

PALLIATIVE CANCER CARE SUMMARIES: AN ENABLER OF TIMELY, COMMUNITY-BASED PALLIATIVE CARE SUPPORT FOR PEOPLE WITH LUNG CANCER IN FIFE

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Introduction

Improving care coordination for people with advanced illness is both a challenge and a priority, with lack of system 'cross-talk' commonly cited as a major barrier.

Following a national survey of GPs, in which a lack of timely and/or meaningful information from Oncology colleagues about their patients with advanced cancer was described, we developed a Palliative Cancer Care Summary (PCCS) in Fife; a single page document to be emailed by Oncology Clinical Nurse Specialists with their patients' GPs and Community Nursing teams.

The document contains important domains such as:

- The diagnosis and its extent
- The person's living and family circumstances
- What the person and their family understand about their illness
- Any current unmet needs
- Future anticipated needs
- Future Care Planning (FCP) initiated within Oncology immediately following diagnosis
- Follow-up plans/ proposed plans

The PCCS is accompanied by a rich and informative booklet for patients and families, called 'Palliative Cancer Care in Fife', which was co-developed with people with lived experience as well as multidisciplinary colleagues

Objective

To evaluate the use and impact of clinical pathway data for a cohort of 30 patients with advanced lung cancer in Fife, for whom PCCS were completed between April 2024 and September 2025

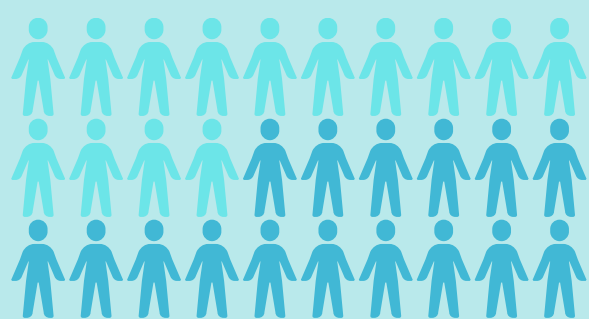
Broader content within the PCCS

Common themes were noted within the content of the PCCS itself:

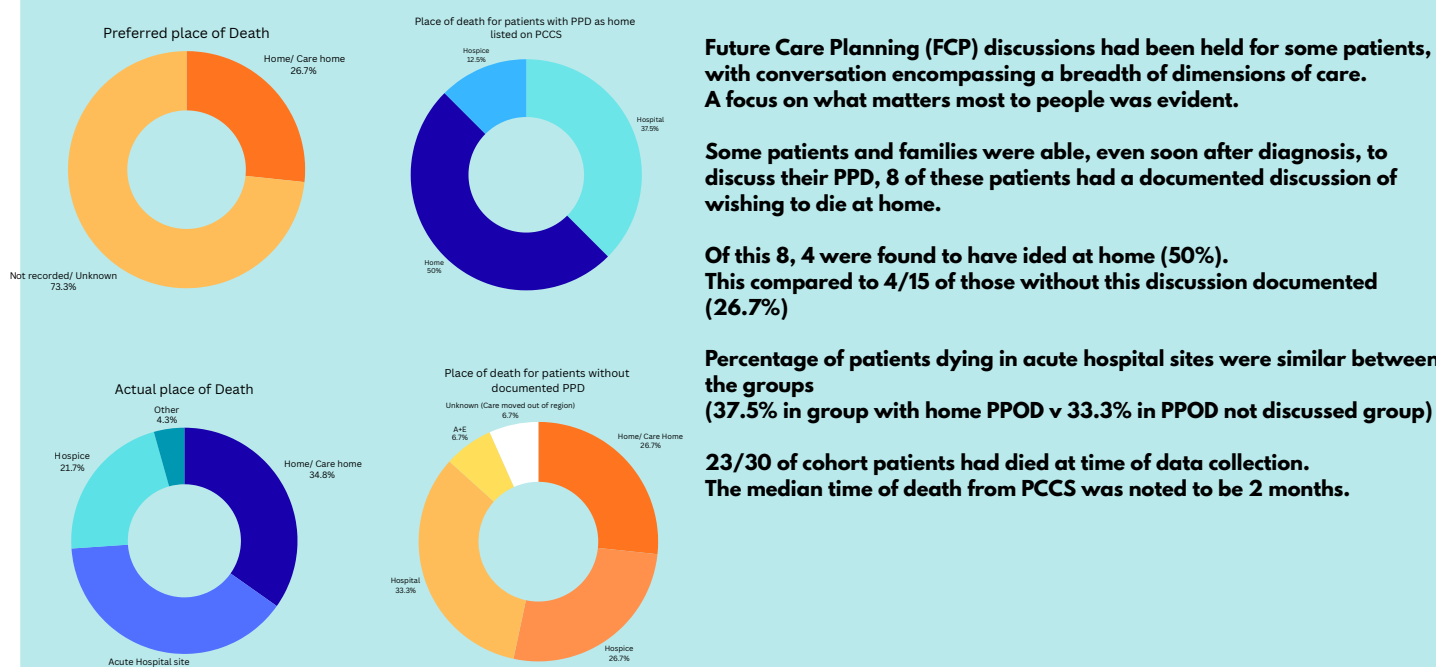
- Language relating to diagnosis and management is simple, clear and consistent. Reducing the likelihood of misunderstanding
- Clarity around follow-up plans (where shared or where to be primary care led) reduced ambiguity.
- Person and family-specific information was well documented and provided meaningful guidance for community colleagues. Eg: A person with lung cancer with learning disabilities - "Takes time to process information, future care planning conversations will need to occur over multiple conversations"

Demographics

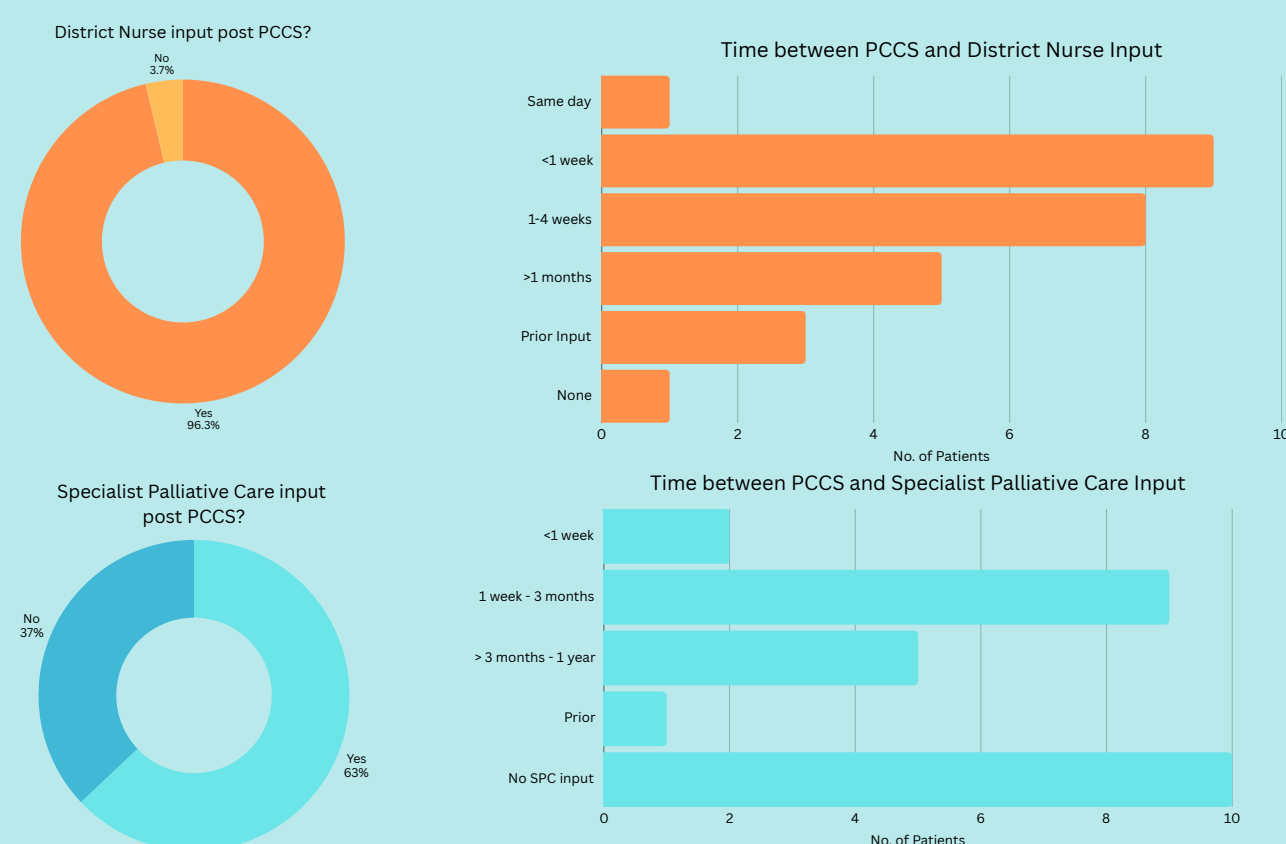
- 14 female, 16 male
- Age range 60-96
- All with incurable lung cancer



Place of Death v. Preferred Place of Death (PPD)

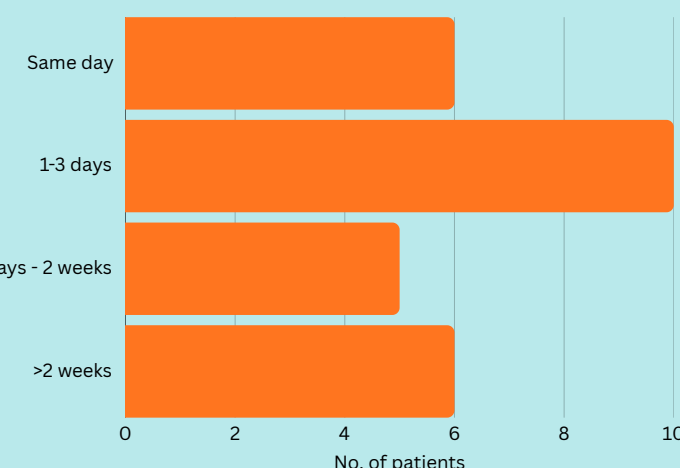


District Nurse and Specialist Palliative Care input



District Nursing teams' feedback: PCCS provides timely, valuable information that enables them to meet their patients proactively. Patients and families feedback confirms that proactive contact is welcome

Time between Best Supportive Care decision and PCCS



Key Learning

- People with lung cancer with a PCCS are often in their last weeks of life at diagnosis
- PCCS facilitates prompt, meaningful, succinct information to be communicated between secondary and primary care
- Prompt contact from District Nursing teams is facilitated for the overwhelming majority
- Specialist Palliative Care is accessed where DN, GP or Oncology teams identify that this is needed
- Future Care Planning is rarely entirely 'completed', but some patients and families are willing and able to talk about future care, even at diagnosis, with some even expressing preferences around place of death

Challenges/ Future Aims

- Inaccurate PCCS dates were identified for 3 patients, excluding their pathways from some analysis
- electronic Key Information Summary (eKIS) become inaccessible when people die, limiting our learning about FCP in the community
- Future analysis will expand on patient numbers and encompass individuals with a range of other cancer diagnoses
- We aspire to make PCCS patient and family-held documents

Key Sources & Acknowledgements

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