clinicians who had not previously been identified for ACP or palliative care. Qualitative interviews with patients, families and primary care clinicians identified areas of acceptability and concern.

Conclusions Effective ACP depends on implementation into routine practice of a feasible intervention acceptable to patients, families, and professionals alike. 4ACP provides an equitable service to all. Since 2017 the ICPS has established as a multi-disciplinary service in July 2014. Patients with uncontrolled cancer pain due to pain severity or with intolerable side effects from analgesia are assessed. If suitable, patients are offered an intervention, including Percutaneous Cervical Cordotomy (PCC). The service strives to provide an equitable service to all. Since 2017 the ICPS has provided a PCC service to the west of Scotland and beyond.

Patients are assessed by our multi-disciplinary team. For a proportion of these patients an intervention is offered to help with refractory pain.

The ICPS uses Scottish Index for Multiple Deprivation (SIMD), a national classification tool. This considers education, health and employment to give an assigned score.

Aim To ensure PCC’s are offered equitably across different deprivation quintiles.

Method Using the ICPS database, a retrospective analysis of all referrals to ICPS since establishment of the PCC Service in March 2017. Excel spreadsheets used to gather information on patients offered a PCC.

Results Since March 2017, 341 patients have been referred. See Table 1: 66 patients were offered a PCC. 11 turned down. 11 subsequently deteriorated and were unable to proceed and those who went to theatre.

Conclusion ICPS offers PCC across the quintiles showing no disadvantage. The weighting of those offered a PCC is towards the more deprived areas. This coincides with patients in more deprived areas of Scotland being a third more likely to have a cancer diagnosis. Further work to look at SIMD quintiles of all referrals could prove meaningful.

### Abstract 125

**PERCUTANEOUS CERVICAL CORDOTOMY – AN EQUIitable SERVICE ACROSS SCOTLAND**

Lesley Somerville, Eilidh Burns, Jonathon McGhie. NHS Greater Glasgow and Clyde

10.1136/spcare-2023-PCC.145

**Background** The Interventional Cancer Service (ICPS) was established as a multi-disciplinary service in July 2014. Patients with uncontrolled cancer pain due to pain severity or with intolerable side effects from analgesia are assessed. If suitable, patients are offered an intervention, including Percutaneous Cervical Cordotomy (PCC). The service strives to provide an equitable service to all. Since 2017 the ICPS has provided a PCC service to the west of Scotland and beyond.

Patients are assessed by our multi-disciplinary team. For a proportion of these patients an intervention is offered to help with refractory pain.

The ICPS uses Scottish Index for Multiple Deprivation (SIMD), a national classification tool. This considers education, health and employment to give an assigned score.

**Aim** To ensure PCC’s are offered equitably across different deprivation quintiles.

**Method** Using the ICPS database, a retrospective analysis of all referrals to ICPS since establishment of the PCC Service in March 2017. Excel spreadsheets used to gather information on patients offered a PCC. Further analysis of those patients who subsequently declined a PCC, those who deteriorated and were unable to proceed and those who went to theatre.

**Results** Since March 2017, 341 patients have been referred. See Table 1: 66 patients were offered a PCC. 11 turned down. 11 subsequently deteriorated and were no longer appropriate. 44 patients went to theatre for a PCC. 6 of those patients were either unable to complete due to technical difficulties or patient tolerance. 38 had a PCC procedure.

<table>
<thead>
<tr>
<th>SIMD – 1</th>
<th>SIMD – 2</th>
<th>SIMD – 3</th>
<th>SIMD – 4</th>
<th>SIMD – 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>66 patients offered</td>
<td>24 (36.4%)</td>
<td>11 (16.7%)</td>
<td>50 (7.8%)</td>
<td>15 (22.7%)</td>
</tr>
<tr>
<td>11 turned down</td>
<td>4 (36.4%)</td>
<td>0</td>
<td>1 (9.1%)</td>
<td>3 (27.3%)</td>
</tr>
<tr>
<td>11 deteriorated</td>
<td>3 (27.3%)</td>
<td>4 (36.4%)</td>
<td>0</td>
<td>2 (18.2%)</td>
</tr>
<tr>
<td>44 attended theatre</td>
<td>17 (38.7%)</td>
<td>7 (16%)</td>
<td>4 (9.1%)</td>
<td>10 (22.7%)</td>
</tr>
</tbody>
</table>

**Conclusion** ICPS offers PCC across the quintiles showing no disadvantage. The weighting of those offered a PCC is towards the more deprived areas. This coincides with patients in more deprived areas of Scotland being a third more likely to have a cancer diagnosis. Further work to look at SIMD quintiles of all referrals could prove meaningful.

**REFERENCE**


**Abstract 126**

**IMPROVING ADVANCE CARE PLANNING: A QUALITY IMPROVEMENT PROJECT AT ST CUTHBERT’S HOSPICE, DURHAM UK**

Louise Nicholson. St Cuthbert’s Hospice, Durham UK

10.1136/spcare-2023-PCC.146

**Background** Everyone approaching the end of life should be offered the chance to create a personalised care plan. Hospice admissions are opportunities to forward plan, exploring preferences of care, resuscitation and emergency health care plans (EHCPs). Clear documentation and communication between teams can prevent distress and loss of dignity from unwanted or inappropriate treatments, and empower patients by respecting their wishes, especially where capacity is lost. This quality improvement project in St Cuthbert’s Hospice in Durham aimed to improve advance care planning including resuscitation and EHCPs, and communicating important patient preferences to the wider community team (Macmillan Specialist Nurses, General Practice).

**Method** Baseline data was collected from current inpatient e-records on SystemOne and handheld notes from community or hospital settings, including:

- Resuscitation discussion on admission
- Confirmation of a paper ‘Do Not Resuscitate’ order
- Escalation planning (preferences for hospital transfer, and place of care at the end of life)
- EHCP documentation
- Utilising SystemOne ‘Alerts’

A ‘Friday Safety Huddle’ confirming clear escalation plans, and a multi-disciplinary team (MDT) meeting checklist identifying if an EHCP was appropriate in discharge planning, were initiated. Data was repeated at fortnightly intervals to reflect the average length of patient stay, over eight weeks (n=37).

**Results** Baseline data (n=9):

- 78% of patients had resuscitation discussions on admission
- 67% had a ‘do not resuscitate’ order
- 22% of patients had SystemOne ‘Alerts’

The introduction of Friday Safety Huddles and MDT checklist prompted appropriate discussions on resuscitation in deteriorating patients, EHCP completion, and improved resuscitation documentation to 100%.

**Conclusion** Hospice multidisciplinary team input provides excellent opportunity to identify specific EHCP requirements. Communicating patient preferences to the wider community team is essential for continuity. SystemOne ‘Alerts’ supplement EHCPs in providing easily accessible handover of patient preferences (resuscitation status, hospital transfer, and care in the end of life).

**REFERENCE**