palliative conditions, we sought to explore whether multimorbidity and disease-count were significant predictors of mortality and healthcare use in emergency department (ED) attenders.

Methods We conducted secondary analyses of inpatient and ED records for Glasgow (Scotland) residents attending the ED between April 2019 and March 2020. We conducted binomial logistic regression and calculated adjusted/unadjusted odds ratios (ORs) with 95% confidence intervals (CIs). Age, sex, ethnicity and deprivation were included in adjusted models. To handle missing data, complete case analysis was conducted and compared with results from post-imputation analyses. Ethical approval obtained from Local Public Advisory Committee.

Results 126,158 attendances by 75,726 eligible persons occurred during the study period. Complete data was available for 63,331 persons. Multimorbidity and disease count were significant predictors of all outcomes in both adjusted and unadjusted models. Complete case and post-imputation analyses produced comparable results. Of particular relevance to palliative care, only a small number of individuals died during admission (n=1.031, 1.6%), but multimorbidity was a significant predictor of this in both crude (OR: 4.41, 95% CI: 3.90–5.00) and adjusted (adjusted OR: 1.80, 95% CI: 1.58–2.05) analyses.

Conclusions Significant associations were detected with access to only 2–3 years historical inpatient data, so further validation of these predictors with greater historic inpatient and primary care data is warranted. We have however shown that these predictors are significant and should be incorporated into models aimed at identifying people at risk of healthcare use and mortality. Improving end-of-life care for people with multimorbidity is an avenue for further research, and robust models which can handle major class imbalances (only 1.6% ED attenders died during admission) should be tested.

101 PUTTING THE 'FAST' BACK IN 'FAST TRACK': A MIXED-METHODS SERVICE EVALUATION

Clark Glasgow, Rachael Harrison, Charlotte Jones, Charlotte Chamberlain. *University Hospitals Bristol and Weston NHS Foundation Trust*

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Background In the Bristol region, 41% of patients die in hospital (2021), despite only 3% wishing to die in this setting. Continuing Health Care Fast Track (CHCFT) provides National Health Service funding to support rapidly deteriorating patients to die outside hospital.

Methods A mixed-methods service evaluation: case-note review of patients with CHCFT referral (March 1st to April 31st 2021) and semi-structured interviews (n=13) with CHCFT discharge staff (nurses, junior doctors, specialist palliative care (SPC) nurses, occupational therapists and hospital discharge team [HDT] (2022)). Key time intervals were calculated (e.g., CHCFT referral to death). Medians, means, ranges and percentages are presented. Semi-structured interviews, conducted using a topic guide, were audio-recorded, transcribed, coded by two health professionals independently and inductive data grouped by higher themes.

Results Of 72 patients referred to the HDT for CHCFT funding, 92% were known to SPC, with a median of four days from admission to SPC referral. Twenty-seven CHCFT patients (37.5%) died in hospital; 30 (41.6%) were discharged with CHCFT funding (14 (19.4%) own home and 16 (22.2%) nursing home), and 15 (20.9%) were discharged without CHCFT.

There was a median of 14.5 days from CHCFT referral to discharge, with a median of 29.5 days between SPC referral and death. Forty-two patients (58.3%) died within 30 days, 50 (69.4%) within 90 days and 67 (93.1%) within 365 days of CHCFT request.

The role of the palliative care expert was commonly emphasised by participants as critical in recognising deterioration and navigating CHCFT. Overall, CHCFT was perceived as disappointingly slow. Major barriers to timely CHCFT included delayed recognition of deterioration, multiple step/duplicated paperwork, ineffective inter-professional communication and insufficient community staffing.

Conclusion Early hospital palliative care assessment with multidisciplinary input is critical to improve timely recognition of dying and discharge. The duration to CHCFT discharge negatively impacts patients and staff.

102 DOES DEPRIVATION STATUS HAVE AN IMPACT ON REFERRAL AND TREATMENT PATTERNS WITHIN THE GREATER GLASGOW AND CLYDE INTERVENTIONAL CANCER PAIN SERVICE (ICPS)?

Eilidh Burns, Kirsty Tolmie, Andrew Crockett. *NHS GGC, Beatson West of Scotland Cancer Centre*

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Interventional techniques are effective in improving pain control and reducing side effects in patients experiencing complex cancer pain. (1) In 2008 Beatson West of Scotland Cancer Centre (BWoSCC) established ICPS. This multidisciplinary service provides a range of interventions including intra-thecal drug delivery (ITDD), cordotomy, and neurolytic procedures. BWoSCC serves a population of 2.5 million people. An objective is to ensure patients have 'equitable access to high quality cancer services'. (3)

Methods The ICPS maintains a database of every patient referral. This allowed us to collect patient demographics, Scottish Index for Multiple Deprivation (SIMD) status and assessment outcomes.

Results 609 patients were referred to the service from 2008 – December 2019. 602 patients included in study, 310 (51%) male, 292 (49%) female. Age range: 16 to 91, median 60. 462 patients assessed -161(35%) proceeded to intervention, 67 (15%) to ITDD trial, 94 (20%) received alternative intervention. Most common cancer types referred were lung, colorectal and upper GI. Comparing ICPS data with wider regional data identified specific cancer types which were more likely to undergo an intervention. Deprivation status of ICPS patients were compared to overall West of Scotland (WoS) population. ICPS saw a higher proportion of patients from both highest and lowest quintile compared to the overall WoS cancer population but this was not statistically significant. The majority of interventions were undertaken in highest deprivation status. 54 (34.6%) patients were quintile 1, 22 (14.1%) quintile 2, 22 (14.1%) quintile 3, 22 (14.1%) quintile 4, 36 (23.1%) quintile 5. The proportion of referrals, clinic assessments and interventions were similar in all of the deprivation quintiles.

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