

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.

Methods The postcodes of all patients with known IPF referred to SPC between January and November 2016 were collected retrospectively. These data were plotted onto a map of regional clinical commissioning groups (CCGs) to compare access.

Additionally, a database of patients prescribed anti-fibrotic medications during the same period was reviewed. A second map was produced showing access to these medications according to CCG.

Results 117 patients received anti-fibrotic medications. Male: Female 102:15, mean age 73. Geographical plotting reveals evidence of some regional disparity with respect to access to anti-fibrotic medication.

49 patients were referred to SPC (consultant based in the ILD clinic). Male: Female 35:14, mean age 75. Geographical plotting reveals a striking centralisation to the Newcastle-Gateshead CCG.

Conclusion Embedding SPC in a non-malignant clinic is possible. On evaluation, disparities are evident with respect to the prescription of anti-fibrotic medications, and more patently SPC input. This may reflect wider inequalities, impacting on patients who live far from the IPF centre. Exploration of contributing factors will be imperative.

P-92 A QUESTION OF FUTILITY? END OF LIFE DECISION MAKING IN THE UK COURTS

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Background What action should palliative care clinicians take if they feel that a medical treatment is ineffective but carers disagree? In the case of incapacitated adults in England and Wales, it is only lawful to withhold life sustaining treatment if it is judged to be futile or overly burdensome to the individual. Disagreements as to an individual's best interests may involve recourse to the courts.

Methods This paper reviews the case law in this area, charting 25 years of judicial decision making on behalf of incapacitated patients receiving life-sustaining treatment.

Results Recent cases illustrate a evolution; from a deference to medical decision making to a rejection of a biomedical 'best interests' decision-making model. Courts now show a willingness to scrutinise what clinicians mean when they invoke the term "futile" to withhold life-sustaining treatment in a person's best interests. The UK Supreme Court's recent narrow interpretation of futility; "*ineffective or being of no benefit to the patient*" has the potential to skew treatment decisions in favour of interventions that have little chance of producing a meaningful improvement in clinical condition.

Conclusion By rejecting the 'medical' view of futility the right of an incapacitated individual to have burdensome or minimally beneficial treatments withdrawn is now interwoven with the judicial interpretation of their best interests. Removing these decisions from the bedside adds additional complexity to end of life decision-making as clinicians may no longer know with certainty that their decision to withdraw life sustaining treatment is a lawful one.

P-93 STANDARDS FOR DOCUMENTATION OF DNACPR DECISIONS AND DISCUSSIONS IN A HOSPICE INPATIENT UNIT & COMMUNITY TEAM

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Background Recent legal cases have clarified requirements for good practice around documentation and communication of Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions particularly where it is clear in advance that CPR will not work for a patient. UK good practice guidance was updated in 2014 and further revised in 2016 to reflect the legal changes, and the NHS Scotland DNACPR integrated adult policy has also been reviewed.

Aim To assess the documentation of DNACPR decisions by inpatient and community specialist palliative care teams in relation to the updated NHS Scotland policy to highlight the areas where education should be targeted. The audit standards are based on the revised UK good practice guidance and aspects of a measurement framework developed by Health Improvement Scotland as part of the Deteriorating Patient workstrands.

Methods A retrospective audit was completed of 20 hospice inpatient unit (IPU) notes and 20 consecutive community team (CT) referrals. Compliance with 5 documentation standards was assessed for: individualised decision-making; correct DNACPR form completion; patient involvement; and good practice around incapacity.

Results 16/20 inpatients and 7/20 community patients already had a DNACPR form in place on admission to the service. Compliance with good practice standards for discussion and documentation was excellent apart from; documentation of review timeframe (40%) for inpatients; and documentation of discussion when CPR was a realistic treatment option - only one of the 7 patients for who CPR might work had documented evidence that a discussion had taken place.

Conclusion Patients coming into contact with the IPU or CT generally encounter good practice with regards to discussion and documentation of a clinical DNACPR decision. However community patients for whom CPR might work are less likely to be given the option to discuss their choices highlighting an education need for palliative care specialists.

P-94 ENHANCED SUPPORTIVE CARE IN EXPERIMENTAL CANCER MEDICINE TRIALS AT THE CHRISTIE NHS FOUNDATION TRUST

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Background Enhanced Supportive care (ESC) is a fresh approach to supporting people through cancer treatment. As its heart is better access to expertise in managing the adverse effects of cancer treatments. ESC is recognised nationally by NHS England, and received a Quality in Care (QiC) award (February 2016).