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.

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 PCNs 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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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 i) the views and preferences of homeless people regarding palliative care, ii) barriers to and facilitators to homeless people accessing palliative care and iii) 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, PsycINFO, 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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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. 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.

**REFERENCES**


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**131 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 screening.