

health care record) and key themes (e.g. need for clinician education & communication skills, executive leadership and dedicated people & systems resource). A targeted QI strategy includes coordinated communication 'do not attempt resuscitate' pathways between care settings, dedicated training resource for rolling clinician education, fit-for-purpose documentation of treatment escalation considerations and a public awareness campaign.

Conclusion(s) The detailed exploration of EoLDM across the region has resulted in a targeted QI strategy. It acts as a springboard for future work to normalise EoLDM. Our vision is that everyone in North Wales can have discussions to support their EoL decision-making at the right time supported by skilled clinicians. Fit-for-purpose pathways and documentation should ensure decisions and preferences are acted upon, within a robust governance framework. Only by learning from one another have we been able to grow together for the people of North Wales.

98 SAINT CATHERINE'S HOSPICE MORTALITY REVIEW; SERVICE DEVELOPMENT AND AUDIT

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Background Following on from the National Guidance on Learning from Deaths (NHS England 2017), and in preparation for the new medical examiner system, we have formalised our mortality review processes. We developed a death analysis template to be completed after each patient death alongside a monthly mortality review meeting (MRM) with multi-disciplinary team (MDT) and hospital input. The template is completed by a patient's key worker, reviewed in the weekly MDT meeting and those triggering certain criteria have an in-depth discussion at the monthly MRM. A random case is also always included.

Methods We performed a quarterly audit of numbers of patients with a completed death analysis template while the system was being embedded. We then performed a more in-depth audit of all patients discussed over the past year in the new MRM. This included both quantitative elements such as age and diagnosis and then also qualitative elements such as themes arising and actioned outcomes.

Results 93% of all patient deaths had a template completed and subsequent discussion at the relevant MDT meeting. 16% of those patients went on to be discussed in a MRM. Time of death to discussion at MRM was a mean of 39 days. Themes for improvement included missed opportunities for advance care planning, earlier referral to palliative care services and resources to improve overall patient wellbeing in the in-patient unit. Examples of actions taken forward include hospital-hospice handover work, positive feedback letters sent to carers and sourcing of an in-patient electronic audiobook library.

Conclusions We have put in place a robust structure to promote learning from deaths. Our work with the medical examiner service is about to begin to add breadth to this and will also importantly include family feedback. With ongoing refinement this new governance structure should continue to impact positively on patient care.

99 HOW ARE OUTCOMES OF SPECIALIST PALLIATIVE CARE MEASURED IN DIFFERENT PATIENT POPULATIONS AND SETTINGS?

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Background Outcome measurement is key to delivering effective, high quality, patient-centred care, as well as commissioning of services. The diversity of patient populations and service models in palliative care makes demonstrating efficacy and comparing services challenging.

Aims 1. To synthesise the evidence on how outcomes of specialist palliative care are currently measured in different populations and care settings.

2. To identify the evidence gaps where specialist palliative care services are under-evaluated.

Design A scoping systematic review of reviews.

Data sources Five databases (MEDLINE, EMBASE, CINAHL, Cochrane Library and Epistemonikos) were searched for reviews published between 2010–2021. Included reviews reported on outcomes of specialist palliative care in an adult population with life-limiting illness. Findings from the reviews were grouped, narratively summarised and compared.

Results 79 reviews met inclusion criteria. There was significant heterogeneity in the specialist palliative care services evaluated and the outcome measures and study designs used in the primary reviews. Health-related quality of life and symptom burden were the most frequently measured patient outcomes across care settings and populations. Health-system outcomes focussed predominantly on place of death and health service utilisation. There is a lack of evidence on outcomes of outpatient services, hospice care and telehealth services. The majority of evidence on population-specific outcomes is focussed on solid-organ malignancy. Evidence in populations with frailty, dementia, multiple long-term conditions and minority ethnic groups is lacking.

Conclusion Palliative care research is limited by a lack of cohesion in use of outcome measures and under-evaluated areas of practice. Expansion and adaptation of services should be driven by a co-ordinated approach to outcome measurement, as well as increased efforts to capture experiences across the breadth of community settings and in non-malignant disease.

100 MULTIMORBIDITY AND DISEASE-COUNT AS PREDICTORS OF HEALTHCARE USE AND MORTALITY IN EMERGENCY DEPARTMENT ATTENDERS: A CROSS-SECTIONAL SECONDARY ANALYSIS OF ROUTINELY-COLLECTED DATA

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Background Having 2 or more chronic conditions (multimorbidity) is associated with increased mortality and healthcare use in community-dwelling populations. In order to develop a nurse-led intervention for people with multimorbidity and

palliative conditions, we sought to explore whether multimorbidity and disease-count were significant predictors of mortality and healthcare use in emergency department (ED) attenders.

Methods We conducted secondary analyses of inpatient and ED records for Glasgow (Scotland) residents attending the ED between April 2019 and March 2020. We conducted binomial logistic regression and calculated adjusted/unadjusted odds ratios (ORs) with 95% confidence intervals (CIs). Age, sex, ethnicity and deprivation were included in adjusted models. To handle missing data, complete case analysis was conducted and compared with results from post-imputation analyses. Ethical approval obtained from Local Public Advisory Committee.

Results 126,158 attendances by 75,726 eligible persons occurred during the study period. Complete data was available for 63,331 persons. Multimorbidity and disease count were significant predictors of all outcomes in both adjusted and unadjusted models. Complete case and post-imputation analyses produced comparable results. Of particular relevance to palliative care, only a small number of individuals died during admission ($n=1.031$, 1.6%), but multimorbidity was a significant predictor of this in both crude (OR: 4.41, 95% CI: 3.90–5.00) and adjusted (adjusted OR: 1.80, 95% CI: 1.58–2.05) analyses.

Conclusions Significant associations were detected with access to only 2–3 years historical inpatient data, so further validation of these predictors with greater historic inpatient and primary care data is warranted. We have however shown that these predictors are significant and should be incorporated into models aimed at identifying people at risk of healthcare use and mortality. Improving end-of-life care for people with multimorbidity is an avenue for further research, and robust models which can handle major class imbalances (only 1.6% ED attenders died during admission) should be tested.

101 PUTTING THE 'FAST' BACK IN 'FAST TRACK': A MIXED-METHODS SERVICE EVALUATION

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Background In the Bristol region, 41% of patients die in hospital (2021), despite only 3% wishing to die in this setting. Continuing Health Care Fast Track (CHCFT) provides National Health Service funding to support rapidly deteriorating patients to die outside hospital.

Methods A mixed-methods service evaluation: case-note review of patients with CHCFT referral (March 1st to April 31st 2021) and semi-structured interviews ($n=13$) with CHCFT discharge staff (nurses, junior doctors, specialist palliative care (SPC) nurses, occupational therapists and hospital discharge team [HDT] (2022)). Key time intervals were calculated (e.g., CHCFT referral to death). Medians, means, ranges and percentages are presented. Semi-structured interviews, conducted using a topic guide, were audio-recorded, transcribed, coded by two health professionals independently and inductive data grouped by higher themes.

Results Of 72 patients referred to the HDT for CHCFT funding, 92% were known to SPC, with a median of four days from admission to SPC referral. Twenty-seven CHCFT patients (37.5%) died in hospital; 30 (41.6%) were discharged with

CHCFT funding (14 (19.4%) own home and 16 (22.2%) nursing home), and 15 (20.9%) were discharged without CHCFT.

There was a median of 14.5 days from CHCFT referral to discharge, with a median of 29.5 days between SPC referral and death. Forty-two patients (58.3%) died within 30 days, 50 (69.4%) within 90 days and 67 (93.1%) within 365 days of CHCFT request.

The role of the palliative care expert was commonly emphasised by participants as critical in recognising deterioration and navigating CHCFT. Overall, CHCFT was perceived as disappointingly slow. Major barriers to timely CHCFT included delayed recognition of deterioration, multiple step/duplicated paperwork, ineffective inter-professional communication and insufficient community staffing.

Conclusion Early hospital palliative care assessment with multi-disciplinary input is critical to improve timely recognition of dying and discharge. The duration to CHCFT discharge negatively impacts patients and staff.

102 DOES DEPRIVATION STATUS HAVE AN IMPACT ON REFERRAL AND TREATMENT PATTERNS WITHIN THE GREATER GLASGOW AND CLYDE INTERVENTIONAL CANCER PAIN SERVICE (ICPS)?

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Interventional techniques are effective in improving pain control and reducing side effects in patients experiencing complex cancer pain. (1) In 2008 Beatson West of Scotland Cancer Centre (BWoSCC) established ICPS. This multidisciplinary service provides a range of interventions including intra-thecal drug delivery (ITDD), cordotomy, and neurolytic procedures. BWoSCC serves a population of 2.5 million people. An objective is to ensure patients have 'equitable access to high quality cancer services'. (3)

Methods The ICPS maintains a database of every patient referral. This allowed us to collect patient demographics, Scottish Index for Multiple Deprivation (SIMD) status and assessment outcomes.

Results 609 patients were referred to the service from 2008 – December 2019. 602 patients included in study, 310 (51%) male, 292 (49%) female. Age range: 16 to 91, median 60. 462 patients assessed -161(35%) proceeded to intervention, 67 (15%) to ITDD trial, 94 (20%) received alternative intervention. Most common cancer types referred were lung, colorectal and upper GI. Comparing ICPS data with wider regional data identified specific cancer types which were more likely to undergo an intervention. Deprivation status of ICPS patients were compared to overall West of Scotland (WoS) population. ICPS saw a higher proportion of patients from both highest and lowest quintile compared to the overall WoS cancer population but this was not statistically significant. The majority of interventions were undertaken in highest deprivation status. 54 (34.6%) patients were quintile 1, 22 (14.1%) quintile 2, 22 (14.1%) quintile 3, 22 (14.1%) quintile 4, 36 (23.1%) quintile 5. The proportion of referrals, clinic assessments and interventions were similar in all of the deprivation quintiles.