only 2/10 had 'protected' SPA time (an important factor in maintaining adequate Continuing Personal Development). This small pilot study is to be extended across the region.

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P-61 DANGEROUS VARIATIONS IN EQUIANALGESIC DOSING FOR TRANSDERMAL FENTANYL

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Background Opioid rotation/switching is common in palliative care, and one of the most common switches is between oral morphine and transdermal fentanyl. The purpose of this review was to highlight the wide variation in equianalgesic doses that exists according to different sources.

Method In January 2016, we reviewed national guidelines and Summaries of Product Characteristics for transdermal fentanyl preparations available in the United Kingdom, to determine recommended equianalgesic doses for oral morphine and transdermal fentanyl.

Results

Abstract P-61 Table 1 Examples of oral morphine dose variations from different sources

Source	Fentanyl dose (micrograms/hour)				
	12	25	50	75	100
BNF	30	60	120	180	240
PCF (stable dose for several weeks)		<135	135–224	225–314	315–404
PCF (stable dose for long periods)	<44	45–89	90–149	150–209	210–269
Durogesic Dtrans (stable dose for several weeks)		<135	135–224	225–314	315–404
Durogesic Dtrans (stable dose for long periods)	<44	45–89	90–149	150–209	210–269
Fencino (opioid rotation due to adverse reaction)	<90	90–134	135–224	225–314	315–404
Fencino (stable, well tolerated opioid therapy)	<60	60–89	90–149	150–209	210–269

See Table 1. As can be seen from the Table, there can be up to a threefold difference in dose of oral morphine for a specific dose of transdermal fentanyl ie, 12 micrograms/hour=30 mg or 90 mg.

Conclusions This review highlights clinically significant (and potentially dangerous) differences in equianalgesic doses of transdermal fentanyl. We would suggest that there needs to be a national/international consensus on equianalgesic doses for transdermal fentanyl.

P-62 RESPONSE TO ONCOLOGICAL TREATMENTS: WHAT OUTCOMES DO ONCOLOGISTS AND PALLIATIVE MEDICINE PHYSICIANS CHOOSE?

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Background There are a variety of ways of describing response to oncological treatments eg, response rate, progression-free survival and overall survival. However, there is limited information about the terminology preferences of oncologists or palliative medicine physicians.

Method All oncologists and palliative medicine physicians (including consultants, specialty trainees and "other" doctors) from four cancer centres in the United Kingdom were contacted in April 2016 to complete an online survey.

The question that was posed was as follows: "A new treatment is developed for carcinoma of the umbilicus which increases the median survival of patients from six months to twelve months. However, 75% of patients have an objective decrease in size of the tumour after six months of treatment. How would you explain the new treatment to a patient with carcinoma of the umbilicus?" Potential responses were: "with treatment you have a 50% chance of surviving twelve months"; "treatment will double your life expectancy"; "the new treatment is a 'game changer'"; "treatment will increase your life expectancy by six months"; and "75% of patients will respond to treatment".

Results There were 111 responses in total (oncologists=97, palliative medicine physicians=14). Table 1 demonstrates the range of responses.

Abstract P-62 Table 1 A table to demonstrate responses between specialties

Possible response	Oncology	Palliative Medicine
With treatment you have a 50% chance of surviving twelve months	18%	14%
Treatment will double your life expectancy	8%	7%
The new treatment is a 'game changer'	2%	7%
Treatment will increase your life expectancy by six months	38%	29%
75% of patients will respond to treatment	34%	43%

Conclusions In both groups, the most popular answers were "treatment will increase your life expectancy by six months" and "75% of patients will respond to treatment", with more oncologists talking about increase in survival and more palliative medicine physicians talking about response rates. These results were somewhat surprising, and so we plan to explore this issue further with a new mixed method research study.

P-63 SUBCUTANEOUS LEVETIRACETAM FOR THE MANAGEMENT OF SEIZURES AT THE END OF LIFE

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Background Current management of seizures at the end of life utilises sedating medications (midazolam and phenobarbital) administered via the subcutaneous route. The subcutaneous administration of levetiracetam presents the possibility of managing seizures at the end of life without causing sedation.
Methods A comprehensive literature review was performed and this data was combined with data from a prospective observational audit undertaken in a regional palliative care network. A search of EMBASE, Medline, CINAHL, ClinicalTrials.gov and the WHO International Trials Registry for "subcutaneous AND levetiracetam" or "subcutaneous AND keppra" or "levetiracetam SC" on the 16 th of July 2015 and updated the search on the 2nd of August 2016.
Results 7 papers were identified from the literature review; 4 case reports and 3 observational case series; reporting on a total of 53 cases where subcutaneous levetiracetam was administered.

We report 20 further cases of subcutaneous levetiracetam administration from a prospective observational case series. Doses ranged from 250 mg-4000mg daily. Oral to subcutaneous conversion ratios where stated were 1:1. Levetiracetam was reported as the sole administered anti-epileptic drug (AED) in 8 cases and no seizures were reported until death in 5 cases. 5 were switched back to enteral Levetiracetam. In 7 cases, Levetiracetam was combined with AEDs to provide seizure control at the end of life. There was one report of a sterile abscess after 25 days of continuous subcutaneous administration.
Conclusions A combined analysis of 73 reported cases world wide of subcutaneous levetiratcetam administration suggests it may have a role in the management of seizures at the end of life. However randomised controlled trials are urgently needed to establish the efficacy and tolerability of subcutaneous levetiracetam administration. If proven to be safe and effective subcutaneous levetiracetam offers the potential to prevent and treat seizures without causing unnecessary sedation at the end of life.

P-64 QUALITY IMPROVEMENT PROJECT- END OF LIFE MEDICATION USE

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Background Palliative care is a multidisciplinary approach to specialised medical care for patients with terminal illnesses, mainly providing relief from symptoms, physical and mental stress of an illness. There are multiple components to managing patients in terminal phase. Anticipatory prescribing of as required medication in advance is one of them. The significance lies in ensuring no delay in responding to a symptom. This retrospective audit was conducted to assess compliance with local guidelines.
Methods Medical records of inpatient Deaths during November and December 2014 were requested and data specifically, medications prescription, was collected. There should be 4 prescriptions with clearly stated route, frequency, indication and maximum dose.
Results Out of 56 patients included in the audit, only 25 patients received end of life care. 24 patients were included as 1 chart was unavailable. Only 74% patients had their regular medication discontinued. The most common choice of documentation was palliation (34%) followed by 'keep comfortable' (29%), with minority using phrases like 'T.L.C', 'stop all treatment'. The audit revealed relatively satisfactory targets for respective prescriptions with the highest 87% for pain followed by 85% for nausea, 78% for agitation and dyspnea and lastly, 74% for respiratory secretion. Only a small number of Syringe driver was used - mainly pain relief with only 17%. Opioid Conversion is rather poor. Only 57% of the patients previously on regular pain relief had accurate dosing following the conversion chart.
Conclusion To ensure anticipatory medication being accurately prescribed, end of life prescription chart would be introduced with opioid conversion chart included. Healthcare professionals should be given teaching and made aware of the chart and hospice service. Palliative care team should review all patients as soon as they are commenced on palliative care however this would not feasible as patients in hospital setting tend to die within days.

P-65 TITLE: MULTI-WARD HOSPICE EXCHANGE PROGRAM

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An exchange program has existed between qualified nurses at St Ann's Hospice and Renal Departments in partnership trusts for over 10 years, the outcomes of which have always been positive and have allowed all staff to develop their knowledge, skills and confidence. With this in mind it was decided to expand the program to include the Cardiology, Haematology and Respiratory departments. The diversity of the acute settings addresses the changing nature of hospice care where patients are admitted with complex clinical reasons, and presents hospices with significant challenges for education and training.

The provision for palliative care is inconsistent across the country, this is particularly true of out of hours. Although it is unfair to directly compare hospices and hospitals, the advantages of sharing specific knowledge and skills across the 2 is clear.

A one week nurse exchange; centred on observations, is agreed between St Ann's Hospice and the Renal, Cardiology, Haematology and Respiratory departments of Central Manchester Foundation Trust. Discussions are underway to include Gastro-enterologly. The program adopts a hands on approach where knowledge and skills are shared through shadowing and observations.
Evaluation Following on from the renal exchange program last year, a new evaluation form has been produced that captures the data in a more quantitative manner, thus allowing outcomes to be more auditable.
Overall Objectives 1. Equip St Ann's staff with the skills and knowledge to deal with more clinically complex patients

2. Raise awareness of individualised end of life care in a hospice setting

The Future This is an ongoing project, aiming to cascade across all hospital specialties, with a view to develop EoLC 'Champions' in each specialty. Our goal would be to see this partnership program replicated in other organisations.