agreement regarding i) the use of advanced analytics on specific clinical scenarios and ii) the critical aspects when using these applications on the frame of PC. The sample included professionals from different countries and disciplines with expertise on chronicity, geriatrics and/or PC. Consensus was defined as >70% of subjects agreement.

Results At this time, fifteen experts have answered the questionnaire (37.5% of whom invited to participate). 78.6% were women, 71.4% were working in a clinical setting >15 years as physicians (57.1%), nurses (35.7%) and psychologists (7.1%) 80% of them considered that the strategy based on an automatic tool (BD based) combined with front-line healthcare staff is the best way for identification of patients who could benefit from early PC approach. They assessed as 'very' and 'extremely useful' the use of BD models on research applications, both as a population health management tool (clinical clustering) and as a tool to improve the prediction of an outcome risk. However, the need for clinical validation and the dearth of evidence of practical benefits are the main critical aspects on the implementation of these tools.

Conclusions The view of experts can contribute to guide BD applications on advanced stages of illnesses. The consensus about the opportunities and gaps on the implementation of these tools will support clinicians in decision making processes.

127 EVALUATION OF THE PROCESS OF SENDING OUT OACC QUESTIONNAIRE TO PATIENTS, PRIOR TO THEIR FIRST PALLIATIVE CARE NURSE SPECIALIST VISIT/ APPOINTMENT, JUNE 2019

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The OACC Assessment Questionnaire is sent out to all appropriate patients at telephone triage who are assessed as needing to be seen within 1–2 Weeks. The Questionnaire looks at IPOS as part of OACC.

This process allows for the Patients to have more time to review their symptoms and to think about their main problems of concern over the last week, along with any practical problems resulting from their illness, prior to their Palliative Care Nurse Specialist visiting them in their own home for their first holistic assessment.

By enabling an opportunity for the Patients to complete the Questionnaire themselves, it reduces reliance on Healthcare Professional Staff assisting them, and gives more autonomy/direction about key issues for them. It can also be used as a channel for Patients and Families to have some open conversation prior to their first visit/assessment, and to give insight into areas we will cover, which are different to a District Nursing assessment.

This review aimed to establish the benefit of sending out the Questionnaire. Also to examine if the action of recording data within the process was robust, and to identify any areas that could be improved.

A random sample of 34 patients was selected for retrospective review of activity from sending out the Questionnaire to examination whether this was completed by the patient or helped by the nurse to complete on the first visit, and scrutiny of the data recorded on Crosscare thereafter.

Overall, it was found that there was benefit of sending out the OACC Questionnaires with 50% of Patients completing this prior their PCNS visit. However, following analysis of the data recorded, we established that we needed to revisit training, particularly for PCNSs for navigating the IPOS windows and recording data therein.

128 PALLIATIVE CARE FOR HOMELESS PEOPLE: A SYSTEMATIC REVIEW OF SYSTEMATIC REVIEWS FOR AN EVIDENCE BASED CLINICAL GUIDELINE

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10.1136/spcare-2020-PCC.148

Background Homeless people die much younger and have higher rates of ill-health compared to the general population. This systematic review of systematic reviews seeks to understand 1. views and preferences of homeless people regarding palliative care, 2. barriers and facilitators to homeless people accessing palliative care and 3. evidence for advance care planning interventions in palliative care for homeless people. This informed the development of a guideline for use by healthcare professionals providing palliative care for homeless patients.

Methods Searches took place of PubMed, Embase, PsychINFO, CINAHL, Web of Science, Medline and Cochrane Library from inception to December 2019. The quality of the studies was assessed using SIGN Methodology checklist 1. The GRADE system was then used to assess the quality of the evidence and strength of the recommendations. Themes were identified following data analysis.

Results Five systematic reviews met the eligibility criteria. Three were rated as moderate quality, one as poor quality and one as unacceptable quality. Nine types of themes were then identified. First, views and preferences; homeless people recall poor experiences of healthcare in the past and have unique concerns regarding their health. Five barriers to palliative care were also identified, namely; lack of basic needs being met, having competing priorities, being ill-informed about their condition, hospice and hostel staff having insufficient knowledge, and poor co-ordination of care. The emerging facilitator was that homeless patients trust the staff they already know. Finally, many homeless patients benefit from advance care planning interventions, if they feel able to engage in the process. The quality of the recommendations was moderate to low. The strength of the recommendations was mostly strong.

Conclusions In this review, the views, preferences, barriers, facilitators, and interventions in palliative care for homeless people were established, informing a new clinical guideline.

129 IMPLEMENTATION OF TREATMENT ESCALATION PLANS (TEP) AND DNACPR DECISIONS AT ST GEORGE'S UNIVERSITY HOSPITALS NHS FOUNDATION TRUST

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10.1136/spcare-2020-PCC.149

Introduction Treatment escalation plans (TEP) are a tool to promote advance care planning, appropriate decision making and good communication between professionals, patients and

carers, in line with national guidelines.^{1 2} In 2018, this Trust introduced guidance that all patients at risk of acute deterioration and/or with a National Early Warning Score (NEWS) of 5 should have a TEP.

Aim To assess the proportion of patients on the palliative care caseload with a TEP and/or DNACPR decision in place over a three-month period.

Methods The palliative care caseload was reviewed weekly between December 2018 and March 2019. Two audit standards were set with a target of 100% compliance:

1. Completion of a TEP
2. Documented decision regarding CPR

Results The total sample size was 545 patients. Whilst the mean compliance with the audit standard for TEP was low (40%), over the three-month audit period there was an increase from 25% to 50%. Medical wards had a higher proportion of patients with a TEP (43%), compared with surgery (35%), ITU (33%) and oncology/haematology (31%). The proportion of patients with a documented decision regarding CPR status was high throughout (98%).

Conclusions Reasons for the increase in uptake of TEP may include increased awareness resulting from the audit process, and the focus on TEP as a priority within the Trust. The results were disseminated at divisional level and to the Deteriorating Adults Governance Group. Recommendations include TEP 'champions' to share examples of best practice, targeted education sessions, adopting appropriate use of TEP as a key quality indicator for the Trust and replacing the paper TEP form with an online version as part of the electronic patient record system. The audit will be repeated in 9–12 months to assess the impact of these interventions.

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IMPROVING COMMUNICATION BETWEEN SECONDARY AND PRIMARY CARE REGARDING ADVANCED CARE PLANS; USING AN ELECTRONIC TOOL

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10.1136/spcare-2020-PCC.150

Background Advanced care planning (ACP) and end of life discussions commonly happen in hospital. However, on discharge into the community there is often a poor handover from the hospital team regarding these decisions. Improving this communication is essential to reduce inappropriate admissions and ensure patient preferences are respected and needs appropriately met by community teams and on readmission to hospital.

Aim We aimed to improve the communication of ACP made in hospital by introducing an electronic ACP record on the discharge summary.

Method Retrospective baseline data was collected between November – December 2018 on an elderly care ward. This included whether ACP happened during hospital, who was this had with, whether they have a 'do not attempt resuscitation' (DNAR) form and would the multidisciplinary team

(MDT) be surprised if the patient died within the next 12 months. A mandatory tick-box was then added to the electronic discharge summary asking whether ACP decisions had been made or not. Further data from the same ward was then retrospectively collected between November– December 2019.

Results In total 71% (n=43) of patients were felt by the MDT that they would not be surprised if they died within the year. 72% (n=43) of patients had a DNAR form. The baseline data (n=23), showed that of those patients with DNAR forms only 29% of discharge letters communicated this decision. The post intervention data (n=20), showed of those with DNAR forms 50% were communicated on the discharge summary.

Conclusions This simple intervention has improved the communication between secondary and primary care teams. However further improvements are needed, the regular changeover of junior doctors means there is variability in how well the ACP is filled in. Further education regarding the importance of clear communication is needed and would be helpful at induction for new doctors.

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GENETIC REFERRALS IN HOSPICE CANCER PATIENTS: COMPLETION OF THE AUDIT CYCLE

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10.1136/spcare-2020-PCC.151

Background The majority of hospice admissions have a cancer diagnosis. An estimated 5–10% of cancers have a familial link. Patients have expressed a wish to participate in genetic screening as it may benefit surviving family members through informing subsequent counselling, genetic testing and preventative action. A hospice stay provides an opportunity to explore this. However, genetic referrals from the local hospice were thought to be infrequent with criteria unclear. The audit aimed to assess and improve the proportion of hospice inpatients with cancer who:

- had a family history recorded
- met a simpler 3–2–1 criteria for genetics referral
- were offered genetic screening if appropriate.

Methods The notes of 36 consecutive admissions with a cancer diagnosis were reviewed. Audit standards were not met so change was implemented through installing an electronic prompt for recording family history, teaching sessions for medical staff, and senior review of family history and genetic screening (if appropriate) of all new admissions. Data collection was then repeated.

Results Results showed audit standards were not being met but there was an improvement after interventions. The proportion of patients with family history recorded increased from 19% to 36%. In these patients, the proportion who met the 3-2-1 criteria was 43% initially and then 30% subsequently. Genetics referral was discussed in the notes in 23% of patients, compared to 6% initially.

Conclusion The interventions have improved the recording of patients' family history and consideration of referral for genetic screening. The findings were limited by information available but a relatively high proportion of patients met the 3-2-1 criteria, some of whom had not previously had genetic