

workbook, GP training, ACP conversations, and a documentation template. Outcomes were the 15-item ACP Engagement Survey for patients and the ACP Self-Efficacy Scale for GPs. Linear mixed models evaluated differences at 3 months (T1, effectiveness evaluation) and 6 months (T2) post-baseline. Analysis was per intention-to-treat.

Results 35 GPs and 95 patients were randomized. Patient ACP engagement did not differ between the intervention and control group at T1 (baseline-adjusted mean difference, 0.34; 95% CI, -0.02 to 0.69; $p=0.062$) or T2 (baseline-adjusted mean difference, 0.20; 95% CI, -0.17 to 0.57; $p = 0.28$). for GP ACP self-efficacy, there were no significant differences between groups at T1 (baseline-adjusted mean difference, 0.16; 95% CI, -0.04 to 0.35; $p = 0.11$) or at T2 (baseline-adjusted mean difference, 0.11; 95% CI, -0.09 to 0.31; $p = 0.27$).

Conclusion ACP-GP did not improve patient engagement and GP self-efficacy more than usual care. Both groups showed patterns of increase from baseline. Trial procedures and the COVID-19 pandemic that coincided with the trial may have increased awareness about ACP, which may have also stimulated the control group to conduct more ACP than expected. It may be necessary to also look further at what patients and surrogate decision makers want and need from the ACP process.

BOS4c.003 ADVANCE CARE PLANS: CREATION, CONTENT AND USE DURING WAVE 1 OF THE COVID-19 PANDEMIC

Philippa McFarlane*, Catey Bunce, Katherine E Sleeman, Martina Orlovic, Jonathan Koffman, John Rosling, Alastair Bearne, Margaret Powell, Julia Riley, Joanne Droney. *The Royal Marsden NHS Foundation Trust, London, UK*

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Background Mortality forecasts associated with COVID-19 stressed a need to prepare adults with advanced disease for possible severe illness and engage with Advance Care Planning (ACP). We aimed to examine ACP engagement and activity during the COVID-19 pandemic.

Methods A retrospective cohort study, comparing the creation, content and use of Coordinate My Care (CMC) records in London prior to and during the onset of COVID-19. Records for people aged 18+, created and published in pre-pandemic period (2018–2019) and ‘wave 1’ (W1) of COVID-19 (20/03/20–04/07/20) were extracted. Demographics, ACP-related content and the use of CMC records created were analysed and compared using descriptive statistics.

Results 56,343 records were included, 35,108 from the pre-pandemic period and 21,235 records from W1. The average records created each week rose by 296.9% ($P<0.005$) in W1. There were fewer records in W1 for those aged 80 years (60.8% vs 64.9% pre-pandemic, $P<0.005$) and who had WHO performance status 4 (34.8% vs 44.2% pre pandemic, $P<0.005$). More people who created records during W1 had an estimated prognosis of 1 year+ (73.3% vs 53.0% pre-pandemic, $P<0.005$), were ‘For Resuscitation’ (38.2% vs 29.8% pre-pandemic, $P<0.005$) and had a Treatment Ceiling of ‘Full Active Treatment’ (32.4% vs 25.7%,

$P<0.005$). More people in W1 listed hospital as their preferred place of care (PPC) and preferred place of death (PPD) (PPC: 13.3% vs 5.8% pre-pandemic, $P<0.005$. PPD: 14.0% vs 7.9%, $P<0.005$). Average monthly non-urgent and urgent record views rose by 320.3% ($P=0.02$) and 154.3% ($P=0.01$) in W1.

Conclusions A large uptake in engagement with ACP is demonstrated during the 1st wave of the pandemic. An increase in use among younger, more independent patients with longer prognoses, with a higher preference for hospital care creating records in W1 compared to before the pandemic, suggests heightened awareness and provision of ACP at this time.

BOS4c.004 TELE-ACP AMIDST COVID-19 PANDEMIC AND BEYOND

Tricia Tan*, James Yiew Hock Low, Lai Kiow Sim, Wan Ling Woo. *Yishun Health, Singapore*

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Background When COVID-19 hit Singapore in 2020, the public was advised to avoid visiting the hospitals unless for essential services. Advance Care Planning (ACP) services in hospital and community had to be stopped to reduce exposure for the public. However, it was not feasible for ACP services to stop with no foresight of when it could resume. Ironically, ACP should all the more be advocated amidst the pandemic.

Henceforth, the team planned and implemented a tele-ACP workflow in February 2020 to ensure accessibility in continuity of care and reduce waiting time for ACP appointments.

Methods Tele-ACP is conducted only via Zoom, given its security and encryption features. Criteria of patients include ability to read basic English, having electronic device with internet access, and having no severe hearing or speech impairment.

Pre-ACP appointment: Zoom details including a guide were sent to patients and/or NHS.

On appointment day: Before session starts, ACP Facilitator will ensure that patient and/or NHS are at a space where there is privacy. Internet stability will also be checked.

Post-ACP appointment: Signatures will be obtained electronically or via post, while ensuring personal data is well-protected.

Results From February 2020 to November 2022, 105 tele-ACPs (14 General ACPs and 91 Preferred Plan of Care) were completed. 45 were completed in 2020 and 2021 each, while 15 were done in 2022 (as of November). The average duration for tele vs in-person ACPs is both about 90 minutes, indicating that the effort and time spent are not any less despite ACP discussions being done virtually.

Conclusions Looking at the number of tele-ACPs completed and how it is still actively carried out despite COVID-19 situation being stable and restrictions lifted, tele-ACP is clearly in healthy demand. This shows that tele-ACP is here to stay, being both sustainable and transferable to multiple settings.