

Conclusion Patients are often referred very late in the terminal phase of their disease process. Whilst the specialist PAH team provide basic symptom control and support, earlier referral and proactive involvement of the HPCT as part of a multidisciplinary team would help address advanced care planning, complex symptom control and end of life care.

P-132 COMBINED ONCOLOGY & PALLIATIVE CARE CLINICS; WORKING IN PARALLEL

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Background Early Specialist Palliative Care (SPC) introduced to patients with advanced lung cancer has recently been proven to enhance quality-of-life and improve survival.¹

Combined Oncology and Palliative Care Clinics (COPCC) have been carried at Royal Cornwall Hospital Trust for over two decades, to enable patients to be reviewed by Palliative Care Consultants (PCC) whilst attending Oncology Outpatient review; enabling the two specialities to run in parallel to improve patient care. The aims of this project were to explore the types of patients seen and content of consultations.

Methods A retrospective review of the current PCC consultation letter of 150 consecutive patients reviewed between 01/2016-06/2016. Data collected by three medical students.

Results Of the 150 patients, 49% had on-going/planned palliative oncological options (POO), 20% optimal supportive/symptom control (SSC), 18% radical treatment and 13% treated with curative intent. 75% had stable disease, 23% deteriorating and 2% in their last month of life.

The main focus of the consultation was symptom control (95%), followed by discussions around aims of palliative/oncological treatment (71%).

For patients who were considered POO or SSC (n=104), 66% were referred/known to the community SPC nursing team. The median number of consultations per patient was 2.9, and patients were known to the service for up to 5 years and 2 months.

Conclusion COPCCs appears to facilitate collaborative working between disciplines to enable optimal symptom control, information sharing and forward planning to patients attending oncology clinics. Unsurprisingly, PCC focus on symptom control and early referral to SPC services in the community. Many patients are seen when they are 'stable' suggesting the service is proactive in approach. COPCCs remove the need for a 'referral' to SPC, and allows patients to be seen who perhaps wouldn't otherwise be referred to SPC.

REFERENCE

1. Temel JS, et al. Early palliative care for patients with metastatic non-small-cell lung cancer. *NEJM* 2010;**19**:733–42.

P-133 COMBINED ONCOLOGY & PALLIATIVE CARE CLINICS; HOSPICE IN-PATIENT STAYS AND PLACE OF DEATH

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Background Early Specialist Palliative Care (SPC) introduced to patients with advanced lung cancer has been proven to enhance quality-of-life and improve survival.

Combined Oncology and Palliative Care Clinics (COPCC) at Royal Cornwall Hospital Trust enable patients to be reviewed by palliative care consultants whilst attending for oncology review; facilitating the two specialities to run in parallel to improve patient care. The aims of this project were to explore the use of inpatient hospice facilities of all patients, and place of death those for those patients who died.

Methods Retrospective case-note review of 150 consecutive patients between 01/2016-06/2016. Data collected by three medical students.

Results Admissions to hospice: 18/150 patients (12%) had at least one hospice admission, with the most common primary reason for admission being symptom control (83%). Total number of admissions of any one patient ranged from one to seven. Length of stay range; one to 46 days, with a median value of nine days. Patients were known to the hospice up to 65 months prior to death. 11/18 patients died during their last hospice admission, and seven were discharged home.

Place of death: 29/150 (19%) patients died at the time of data collection; 12 (41%) died at home, 11 (38%) died in a hospice, 3 (10.5%) died in acute 3 (10.5%) or 3 (10.5%) community hospitals.

Conclusion Access to SPC in COPCCs appears to enable early contact with inpatient hospice units, and enable more patients to die in hospices and at home. 38% of this study's deceased patients died in a hospice; a 2.3 fold increase compared to hospice deaths of cancer patients specifically (16.4%).² The number of deaths is small and warrants follow-up studies.

REFERENCES

1. Temel JS, et al. Early palliative care for patients with metastatic non-small-cell lung cancer. *NEJM* 2010;**19**:733–42
2. National End of Life Care Intelligence Network.

P-134 SHOULD SIM MAN DIE? FINAL YEAR MEDICAL STUDENTS' BELIEFS AND ATTITUDES REGARDING DEATH IN SIMULATION

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Background Learning to deal with death is an essential for medical graduates but there is no educational consensus whether sim man should die in undergraduate simulation. Concerns include being too distressing for students or