Results Postcode of the patients home address; the data showed a spread across the deciles with a mean in the centre of 5th decile with 1st, 2nd and 10th deciles having greatest numbers. Primary diagnosis was malignant in 70% of patients and non-malignant in 30%

Religion 62% of patients were documented as having a religion, these were Christianity (57%), Hinduism (1%), Jewish (1%), Sikhism (2%) and others (1%).

Ethnicity 68% were White British, 6% were from a BAME background. 26% did not have an ethnicity recorded.

Conclusions St Oswald’s is providing increased access to non-malignant conditions including; neurological, respiratory and cardiac conditions. The patient population served appears diverse in relation to socioeconomic status. Some ethnic groups and religions remain underrepresented, this has provided areas to consider for our equality, diversity and inclusion steering group.

REFERENCES

Abstracts

130 MIXED-METHODS STUDY TO UNDERSTAND AND IMPROVE THE VALUE OF DIGITAL PALLIATIVE CARE MULTI-DISCIPLINARY TEAM MEETINGS (MDTMS) IN A TERTIARY ONCOLOGY CENTRE
Phoebe Wright, Talha Niaz, Joanne Doney, Angela Halley, Royal Marsden Hospital
10.1136/spcare-2023-PCC.150

Background Despite minimal evidence regarding utility, and no national guidelines, MDTMs are embedded within palliative care. However they are costly so efficiency must be maximised (De Leso et al, 2013).2 The function of MDTMs includes coordinating care for complex patients (Borgstrom et al, 2021).1 This project aimed to review completeness of local electronic MDTM documentation and assess staff’s views of the meeting’s purpose and associated documentation.

Methods Mixed methods project 1) Retrospective data analysis of completeness of digital data entries in palliative care MDTMs over a 6-month period at a tertiary referral cancer centre. 2) Survey of MDTM members to understand what they felt the role of the MDTM was, what it should be, and how to best capture the data electronically.

Results MDTM entries from 329 patients were reviewed. While some domains were completed for the majority of patients eg. Phase of Illness and Performance Status (>95% of patients), other domains were poorly completed, eg. estimated prognosis (33%) and preferred place of death (24%).

The survey was completed by 27 MDTM members from 7 disciplines. Members felt that the sharing and receiving of information was the purpose of the MDT – both currently and ideally. However while members felt that allowing shared decision making was important in their ideal MDT, they didn’t feel the current MDT fulfilled that purpose as strongly. In addition while members reported feeling comfortable contributing to discussion, some members thought there should be more discussion from different disciplines.

Conclusions MDTM members felt that the main purpose of the meetings was to discuss complexity, and that meetings had a positive impact overall, with more of a positive impact on MDTM members than patients. MDTM members value the MDT but feel that there could be more discussion amongst members to avoid it feeling like a ‘box-ticking’ exercise.

131 A FRESH APPROACH TO EMBED OACC OUTCOME ASSESSMENTS INTO PRACTICE
Pia Amsler (on behalf of the OACC Task & Finish Group), Charlotte Brigden, Pilgrims Hospices, East Kent
10.1136/spcare-2023-PCC.151

Background The Outcome Assessment and Complexity Collaborative (OACC) is a suite of measures designed to assess patient related clinical outcomes. It now guides service development of virtually all palliative care services in the UK. Pilgrims Hospices in East Kent, implemented three of the six OACC measures of in 2016 (AKPS, POI, IPOS). However, there has been limited training since and further development hampered by the geographical challenges of the service. The hospice were keen to support their clinical strategy with clearly defined targets and clinical outcomes, promoting service and staff development. The employment of a new Consultant led to a review of current practices around OACC which identified shortcomings.

Methods A ‘Task and Finish’ group agreed an implementation program with new Key Performance Indicators to demonstrate clear outcomes, reflecting the clinical work, and caseload complexity. Standard Operating procedures were agreed. Consultant-led Mandatory training for all clinical staff was provided and extended to administrative staff and the Board of Trustees.

All six OACC measures were introduced.

Enthusiastic individuals formed the ‘Group of OACC Champions’ providing a ‘bottom up’ approach. A brooch on their work uniform allows easy identification. This group meets regularly to reflect on the agreed standards; discuss outcome reports and how to share them; and decide how to develop OACC further.

Results Early reports have shown an increased uptake of OACC measures (admission IPOS up from 78% to 92.2% between 2021–22), better understanding of the measures and the ability to demonstrate positive patient outcomes as the result of hospice input.

Conclusion This project shows how an organisation can redefine their clinical strategy over ten months. Support from senior leads with a clear and shared vision is vital to allow a bottom up approach by the workforce. An inclusive and constructive approach is vital which should be led by interested individuals.

132 IMPROVING ADVANCED CARE PLANNING IN SEVERE FRAILTY
Prianka Sawney, Habib Rehman, Saleh Ali, Dula Alczejic-betci, Elise Clarke, Khulsum Khan, Kyle Roughneen, Elenna Leigh. Ageing, Complex Medicine and Stroke, Wrightington, Wigton and Leigh Teaching Hospitals NHS Foundation Trust; Histopathology, Liverpool University Hospitals NHS Foundation Trust; Edge Hill University Medical School
10.1136/spcare-2023-PCC.152
**Abstracts**

**Introduction** NICE guidance recommends that doctors need to identify patients who are approaching their final year of life, through the utilisation of tools such as the Clinical Frailty Score (CFS). The ‘Getting it right first time’ (GIRFT) document recommended that all local health systems identify older people in the last phase of life and offer them Advanced Care Planning (ACP). Wigan has a large population of frail patients who would benefit from ACP discussions.

**Aim** Initiate a strategy for identifying patients with severe frailty and establish a process for implementing ACP.

**Method** Retrospective discharge data was used to identify patients aged ≥65 years, with a CFS of >7, over an 12-month period. The cohort was examined to see if they had been recognised as a patient who would benefit from ACP or if an aspect of ACP had been completed during their admission. In total, 50 patients were selected.

**Results** Initial data showed that we were poor at identifying and completing ACPs for patients with severe frailty. No advanced care planning decisions (0%) were taken during this period. Education (PDSA cycle 1) on ACPs for the ward doctors led to an improvement regarding ACP discussions. However, we were still poor at identifying severe frailty. Education (PSDA cycle 2) for nursing staff was undertaken, which highlighted inaccuracies with calculating CFS. Further PDSA cycles included a geriatric frailty score assessment, introduction of Electronic Palliative Care Coordination Systems (EPACCS) and frailty posters and cards.

**Conclusion** Severe frailty is an end-of-life state and should trigger a healthcare professional to identify and sensitively discuss end of life needs and preferences. Despite the best intentions of the medical team, implementing a sustained and successful approach to ACP remains challenging within an inpatient setting.

---

**END OF LIFE CARE ON ICU**

Rebecca Newell, Charlotte Richardson, Valerie Potter. Newham University Hospital, Barts Health NHS Trust

**Background** End of life care (EOLC) on intensive care units (ICU) comes with a number of challenges. This includes rapidly deteriorating patients, complex decisions regarding the withdrawal/cessation of medical interventions, specific care needs for sedated patients, and psychological considerations for grieving family and friends.

**Methods** A multiple cycle QIP was carried out at Newham University Hospital. EOLC in ‘expected deaths’ was audited against local guidance. This is summarised in the Barts Health individualised care plan for the dying patient; Compassionate Care Plan (CCP). Data was collected through review of mortality lists and electronic patient records. Further cycles were completed following interventions; firstly, EOLC trolleys with information for staff, patients and families, alongside creating a designated EOLC champion nursing role. Secondly teaching sessions on EOLC.

**Results** Initial data was taken from the two month period May-June 21. There were 14 expected deaths: 4 patients were referred to palliative care (29%); 2 patients were supported with the CCP; 2 patients had documentation into consideration of spiritual support. For patients not sedated, medications for symptom control were not always prescribed.

Following the first interventions, Jan-Mar 2022 was analysed. There were 23 expected deaths: 8 (35%) were referred to palliative care; 6 patients (26%) were supported with the CCP; 12 patients had documentation pertaining to symptom control; 9 (39%) patients had documentation of their spiritual needs, with chaplain visits.

Following the second intervention, a further two-month period was assessed. There were 14 expected deaths: 50% were referred to palliative care; 6 patients had documented considerations into spiritual care; un-sedated patients had their symptoms assessed through documented discussion with them.

**Conclusions** This QIP demonstrated interventions such as education, a designated EOLC champion and easily accessible resources increased spiritual care considerations, improved management of patient’s symptom control needs and increased referrals to the palliative care team.

---

**RESTRUCTURING THE HOSPICE MDT MEETING: WHAT DO HOSPICE HEALTHCARE PROFESSIONALS WANT AND NEED FROM THEIR MDT MEETINGS?**

Adeola Akindele, Richella Ryan. Arthur Rank Hospice Charity

**Background** Multidisciplinary team (MDT) meetings are important in various specialties to ensure organised and collaborative care for patients. In palliative care, the MDT includes but is not limited to doctors, nurses, therapists, psychologists, chaplaincy staff and social workers. Understanding the collective goal and individual roles within MDT meetings is important to ensure efficient delivery of patient care.

**Methods** We conducted a survey of staff expectations and experiences of the MDT meetings held in the inpatient unit of a 21-bed hospice. The survey consisted of 15 multi-choice questions, with space for free-text responses.

**Results** There were 20 responses from doctors, nurses and allied health professionals out of 44 recipients. The most highly ranked professional benefits from the MDT meeting were: improved continuity of care between professionals (ranked as the top benefit by 42%), improved communication between professionals and collegiality. 41% of people felt that MDT meetings helped them save time. Where respondents felt that MDT meetings did not save time, it was because they felt decisions were delayed until the meeting. There was no consensus on whether the integrated palliative care outcome scale (IPOS) should be reviewed in weekly MDT meetings. Respondents attending remotely highlighted that they sometimes did not feel part of the meeting with the hybrid video format which served to reinforce a medical/nursing dominance over other disciplines. To achieve more effective MDT meetings, suggestions focused on the need to value the contributions from all disciplines.

**Conclusions** The respondents acknowledged the role of MDT meetings as an important tool to communicate the care of patients between members of the team. Making these meetings truly multidisciplinary remains a challenge and more work is needed to explore ways of promoting and achieving this.