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 (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

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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)?

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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-the-cal 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, 34 (6%) 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.
Conclusions In conclusion, deprivation status does not significantly impact on referral or treatment patterns within ICPS. Findings suggest patients had equitable access to the service and deprivation status did not affect the likelihood of receiving an intervention.

EXTENDING THE HOSPICE WALLS: DEVELOPMENT OF A SERVICE TO REACH NEWCASTLE’S HOMELESS POPULATION

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Background Across Britain 227,000 households experience the worst forms of homelessness. The national prognosis for a homeless person is 45 years of age. In Newcastle it is just 42. Marie Curie acknowledges the inadequacies of end of life care outside of those we reach directly, and the team at Marie Curie Newcastle decided to focus on expanding the boundaries of the hospice. As a consequence the team developed an outpatient service to address the needs of this often overlooked population.

Method Individuals identified for inclusion in the service were: homeless adults and those with a relevant past medical history. Homeless persons could also be included if they are considered to have a life expectancy of 6 months or less in the absence of diagnosed conditions. The service narrowed its focus further to those in hostel environments focusing on 7 in Newcastle City Centre.

Results The team enrolled 14 people appropriate to access the service. 3 suffered from cancer or suspected cancer, 9 suffered from other chronic health conditions, 1 had a strong history of sudden cardiac death, and 7 had multiple comorbidities. Service development focused initially on building rapport, and now provides psychological support around historical and current trauma, grief and substance misuse. Practical support included using the hospice outpatient setting for blood tests, ECGs and provision of a home nebuliser machine to reduce hospital admissions. Finally the service has provided the opportunity to engage in ACP discussions as well as to move two people from the hostel to care facilities.

Conclusion The service has faced many barriers in its development, including a lack of trust in institutions, nomadic lifestyles and the taboo of the hospice environment. As a result, at present the service mostly functions by visiting individuals in the community. In the future we hope that the service will be able to reach more people and help to begin to address the health inadequacies in our region.

CORNEAL DONATION IN A HOSPICE IN-PATIENT WARD

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10.1136/spcare-2023-PCC.124

Background Unlike organ donation, most people are eligible to donate their corneas when they die. The organ tissue donation and transplantation activity report 2021–2022 demonstrated an increase of 27% in the number of corneas retrieved, however, there remains a significant shortage. The NHS Blood and Transplant for 2021/22 highlighted that almost 1 in 10 people who joined the organ donation register, opted out of corneal donation. However, encouragingly, when people were educated on the benefits, 51% of people who initially said that they would be least likely to donate their corneas, said that they would be willing to donate.

Methods Between the 01/01/21 to 31/03/21 87 patients were admitted to a specialist adult inpatient palliative care unit. 60 patients were identified as potentially eligible for corneal donation after death with the remaining 27 ineligible. Data was collected on the frequency of discussions, the timing of discussion and which health care professional (HCP) led the discussion. The overall outcomes were also analysed.

Results Within the group of eligible patients, in 67% there was no documentation regarding this discussion nor any reason for this not being discussed. Discussions commonly occurred after death (45%) and were undertaken by staff of various disciplines. Of the 18 eligible patients with whom donation was discussed, 10 patients expressed a wish to donate their corneas after death and 9 went on to have a successful harvesting.

Conclusion Compared to previous data the number of successful corneal donations has increased but there is still significant room for improvement. An increase in knowledge and awareness can change public attitude towards corneal donation, therefore we should be aiming to make all eligible patients aware. Targeted education for HCP surrounding corneal donation will increase confidence and proactivity around discussion. This should help address the current national shortage of corneal donors.