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LEARNING FROM OUR PATIENTS: 3 YEARS OF DELIVERING FUTURE CARE PLANS WITHIN CROSSHOUSE RENAL DEPARTMENT

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Introduction Since 2019 the Renal Department at Crosshouse University Hospital have introduced Future Care Plans (FCP) for targeted patients with end-stage renal failure to improve shared decision making and patient centred care. This is a review of the impact of these plans in the 53 patients who have since died to learn from their experiences.

Methods Key demographic features were compiled from the electronic record (clinical portal and SERPR) followed by qualitative analysis of 'what matters to me' and symptom burden. Measurable outcomes of time between FCP and death, number of hospital admissions, DNACPR discussions and preferred place of care were recorded.

Results Patients described an average of 3 symptoms with the most common being reduced mobility, fatigue, reduced appetite and pain. When asked what mattered to them, the most common responses were family (83%), quality of life (72%) and avoiding futile treatments (64%). The breadth of responses were grouped into social, medical, spiritual and recreational themes. There was an average of 8.8 months between FCP and death, with an average of 3.3 admissions over the last 12 months of life. All patients discussed escalation and resuscitation, with 94% having DNACPRs in place by time of death. 57% of patients said they would prefer to die at home but 55% of patients died in hospital and 45% died in community. Of those with a preference, 50% died in their preferred location.

Conclusions The introduction of FCPs has been a success in exploring and recording patient priorities and preferences. They have facilitated high rates of completed escalation plans but it remains challenging to quantify the impact they have had on quality of life. We will build on these lessons by encouraging early referral, involving the full MDT and ensuring ongoing conversations with our patients to prioritise what matters most to them.

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ADVANCED CANCER CARE IN THE COMMUNITY IN SCOTLAND: A NATIONAL SURVEY OF GENERAL PRACTITIONERS

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Background Most people with deteriorating health prefer care that is home-based, providing sufficient support is available. Recent Scottish research has shown that people with advanced cancer are high users of acute care near the end of life, and at questionable value. The mainstay of advanced cancer care in the community is Primary Care. A large research study is underway examining care pathways, outcomes and experiences for people with advanced cancer in Scotland. The aim of our study was to explore GPs' perspectives of advanced cancer care in the community to inform the development of improved care pathways for patients and families.

Methods We undertook a national, online survey of GPs in Scotland via the platform Qualtrics. Question domains

included communication from Oncology teams, enablers and barriers to community care and the current care offer in their practice. The survey was piloted with Regional Lead Cancer GPs, who later distributed the survey invitations regionally.

Findings 197 GPs completed the survey. 80% of respondents reported receiving written communication from Oncology about their patients' clinical management plans either 'always' (16%) or 'most of the time' (64%). Only 43% and 11% of respondents respectively reported a similar level of communication around patient understanding and anticipatory care planning. The presence or absence of adequate time was the most frequently identified enabler and barrier to delivering care. A large majority reported that their patients receive timely anticipatory care planning and clinical assessments from GPs. A wealth of constructive suggestions for improved care were provided.

Conclusions GPs are core providers of advanced cancer care in the community, but require adequate time and up to date information to do their job effectively. National Cancer and Palliative Care strategies and associated policies are under development by Scottish Government. Our findings will be shared with key stakeholders in this process.

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IMPACT OF A SPECIALIST RENAL SUPPORTIVE CARE NURSE IN END-STAGE RENAL DISEASE IN FIFE

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Background In patients with multiple comorbidities, and the elderly, dialysis does not always offer a survival benefit. Even when dialysis may improve prognosis there are significant burdens to patients. Patients on dialysis spend more time in hospital and are less likely to die at home or in a hospice compared to those managed conservatively. In 2017 NHS Fife created a Renal Supportive Care Nurse (RSCN) post dedicated to the supportive care of patients with advanced renal disease ('Renal Supportive Care Pathway' (RSCP)).

Aims To evaluate the impact of the RSCN role on the care of people with End-Stage Renal Disease (ESRD) in Fife.

Methods Patients with ESRD were identified from the NHS Fife renal service patient administration system. Data were collected on two 40 patient cohorts who died of ESRD. Cohort A died prior to the introduction of the RSCN, and Cohort B died following the introduction of the RSCN.

Results There was no significant difference in the sex-ratio or age between Cohort A and Cohort B. Patients in Cohort B were significantly more likely to have conservative care (65% vs 3% in Cohort A), significantly more likely to have an electronic Key Information Summary (70% vs 18%), and significantly more likely to die in a community setting (73% vs 25%). The median number of tests performed on patients in their last 30 days of life was significantly lower in Cohort B (reduced by 63%).

Conclusions The RSCN and the implementation of the RSCP have had a positive impact on the care of patients with ESRD, leading to a reduction in the medicalisation of a frail population, and an increase in community-based care, including at EOL. The RSCN has also been a valued addition to the renal team in Fife and this work provides objective evidence of her impact.