maintaining training within rapidly changing workforces is acknowledged.

P118 ADVANCE CARE PLANNING IN CARE HOMES: AN EXPLORATION WITH STAFF, RESIDENTS AND FAMILIES

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Aims To explore staff, residents and families' experience of participating in advance care planning discussions.
Background/literature review: Within the UK, implementation of the Gold Standards Framework in Care Homes (GSFCH) programme is being promoted to develop the quality of end of life care for frail older people living/dying in care homes (DoH 2008). An integral part of this involves advance care planning (ACP) discussions. This study explored the experience of initiating and undertaking these discussions.
Methods A qualitative descriptive study was undertaken in three nursing homes implementing the GSFCH programme. Following an ACP discussion, semi-structured interviews were undertaken with the resident, their family member/s and the staff member undertaking ACP. Thematic analysis was used to identify the main categories and themes.
Results Twenty eight interviews were carried out. Five main categories arose: understanding ACP; undertaking ACP discussions; the impact of ACP discussions; use of documentation; and, relationship and rapport.

Staffs understanding of ACP varied and this affected the depth of their discussions with families and residents. The use of documentation either acted as a useful prompt or limited the discussion, blocked opportunistic cues and encouraged a 'tick-box' exercise. Staff had to face their fears around discussing death and dying. The assistance of a trained facilitator helped staff to develop knowledge, skills and confidence with end of life conversations. Residents were open to having ACP discussions, though the way it was introduced could impact on the result. Families found comfort that their loved ones future care had been considered.
Conclusions Care home staff need to develop the knowledge, skills and confidence to engage in discussions around end of life care. The assistance of a trained facilitator who role models this process would enable this.

P119 IMPROVING END OF LIFE CARE IN WORCESTERSHIRE: ADVANCE CARE PLANNING

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Advance care planning (ACP) is a process of reflection and communication in which a person with decision making capacity is able to express his/her wishes regarding preferences and wishes for their end of life care. The End of life strategy (2008) highlights the need for proactive guidance in exploring a person's preferences and wishes at an early stage within life limiting illness, resulting in the potential of unnecessary and unwanted crisis interventions being minimised. The newly formed, three clinical commissioning groups (CCG'S) for Worcestershire have acknowledged ACP as a priority and commissioned a countywide project, under the auspices of the End of Life and Palliative Care network for Worcestershire the role out and implementation of the new countywide ACP documents, this is seen as critical components of the quality improvement process in health and social care (Help the Hospices,2012).

A 12 month project overseen by an ACP Project Manager and hosted in collaboration with St Richard's Hospice will see the Implementation of a training and awareness programme across all health and social care providers being undertaken. This is to enable collaborative countywide working and embed the ACP documents in to practice. Training and awareness will be developed for the workforce to enable underpinning knowledge and skills required in supporting patients through ACP discussions.
Enabling:

- Patient choice regarding preference and wishes as end of life approaches
- Proactive guidance for preferred place of care
- Minimise crisis admission as end of life approaches

A skilled workforce across health and social care will enable a consistent approach to advance care planning countrywide ensuring a patient's wishes and preferences are elicited, documented and shared.

Integrated care at end of life within the changing health and social care policy landscape will be delivered in line with the recommendations from, Preparing for the future: key operating principles (Help the Hospice,2012).

P120 THE IMPACT OF ADVANCE CARE PLANNING OF PLACE OF DEATH, A HOSPICE RETROSPECTIVE COHORT STUDY

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Objectives There is limited evidence of the impact of advance care planning (ACP) on outcomes. We conducted a retrospective cohort study on deaths of all patients known to a hospice in a 2.5-year period to see if use of ACP affected actual place of death, hospital use and cost of hospital care in the last year.
Results 969 patients were included. 550 (57%) people completed ACP. 414 (75%) achieved their choice of place of death. For those who chose home, 34 (11.3%) died in hospital; a care home 2 (1.7%) died in hospital; a hospice 14 (11.2%) died in hospital and 6 (86%) who chose to die in hospital did so. 112 (26.5%) of people without ACP died in hospital. Mean number of days in hospital in the last year of life was 18.1 in the ACP group and 26.5 in the non-ACP group ($p < 0.001$). Mean cost of hospital treatment during the last year of life for those who died in hospital was £11,299, those dying outside of hospital £7,730 ($p < 0.001$). Mean number of emergency admissions for those who died in hospital was 2.2 and who died elsewhere was 1.7 ($p < 0.001$).
Conclusions ACP can be used routinely in a hospice setting. Those who used ACP spent less time in hospital in their last year. ACP is associated with a reduction in the number of days in hospital in the last year of life with less hospital costs, supporting the assumptions made in the End of Life Care Strategy 2008.

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