is embedded within 'last days of life' symptom management guidelines and is usually limited to the prescribing and administration phases (predominant in England and NI). Type 2 'Anticipatory Care': AP guidance covers more than the 'last days of life' period and documents specifically address all 5 phases of the AP process (predominant in Scotland). National frameworks supporting both approaches exist in Wales. Significant guidance gaps were identified with the type 1 approach, particularly in relation to: 1) timing of the decision to prescribe, 2) transition from prescription to administration, and 3) drug disposal.

Conclusions Despite its complexity, AP is often treated as a simple component of 'last days of life care' within governance documents, resulting in important guidance gaps. National guidance development work is underway to address these gaps.

12 A SERVICE EVALUATION OF HOSPICE ADMISSIONS FOR PATIENTS WITH MOTOR NEURONE DISEASE AND DUCHENNE'S MUSCULAR DYSTROPHY AND BARRIERS TO THEIR TRANSITION AND ADMISSION

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Background and introduction With DMD patients now living in to their 30's, there is a greater need for them to transition into adult services. Given their needs are often similar to MND patients, looking at barriers to hospice admissions for both these groups could help provide indicators for service development.

Methods All UK hospices were contacted with the following survey either in person, telephone, email or using the enquiry form on their webpage:

- Do you take Motor Neurone Disease Patients?
- What are the barriers to admitting such patients?
- Do you take patients with Duchenne's Muscular Dystrophy?
- What are the barriers to admitting these patients?
- Do you take patients on NIV?
- What training do staff have on using NIV?

Results 78 responses from 191 hospices. 98.7% admitted MND patients and 93.6% would admit DMD patients; however 51.3% had not had any referrals for DMD.

Barriers were identified as challenges rather than barriers. The top four for each group were:

MND

1. Staffing levels and high dependency
2. NIV
- 3a. Bed availability
- 3b. Difficulty managing their needs

DMD

1. Patients remaining under children's services/difficulty with transition
2. Difficulties managing their needs
- 3a. Not being referred
- 3b. No respite in adult hospices

93.6% of hospices would admit patients on NIV, but most of them often found this challenging and wouldn't start NIV or amend the settings; staff of only 23% had formal training on NIV.

Conclusions While it's difficult to provide answers for wider service issues like staffing and bed availability, we need to be providing increased services for transitioning DMD patients into adult care. Commonly hospices were worried about the complexity of care that these patients require, including familiarity with equipment and use of NIV. Going forward, it is necessary to work with children's services to develop learning packages for adult hospices to feel more comfortable with these admissions.

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13 PRACTICES, ISSUES AND POSSIBILITIES AT THE INTERFACE BETWEEN GERIATRICS AND PALLIATIVE CARE WITHIN THE HOSPITAL: AN EXPLORATORY STUDY (INGAP)

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Introduction With the expansion of palliative care into non-malignant conditions, there is an increasing emphasis on inter-disciplinary working between extended geriatric teams and palliative care. This inter-disciplinary working has evolved organically and more needs to be known about current working practices. This is of policy and clinical interest as the elderly patient population continues to grow.

Methods An exploratory case study was undertaken of end-of-life care for older in-patients in a London hospital. Staff from all grades and roles within palliative care and geriatric medical/nursing teams, patients and carers were invited to be interviewed, according to a protocol approved by HRA. 30 semi-structured qualitative interviews were conducted with staff, two with patients and five with carers. Questions covered: recent examples where teams worked together; staff perceptions of collaboration, working practices and issues; patient and carer perceptions of clarity as to who was providing care. Interviews were transcribed and thematically analysed focusing on: examples of successful collaboration; areas of tension, duplication or confusion about responsibilities; suggestions for future practice.

Results Participants were overwhelmingly positive about collaboration between the teams. Examples of what currently works well were: the referral process to the palliative care team; inter-team communication and use of face-to-face handovers; unity between the teams when communicating with patients and families. Areas of concern and for future development were: improving collaboration between palliative care and physiotherapy and occupation health; the need for continual on-ward education given rotation of junior medical staff; embedding palliative care within multidisciplinary team meetings within the ward. Patients and carers did not generally distinguish between the teams and presumed collaborative working practices.

Conclusions A commitment to working together was important. The findings are also relevant to understanding good practice between older persons ward teams and other specialisms.