whose role it is. Volunteers and support workers may be advantageous in having these conversations with the right support and development.

Methods There is a mixed methods approach to this research in two separate stages, involving 14 volunteers and support staff.

First stage Face to face qualitative interviews prior to exposure of new training/model of developing these conversations and pre-training Likert questionnaire have been undertaken.

Results Thematic analysis using NVIVO, to address study objectives from first stage, has identified variables in how participants engage with individuals prior to this support and training. Emerging themes are: discussions around whose role is it; feeling valued within their role; being given 'permission' and motivation around having these conversations.

Conclusions Second stage is now being undertaken, emerging themes will be presented in APM Conference. This stage will focus on identifying whether a different approach has helped, and volunteers' feedback will inform training developments and dissemination about how to support volunteers in having honest conversations about quality of life.

130 FRAILTY SCORING IN PATIENTS WITH END STAGE RENAL FAILURE

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Background In the end stage renal failure (ESRF) population frailty is associated with early mortality, increased hospitalisations, and significant symptom burden. After identifying a high degree of frailty in patients withdrawing from dialysis in our population we examined the use of formal frailty scoring and its use in identifying deteriorating patients on renal replacement therapy (RRT).

Methods The Rockwood Clinical Frailty Scale (CFS) is a 9-point scale which enables measurement of frailty it has high inter-rater reliability and correlates well with objective measures of frailty and has been validated in the ESRF population. We introduced routine recording of the CFS for all ESRF in our region for patients at three monthly intervals and for low clearance patients at the time of RRT education.

Results A total of 1663 scores (range 1–9) have been recorded in 798 patients. Mean age 63.9 years. Of those patients currently undergoing haemodialysis the median CFS score was 4 (n=533). The median score prior to death was 5.5. Evidence of deterioration in CFS score (last score greater than the first) was present in 50% (14/28) of those who were deceased at follow-up, whereas a deteriorating score was only present in 22.3% (97/435) of those who remained alive, $p=0.001$. A documented score of 6 or greater was present in 51.4% (38/74) of those who subsequently died vs. 21.7% (158/727) of those who remained alive, $p<0.001$.

Conclusion Deterioration in frailty score is associated with death at follow-up. Furthermore, a score 6 or greater at any point is predictive of death at follow-up. Routine monitoring of frailty using the CFS provides a simple tool to identify patients who are deteriorating and at risk of death. High or deteriorating CFS score should trigger clinical review and anticipatory care planning where appropriate.

131 A PROSPECTIVE COHORT STUDY DESCRIBING THE STABILITY OF CARE PREFERENCES IN FRAIL OLDER PEOPLE FOLLOWING ACUTE ILLNESS

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Background Care should be responsive to preferences but there is little evidence regarding the stability of care preferences, particularly in frail older people after acute illness.

Aim To describe the stability of preferred care outcomes in frail older people in the six months following acute illness.

Methods Prospective cohort study of frail older adults with recent acute illness requiring secondary care review or admission, surveyed at three time-points over six months. Participants rated the importance of six preferred care outcomes chosen from literature review (to extend life, be comfortable, improve quality of life, remain independent, support others, stay out of hospital) on a 0–4 Likert scale, and were then asked to prioritise the most important. We used descriptive statistics to analyse preferences at baseline and the stability of preferences during the study.

Results 67 participants; 63% female, mean age 84 (standard deviation 7.41). 10 participants (15%) died during the study. At baseline, all preferred outcomes were rated mean $>3.3/4$ in importance, except 'to extend life' (2.08/4). Most frequent baseline priorities were: stay out of hospital (20%), support others (16%), and improve quality of life (16%). During the study, the importance ascribed to each preferred outcome was largely stable, but what was most important changed at 66% of $n=85$ opportunities. Overall, being comfortable became most important for more patients during the study (increasing from 5% to 14%, (Chi2 4.41, $p=0.036$)), whilst there was a non-significant trend away from staying out of hospital being most important (27% to 22%).

Conclusions For frail older people, the importance of preferred care outcomes remains stable after acute illness, but the outcome ranked as most important frequently changes. Due to its stability, the level of importance ascribed to preferred outcomes may be more useful in clinical practice and advance care planning.

132 DESCRIBING DEPREScribing – WHEN ARE WE STOPPING MEDICATIONS IN PALLIATIVE CARE?

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Introduction Deprescribing is the process of withdrawal of medication with the goal of improving patient care. Research currently is in the context of polypharmacy and geriatrics, however despite its ubiquity within palliative care there is a paucity of research in this context. Anecdotally, deprescribing is performed adhoc and using 'common sense' but there appears no clear data on rational, benefit and whole numbers involved.

Aim To gather data on current deprescribing practice within palliative care, with the aim to inform our own specialty and others.

Methodology Prospectively palliative in-patient hospice and community patients had medications deprescribed recorded and the rational. This was prospectively gaining a timeline of medication stops respective to date of death.

Results Data collected from 13/3/18 to 30/06/18 with 647 medication stops of 197 differing medications. 56% (361) medication stops were due to approaching end-of-life. 15% (93) due to swallowing difficulties, 17% (109) due to rationalising medications.

The median number of days of palliative care deprescribing any medication before death is 4, with 25% being 1 day and 75% being 9 days before death. Groups were identified and individually measured, including statins (median 5 days), Beta-blockers (median 2), ACEi (median 5), anti-platelets (median 9), Warfarin/NOACS (median 5).

Conclusion/discussion By describing deprescribing current practice we outline the short timespan between deprescribing and death for medications arguably of minimal patient benefit at this point in life. The rational for stopping correlates with this postulation, outlining we are stopping the vast majority of medications due to the dying phase rather than preemptively.

133 PALLIATIVE RADIOTHERAPY IN LUNG CANCER – FUTILE OR WORTHWHILE?

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Background With timely integration of palliative care alongside oncology management, needs of patients are met in a more coherent approach challenging the misperception that there is transition point to palliative care. Therefore the project aimed to understand the timing of radiotherapy in relation to death and inform the clinical decision making regarding the appropriateness of radiotherapy for these patients.

Methods Retrospective case-note review of patient records over a 1 year period (January 2017 to January 2018) who had received radiotherapy with a diagnosis of a lung cancer.

Results 86 patient were identified and the majority had a diagnosis of lung cancer(97%) with the patients having radiotherapy to their primary lung lesion (35%), bone metastases (35%), for malignant spinal cord compression(14%) and brain metastases(9%) mainly. 36% of patients had a performance status (PS) of between 0–1, 44% having a PS of 2 and then 12% having PS3-4. Interestingly 10% of patient had no PS recorded. 32% of patients had one fraction of treatment with 67% having a fractionated regimen ranging from 3–12 treatments. 16% of patients died within 30 days having had their treatment and a further 15% within 59 days with 55% of those patients having had fractionated regimens (Range 5–12).

Conclusions This project highlights that PS is not always recorded for patient but still a key indicator on the appropriateness of radiotherapy. Given the debate about timing and then effectiveness of radiotherapy and proximity to death, a considerable proportion of patients are having a fractionated regimen before gaining optimal effect of the their treatment. Therefore PS coupled with some understanding of prognosis may help in deciding whether a single high dose fraction maybe more advantageous for the patient than a prolonged fractionation regimen in supporting their symptoms.

134 COMMUNICATION WITH PALLIATIVE CARE PATIENTS ABOUT DRIVING AND OPIOIDS

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10.1136/bmjspcare-2019-ASP.157

Background Recent changes in the law regarding liability and driving offences whilst on opioids, highlighted by the MHRA, reinforces the importance of communication about driving whilst taking medication and the law. A robust approach to communicating and documenting this information is required.

Methods The audit standard was NICE CG140: 'Opioids in palliative care: safe and effective prescribing of strong opioids for pain in palliative care of adults'. Patients seen in January 2015 in outpatients, day unit, inpatients and the community initiated on opioids or had dose titration, were reviewed. Cases were excluded if had an ECOG of 3–4. The data was analysed and presented at our clinical governance meeting. This triggered a redesign of our inpatient admission proforma. The method of documenting driving status on electronic patient records was changed and promoted. Driving safety leaflets were made available. The audit cycle was completed in June 2017.

Results Pre-implementation, 33 cases were included in analysis. 9% of cases had their driving status documented. 0% had documentation of discussion of side effects and 9% documented that the patient was informed about the consequences of driving on opioids. On re-audit, 20 cases were analysed. Driving status was documented in 50% of cases, 30% showed discussion of side effects, and 30% documented consequences of driving on opioids.

Conclusions It is the clinician's responsibility to appropriately counsel patients on risks of driving whilst taking medications, to provide 'medical defence'. Although conversations often occur, they are seldom documented and can therefore not be evidenced. Having written information to offer can provide evidence, but is no substitute for thorough conversation and eliciting comprehension. In our department, more needs to be done to educate the SPCT to ensure this is done routinely as part of the first assessment, and reviewed frequently, with changes to medications being a prompt.

135 IS PATIENT-LED FOLLOW-UP (PLFU) AN ACCEPTABLE AND EFFECTIVE SERVICE FOR HOSPICE COMMUNITY PATIENTS? A CROSS SECTIONAL COHORT OF HOSPICE COMMUNITY PATIENTS ON PLFU (LITERATURE SEARCH)

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Background The current economic climate, increasing cancer survivorship, frailty and palliative care needs has led to a focus on resources. One method being evaluated is patient-led follow-up (PLFU) as a safe, more cost-effective alternative to traditional follow-up. Evidence shows that traditional appointments do not necessarily coincide with patient need or symptoms, and the volume of reviews limits the ability to respond to more urgent needs. Studies in rheumatology and breast cancer patients have demonstrated that nurse-led telephone helplines, education sessions, and open-access in 'low-risk' groups resulted in significant reductions in healthcare utilisation without compromising clinical or psychological wellbeing.