedback was collected via a 1–5 scale (1=strongly disagree, 5=strongly agree), and showed:

They felt their clinical knowledge increased (3.5 vs 4.0)

They felt their confidence increased (3.6 vs 4.1)

They felt they would learn/had learnt something new from the day (4.3 vs 4.7)

Free text feedback explained that trainees felt it was a fun and effective way to learn, and that it was especially beneficial to have other members of the multidisciplinary team present, and to receive feedback from acute medics.

Conclusion Simulation seems to be an acceptable, enjoyable, and effective way to teach palliative medical emergencies. Trainees are keen for simulation to be incorporated into their training.

Free papers 13–15 | New models of care

13 OPTIMISING THE MANAGEMENT OF PATIENTS WITH CANCER PAIN: DEVELOPMENT AND EVALUATION OF THE RAPID ACCESS MULTIDISCIPLINARY PALLIATIVE ASSESSMENT AND RADIOTHERAPY (RAMPART) CLINIC

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10.1136/bmjspcare-2018-ASPabstracts.13

Background Patients with cancer-induced bone pain often wait weeks to receive palliative radiotherapy treatment and to be assessed by specialist palliative care and allied health services. While waiting, they experience debilitating physical problems and psychological distress. This paper reports on the development and evaluation of RAMPART, a 'one-stop' multidisciplinary clinic at University Hospital Southampton. This innovation has not previously been reported in the UK.

Methods The clinic model involves a single visit and combines assessment by palliative medicine, clinical oncology and allied health professionals, with the planning and delivery of palliative radiotherapy. The intervention also involves signposting, onward referrals and supported self-management of physical, psychological and social concerns. A patient satisfaction questionnaire and Macmillan's Holistic Needs Assessment are performed on the clinic day and repeated one month later. Open response questions are asked on the day and at 1 month.

Results Overall, 87% of patients were very satisfied and 13% were satisfied. Patients' global concern score decreased by 1.9 points, mean score 7.1 (range 4–10) on clinic day to 5.2 (range 2–8) at 1 month. There was a reduction in pain score by 2 points, mean score 6.8 (range 3–10) on clinic day to 4.8 (range 0–8) at 1 month. The RAMPART clinic model successfully reduced the median time from referral to radiotherapy from 22 days in the comparator cohort to 8 days in the RAMPART cohort. Qualitative data findings are that patients felt supported, enlightened, informed and valued by the comprehensive nature of the assessment. Patients felt their symptoms and quality of life had improved.

Conclusions Implementing a multidisciplinary palliative radiotherapy clinic is feasible, valued by patients and effective in reducing pain, other patient concerns and time from referral to treatment. This model helps to bridge the gap between hospital and community services and may be transferrable to other areas.

14 ENHANCED SUPPORTIVE CARE – JOINT WORKING BETWEEN SUPPORTIVE CARE AND ACUTE ONCOLOGY TO DELIVER RAPID ACCESS TO EXPERTISE

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10.1136/bmjspcare-2018-ASPabstracts.14

The Enhanced Supportive Care (ESC) clinic provides patients with better access to supportive care services. It allows any Christie patient with problems relating to their cancer, or cancer treatment, to be seen without delay. This helps to reduce the escalation of symptoms and medical problems that could potentially lead to hospital admission. ESC clinic is a new joint service provided by Supportive Care and Acute Oncology teams.

A six month pilot has demonstrated a reduction in emergency admissions to the Christie, a reduction in patients sent elsewhere within Greater Manchester (GM), a reduction in the need for GP follow up appointments, reduced length of stay and has facilitated early discharges from the Oncology Assessment Unit (OAU), which improves patient flow.

Referrals into the ESC clinic are received from multiple areas, namely:

- Acute Oncology Management Service/Hotline