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.

Abstracts

P-92 A QUESTION OF FUTILITY? END OF LIFE DECISION MAKING IN THE UK COURTS
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10.1136/bmjspcare-2017-00133.91

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 is 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.
We previously piloted ESC in several disease groups. The work demonstrated that timely supportive care improves patient experience and reduces hospital admissions.

Incorporation of ESC within experimental cancer medicine is new in the UK. The aim is to help maximise patient recruitment and retention and enhance the patient experience within the context of experimental cancer medicine clinical trials (Phase I and non-randomised Phase II clinical trials).

**Methods** A joint clinic was set up between the Experimental Cancer Medicine Team (ECMT) and the Supportive Care Team (SCT). These clinics are staffed by consultants from each team, research nurses and fellows and a clinical nurse specialist in supportive care. Patients being considered for or currently participating in a clinical trial are offered early referral to the supportive care team for assessment and management.

**Results** The pilot project began in September 2015. To date the SCT have undertaken 132 patient consultations within the ECMT. The predominant referral has been for optimisation of pain control, which is managed with specific consideration of the restrictions in the concomitant medication prescribing within Phase I trials.

**Conclusion**

The ECMT at The Christie is the first early phase clinical trials unit to adopt ESC into practice. The ESC approach is now a routine part of the ECMT assessments of trial patients. Next steps will be to measure the impact of ESC on patient experience, eligibility for clinical trials, and admission avoidance.

**P-96**

**The Management of TA – Survey of Nurses Working in a Specialist Palliative Care Unit**

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10.1136/bmjspcare-2017-00133.95

**Background** National formularies recommend a step wise approach to Terminal Agitation (TA) using benzodiazepines and anti-psychotics.

Within our 21 bed specialist palliative care unit, a flowchart for management of TA was created in response to reviews where medical and nursing staff felt TA had been poorly controlled.

Four months after the introduction of the local guidelines, we conducted a spot survey of trained nursing staff to ascertain confidence toward management of TA.

**Methods** A standardised protocol for management of TA was created in response to reviews where medical and nursing staff felt TA had been poorly controlled.

Four months after the introduction of the local guidelines, we conducted a spot survey of trained nursing staff to ascertain confidence toward management of TA.

**Results** 11 of 12 nurses (all female) responded. Mean age 42 years (25-56), with a mean of 15 years since qualification.