

135 IDENTIFICATION OF PATIENTS WITH ADVANCED LIVER DISEASE NEARING THE END OF LIFE WITHIN A SECONDARY CARE HEPATOLOGY SPECIALIST SERVICE

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Introduction Non-malignant liver disease is the 3rd most common cause of death in working-age adults. Those affected spend significant durations in hospital in the last year of life, focusing on disease modification with little regard to symptom management and quality of life. We aimed to estimate the mortality rate for patients with cirrhosis within a secondary care hepatology specialist service. We also quantified the number of inpatients meeting the criteria of screening tools designed to identify patients with liver disease nearing the end of life.

Methods We used locally collected routine data to estimate the mortality rate for patients known to the hepatology service with cirrhosis. We used the Supportive and Palliative Care Indicators Tool (SPICT) and Bristol Screening Tool (BST) criteria to identify inpatients with liver disease who may be nearing the end of life, analysing patient records prospectively for three days over a three-week period (4–18/8/22) on one 25-bed hepatology/gastroenterology ward.

Results Using the 586 patients known to have cirrhosis on the local database (1/9/22) as a denominator, we estimated a mortality rate of 10% in 2021, 7% in 2020 and 8% in 2019. From our inpatient analysis, we identified 37 patients with liver disease, 25 after removing duplicates (patients admitted ≥ 1 day). Of these 25, 9 met SPICT, 5 met BST and 5 met both criteria.

Conclusions We have identified a significant mortality rate of up to 10% of patients with cirrhosis being managed by a secondary care hepatology service. Of those admitted with liver disease, potentially one-third are nearing the end of life. This emphasises the importance of considering a parallel planning approach with disease modification alongside palliative and end of life care. Locally, we are developing an advanced liver disease multidisciplinary team who will use SPICT to better identify patients and facilitate this approach.

136 A SERVICE EVALUATION OF INVERURIE MEDICAL PRACTICE AND RHYNIE SURGERY EXAMINING THE LINK BETWEEN LOWER SOCIOECONOMIC GROUPS AND PLACE OF DEATH IN CANCER PATIENTS

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Introduction Up until recently, the link between lower socioeconomic groups and poor palliative care outcomes has been understudied. Increasing literature in the area continues to point towards a predictive value of socioeconomic index on palliative care outcomes including place of death. Delivering palliative care in rural settings also has its challenges, with some literature finding rurality to also be linked to poorer palliative outcomes.

Methods The 50 most recent cancer deaths occurring at a rural and an urban GP practice were requested for analysis. Place of death and type of cancer diagnosis was recorded for

each patient. The home postcode was also noted in order to map each patient to the Scottish Index of Multiple Deprivation (SIMD). Mean SIMD vigintiles were compared across all recorded places of death, and logistic regression models were run to assess the predictive value of SIMD vigintile on place of death.

Results Across all project patients, as well as when examining each GP practice individually, the mean SIMD vigintile was only found to be statistically significantly lower in those who died in supported housing. Logistic regression models also found that SIMD is not predictive of place of death within this project population.

Discussion The reasons underpinning the palliative poverty gap are complex, and indeed addressing the root cause of many of these issues lie outwith the scope of palliative services. There are however a number of published interventions made by palliative caregivers that have found to be successful in decreasing the gap.

137 TIME FROM HOSPITAL PALLIATIVE CARE TEAM REFERRAL TO FIRST REVIEW- AN AUDIT OF QUALITY OF SERVICE PROVISION

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Background The provision of high-quality person-centred specialist palliative care requires effective mechanisms to ensure timely input of services. The time between referral and initial review is a marker of efficient service functioning.

The aim of this project was to audit compliance against the local standard that 'patients referred to the hospital Symptom Control and Palliative Care team should be reviewed within 24hrs unless there is an appropriate documented clinical reason'.

Methods Multi-cycle audit:

Cycle 1: Baseline retrospective audit of referrals 01/04/2020–31/03/2021.

Cycles 2&3: Rolling prospective two-weekly audit of inpatient referrals 22/08/22–25/09/22.

Data were extracted from the electronic patient record, departmental activity database (aligned to the electronic patient record but with separate data entry) and patient handover lists.

Results Cycle 1: Of a total 1909 referrals, information about timing between referral and review was available for 1898. 99% of these patients were reviewed within 24hrs. 18/19 patients reviewed >24hrs had appropriate documented reasons for the delay e.g., planned future assessment. 18 inaccuracies between the electronic patient record and the activity database were reconciled. (missing/incorrect dates).

Prior to cycle 2, the handover list design was updated and team training provided.

Cycles 2&3: 95% and 100% of inpatients referred were reviewed within 24hrs of referral respectively.

Conclusion Adherence to local operational policy ensures timely review for patients referred to the hospital Symptom Control and Palliative Care team and provides one measure of quality of care. Activity monitoring embedded within the electronic clinical record would reduce duplication of data entry and data mismatch. Effective mechanisms to support prompt