

168 **EARLY INTEGRATION OF PALLIATIVE CARE IN ONCOLOGY – WHAT DO STAFF AND PATIENTS THINK?**

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Background Trials have proved the benefits of early Palliative Care involvement in Oncology care, such as improved quality of life, better understanding of disease and better symptom control. Based on these we have introduced a new model of Integrated Palliative Care at the Royal Marsden - the ‘Triggers’ service since March 2017. It involves the use of a palliative care referral ‘Triggers’ tool to triage patients’ palliative care needs. This tool was designed by the London Cancer Alliance Palliative Care and End of Life Care Pathway Group, now RM Partners.

Methods A feedback questionnaire was devised with patient input to assess the impact of the service for patients and staff in the clinics offering the Integrated Symptom Control and Palliative Care Service (ISCPC). The results are used as part of the continuous service quality improvement process. Descriptive analysis of the questionnaire responses and thematic analyses of the free text comments was carried out. This project was approved as a service evaluation by the Hospital Committee for Clinical Research.

Results Feedback collected from 42 staff and 88 patients in the Gynaecology, Renal, Gastro-Intestinal and Lung Oncology clinics currently using the ISCPC service.

- 93% staff felt positive about the value of this service for patients and families.
- 93% staff felt the service had a positive impact on patients.
- 90% patients felt positive about meeting the ISCPC team during their clinic appointment.
- 91% patients found the service helpful in improving their care experience.
- Themes emerging on initial free text comment analyses include an improved care and support experience for the patients and an increasing demand for early integration of palliative care into oncology services.

Conclusions Staff and patient feedback about the ISCPC service in Oncology Clinics was largely positive. They felt that the ISCPC service had improved their overall care experience.

169 **ACCEPTABILITY AND EXPERIENCE OF A NEW INTEGRATED ONCOLOGY AND PALLIATIVE CARE ‘TRIGGERS’ SERVICE FOR CANCER PATIENTS: A QUALITATIVE STUDY**

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Background Clinical trials demonstrate that early referral to specialist palliative care improves patient outcomes in terms of quality of life and symptom control. This qualitative research study is part of a mixed methods evaluation of a novel early integrated Palliative Care (‘Triggers’) service for cancer patients. The Triggers service involves the use of a palliative care referral ‘Triggers’ tool for healthcare professionals to

proactively identify patients who should be referred to palliative care.

Aims To explore the acceptability of the ‘Triggers’ service and experiences of early palliative care for healthcare professionals using this service.

Methodology This study has extensive Patient and Public Involvement input and was approved by the hospital Committee for Clinical Research and the Research and Ethics Committee. Using the Grounded theory approach, qualitative in-depth semi-structured interviews were carried out with eleven healthcare professionals who work in the oncology outpatient clinics, where the ‘Triggers’ clinical service is taking place.

Results The use of a palliative care referral ‘Triggers’ tool to underpin an early integrated palliative care service is acceptable. Emergent themes were:

1. What’s in a name?–The effect of the name and its associated connotations with death and dying.
2. A rose by any other name–Thoughts about changing to an alternate name.
3. Timing is everything–Observations about the timing of the ‘Triggers’ service in clinic.
4. All you need is more–Resource limitations and an ideal scenario of a joint approach to delivering care.
5. Constantly redefining the future–Uncertainties about the future with new cancer treatments, associated symptoms and changing prognoses.

Conclusion An early integrated palliative care service is acceptable to healthcare professionals. Considerations for future care include the benefits of re-marketing and defining the optimal time for introducing palliative care to oncology patients.

170 **RESPECT (RECOMMENDED SUMMARY PLAN FOR EMERGENCY CARE AND TREATMENT): AN AUDIT IN COMMUNITY CARE HOMES IN COVENTRY AND WARWICKSHIRE**

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Background ReSPECT is a process that creates personalised recommendations for clinical care in a future emergency when unable to express choice. It encompasses cardio-pulmonary resuscitation decision making and supports broader individualised conversations. The process is endorsed by the Resuscitation Council (UK) with Coventry and Warwickshire an early implementer in 2017. This is the first known community audit.

Methods 5 GP practices with care home responsibility were identified. Consent was sought from each practice and care homes were informed. Data was collected by a Macmillan GP or Care Home Lead Nurse on behalf of GP practices (April–June 2019). The proforma was based on a tool used by local acute NHS Trusts.

Results In 224 residents, 114 ReSPECT forms were completed (64%; range 54–96%). In 2 care homes old DNACPR forms were found. 59% were completed in the community with 79% (range 19–100%) completed by a doctor. Demographics were well completed. 28% recorded other Advance Care Planning documents were in place. The goal of care was completed in 48%; of these 96% stated symptom control. Detailed clinical recommendations were recorded in 65% (range 28–81%). The

CPR decision was completed in 100%, with 94% DNACPR (range 86–100%). A capacity decision was recorded in 93% and emergency contacts in 38% (range 8–88%).

Conclusions The process has been embedded across Coventry and Warwickshire, however more care home residents could be supported and old DNACPR paperwork should be reviewed. Nurse led completion is more evident in the community. Documentation of patient involvement using the optional personal preference section is limited. The form is widely used as a DNACPR form; the potential for documenting the goal of care and specific clinical recommendations is not being fully utilised and should be a focus for training. Patients and carers could be encouraged to complete the emergency contacts section.

171

1 SPECIALTY 3 SETTINGS: THE INFLUENCE OF COMBINED ONCOLOGY AND PALLIATIVE CARE CLINICS (COPC) ON CONTACTS WITH PALLIATIVE CARE IN HOSPITAL, COMMUNITY AND HOSPICE IN CORNWALL

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Background Evidence suggests palliative care involvement alongside oncology care improves quality of life, planning and communication for advanced cancer patients. However, little information exists about the impact of such involvement on access to the speciality across care settings. This study examines the influence of COPC versus Standard Oncology Clinics (SOC) on palliative care contacts in hospital, community and hospice settings.

Methods Fifty-nine COPC patients were compared with fifty-nine SOC clinic patients, all with lung malignancies. 56/59 COPC patients and 59/59 SOC patients were first seen within 2017–2018. Data about involvement of community and hospice palliative care services was collected for 12 months from first contact with palliative medicine oncology consultant respectively. Hospital palliative care involvement was measured from 1 month before to 12 months after first consultant contact (thereby including those first diagnosed during a hospital admission).

Results Hospital palliative care services provided 28 care episodes in 20/59 (34%) COPC patients, compared to 19 in 14/59 (24%) SOC patients. Patients were already known to community palliative care teams in 15/59 patients attending COPC increasing to 46/59 within next 12 months. In SO the figures were 8/59 increasing to 24/59. Although higher numbers in the COPC group, the rate of increase is similar (approximately 300% increase over 12 months in each group) 7/59 (11%) of COPC compared with 3/59 (5%) of SO patients were admitted to a local hospice in 12 months from first contact.

Conclusions Review in COPC compared to SOC appears to increase access to hospital, community and hospice specialist palliative care services. This study involves a relatively small number of patients with lung malignancies, and larger studies, including patients with other types of malignancy, should expand the information available. Further data is also needed to evidence whether access to these services improves outcomes for patients and families.

172

THE INFLUENCE OF COMBINED ONCOLOGY AND PALLIATIVE CARE CLINICS (COPC) ON HOSPITAL ADMISSIONS AND VARIOUS OUTCOMES FOR PATIENTS WITH LUNG MALIGNANCIES IN CORNWALL

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Background Evidence suggests early palliative care involvement (PCI) alongside oncology care improves quality of life, planning and communication for advanced cancer patients. Previous work in Cornwall suggested COPC reduced number and length of hospital admissions in oncology patients with varied cancer diagnoses. This study examines findings in lung cancer patients.

Methods Baseline data was collected for fifty-nine patients attending lung cancer COPC or Standard Oncology Clinic (SOC), including (but not limited to) mortality rates, average survival of those who died, performance status, and stage of disease. Over 12 months from initial oncology or palliative medicine consultant contact, rates of hospital admissions, length of stay, reasons for admission, and preferred place of discharge were recorded.

Results Background data suggested there was little difference in the baseline data for patients attending the 2 clinic types, except that performance status was somewhat worse for the COPC group (ECOG for COPC patients 1=19, 4=8, versus SOC 1=25, 4=2 with ECOG 2 and 3 same number each group). Mortality rates were similar. Of deaths, survival was 4.82 months COPC versus 5.33 SOC. COPC patients had 56 hospital admissions, and SOC 49. Average Length of stay was similar across the 2 groups. Reason for admission differed between the 2 groups: COPC/SOC complication of disease (60.7% versus 44.9%) COPC/SOC complication of treatment (12.5% versus 38.8%). COPC recorded Preferred Place of Discharge in 37.3% of admissions versus SOC 18.6%. Rates of achievement were similar. COPC recorded other advance care planning in 41.0% patients versus 10.2% SOC.

Conclusions In lung cancer patients rates of hospital admissions and LOS were not reduced by COPC input, but reasons for admission were different. Despite poorer performance status results there was no difference in the average number of months survival of those who died within the 12 months analysed.

173

NON-INVASIVE TECHNOLOGY TO SUPPORT CLINICAL CARE IN PALLIATIVE HEAD AND NECK CANCER: A SYSTEMATIC REVIEW OF THE USE OF BIOELECTRICAL IMPEDANCE ANALYSIS FOR BODY COMPOSITION ASSESSMENTS

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Background/Aims Head and neck cancer is associated with significant pathophysiological impacts on body composition, which can create problems such as dehydration, poor nutrition and cachexia. Bioelectrical impedance analysis is a non-invasive body composition assessment tool which is increasingly being

What are the specific distinctions in the transformation of primary health care in Russia and CEE countries? What is the relative strength of primary care models? Does Russia prove the effectiveness of an extended composition of primary care in the prevailing organizational form of polyclinics? Although the list of questions was designed to evaluate the integration of care, some questions also relate to the characteristics of PHC. The major limitation of our study is that our capacity for making detailed comparisons across all indicators is much more limited than in the PC Monitor study – a project with dozens of organizations involved.

Palliative Care in General Practice. Workshop conducted in partnership with Primary Health Care Networks Presenters Dr Alison Kearney CN Anne Hales. RBWH Supportive and Palliative Care. Workshop Outline. – Palliative care should be based on need not prognosis or age, including any chronic or malignant disease, even if the trajectory is ambiguous or unknown. – RBWH 60:40 ratio. Source: The GSF Prognostic Indicator Guidance The National GSF Centre’s guidance for clinicians to support earlier recognition of patients nearing the end of life <http://www.goldstandardsframework.org.uk/>. Important trends in palliative care delivery (2). – Very Explicit instructions are needed for the nursing staff and the families. – For example. Chapter Outline INTEGRATING PALLIATIVE CARE FROM THE TIME OF DIAGNOSIS Advantages of Early Integration of Palliative Care Enhancing Integration of Palliative Care When Cure is No Longer Possible MAKING THE TRANSITION TO PALLIATIVE CARE Discussing a Change in Prognosis Discussing Goals of Care Eliciting Children's Goals Creating a Plan for Care Based on Goals Appointing