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REVIEW OF MND PATIENTS KNOWN TO THE SPECIALIST PALLIATIVE CARE TEAM TO IMPROVE SERVICE PROVISION

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Introduction Dudley Group NHS Trust provides support to patients with a diagnosis of Motor Neurone Disease, working in conjunction with the Regional Specialist Motor Neurone Disease service based at University Hospital's Birmingham and Primary Care Services. Care is provided by the Specialist Palliative Care (SPC) department, Dudley Rehabilitation Service, Community Dietitians, Speech and Language services, and District Nursing. Currently all patients are discussed in a bi-monthly MDT meeting attended by the MND CNS (from UHB) and health professionals from the SPC team, Dietician and Speech and Language Therapist. A review of MND patients known to the specialist palliative care team to see if any themes was carried out.

Method Using a proforma a review of patients known to the Specialist Palliative team on the 5.4.22 and deaths during 2022 was carried out using Somerset where MDT and visits are recorded.

Results Eighteen patients known to the specialist palliative care team during this period, 12 male and 6 female. Of the 18 patients 10 died during the review period (Jan – July 2022) with 6 dying at home and 4 in hospital. With regards to the hospital deaths 2 had no DNACPR or ACP in community and this was completed in hospital. Advance care planning discussions were documented for 9 of the patients. There was documentation that some of the patients were GSF blue and therefore, not commenced yet, however, for a number there was documentation that ACP discussions had been challenging. DNACPR in place for 11 of the 18, however for 3 of these were completed in hospital.

Discussion This review has provided useful information regarding the challenge of Advance care planning and that 40% of deaths occurred in hospital. Next steps are to agree standards for referral, discharge and min review when on the caseload and who should be involved including nursing, medical and therapy.

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REVIEW OF PATIENTS KNOWN TO COMMUNITY SPECIALIST PALLIATIVE CARE TEAM THAT ARE ADMITTED TO DUDLEY GROUP OF HOSPITALS NHS FT

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Introduction The Specialist Palliative Care team in Dudley is an integrated team and therefore, when patients known to the team are admitted to Russells Hall Hospital an email alert is triggered that the hospital team can process. Approximately 50% of the patients on the hospital caseload are patients known to the community part of the integrated team. Therefore, a review of these admissions was planned to identify any themes to improve patient outcomes.

Method Review of March 2022 patients on the hospital caseload using proforma to capture information including diagnosis, reason for admission and if admission was organised by the specialist palliative care team.

Results In March 2022 there were 24 admissions to Russells Hall Hospital for 19 patients known to the community team. Two patients had 3 admissions and 1 patient 2 admissions. Most patients had a cancer diagnosis. With regards to the admissions 5 were arranged by the community specialist palliative care team. The admissions were for a range of reasons including possible malignant spinal cord compression, chemotherapy side effects, symptoms including pain, nausea and vomiting and breathlessness that required further investigation. The minimum a patient should be seen in community known to the specialist palliative care team is monthly and of the admissions only 1 patient had not been seen within a month of admission.

Discussion With the caseload held by the hospital team having approximately 50% of patients known to the community team this review has provided assurance that admissions were appropriate. Next steps include a review of criteria for prioritisation of patients either known to the integrated team or ward referrals and criteria for minimum number of visits including consideration of phase of illness supporting the need of specialist input.

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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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Background 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. The 4ACP study evaluates integrated ACP in Scottish primary care. 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).

Methods A mixed-method, healthcare implementation study following StaRI guidelines implements the four ACP steps. National primary care datasets from approximately 5,800,000 GP-registered patients screened using the AnticiPal search conducted before and after ACP implementation case studies with 16 diverse GP practices in four Scottish Health Boards (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, screened cohort outcomes.

Results Approximately 0.6% of GP registered patients in Scotland who had not previously identified for palliative care screened positive for ACP. 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