

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.

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WITHDRAWAL OF DIALYSIS; END OF LIFE CONSIDERATIONS AND ADVANCED CARE PLANNING

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Background Dialysis withdrawal is the commonest cause of death in patients with end stage renal disease aged >75. Factors contributing the withdrawal have been described but to what degree advanced care planning (ACP) is initiated is unknown. We sought to describe current practice within a large renal unit.

Methods We performed a retrospective analysis of patients who died following dialysis withdrawal from 2015–2017. Patient demographics, markers of health, triggers for withdrawal, admissions, timing and degree of ACP discussions were extracted.

Results 52 patients were included. Median age at death 76 interquartile range (IQR) (70, 81) years. Median duration of dialysis was 42 (IQR 10.5, 75) months with 30.8% dying within one year of commencement of dialysis. Median Charlston co-morbidity score was 8 (IQR 6, 9) with documentation of 'frailty' present in 52% of the cohort. 25% of the patients had an acute event triggering withdrawal. ACP was discussed with 34% of patients with 82% of patients achieving their preferred place of death where this was documented. Median length of last admission was 24 days (IQR 11, 43) compared with 11 days (IQR 0, 55) if the patient had an ACP (p-value 0.736).

Conclusion We are not good at initiating timely ACP in deteriorating dialysis patients despite identifying such patients. With an increasingly frail, multi-morbid population the need for these discussions will increase. Early ACP discussions with frail patients starting dialysis may inform later conversations and improve their quality of care. Encouragingly asking about preferred place of death improved the likelihood of achieving a death in the patients preferred location. Identification of poor prognostic markers such as dementia, introducing staff training in palliative care and adopting routine frailty scoring may guide timely conversations in anticipation of deterioration in vulnerable patient groups.

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THE INFLUENCE OF COMBINED ONCOLOGY AND PALLIATIVE CARE CLINICS (COPC) ON HOSPITAL ADMISSIONS

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Background Current evidence suggests early palliative care involvement (PCI) alongside oncology care improves quality of

life, planning and communication for advanced cancer patients. Little is known about the impact of PCI on hospital admissions.

800+consultations per year occur in Combined Oncology and Palliative Care clinics (COPC) at Royal Cornwall Hospital, each patient seen by the appropriate specialty consultant. Less COPC patients received radical or potentially curative treatment. This study examines the influence of COPC versus Standard Oncology (SO) clinics on hospital admissions.

Methods Fifty-five COPC patients with Breast, Prostate or Gastro-intestinal cancers were compared with fifty-eight attending SO (matched diagnoses). Number of non-elective hospital admissions and length of stay (LOS) were examined during a 12 month period.

Results In the COPC there were 45 admissions (LOS 4.3 days), and 70 admissions in the SO (LOS 5.6 days). The main reason for admission was a symptom/complication of diagnosis: COPC 84%; SO 86%. Of these complications of treatment were the reason in 10.5% of COPC admissions; but in 26.7% of SO admissions. 87% of COPC patients, and 81% of SO patients were discharged home.

45% COPC and 37% SO patients died within 12 months.

Conclusions Being reviewed in an integrated COPC compared to SO clinic appears to reduce the number and length of hospital admissions for advanced cancer patients. Spending less time in hospitals is important for patients, potentially increasing quality of life. Unsurprisingly, symptoms/complications of cancer were the main reason for admission, relating more often to complications of treatment in the SO group. More patients in the COPC group were discharged home. Reasons behind this were not explored, but may be due to planning discussions in clinics. Findings from this study may aid service development, but a larger cohort is needed to demonstrate statistical significance.

139 MULTI-PROFESSIONAL WORKING TO SMOOTH THE INTRODUCTIONS OF ENHANCED SUPPORTIVE CARE (ESC)

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Background The best of palliative medicine and care is underpinned by multi-professional working to optimise symptom management and quality of life once disease specific treatments are no longer appropriate. However, physical and emotional issues are common much earlier in the disease trajectory, during diagnosis and challenging treatments, but aren't always addressed as vigorously as later. The concept of Enhanced Supportive Care is to change this, offering the benefits of good palliative care and medicine alongside active anti-cancer treatments. There's international evidence that this can lead to improved symptom management, quality of life and survival. Thus, NHS England is championing a national pilot, of which we're part, offering ALL patients receiving systemic anti-cancer therapies with palliative intent referral to the ESC team.

Method Discussions with oncologists, palliative care teams, cancer site specific nurses and chemotherapy team, explaining the background and concept. Working closely with oncology IT team designing electronic referral and data collection pathways. Team development – initially a palliative care and

oncology trained nurse supported by a palliative oncology consultant, later adding a GP.

‘Tools’- King's Fund Patient Outcome Score (IPOS) – primary tool and Hospital Anxiety and Depression Score (HADS).

Changing mind-sets promoting PRO-active rather than RE-active referrals.

Results Rising referrals – 35 in February, 72 in November. Reduction of scores (improvements) in all domains of IPOS, other than nausea and fatigue, improved quality of life and avoided admissions.

Conclusion and future Introducing this new service has been challenging and exciting, involving broadening the ‘multi-disciplinary team’ concept, diplomacy, tact and collaborative working, promoting our skills as an additional benefit, not in competition with other professionals, focusing on the patients quality of life. Our long-term goal is remit expansion to all patients receiving anti-cancer therapies, irrespective of disease stage and treatment intent.

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140 THE EFFECTIVENESS OF CIRCUIT TRAINING ON PHYSICAL ABILITY IN PALLIATIVE CARE PATIENTS

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Background Structure exercise groups within palliative care are becoming a more common feature of standard hospice provision, supported by increasing evidence of the benefits for patients on both their physical and emotional function. This small audit reviews the circuit group running at the Wisdom Hospice over a 2 year period, analysing the outcomes for all patients completing the 6 week programme.

Methods All patients joining the circuit group are assessed using 3 physical measures and 1 quality of life measure, prior to starting. These measures are then repeated every 6 weeks while the patient is attending. The number of patients attending the group between 2017 and 2018 were recorded and from those the data of patients who had completed at least 6 weeks and had 6 week outcome measure data were analysed for the audit. There were 28 patients who had attended the group for between 1 and 5 sessions in the same time period.

Outcomes There were 7 patients who completed at least 6 weeks of circuit training between January 2017 and November 2018. All of these patients showed improvements in their physical outcome measures and all showed maintenance or improvement of their quality of life measure. The physical improvements showed an average of 33% in the Timed Up and Go Test; 68% in the 2 min timed walk test; and 29% in the functional reach test. The quality of life measure EORTC-QLQ-PAL showed an average improvement of 1 point in both the sections.

A large number of patients who attended for less than 5 sessions all dropped out due to becoming less well.

Conclusions This audit further supports the evidence that palliative care patients can undertake cardiovascular, strength and balance training with significant improvements in physical function. It also highlights the need for early referral into such programmes.