Average length of hospital stay in the last 30 days of life fell, equating to a saving of 220 bed days or £88000/year

Patient/relative feedback was very positive.

Discussion The data suggests ESC is acceptable to and benefits patients. Fixed term funding is enabling the service to be expanded short term. Robust data collection and service analysis continue.

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A HOSPICE BASED RENAL SUPPORTIVE CARE SERVICE: AN EVALUATION OF THE FIRST 3 YEARS

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10.1136/spcare-2020-PCC.199

Background St Barnabas House launched a Renal Supportive Care (RSC) Service in April 2016. This consists of a RSC Clinical Nurse Specialist (CNS), consultant support and joint working with the local secondary care renal team. Since 2016, 110 patients with advance renal disease (CKD 5) have been referred to our RSC service, approximately 3% of the hospice's total referrals each year from a baseline of <1%. We audited the service to measure impact and inform ongoing service development.

Methods We performed a retrospective audit of system 1 data and data prospectively collected by the RSC CNS for patients on the RSC caseload between April 2016 to August 2019. Data included referral source, reason, duration, outcome and information regarding intervention, advance care planning (ACP) and place of death.

Results 139 referrals were received for 110 patients. Mean duration of referral was 105 days range (1–1103). Referrals were made for symptom control (42%), ACP (39%), Psycho-social support (13%), decision making support - dialysis versus conservative care (6%) and stopping dialysis (2%), patients imminently dying were referred to the non-disease specific CNS team. 49% of patients accessed another hospice service eg Day Hospice in addition to RSC CNS input. Face-to-face patient contacts occurred in patient's homes (83%), outpatients (16%) and hospital (1%). 66 patients were discharged following a completed care episode, 29 of these were re-referred. 52 patients died, 38 (73%) had their preferred place of death (PPD) recorded prior to death. In this group 1 (3%) died in hospital. The rate of hospital death increased to 46% (6 out of 14) in patients without a documented PPD.

Conclusions The RSC service at StBH has increased access to specialist palliative care for people with advanced renal disease. Participation in ACP for these patients increased the likelihood of achieving a death outside of hospital.

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COST-EFFECTIVENESS OF COPD MANAGEMENT IN THE UK

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10.1136/spcare-2020-PCC.200

Introduction Chronic Obstructive Pulmonary Disease (COPD) is a long-term condition characterised by breathlessness. The

WHO has projected a 30% increase in total COPD deaths worldwide over the next decade. In 2012, COPD accounted for 29,776 deaths in the UK, and it costs the NHS over £8,000,000 annually.

Method This systematic review was conducted via searches on PubMed, using key words 'COPD', 'Management', 'Cost-effectiveness', 'exercise', 'QALY', 'UK' and 'Pulmonary Rehabilitation'. Studies with non-cost-effective interventions were removed. Studies using 'Quality Adjusted Life Years' and/or 'Incremental cost-effectiveness ratio' were considered for this review. Prices were adjusted for inflation.

Results Studies reviewed suggest that current standard care is cost-effective by NICE standards (£20,000 to £30,000 per QALY). Cost effectiveness was improved with the addition of roflumilast to ICS/LABA therapy, where adding roflumilast led to an ICER of £24,976 per QALY gained for severe and very severe COPD in 2018. Tiotropium (£1934–£2548 in 2018] per QALY) proved to be a superior treatment over ipratropium (£2256–£2973 in 2018] per QALY) and salmeterol (£2143–£2823 in 2018] per QALY). Umeclidinium bromide added onto ICS/LABA therapy led to an ICER of £1310 per QALY, an improvement over Tiotropium. Adding pulmonary rehabilitation to treatment for COPD was likely to result in financial benefits, with mean incremental cost of adding PR was -£152 (-£200 in 2018). Physical activity improved cost-effectiveness versus sedentary lifestyle, reducing exacerbations and increasing QALYs.

Conclusion Current medical management is well optimized with regards to price per QALY gained. Umeclidinium should be considered for treatment instead of tiotropium. Physical Activity reduces exacerbations, increases QALYs and improves cost-effectiveness. However, data on cost-effectiveness of PR for COPD were insufficient. Furthermore, cost-effectiveness data of medical treatment should be updated as drug prices may have changed.

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IMPLEMENTING PATIENT CENTRED GOALS INTO A BREATHLESSNESS SYMPTOM MANAGEMENT CLINIC

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10.1136/spcare-2020-PCC.201

Introduction Space to breathe is a 5 week programme, with a rehabilitative focus, launched in January 2019 and designed through a Breathlessness steering group. A literature review recommended the use of the Goal Attainment Score (GAS) (Brighton 2018) and this was included into holistic measures of the breathlessness service. GAS light was chosen to reduce user burden and form part of the assessment of the service, complementing the rest of the Outcome Assessment Complexity Collaborative (OACC) suite and Chronic respiratory Questionnaire (CRQ) and Medical Research Council score of breathlessness (MRC) scores improved.

Method The programme is based on the Cambridge Breathing Thinking Functioning approach (Cambridge University Hospitals NHS Foundation Trust 2019) and with a focus on mastery of symptoms of breathlessness. Sessions include taught educational sessions followed by group discussions and exercise. Participants were supported by carers and clinicians to set patient identified SMART goals. GAS light