

IPOS scores on initial assessment at one centre (N=15), recorded the main symptoms as breathlessness, weakness and anxiety. Family anxiety was the highest scoring aspect of the IPOS. The medical management at the end-of-life was, however, generally uncomplicated; the total opioid (oral morphine equivalent) and benzodiazepine doses administered in last 24 hours before death were relatively low, median dose (range) 31.25 mg (5–160 mg) and 15 mg (0–30 mg) respectively.

Conclusions Should a further surge of COVID-19 cases occur, many cancer patients dying with COVID-19 could be appropriately managed by non-specialist physicians supported by comprehensive guidelines, ward-based teaching and specialist palliative care input for more complex cases. High levels of family anxiety could be improved by enhanced family support and communication about end-of-life wishes and priorities; healthcare services should have a particular focus on supporting the shadow pandemic of loss.

27 EVALUATING THE ROLE OF THE ROYAL FREE LONDON NHS FOUNDATION TRUST PALLIATIVE CARE TEAMS DURING THE COVID-19 PANDEMIC

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Background The SARS-Cov-2 pandemic resulted in a rapid and unprecedented shift in the number of patients admitted to hospitals. In this trust palliative care provide a 9–5, 7 day/week liaison service. We evaluated the role of the palliative care services during the peak of the pandemic.

Methods We conducted a retrospective analysis of the demand on palliative care team (PCT) at the two acute hospital sites; Royal Free Hospital (RFH) and Barnet Hospital (BH). Trust referral data was recorded for a 6-week period between 18/03 and 29/04, 2020. Patient outcomes were documented on a standardised Excel-database. Clinical notes were audited at random to ensure quality of data capture.

Results During the period studied there were 597 deaths between both sites, 393 (66%) of which were documented as Covid-19 related. BH referred 178 patients to the PCT, of which 90% were Covid-19 related. RFH referred 99 patients, of which 58% were Covid-19 related. Clinical support provided to the wards caring for the patients was predominately in person at BH (97%) and via telephone at RFH (76%), with an average time to death after referral of 1.9 days at BH and 2.8 days at RFH. Approximately 16% of patients at both sites were discharged to other services for on-going care or end-of-life-care at home. The majority of pharmacological interventions were as-required medication (>85%) with fewer patients than anticipated needing a syringe driver (<60%). Clinical notes confirmed that most patients became symptomatic quickly, died rapidly after referral and communication with families via telephone was well documented.

Conclusions The two PCTs had different clinical experiences, this can be explained by the populations that each site serves, the structures within the teams and their physical location in relation to the wards. Excellent patient outcomes remained the same suggesting that both PCTs adapted well, with further shared learning planned.

28 A REVIEW OF CARDIOPULMONARY RESUSCITATION (CPR) AND TREATMENT ESCALATION PLAN (TEP) DECISION-MAKING IN AN ACUTE LONDON TRUST DURING THE COVID-19 PANDEMIC – AN AUDIT-BASED STUDY

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Introduction National guidance early in the COVID-19 pandemic encouraged frontline hospital staff to have discussions and make early decisions with patients regarding appropriateness of CPR and other medical treatments if they were to deteriorate.

An audit of CPR and TEP decisions was carried out in our trust at the pandemic peak and four weeks later compared to data from the previous year.

Methods Admission data was used to determine the peak of COVID-19 admissions. Electronic records of all adult inpatients (excluding maternity and Emergency Department) were reviewed and any completed CPR decisions and TEPs on the 2/4/20 (peak) and 30/4/20 analysed using the same criteria as previous CPR and TEP audit.

Results and Discussion There was a 3-fold increase in patients with a CPR decision at the peak (77%) of the pandemic, compared with pre-pandemic (26%), with a marked increase in number of decisions 'For CPR' from 1% pre-pandemic to 33% at peak. However, this increase in number of CPR decisions reduced 4-weeks post the peak to 58% as the pressure on admissions and ICU beds decreased.

The number of patients with a 'No CPR' decision with a TEP increased from 59% pre-pandemic to 88% at the peak suggesting an increased focus on reviewing benefits of treatments such as ventilation together with a CPR decision. This declined to 53%, below pre-pandemic levels, at 4-weeks.

70% of CPR decisions were made within 2 days of admission at the peak which declined to 65% 4-weeks later.

Conclusions At the peak of COVID-19 related admissions, the data set shows a marked increase in CPR decisions and completed TEPs compared to pre-pandemic baseline, indicating that the importance of such conversations and prioritisation of resources became a focus for healthcare professionals. The increase was not, however, sustained. Maintaining focus on early decision-making remains the challenge.

29 DISCUSSIONS OF PREFERRED PLACE OF DEATH IN SECONDARY CARE DURING THE COVID-19 PANDEMIC

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Objectives Achieving Preferred Place of Death (PPD) may form part of a 'good death' for some patients and loved ones. In many circumstances, it may not be possible to facilitate a death outside of hospital during the COVID-19 pandemic but this does not exclude the need for constructive discussions of PPD in order to address this. The aim of this audit is to determine whether PPD is being discussed in a secondary care setting alongside Treatment Escalation Plans (TEPs) and explore influencing factors.