160 IMPLEMENTATION OF SERIOUS ILLNESS CARE PROGRAMME UK FOR PATIENTS WITH ADVANCED CANCER: FEASIBILITY STUDY

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The Serious Illness Care Programme is a complex intervention developed in the US to improve communication between clinicians and patients with serious illness. In collaboration with Ariadne Labs the programme has been developed for use within the UK, with pilot implementation funded by NHS England. Within the programme, clinicians are trained in use of a Serious Illness Conversation Guide (the guide), to structure conversations with patients/families. A feasibility of the UK programme is underway, within one North West cancer centre.

Aim To present interim results from the feasibility study

Methods Data on the use and experience of the UK programme, from the perspective of clinicians and patients

Quantitative Data: Questionnaires:
Clinicians – pre/post training:
• confidence;
• attitudes to care of the dying;
• acceptability of serious illness care programme

Patients – pre/post serious illness conversation:
• Quality of clinical communication;
• Quality of life;
• Anxiety;
• depression.

Qualitative Data: In depth interviews:
Clinicians: experience of the UK programme, education and training and engaging patients in serious illness conversations
Patients: experience of engaging in serious illness conversations, including their acceptability of the approach

Results Quantitative Data: Results will be presented to assess the feasibility and acceptability of the UK programme:
• Proportion of patients identified conversations and participation in study measures
• Illustrate any indicative improvements in communication and patient outcomes.

Qualitative Data: Thematic Analysis to explore perceptions and experience of the programme: results will highlight main themes, such as: Conversation Value; Holistic and Compassionate; Opening up conversations with family members; Breaking the ice; Timing of conversation and Prognosis.

Conclusion Results from this study suggest these conversations promote shared decision making and individualised care planning, and espouse ‘holistic’ and ‘person centred’ care. Further research and evaluation is required to understand the effect of the UK programme on patient outcomes.

161 E ASSESSING THE IMPACT OF ENHANCED SUPPORTIVE CARE USING THE INTEGRATED PALLIATIVE CARE OUTCOME SCALE (IPOS) AT THE CHRISTIE NHS FOUNDATION TRUST

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Enhanced Supportive Care (ESC) is a new UK initiative that integrates supportive care within oncology. At its heart is better access to expertise in managing the adverse effects of cancer and cancer treatments to enhance the patient experience and reduce the need for hospital admission.

ESC is award winning and has been recognised nationally by NHS England.

The aim of this audit was to measure the impact of ESC using the Integrated Palliative Care Outcome Scale (IPOS). This is a validated tool that can be used in clinical audit, research and training to measure symptom burden.

Method 47 patients referred into the supportive care service, were randomly selected to complete the IPOS tool within 3 areas (inpatients, outpatients and trials unit) during May to October 2016. For all areas a baseline IPOS was completed prior to the initial assessment by supportive care. Subsequent IPOS were completed approximately 3 days later for inpatients. Outpatients and trial patients were reviewed at various time points depending on the timing of their follow up appointments. Outpatients had an average follow up of 41 days. Trial patients had an average follow up of 15 days.

Results The overall IPOS score is the sum of the score of each of the 17 questions and can range from 0–68. A reduction in the IPOS score demonstrates an improvement in physical and psychological patient symptom burden. 16 inpatients completed the IPOS and demonstrated a 50% improvement in overall mean symptom score. 5 experimental cancer medicine patients completed the IPOS and demonstrated a 49% improvement in overall mean score. 26 oncology outpatients completed the IPOS and demonstrated a 2.5% deterioration in overall mean score, demonstrating a possible correlation between frequency of supportive care review and symptom burden.

162 UK AND IRISH HOSPICE AND SPECIALIST PALLIATIVE CARE UNIT EXPERIENCE OF ASSISTED VENTILATION IN MOTOR NEURONE DISEASE

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Aim To assess and describe the experience of assisted ventilation in motor neuron disease (MND) among patients and families in five tertiary palliative care units in the UK and Ireland.

Method A retrospective observational study was conducted at five tertiary palliative care units in the UK and Ireland.

Results Data collection methods included interviews (clinicians and family carers), observations, focus groups and case notes. From 2010 to 2016, 22 patients with MND died in the five hospices. Eight of these patients died after assisted ventilation. All eight had access to access to advanced respiratory care. The median survival after death was 19 days (range 1–69 days).

Conclusion The experience of assisted ventilation in the five hospices was in line with current best practice and demonstrated the importance of access to this type of care.
An increasing number of patients with motor neurone disease (MND) in the UK and Ireland are using assisted ventilation to control symptoms and prolong life. A small proportion of these are initiated on long term tracheostomy ventilation (TV). NICE guidelines dictate that MND patients should routinely receive specialist palliative care input, yet research into the management of TV MND patients in the hospice setting is limited.

Objective

The aim of this study was to explore the extent to which hospices and specialist palliative care units (SPCUs) in the UK and Ireland currently manage MND patients using assisted ventilation, especially TV.

Methods

A literature review was used to guide the development of an electronic questionnaire which was sent to medical directors or lead physicians in all hospices/specialist palliative care units in the United Kingdom and Republic of Ireland. The questionnaire was sent to 184 units.

Results

The response rate was 41.3% (n=76). 97% units admit MND patients on non-invasive ventilation (NIV) but only 33% admit TV MND patients (n=22). However 40% of respondents indicated that community palliative care support was provided to TV MND patients. 61 respondents indicated adequate expertise in the management of NIV, while only 6 indicated adequate expertise in managing TV. While the majority of respondents (96%) indicated that Advance care planning was routinely offered to the MND patients, less than half routinely included conversations regarding ITU admission (40%) or invasive ventilation (39%). Only 11 (14%) of respondents indicated having personal experience of withdrawal of TV in MND patients.

Conclusion

This study has highlighted a perceived lack of expertise in the management TV MND patients within hospices/SPCUs with less than half of units allowing admission for TV MND patients. There is a need for further research in this area.