awareness is necessary to ensure that ACPs are reviewed appropriately.

57 WHO WOULD KNOW? EMBEDDING FUTURE CARE PLANNING FOR ALL PATIENTS APPROACHING THE END OF THEIR LIVES

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Background Future Care Planning (FCP) empowers individuals to receive the care and treatment they choose towards the End of Life (EoL). Developing personal Advance Care Plans (ACPs) and Anticipatory Clinical Management Plans (ACMPs) improves patient and family satisfaction and reduces 'burdensome' treatments yet is not universally offered. An evaluation of current FCP across a locality was undertaken to establish current practice, explore barriers to implementation and guide future work.

Methods

1. Case note review of patients known to specialist palliative care services(SPCS) for evidence of FCP and information–sharing between organisations (n=52)
2. Review of ACMP content and information–sharing between organisations (n=50)
3. Health–care professional survey of knowledge, experience and expectations of FCP (n=39)

Results Preferred Place of Care was documented for 85% of patients known to SPCS, but there was limited documented evidence of other forms of FCP (uDNACPR:38%, ACMP:2%, ADRT/LPA:0). FCP undertaken by SPCS was rarely available in hospital records. The number of ACMPs is increasing (49 (2017/18) c.f. 198 (2018/19)), predominantly for care home residents, with 60% developed by newly appointed frailty practitioners. They consistently included key EoL topics but only 38% were available within hospital records. Staff had limited knowledge and experience of FCP, and the processes for recording and sharing patients wishes. They felt more training and more time would enable them to facilitate more ACP conversations

Conclusions Not all patients are currently offered an ACP conversation. Although information packs are available further promotion is required to ensure they are given. There is a need to continue current network-wide ACP training; additional targeted support for those in key roles has been introduced. Collaborative working between SPCS, frailty, acute and primary care teams is ongoing to ensure a consistent approach, and shared documentation and processes to ensure patients wishes are respected as they move between care settings.

58 ANTICIPATORY PRESCRIBING AND USE OF SYRINGE DRIVERS – CROSS BOUNDARY AUDIT OF PRACTICE

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Background Anticipatory prescribing and use of syringe drivers at end of life is now established practice. A national report outlined the need to ensure safe, appropriate and individualised prescribing for patients at end of life, considering available guidance to aid decision making. Within our locality we deemed it vital to demonstrate we are complying with guidance.

Aims To ensure safe and effective care of patients at end of life, with an individualised approach to decisions and compliance with guidelines, policies and procedures.

Methods Questions were developed through collaborative discussion and data collection tool produced. Retrospective audit cross settings was undertaken based on place of death to avoid duplication.

Results 71 cases included for full analysis. Largest proportion in Hospice. Spread of gender, age, diagnosis. Substantial data was collected on core drugs at end of life. Using agitation as an example, 93% had an individualised approach to prescribing: all had a dose and route; 1 no frequency although this was felt to be a documentation error; 31% had a maximum dose; 93% had an appropriate dose adjustment for renal impairment. In the last 24 hours of life the total dose of midazolam: Hospice median 1.25 mg and mean 8.2 mg; hospital 0 mg and 1.7 mg and community 0 mg and 5 mg respectively. Similar results were found for other drugs in terms of quality of prescriptions and individualised nature of decision making.

Conclusion Individualised approach to prescribing was evident overall, with a high standard of prescribing. Some incomplete prescription although felt due to data collection errors. Doses of medications in line with network guidelines. Need to improve discussion with patients and families regarding medications, syringe drivers and side effects. The three organisations involved developed individual action plans including improvements in documentation and where electronic prescribing had commenced, embedding this.

59 IMPROVING IDENTIFICATION AND RECORDING OF THE GOLD STANDARDS FRAMEWORK (GSF) WITHIN RUSSELLS HALL HOSPITAL, DUDLEY

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Introduction Measuring performance in End of Life Care within an acute setting is a complex and difficult task. GSF implementation within a hospital setting can improve quality of care, patient satisfaction and an increase in advance care planning. This study aims to show how by developing an internal hospital application and protocol for GSF patients, improved data collection can be transformed from data into intelligence and impact on delivery of high quality, individualised end of life care.

Methods Most wards within Dudley had different ways of capturing GSF identified patients and recorded information manually. Informatics and the Specialist Palliative Care team developed an internal application to monitor all patient admissions against a GSF outcome and to provide additional information such as preferred place of care and ACP. This provided the ward with a visual management tool, easily identifying end of life patients and the ability to capture essential end of life metrics.

Results Since the launch of this application, analysis of the data has demonstrated an increase in the percentage of adult