derbyshire.eolcare.uk) was launched in October 2015. As well as a library of resources, the website offers users the option to create an individualised learning portfolio. This can be linked to existing accredited resources (eELCA) as well as signposting to local face to face educational events.
Results In the period 1.10.2016–30.9.2017, 9862 sessions were conducted on our website, by 5842 users. The average number of pages viewed per session was 3.6 with an average session duration being 3'34 'More than 50% of users in this period were new to the website and our low bounce rate suggests that people who came to us found what they were looking for. The most popular resource was symptom management guidance.
Conclusions This novel website is a well-used platform for a suite of resources, as well a means of educational support for those engaging in end of life care.

110 IMPROVING PALLIATIVE CARE AND ADVANCE CARE PLANNING IN END STAGE HEART FAILURE IN A GENERAL HOSPITAL SETTING

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10.1136/bmjspcare-2018-ASPabstracts.137

Background Advance care planning (ACP) is an integral part in the management of end stage heart failure (HF). This is often poorly done in medical wards. To improve this aspect of care, we focussed on discussions with patients and their families regarding prognosis and ceiling of care, explored patients' wishes for end of life care including hospital admission avoidance, liaised with palliative care team on pre-emptive medications for treatment in community and communicated with GPs on advance care management. This study presents the outcomes of these interventions.
Methods End stage HF was defined as patients with severe refractory symptoms (New York Heart Association class 3 and 4) despite optimal medical treatment. This diagnosis was confirmed by echocardiogram and clinical assessment by HF team. The following interventions were used to improve ACP:
training at departmental induction meeting to identify end stage HF patients;
medical teams encouraged to initiate ACP discussions;
poster to remind junior doctors of the relevant information to include in discharge summaries to GP

Data were extracted from medical records and discharge summaries to assess the impact of these interventions.
Results Data were collected from 63 patients between August 2016 and March 2017. Discussions on prognosis and ceiling of care improved from 8.6% to 25.0% and 14.3% to 28.5% respectively. There was better communication to GPs on inpatient (2.8% to 21.4%) and community (8.6% to 21.4%) palliative management. Pre-emptive medication prescribing increased from 8.6% to 14.3%. There was discrepancy in ACP documentation in medical records vs discharge summaries (38.1 vs 25.0%).
Conclusions Despite improvement in ACP and its communication to primary care, significant gaps still exist. This study highlights the challenges in implementing this aspect of care in acute medical setting. Innovative strategies at trust organisational level are needed to deliver this care more effectively.

111 THE EPIDEMIOLOGY OF THE OUT OF HOURS GENERAL PRACTIONER'S PALLIATIVE WORKLOAD IN SHROPSHIRE

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10.1136/bmjspcare-2018-ASPabstracts.138

Introduction There is a paucity in information or standards regarding palliative care being performed by the general practioner (GP) out of hours (OOH). The need for evidence is pressing as discussions are held as to whether 24 hour specialist palliative care cover is required, or whether generalists are capable of dealing with emergency OOH palliative care.
Aim This poster seeks to provide evidence for this discussion by outlining the patient's demographics, the GP's workload, social issues and symptomology encountered. By quantifying the current challenges faced, we can focus on defining what is needed in the future.
Methodology Using Shropshire Doctors Co-operative Ltd (Shropdoc's) recorded data we have collated a representative picture of the palliative care practice over a year period from 161 OOHGP interactions.
Results Palliative care makes 11.5% of the total OOHGP Home Visits (HV). There is a positively skewed distribution with a median age 81 with 56% female. Saturday followed by Sunday are the most active days with more HV over the weekend than the rest of the week combined. Overall 56% of OOHGP HV are for patients who are expected to die within the next 48 hours with 80% of the symptoms being agitation, secretions and pain in this group. Social issues were documented in 21% of HV with multiple concerns highlighted, however adjusting for a prognosis estimated less than 48 hours the focus shifted to family distress (3x more likely) and future planning (5x more likely).
Conclusion The greatest demand is all weekend and from 17:00–21:00 throughout the week. These finding could provide weighting to arguments of provisions of OOH care. The patients seen are appropriate and the symptomology encountered is heterogeneous but the majority can be distilled to end-of-life emergency symptoms. This highlights the varied and predictable unpredictability of palliative care and a largely unrecognised contribution to social-care and future-planning OOH.

112 THE TREATMENT, INTERVENTIONS AND HOSPITAL ADMISSIONS AS PART OF THE OUT OF HOURS GENERAL PRACTIONER'S PALLIATIVE WORKLOAD IN SHROPSHIRE

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10.1136/bmjspcare-2018-ASPabstracts.139

Introduction There is a paucity in information or standards regarding palliative care being performed by the general practioner (GP) out of hours (OOH). The need for evidence is pressing as discussions are held as to whether 24 hour specialist palliative care cover is required, or whether generalists are capable of dealing with emergency OOH palliative care.
Aim This poster seeks to provide evidence for this discussion by outlining treatments instigated, interventions made and hospital admissions arranged OOH. By quantifying the challenges faced, we can define what is needed in the future

Methodology Using Shropshire Doctors Co-operative Ltd (Shropdoc's) recorded data we have collated a representative picture of the palliative care practice over a year period from 161 OOHGP patient interactions.
Results 31% of home visits (HV) had documentation of potential reversible factors and out of those 72% were with the patient's estimated prognosis greater than 48 hours. Infection being the most common (57%) reversible factor, the majority being a lower respiratory tract infection. Overall 5.7% of OOH GP palliative HV's resulted in hospital admission, however this decreased to 0.6% adjusting for an estimate of the patient's prognosis to be less than 48 hours. 16% were admitted if the patient had a potentially reversible co-existing condition. 33% of consultations had documentation regarding a continuous subcutaneous infusion (CSCI), 86% of CSCI interventions were made with a prognosis of less than 48 hours. There were CSCI infusion issues requiring an OOHGP 3.4% of the time. Overall anticipatory medications were prescribed 39% of the time.
Conclusion The OOHGP deals with a wide variety of scenarios for a heterogeneous population. The symptoms and treatments instigated are on the most part expected within emergency palliative care. This data begins to quantify and describe the role being performed by OOHGP and has implications for service provision and potentially the necessity of 24 hour specialist palliative provision.

113 THE SWINBURNE SLOT: A CLINIC-BASED SERVICE FOR DETERIORATING PATIENTS WITH INTERSTITIAL LUNG DISEASE

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10.1136/bmjspcare-2018-ASPabstracts.140

Introduction and objectives Patients with interstitial lung disease (ILD) can deteriorate quickly. It can be difficult to determine whether this is due to disease progression or other potentially reversible processes. Such patients are often known to multiple services; carer feedback in 2016 highlighted it is difficult to know who to approach. In response, the Newcastle ILD team introduced a weekly 30 min rapid access clinic slot (Swinburne Slot, SS) with the aim of determining reversibility and to support patients in their preferred place of care. Our objective was to evaluate this service, which may have practice implications for other teams.
Methods We collected data on how the SS was utilised between 12/09/2016 and 21/03/2017. This included appointment outcome; for example, further imaging or referral to specialist palliative care. Additionally, we collected data on acute hospital admissions within 30 days. Data were obtained using electronic medical records and telephone calls to General Practitioners.
Results The SS was utilised 24 times during the 28 week evaluation period. The most frequent clinic outcomes were adjustment to medication (n=19) and same day palliative care review (n=12). There could be multiple outcomes per patient. Six patients were admitted to hospital within 30 days with an ILD-related problem. Six patients died between the start of the evaluation and the end of data collection.
Conclusions Carer feedback highlighted a deficiency in our service. Our response, the SS, was well utilised, resulting in adjustment to patient management and improved access to palliative care. We present the SS as a workable model which could be replicated by other multidisciplinary teams.

114 PALLIATIVE CARE AND THE ACUTE STROKE WARD: NEW BEGINNINGS?

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10.1136/bmjspcare-2018-ASPabstracts.141

Background Despite advances in managing stroke, death and severe disability are common outcomes. Many patients unfortunately have profound irreversible damage on a background of multiple co-morbidities. However there is also a group of patients where the extent of irreversibility is unclear and the likelihood of survival may be longer, which leads to complex issues around capacity and decision making, whether clinically assisted nutrition and hydration is appropriate and ongoing symptom management. Difficulties can arise in recognising dying when the trajectory of the disease is not easily predicted.
Method Since May 2016 a member of the palliative care team has attended the board round on the acute stroke ward on a weekly basis to provide direct advice or take referrals while discussing all ward patients.
Results Over 12 months the palliative care team was involved in the care of 37 patients. The average Karnofsky Performance Score (KPS) of patients seen was 20. 57% referrals were related to managing patients in the last few days of life with 76% needing advice regarding symptom management. Nearly a third of referrals involved supporting the team in appropriate decision making around escalation of care in particular use of artificial feeding in patients who lack capacity.
Conclusions Stroke patients do have palliative care needs. The acute stroke team valued having regular input from the specialist palliative care team in particular with regard to recognising and managing the last few days of life and help in decision making around long term feeding in patients with an uncertain prognosis who lacked capacity. Funding has been approved to develop this work further with a pilot project enabling a palliative care CNS to have designated time to work on the general stroke wards from 2018.

115 EVALUATION OF THE USE OF A PATIENT HELD RECORD IN SPECIALIST PALLIATIVE CARE

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10.1136/bmjspcare-2018-ASPabstracts.142

Introduction The Royal College of GPs in Northern Ireland created a Patient Held Record (PHR) for patients with progressive, life-limiting illness and their families. This study evaluates its usefulness in the specialist palliative care context.
Methods A prospective longitudinal cohort study through a hospice community service. Patients were given questionnaires with the passport and after 4–6 weeks. Hospice Healthcare Professionals (HCPs) completed a questionnaire and focus group after 8 months.
Results From September 2016–June 2017, 550 patients were screened, 347 (63.1%) were offered a passport and 259