

Results The search identified 6,611 unique citations. Further references may be identified by hand-searching references of included articles and contacting authors. Title and abstract screening has identified 278 potentially relevant papers so far.

Conclusions Full text review of relevant citations is underway. The review will be completed by autumn 2019. The results will document how ED has been evaluated in this setting and pinpoint what elements may prove most effective and in what context. This will inform future research in the development and assessment of ED-based psychotherapeutic interventions in the palliative care setting.

4 THE PLACE OR THE ENVIRONMENT: WHAT IS A MORE PREFERRED OPTION AT THE END OF LIFE FOR PEOPLE IN WALES?

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Introduction Public preference to die at home has been well documented in the literature (Schou-Andersen et al., 2016). An indicator of measuring success of End of Life Care Delivery Plan of Welsh Government is the proportion of patients who are cared for in their preferred places (Welsh Government, 2017). Uncertainties around accessing facilities to meet clinical and psycho-social need may have influence on changing public preference.

Aim To identify public preferences at end of life.

Method Online public survey using JISC tool. Data were analysed using descriptive statistics and thematic approach for this mixed method study.

Results 2210 people (Age: Mean+SD; 55+14 yrs) participated in the survey (29% were patients/cares, 23% academic/health professionals and 48% with no caregiving/bereavement experience) Only 31% of total surveyed believed that EoLC facilities were accessible and 49% thought these facilities were insufficient to meet the need. More people preferred to be surrounded by loved ones (62%); having access to trained professionals (84%), die in dignity (55%); be peaceful (40%); be symptom-free (30%), take part in care decision (26%) than those who preferred to be at home (24%). Preferred services and environment were expressed with free text by 189 and 87 respondents. Most people preferred their choices being respected; a large portion advocated for euthanasia. Pain management and having access to trained professionals came as preferred options by many but very few people preferred being at home.

Conclusions Access to trained support and having loved ones around them in a peaceful dignified environment outweigh the importance of a physical place of care.

5 UNDERSTANDING THE NEEDS OF DIVERSE COMMUNITIES IN PALLIATIVE CARE

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Current estimates suggest 1 in 4 people miss out on palliative care.¹ Older people, people with non-cancer conditions,

from BAME backgrounds, or with learning disabilities are some groups that face barriers to good end of life care.² With more people living and dying from complex chronic illnesses³ and estimates that by 2051 20–30% of the UK population will be ethnic minorities⁴, these groups' needs will significantly influence the growth in future palliative care demand.

2 projects in South Wales explored these barriers for people:

- from BAME backgrounds;
- with dementia;
- with learning disabilities; and
- from religious and non-religious backgrounds

We consulted 499 people through focus groups and interviews.

Findings

- People's understanding of palliative care is limited. Accessible and tailored communication would reduce fear and increase trust in services.
- People with non-cancer conditions and from BAME backgrounds feel they are less likely to be referred to palliative care. Some reported experiencing discrimination. Less restrictive referral processes would reduce barriers.
- People decline services for fear that their spiritual, cultural, or diagnosis-related needs will not be met. Staff need increased understanding of diverse needs and skills to meet them, and this inclusion should be promoted within communities.

As palliative care need increases and demographics shift, services will support an increasingly diverse patient population. It is vital that we work in partnership across the health and social care system to reduce systemic barriers to access services. We must also recognise the value of communities, and the experience and knowledge they have, to help us improve.

REFERENCES

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6 BREAKING BAD NEWS TRAINING: LESSONS FROM OUTSIDE HEALTHCARE

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Healthcare workers frequently break bad news, but often lack formal training. Other job sectors (e.g. military and human resources) also break bad news on a regular basis. Lessons from these sectors may be valuable when developing training resources within healthcare.