1st October 2019. Patients were subsequently asked about driving, where appropriate, and the junior medical team provided education on the national drug driving guidance.

**Results** All 18 patients:
- Had prescriptions of medications listed in the drug driving guidance
- There was no knowledge or documentation of whether a patient was a vehicle driver

5 patients admitted for end of life care were therefore excluded from further analysis. When the 13 patients were asked:
- 10 patients were not vehicle drivers
- 3 patients were vehicle drivers

The drug driving guidance was discussed within the department’s service improvement meeting. An addendum on the clerking proforma was made to include whether the patient was a vehicle driver or not. If a patient was a vehicle driver it was highlighted on the joint MDT handover list, and if prescribed medication listed in the drug driving guidance, they were counselled on this. This was also communicated on the discharge summary for ongoing continuity of care.

**Conclusion** This project enabled joint collaborative work between doctors and the pharmacy team. It also highlighted the importance of not making assumptions about palliative care patients not driving a vehicle. Discussing the drug driving guidance with the medical team ensured that a patient was aware of the government guidance and ensuring public safety. A re-audit is planned in 2020 to ensure that this change in practice remains embedded.

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**ONE HOSPITAL CLINIC – ACHIEVING DEATH AT HOME AND HOSPICE FOR PATIENTS WITH PULMONARY FIBROSIS**

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**Background** Pulmonary fibrosis is a chronic respiratory condition with a poor prognosis and significant symptom burden, yet has traditionally been managed purely by respiratory physicians. It was the experience in the Greater Manchester town of Wigan that many patients with pulmonary fibrosis were not recognised to be in the last year of life and often presented to and ultimately died in hospital during their final illness. There were missed opportunities for improving symptom control, advance care planning (ACP) and achievement of preferred place of death (PPD).

**Methods** A new service was established where a Palliative Medicine Consultant and clinical nurse specialist reviewed patients in a dedicated clinic running alongside the respiratory clinic. The monthly face to face clinic was complemented with a fortnightly telephone follow up clinic in-between. Symptom issues were addressed guided by Integrated Palliative care Outcome Scale (IPOS) completion, hand-held fans given out to help manage breathlessness, referrals considered to the local AHP-run palliative care out-patient centre and ACP and PPD discussed and recorded.

**Results** Since December 2017, to date 36 patients with Pulmonary Fibrosis have been referred to the clinic. Three patients died prior to review. Of the 33 who have been assessed, 9 remain under active follow-up, 6 have been discharged to community palliative care services, 1 back to GP and 17 have died. Advance care planning was initiated in 26 patients (79%) and completed in 18 (55%). Of the 17 patients that died, all but two died out of hospital (88%), 11 in their own home/nursing home and 4 in hospice, significantly greater than national averages for non-malignant conditions.

**Conclusion** The development of a hospital-based dedicated palliative medicine clinic for patients with Pulmonary Fibrosis has resulted in a majority of out-of-hospital deaths for this group of patients.

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**SURVEYING THE USERS OF AN OPEN-ACCESS SUPPORT SERVICE FOR PEOPLE AFFECTED BY AN ILLNESS THAT HAS NO CURE**

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**Background** In the UK, palliative care is a growing specialty; however, national inequalities in access to services persist. Those who are male, older, more deprived, belong to ethnic minority groups and have non-malignant disease are relatively
under-represented in clinical services. An open-access service in the North of England provides a breadth of support to people affected by palliative diagnoses, without requiring clinical referral, with dedicated support to address some of these inequalities. We report on an evaluation of this service.

**Method** This study was conducted as a secondary data analysis of an annual service evaluation. Characteristic data of service users was collected through an anonymous cross-sectional survey. One-hundred and fifteen responses were acquired via convenience sampling over the period of one week. Data was compared against the characteristics of local specialist palliative care services, local census data and historical MDS data through descriptive and inferential techniques (chi-squared test).

**Findings** The open-access service was found to have a significantly higher proportion of non-cancer patients (75%) compared with clinical services (27%) and MDS data (24%), highlighting that this is a potentially valuable approach to improving access for this under-represented group (p=0.05).

Conversely, attendees were more likely to be female (<0.001), under 75 (<0.001), live in the local area (<0.001) and have religious beliefs (<0.01), highlighting areas for further development.

**Conclusion** This service evaluation has highlighted a potential approach for improving access to specialist support for people with non-malignant disease and members of minority ethnic groups; formal research evaluation is recommended. Outstanding challenges include broadening access for men, older people, non-religious people and the wider area.