

Participants described the transition period as a difficult time for both the YP and their families, with a perceived lack of adult services available for them. All groups agreed that the pilot project had a positive impact on the YP and their families, with the social benefits highlighted as a key factor. All participants were keen for the project to continue, ideally on a more frequent basis with more overnight stays, and the parents were keen to be more involved in the running of the service.

Conclusion The key stakeholders in this service were all positive regarding the impact the service has had on the YP and their families, and were keen to see it continue. This pilot models a service that could be adopted by other organisations.

P-89 RECORDING PREFERRED PLACE OF DEATH: A DYNAMIC PROCESS

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A patient's preferred place of death (PPD) is frequently used as a marker for quality of end of life care. However, surveys of patients with life-limiting conditions indicate that "dying in preferred place" is not their highest priority (Actions for End of Life Care NHSE 2014-2016). As end of life approaches other priorities often take precedence and PPD may change.

Aim of our audit To establish how many inpatients referred to our hospital Supportive and Palliative Care Team (SPCT) had PPD recorded, what their preferences were and whether they changed.

Methods Data was extracted retrospectively from a database of inpatient deaths referred to the SPCT between July and August 2016

Results 63 patients had a PPD recorded - 33 patients at initial consultation and 30 patients at subsequent consultation. Initial PPD was acute hospital (25), home (16), no preference (9), hospice (9), care home (4). 13 patients (21%) changed their PPD during their admission. 6 patients with initial PPD home or hospice changed to acute hospital. 4 people changed their preference to care home (from hospice or home). From 16 patients whose initial PPD was home, this remained their final preference in 7 cases. 6 patients changed their PPD more than once.

Conclusions Our data shows that almost half of patients do not discuss PPD at initial consultation but are happy to state preferences subsequently. This could be due to development of rapport and relationship with SPCT members. Interestingly, PPD changed during the hospital admission in one fifth of cases with the majority electing to not spend last days of life at home. This could be due to changes in condition, symptoms and performance status coupled with perceived burden on caregivers. Discussing preferences for place of death should be a dynamic process as care related priorities may change as end of life approaches.

P-90 PRACTICE IMPROVEMENT PROJECT: PALLIATIVE CARE SERVICE PROVISION FOR PEOPLE WITH DYSPNOEA

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Background A scoping exercise and literature review of national and local initiatives highlighted innovation and evaluation as critical elements of change within the healthcare system, where NHS policies require healthcare professionals to research effective ways to deliver healthcare, including evaluation and service improvement. Gaps were identified through reflection in and on practice, within a dyspnoea clinic in a palliative care setting. The purpose of this practice improvement project was to promote patient-centred care, within which care decisions reflected the needs, values and beliefs of the palliative care service users and those providing the care.

Method Firstly, a concept analysis approach was used to: a) identify service user needs b) demonstrate that improvement in practice was necessary and c) facilitate change. Secondly, a collaborative nurse/physiotherapist approach was chosen as a model of best practice for the delivery of the non-pharmacological approach to dyspnoea. Finally, an improvement framework which consisted of six elements 1) person-centredness, 2) evidence, 3) improvement processes, 4) enabling and sustaining change, 5) leadership and facilitation, 6) learning and development was used to enable best practice to be implemented into the clinic.

Findings The literature review confirmed that the non-pharmacological approach to dyspnoea within a clinic setting continued to be gold standard best practice. It also highlighted that this approach could support people with cancer who were breathless but did not have lung metastases, as well as other chronic lung conditions and those with heart failure. Therefore, the referral criteria, documentation and outcomes for the clinic were revised and widened to include these conditions.

Conclusion This evidence based improvement project reflected the needs, values and beliefs of people with dyspnoea and those providing the care meeting policy recommendations and hospice requirements. In doing so it provides information that would help in the future commissioning of dyspnoea clinics.

P-91 INTEGRATION OF SPECIALIST PALLIATIVE CARE INTO A TERTIARY NON-MALIGNANT SERVICE: EVALUATION OF POTENTIAL GEOGRAPHICAL DISPARITY

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Background Idiopathic pulmonary fibrosis (IPF) is a progressive, scarring disease of the pulmonary interstitium. Though emerging anti-fibrotic therapies (Pirfenidone and Nintedanib) are available for selected patients, the symptom burden remains high (breathlessness, cough) and disease trajectories are variable. Resultantly, NICE recommends incorporation of specialist palliative care (SPC) into IPF services.

Only designated IPF centres can prescribe anti-fibrotic medications. This approach generates risk of geographical healthcare inequalities.

IPF services for the North East and Cumbria are delivered by the Royal Victoria Infirmary in Newcastle upon Tyne. SPC support from Marie Curie Newcastle was incorporated in January 2016. We present an initial evaluation of our novel collaborative service.

Aims Aims were (1) to map the distribution of patients prescribed anti-fibrotic medications, and (2) to map the distribution of patients who were referred to clinic-based SPC.