

Methods This study was conducted in a specialist palliative care unit with 20 inpatient beds and day therapy unit. Discussions were held with the counselling, medical and nursing staff to develop the support service. A survey was distributed to MDT members, giving 24 anonymous responses. Subsequently, a monthly emotional support forum was piloted, facilitated by a ward nurse and supported by the counsellors and ward manager. A follow-up survey was distributed 16 months later with 32 respondents.

Results The initial survey identified staff may benefit from emotional support, with over 50% experiencing disturbed sleep, intrusive thoughts and feeling sad or depressed at some point over the past month. Preferred options were mindfulness sessions and an emotional support forum. Over 70% of respondents to the second survey attended the forum at some point. Of those, 85% felt it an inclusive and safe environment and 74% found it helpful. 48% could not attend as often as hoped, predominantly due to time constraints and staffing. There were no significant differences between measures of anxiety and depression before and after forum introduction.

Conclusions Staff were more aware of the counselling service to support patients/relatives than themselves, but many engaged with the forum and found it helpful. Areas for improvement include increasing awareness and facilitating forum attendance. This study was not designed to detect objective changes in anxiety/depression, however, our qualitative findings support the forum as a low cost and convenient approach to improving staff wellbeing.

18 HEART FAILURE AND PALLIATIVE CARE: AN INTEGRATED SERVICE FOR PATIENTS ACROSS HOSPITAL AND COMMUNITY SETTINGS

JR Ross, F Hodson, S Karwatowski, M Albarjas, R Nash, J Smith, R George. *St Christopher's Hospice, King's College Hospital, Princess Royal University Hospital*

10.1136/bmjspcare-2019-ASP.17

Background An integrated clinical service for patients with end-stage heart failure (HF) was funded by Bromley Clinical Commissioning Group; Bromley has no community HF nurse specialists.

Method Six GP practices participated and referral criteria were agreed. Patients were assessed and followed up by an Advanced Nurse Practitioner, with experience in HF and palliative care (PC), who worked closely with cardiology consultants and HF/PC hospital teams, the Community PC Team (St Christopher's Hospice) and primary care colleagues. Following initial assessment, patients were discussed at joint MDMs to assess both cardiac and palliative needs. We report data from the service evaluation of this clinical pilot.

Results 102 patients, mean age 84.2 ± 10.2 years, were referred over 1 year. 89 were accepted. 55 (61.8%) had LVSD, 14 (15.7%) patients had HF with preserved ejection fraction, 13 (14.6%) had predominately valvular dysfunction, 5 (5.6%) had right sided HF. Patients had multiple co-morbidities, significant renal impairment and mental health diagnoses (depression and dementia). Two thirds required considerable assistance or were immobile >50% of the time, with 18% predominately bed-bound. 29 (33%) lived alone, 49 (55%) with family, and 12% in care homes. The majority of carers were female (86%), 25% of carers frequently/nearly always 'did not have time for themselves' with 40% reporting a significant impact of caring

on their own health. Meta-Analysis Global Group in Chronic Heart Failure (MAGGIC) scores were not accurate in predicting outcome. 44% of patients died during the pilot. Of these, 69% died at home/hospice (41%/28%) versus 31% in hospital. Further PROMs including integrated palliative care outcome scale (iPOS) will be presented.

Conclusion This pilot was positive and demonstrates benefits and challenges of joint working between integrated teams. We will discuss how ongoing integrated practice can be developed locally with dissemination of good practice and joint working to other groups.

Free Papers 19 – 21 | Training

19 DO PALLIATIVE CARE CHAMPIONS INCREASE STAFF CONFIDENCE TO HAVE DIFFICULT CONVERSATIONS?

Jane Manson, Helen Blomfield, Louise Patterson, Angela Todd, Lisa Farndon. *Sheffield Teaching Hospitals*

10.1136/bmjspcare-2019-ASP.18

Background Previous research and recent media coverage have identified that healthcare professionals who don't work in a palliative care setting do not feel comfortable talking to patients about palliative-related issues. As caseloads become more frail and complex, there is an increasing need for staff members at all levels to feel more confident discussing issues such as advanced life planning, deteriorating function, and future care needs. Champions have proven to be highly effective in knowledge translation in order to instigate positive changes in healthcare, however there is no evidence evaluating the 'champion approach' in palliative care or in a rehabilitation setting.

Aim To evaluate the introduction of the palliative care champion role on staff confidence and patient outcomes.

Methods A cohort study of four bed-based intermediate care units (2 intervention, 2 control) was used. Three champions based in the two intervention units received specialist training and disseminated this to the remaining cohort. This was followed by a 5 month data collection period.

Results Confidence of the intervention unit staff increased an average of 1.9 points on a scale of 1–10 post training (0.1 control). This confidence continued to increase to an average of 2.4 points following the 5 month intervention period (0.3 control). There was no change to perceived contact with palliative patients or barriers to conversation.

Conclusion Introducing palliative care champions could be an easy, cost-effective way of increasing staff confidence to have difficult conversations with patients.

20 TO EXPLORE THE UTILITY OF THE BREATHING, THINKING, FUNCTIONING (BTF) CLINICAL MODEL IN MANAGING BREATHLESSNESS THROUGH A PRACTICAL WORKSHOP AIMING TO EQUIP PROFESSIONALS

Declan Cawley, Aileen McCartney, Anna Spathis. *Wisdom Hospice, University of Cambridge*

10.1136/bmjspcare-2019-ASP.19

Background Breathlessness is a common and distressing symptom within progressive respiratory conditions. Emerging research advocates that irrespective of diagnosis, management

is harmonised. Evidence identifies a more holistic, non-drug approach to effective management. This study aimed to embed the Breathing, Thinking, Functioning clinical model in managing breathlessness into clinical practice, equipping and enabling professionals to cascade the approaches to patients and carers.

Methods Multi stage approach:

1. A 2 hour practical workshop to understand the Breathing, Thinking, Functioning (BTF) conceptual model of breathlessness will be offered to all staff within the palliative care teams (community, inpatient and hospital) under MCH CIC management.
2. Staff will complete pre and post questionnaires following this intervention, looking at experience, confidence and utility in managing breathlessness with questionnaires at 3 month follow-up.

Results 40 professionals attended the practical workshops (n=4) with participants initially rating their experience ('quite a bit' and 'very well') in managing breathlessness with 15% (6/40) compared to 77% (31/40) post-intervention, along with confidence increasing from 15% (6/40) to 72% (29/40) within the same group. Feedback was very positive with 88% (35/40) participants identifying the utility of this model in clinical practice. Follow-up at 3 months identified that confidence was still relatively high at 64% (14/22) despite lower response rate 55% (22/40).

Conclusions This work identified the usefulness of the BTF model in the management of refractory breathlessness in progressive respiratory disease. Professionals initially rated themselves low in confidence managing breathlessness but after the workshop, identified confidence increasing by 57%. Despite the significantly reduced numbers at 3 month follow-up (22 vs. 40), this project still identified 64% of attendees identifying themselves as confident ('quite a bit' or 'very well') in managing breathlessness, compared with an initial 15% of participants. This practical workshop approach has the potential to equip professionals in the effective management of refractory breathlessness.

21 DOES A ONE DAY HOSPICE PLACEMENT FOR MEDICAL STUDENTS DO MORE HARM THAN GOOD?

Jason Ward, Clare Rayment, Jennifer Hallam. *University of Leeds*

10.1136/bmjspcare-2019-ASP.20

Background In their first year as a doctor, F1s will care for 40 patients who will die and 120 patients in the last year of life. However, research shows junior doctors are often unprepared. We present data on the value of extending a hospice placement from 1 day to 4 days.

Methods Students were randomly allocated to 1 day or 4 days in 3 different hospices. Students completed a thanatophobia scale, self-efficacy in palliative care scale and placement evaluation questionnaire. Performance in palliative medicine and oncology questions in end of year summative exams were compared.

Results 153 students undertook the 4 day placement. All students (1 and 4 day) had improved self-efficacy scores. 4 day placements had a greater effect on the global score and individual questions. Thanatophobia scores were reduced for the 4 day but not the 1 day placement. Students feedback was overwhelmingly positive highlighting the high quality of teaching, alignment of classroom and placement teaching,

opportunities for work based assessments, medicines management, communication skills and interprofessional learning. 4 day students scored significantly higher in palliative medicine and oncology OSCE stations, higher for palliative medicine written questions, approaching significance in oncology written questions.

Conclusions Extending placements in hospices to 4 days significantly improved student's self-efficacy in palliative care and reduced thanatophobia when compared to a 1 day placement. Students valued the placements and as well as learning specific subject knowledge they developed many generic skills. 4 day students did better in both their oncology and palliative care OSCE stations and better in written palliative medicine questions. Students may have increased feelings of helplessness in caring for dying patients when they only attend a hospice for 1 day. Medical Schools should be encouraged to extend placements in palliative care and be aware for the potential increase in distress when only a short placement is provided.

Free Papers 22 – 24 | End of Life Care

22 GENERAL PRACTITIONERS' DECISIONS ABOUT PRESCRIBING ANTICIPATORY MEDICINES AT THE END OF LIFE: A QUALITATIVE STUDY

Ben Bowers, Kristian Pollock, Sam Barclay, Stephen Barclay. *University of Cambridge, University of Nottingham*

10.1136/bmjspcare-2019-ASP.21

Background General Practitioners (GPs) have a central role in decisions about prescribing anticipatory medications (AMs) to help control symptoms at the end of life. Little is known about GPs' decision-making processes in prescribing AMs, how they discuss this with patients and families, and the subsequent use of prescribed drugs.

Aim To explore GPs decision-making processes in the prescribing and use of AMs for patients at the end of life.

Methods A qualitative interpretive descriptive enquiry with a purposive sample of thirteen GPs working across one English county. Data were collected between June and December 2017 via audio recorded semi-structured interviews and analysed inductively using Braun and Clarke's thematic analysis.

Results Three themes were constructed from the data: (1) 'Something we can do'. AMs were a tangible intervention GPs felt they could offer to provide symptom relief for patients approaching death. (2) 'Getting the timing right'. The prescribing of AMs was recognised as a harbinger of death for patients and their families. GPs would discuss AMs when they felt patients were ready, preferring to prescribe drugs weeks before death was expected whenever possible, while recognising this meant that many prescribed AMs were never used. (3) 'Delegating care whilst retaining accountability'. After prescribing medications, GPs relied on nurse to assess when to administer drugs and keep them updated about their use.

Conclusion GPs view AMs as key to symptom management for dying people. AMs are routinely prescribed even though they are often not used. In order to feel comfortable delegating care, GPs need regular access to nurses and trust in their skills to administer drugs appropriately. Patient and family experiences of AMs, and their preference for involvement in decision-making about their use have not been studied to date: we are addressing this important knowledge gap.