

Aims To develop a core outcome set for touch-based complementary therapies in palliative care.

Methods Potentially relevant outcomes were identified by screening published randomised control trials of touch-based therapies in clinical populations identified in a systematic review, and qualitative studies of complementary therapies in people with advanced disease. Semi-structured interviews were conducted with patients and complementary therapists to identify additional relevant outcomes. Patients, complementary therapists and academics rated the importance of the identified outcomes in a modified online Delphi survey. Outcomes for which $\geq 70\%$ of the group agreed were critically important and were discussed and voted on in a consensus meeting.

Results 59 unique outcomes were identified from published literature and interviews. Of these, 17 were deemed critically important in the Delphi survey. From voting in the consensus meeting, five outcomes were selected for inclusion. An additional three outcomes were identified as important to patients and were incorporated. The final core outcome set comprises; Anxiety, Sleep quality, Overall mental wellbeing, Pain, Muscle relaxation, Mental resilience, Enjoyment and Patient satisfaction.

Conclusions A Core Outcome Set reflecting the priorities of patients, complementary therapists and academics has been developed to be used in palliative care clinical trials.

Impact Use of the core outcome set in future trials will standardise outcomes and allow for better data comparison and synthesis. Improving the evidence base will help us bridge the gap between patient experience and trial outcomes and better understand the effect of complementary therapies for patients receiving palliative care.

48

WHAT KINDS OF SPIRITUAL AND/OR RELIGIOUS INTERVENTIONS FOR THE WELLBEING OF PEOPLE LIVING WITH TERMINAL ILLNESSES DID RCTS INVESTIGATE IN 2011–22? FINDINGS FROM A COCHRANE REVIEW, UPDATING A PREVIOUS REVIEW (CANDY ET AL. 2012)

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Introduction People with terminal illnesses may have spiritual and/or religious concerns and often value professional assistance with addressing these. It is again being increasingly recognised that, as Cicely Saunders originally argued, attending to the spiritual and/or religious needs of people approaching the end-of-life benefits their health and wellbeing overall.

Aims To explore the detail of spiritual and/or religious interventions for the wellbeing of adults with terminal illnesses in randomised controlled trials (RCTs) included in a 2011–22 Cochrane review.

Methods We systematically searched six databases (AMED, CENTRAL, CINAHL, EMBASE, MEDLINE, and PsycINFO) for RCTs of spiritual and/or religious interventions for the wellbeing of adults with terminal illnesses between 2011 and 2022. Our primary outcomes were spiritual wellbeing, psychological wellbeing, quality of life, coping, death distress, and quality of death/dying.

Results We identified 2569 citations, retrieved 98 full-texts, and included 40 studies, a much larger number and proportion than the 2012 review (40/2569 vs 5/3868).

Studies were conducted globally: in Africa, the Americas, Asia, Australasia, and Europe. Interventions varied. Most involved psychotherapy (14) or life reflection (13). Five were explicitly spiritual or religious, e.g., Islamic prayer, or Buddhist chanting. Five comprised explicit spiritual/religious elements within a palliative care intervention. The remaining three investigated meditation or mindfulness.

Studies also varied in their comparators, outcomes assessed, and outcome measures used. This variability between studies restricted and limited inter-study comparisons.

Conclusions Increasing numbers of RCTs in this field are being conducted internationally. However, they vary widely in the interventions they investigate, the outcomes they address, and the measures they use.

Impact This important, under-researched field is growing, with increasing numbers of RCTs investigating spiritual and/or religious interventions for wellbeing. However, studies are highly diverse, and, while variation is to be expected in a developing field, too much prevents comparisons of study findings. More consistency of design would enable more inter-study comparability.

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49

BURDEN AND CHALLENGES OF MALIGNANT BOWEL OBSTRUCTION: A QUALITATIVE STUDY

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Introduction Malignant bowel obstruction (MBO) is a distressing complication of cancer, causing symptoms including nausea, vomiting, pain, and constipation. It has a profound effect on quality of life, often requiring hospitalisation. There is a lack of data indicating how outcomes used to evaluate MBO in research and clinical practice are related to the patient experience, and what key features are important to them and their caregivers.

Aims To explore key features of the lived experience of people with MBO, their caregivers, and perspectives of healthcare professionals.

Methods Semi-structured interviews with people with MBO, their caregivers and healthcare professionals who manage this condition. Data were analysed using thematic analysis.

Results Eight people with MBO, two caregivers and 19 healthcare professionals were interviewed. Five themes were generated: 1. Symptom and treatment burden; 2. Psychological, social and functional implications; 3. Complexities and challenges of care (variability and uncertainty of management outcomes); 4. Collaborative care and communication; and 5. Nature and trajectory of MBO. The interviews highlight the devastating impact of symptoms of MBO, and side effects of treatment. MBO affected psychological, social and functional aspects of patients' quality of life. Healthcare professionals described the complex challenges of managing MBO, from uncertain guidelines to the variability of each individual case and the difficulties surrounding communication of a diagnosis of MBO, and its impact.

Conclusions These findings highlight the challenges posed for healthcare professionals managing MBO, and the high burden of symptoms on patients and caregivers, including psychological and social impact on patients' quality of life. Patient-relevant goals of care should be collaboratively explored and understood by practitioners, patients and caregivers.

Impact Outcomes from these interviews have been used to inform a core outcome set for inoperable MBO, focused on prioritising patient-relevant outcomes that should be measured in research and clinical practice.

50

MAKING ACP WORK FOR PEOPLE IN PRACTICE: IMPLEMENTATION OF A STRUCTURED ADVANCE/ANTICIPATORY CARE PLANNING INTERVENTION IN SCOTTISH PRIMARY CARE (4ACP)

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Introduction Advance/Anticipatory Care Planning (ACP) for people with terminal illnesses helps deliver personalised care, support wellbeing, and reduce healthcare crises. Patient and family acceptability/engagement, timely approaches from professionals, and sensitive communication are key. Four ACP steps use nationally recommended interventions; 'AnticiPal' primary care electronic record search (READ code-based screening), GP review (identification and assessment); ACP public information from NHS Inform (<https://www.nhsinform.scot/acp>) plus professional education (REDMAP framework for ACP discussions – <https://ihub.scot/acp>), and electronic care planning records (Key Information Summary care coordination system).

Aims To implement and evaluation integrated ACP in Scottish primary care using the 'Four Actions ACP' process.

Methods A mixed-method, healthcare implementation study following StaRI guidelines. National primary care datasets from approximately 5,800,000 GP-registered patients screened using AnticiPal conducted before and after ACP implementation case studies with 16 diverse GP practices in four Scottish Health Boards lasting 12 weeks each (study population approximately 100,000). Practice case study data include; AnticiPal screening outputs, GP 'Thinking Aloud' interviews of AnticiPal list assessments, patient-carer and linked GP

interviews following ACP conversations, ACP plans recorded, AnticiPal cohort outcomes.

Results Approximately 0.6% of GP registered patients in Scotland screened positive for ACP review/planning discussions (pre-excluded if on palliative care register). Of these, 61.6% had no Key Information Summary or documented ACP. Practices found 4ACP straightforward to implement with potential to improve ACP for significant numbers of deteriorating patients known to clinicians but not identified for ACP or palliative care. Ongoing qualitative interviews with patients, families and GPs, and ACP outcomes data will be available for presentation.

Conclusions Effective ACP depends on implementation into routine practice of a feasible intervention acceptable to patients, families, and professionals alike. 4ACP provides robust evaluation of national ACP programmes in Scotland and informs refinement and implementation at scale of the AnticiPal search tool and outputs for GP practices.

Impact National (Scottish) data provides key public health information about the unmet need for anticipatory care planning. Implementation of screening in 16 diverse GP practices provides a systematic process for identification of ACP needs in practice, impact ca 100 K patients. Use of NHS Inform/REDMAP tools for clinicians will directly impact all patients undertaking ACP in the case study practices. Robust evaluation of the implementation impacts policy about and provision of ACP in Scotland and, through our contacts in England and Northern Ireland, at a UK level.

51

CHANGING NEEDS AND GEOGRAPHICAL VARIATION IN PALLIATIVE CARE FOR LUNG CANCER

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Introduction 26,935 people died from lung cancer (2020) in England. 1 year survival remains low, so palliative care remains a critical part of care for lung cancer patients.

Aims To use national linked Office for National Statistics mortality and hospital episode statistics (ONS-HES) to describe variation in geographical need and opportunities for improving palliative care (PC) for lung cancer patients.

Methods A sub-set of an ONS-HES linked mortality dataset for England with people who died with lung cancer as the underlying cause (ICD-10 C33–34) was analysed for: age at death, gender, need for early PC (1-year survival), and proxy indicators of quality: place of death, >3 emergency admissions in last 90 days (3+EAs), seen by Palliative Care Team (PCT) in final admission.

Results Provisional results. 51% of people dying from lung cancer in 2020 were aged >75 years and 47% female. Both age at death and % females have increased significantly over the past 2 decades. One year survival (2019) varied across CCGs from 40.2–57.7%. The % of lung cancer patients dying at home in England jumped from 33.3% (2019) to 44.0% (2020), home becoming the commonest place for the first time. However, this varied 31.6–57.2% across CCGs. 3+EAs dropped from 12.6% (2019) to 10.5% (2020) but significant variation persistent across NHS Regions 9.5–12.0%. The % seen by (PCT) in final hospital episode increased from 33.2% (2012) to 45.5% (2019), varying 21.3–62.1% across CCGs.