Furthermore, qualitative evidence suggests PLFU patients felt empowered. Within palliative medicine, focus has shifted towards Phase of Illness to determine follow-up frequency, with stable patients being moved towards PLFU.

**Methods** A cross sectional cohort of PLFU patients is being followed for six months. Data being collected includes Phase, Karnofsky Performance Score (KPS), diagnosis, Integrated Palliative care Outcome Scale (IPOS) and outcome.

**Results** The project is ongoing but preliminary findings include identifying two cohorts frequently assigned to PLFU; nursing home patients, and breast cancer patients. Breast follow-up appears to be leading the way in PLFU, therefore patients transitioning from oncology follow-up to palliative care may be more amenable to a PLFU approach.

**Conclusions** The literature has demonstrated PLFU as a safe, cost-effective alternative to traditional follow-up and a way of ensuring a reactive service with resources to respond to crises whilst encouraging self-management and patient empowerment.

Our study aims to demonstrate how PLFU translates to palliative care, and how we might identify those patients who would be candidates for this approach. It also aims to gain qualitative feedback from focus groups of both patients and relatives of deceased patients who can reflect on the transition to PLFU.

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**EMPOWERING PATIENTS AND CARERS: A PROGRAMME TO ENCOURAGE 'THINKING AHEAD' IN THE SUPPORTIVE PHASE OF A PALLIATIVE CANCER DIAGNOSIS**

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Background The Harrogate and District Hospital Health and Wellbeing Project has successfully delivered education programmes to patients living with and beyond a cancer diagnosis. In 2018 the Palliative Care Team (PCT) was approached to develop a programme with focus on patients with a palliative diagnosis and their carers.

The aims of the programme include: to keep patients as well as possible for as long as possible; offer support to carers; provide information on local services; discuss advance care planning (ACP) and choices for future care.

**Methods** The programme is delivered by a range of professionals (e.g. PCT (Consultant and Clinical Nurse Specialist (CNS)), Psychologist, Welfare and Benefits Specialist, Carers Resource, Occupational Therapy). Referral is by Oncologist or Cancer CNS. Referral criteria includes: a palliative diagnosis for at least two months; palliative treatment or best supportive care and likely to be in the last year of life. Patients must be well enough to attend three two hour sessions over a six week period. Patients and their carer can either attend alone, together or the carer can attend alone. Maximum number of attendees is 12 per programme.

**Results** Three programmes have been delivered in 2018. Total number of attendees is 26. The patients had a range of diagnoses. Drop-out for those who have attended the first session is very low. The programme has evaluated extremely well. Sessions are reported to be informative and interesting. It has facilitated discussion of ACP in an environment with attendees supporting each other. Knowledge of local services and options for future care has resulted in informed decision making.

**Conclusions** The ‘Thinking ahead’ programme will continue in 2019 with an increase in number of sessions to meet increasing referrals. The model has the potential to be developed for patients with a non-malignant diagnosis.