

- Survey of career aspirations and development needs of doctors working in SAS grade or similar posts;
- Holding networking/educational events for SAS doctors;
- Producing a training and development framework for doctors working in SAS grade or similar roles who wish to progress in their careers.

Results All elements of the project have been achieved and the Training and Development Framework was launched in May 2019. Details of the mapping, the survey of development needs and the educational events will be shared. The project has benefited hugely from collaborative working with colleagues in Cheshire and Merseyside, who had already developed and implemented a Training and Development Programme for SAS doctors in their region.

Conclusion It was evident that providing the opportunity for SAS doctors to network with colleagues from other hospices and palliative care teams was particularly valuable, and has led on to the development of peer-led initiatives such as a Medical Directors Forum and a WhatsApp group. Further work to embed the Training and Development Framework and further support SAS doctor development in the region is currently being planned.

P-51 IMPROVING CONFIDENCE IN COMPLETING RESPECT FORMS

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ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) forms were introduced in Royal Derby Hospital a year ago. ReSPECT prompts clinicians to record more than just 'CPR' decisions, and should include personalised recommendations for patients' care in a future emergency. Anecdotally we felt junior doctors were uneasy with ReSPECT, and that forms were often 'partially completed', reducing their value to clinicians and patients alike. An audit of ReSPECT forms confirmed poor completion in some areas of documentation.

We organised a pilot teaching afternoon for Core Medical Trainees (CMTs), incorporating a Powerpoint presentation on ReSPECT, handouts of 'mock forms', and role play. In groups of six, alongside a facilitator, CMTs worked through vignettes of clinical scenarios requiring a ReSPECT form to be completed. Ground rules ensured confidentiality and opportunity for 'time out'.

CMTs engaged enthusiastically with scenarios – in each, one trainee acted as a patient/relative, and another as the doctor. Facilitators led reflection and learning pre- and post- each scenario. Ten trainees completed pre- and post- course questionnaires. Despite 80% reporting formal ReSPECT training previously, 30% and 20% rated themselves 'not confident' to have ReSPECT discussions with patients/relatives respectively, pre-course. None of the CMTs had completed online ReSPECT learning, and 60% reported informal 'on the job' learning.

Post-course none reported lack of confidence. The pre-/post- course numbers who reported confident rose from 10% to 40%, and from 10% to 50%, in discussions with patients/relatives respectively. Free text comments about the session were positive. A re-audit of ReSPECT forms is planned in the

summer-it will be interesting to review whether forms completed by CMT doctors have changed.

We hope to embed similar ReSPECT teaching into junior doctor teaching in the trust at August change over, to allow all juniors practical 'simulated' experience in ReSPECT in addition to formal learning online and through presentations.

P-52 END OF LIFE CHAMPIONS: EDUCATING AND EMPOWERING NURSES IN THE ACUTE HOSPITAL SETTING

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Background/Aims The End of Life Care Strategy for England has highlighted the delivery of high-quality end of life care in hospitals as an area of priority (Department of Health, 2008). The National Survey of Bereaved People (ONS, 2016) found, however, that relatives of people who died in hospital rated overall quality of care significantly worse than any other place of death. Barriers to the provision of good end of life care have shown to include a lack of education and poor attitudes from nurses and clinicians (Gardiner, Cobb, Gott & Ingleton, 2011).

We set up an End of Life Champions programme in 2017 aimed at empowering nursing staff to recognise end of life patients in a timely manner, and to feel confident in providing good, holistic end of life care to patients and their families in the ward setting.

Methods A two-day course was provided which covered a variety of areas surrounding end of life care. Delivery methods consisted of Powerpoint slides, group-work, and scenarios. The palliative care team then went on to assist the champions to take action in improving end of life care in their clinical areas.

Results Each champion completed a pre- and post-study day evaluation based on their confidence levels. Results showed a significant improvement in each session topic ranging from 13% to 36%. Comments from some of the champions stated they found the course had given them a whole new perspective on how to approach end of life care, and also that they now felt empowered to challenge poor practice.

Conclusions Educating and supporting nurses in the acute hospital setting has been found to lead to increased levels of confidence and to actively improve care in their clinical areas. This thus enables translation of UK policy into practice. The end of life champions' work is being extended across all hospital sites and is ongoing.

P-53 TEN MINUTE SHARING AND LEARNING

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Without doubt one of the biggest challenges faced by hospices is providing education to their staff. While we do provide internal study days, we wanted to offer ongoing education alongside. We trialled ten-minutes sharing and learning sessions after lunchtime handovers to offer education in bite-sized chunks, to either enhance knowledge and skills or to promote awareness, with the aim of improving standards of patient