

Broad areas workers found helpful were good communication from managers, flexibility of duties on return to work (including temporary non-clinical roles), sympathetic support from colleagues and access to counselling support from organisations.

Broad areas workers found unhelpful were an absence of meetings and communication from managers, rigid compassionate leave policies and perceived lack of recognition of their loss.

Conclusions There was variation between individuals about factors they perceived to be helpful. This suggests a rigid approach universally applied is unlikely to support all employees. In our opinion, early sympathetic meetings with management offering temporary adjustments to roles (and/or hours), sensitive informing of colleagues and signposting to counselling options is likely to have a positive impact on staff wellbeing.

2 MAPPING OF BEREAVEMENT SERVICES ACROSS THE NORTH EAST OF ENGLAND – A SURVEY OF GENERAL PRACTITIONERS REFERRING PRACTICE

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Background Recent national guidelines have identified the importance of bereavement support. However, evidence suggests that bereavement services are provided inconsistently. We aimed to map bereavement services used by GPs across the North-East-of-England to identify inequalities.

Method An electronic bereavement service questionnaire was produced through consultation with Northern England Clinical Networks and CCG end-of-life-care leads and was then reviewed by a local GP focus group. The questionnaire was then distributed to CCG EOLC leads who cascaded it to all 392 practices in the North-east of England. A Reminder email was sent after 4 weeks.

Results 85 (22%) GP practices completed the survey. Only 43.5% and 9.4% of practices reported that they had a bereavement policy and that the majority of their GPs' had had bereavement training respectively. 21% reported that they would not refer patients anywhere for bereavement support. The remaining 79% listed 18 services that they refer to, most commonly; hospices(21%), CRUSE(17%), MIND(15%), Macmillan(10%) and their own in-house counsellor(10%) and 25 services that they recommend for self-referral, CRUSE(65%), talking therapy(16%), hospice(14%), Improved Access to Psychological Therapies(11%).

Conclusion A wide range of bereavement services are used across the region. They mainly depended on charitable funding. One fifth of responding GP practices reported that they would not refer patients for bereavement support. This was associated with comments including "local services have been decommissioned" and "not aware of any services to refer to". This highlights the wide variation in use and availability of bereavement services across the region, and the problems of service withdrawal, lack of funding and lack of clarity on who is responsible for bereavement support. This will be invaluable in providing evidence to commission future bereavement services.

3 INNOVATIVE FOUR STEP BEREAVEMENT SERVICE AT A TERTIARY CANCER CENTRE

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Background Bereavement is defined as the state of a loss when someone close to you has died. It is important that people closely affected by a death are communicated with in a sensitive and timely manner and that those at risk of pathological bereavement reactions are identified and supported. At a tertiary cancer centre it was recognised that families need time and support soon after the death of their loved one.

Aim To deliver a 'day after death' service providing personalised bereavement support to families/carers and learn lessons about care by discussing their experiences.

Methods At our tertiary cancer centre we implemented an innovative 4 step approach to supporting bereaved families and carers:

1. Comprehensive documentation including a bereavement risk assessment at the time of death.
2. Innovative 'day after death' service.
3. Post bereavement contact if accepted.
4. Face to face follow up where required.

The bereaved families/carers meet with a senior member of the Nursing Team who knew the patient on the next working day. They meet in a private room away from the wards and discuss how they are coping with their loss and listen to any questions/concerns they may have. The relevant paperwork is then provided. This also provides the opportunity to follow up the bereavement risk assessment undertaken by the ward staff.

Following the meeting a reports is shared with the Director of Nursing and discussed at the Trust Executive meeting.

Results There have been 84 deaths within the tertiary cancer centre in the last 12 months. All bereaved families/carers have received the day after death service. This has enabled us to provide comprehensive and personalised bereavement care. It also enables us to identify those people likely to have complex bereavement and signpost to local specialist support services.

Conclusions We have successfully implemented a 4 step innovative service delivering personalised bereavement care.

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4 TYPE, INTENSITY AND QUALITY OF INFORMATION GIVEN BY PHYSICIANS DURING THE CANCER JOURNEY OF PALESTINIAN CHILDREN WITH LEUKAEMIA: BETWEEN REVELATION AND CONCEALMENT

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Background Despite the accumulation of evidence that supports the importance of giving parents detailed information, there is less evidence to support the notion that providing 'negative' information has a harmful effect on both parents and children. This study explored the communication of information across the cancer journeys taken by children from