

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.

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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.

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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 whom 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.

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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).