

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.

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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.

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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.

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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