Supportive and palliative care research and audit conference

Wednesday 30 November 2016

Oral and poster abstract submission template

Abstracts must conform to the following requirements:

- Include a short title (up to 20 words) and the author's names (asterisk the presenting author)
- Maximum length: 250 words
- Structure: background/objectives, methods, results, implications
- Include presenting author's contact details (including name, job title, institution and email address).

Abstracts should be submitted to samantha.wilkinson@srft.nhs.uk by 5pm on Friday 30 September 2016.

Title: What does complexity mean to patients and professionals? Part 2: Capturing complexity at individual patient level

Author(s): *Cathryn Pinto, Sophie Pask, Katherine Bristowe, Liesbeth van Vliet, Caroline Nicholson, Catherine J Evans, Rob George, Katharine Bailey, Ping Guo, Barbara A Daveson, Irene J Higginson and Fliss E M Murtagh

Institution: Cicely Saunders Institute, King's College London

Job title: C-Change Research Assistant

Email address: cathryn.pinto@kcl.ac.uk

Abstract

Background: People with advanced illnesses have a range of complex needs and symptoms. We need to understand how this complexity can be measured using individual patient-level criteria to inform casemix development and palliative care resource allocation. Our study aimed to explore palliative care stakeholders' views on capturing complexity at individual patient-level.

Methods: Face-to-face semi-structured interviews, conducted in 6 UK centres, with 65 diverse stakeholders (patients, family carers, professionals, managers and senior leads in palliative care), purposively sampled by geographical location, background and setting. Data was analysed using Framework analysis.

Results: The main themes included the acceptability of measuring and classifying complexity, defining classes of complexity, and benefits/challenges to classifying complexity at individual patient level. Most participants acknowledged the importance of measuring complexity. There were mixed views about classifying complexity. To measure complexity meaningfully, holistic needs (physical, psychological, social and spiritual) should be captured, but also number, severity, range, and temporality of needs, and the level of support required to address these needs. Using an individual patient-level classification (casemix) was perceived to offer benefits for improving palliative care resource allocation, but needed to be truly reflective of complexity, and feasible in practice.

Implications: There is broad support among stakeholders for capturing complexity at individual patient level. Reflecting holistic needs plus other dimensions of complexity will make a casemix classification more meaningful for palliative care. The benefits and challenges identified here need to be taken into account before implementing a casemix classification in palliative care.