Results Low fluid intake was significantly associated with increasing thirst severity (Beta=−0.223, p=0.037). Increasing morphine dose also corresponded with increasing thirst (Beta=0.250, p=0.025). Oral care regimes were present in n=39 (43.3%) and their use was associated with higher thirst scores (Beta=−0.200, p=0.051). Daily fluid intake was 0–499 ml in 27 (30%); 500–799 mls in 42 (46.7%); and >800 mls in 21 (23.3%) participants. Lower oral daily fluid intake was associated with shorter median survival (800 mls=172 days, p=0.004). Oral fluid was an independent predictor of survival following adjustment with cox regression.

Conclusion In this advanced cancer sample, oral fluid intake was a statistically significant predictor of survival. Patients with fluid intake of <800 mls/day had higher thirst and shorter survival compared to those drinking larger volumes. Future studies can aim to improve mouth care and fluid intake in patients drinking <800 mls/day, to examine if this improves clinical outcomes.

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25 EVALUATION OF A MULTI SITE SPECIALIST PALLIATIVE CARE AT HOME INTERVENTION

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Background The Midhurst Macmillan Specialist Palliative Care at Home Service was founded in 2006 to improve community-based palliative care provision. Principal components include; early referral; home-based clinical interventions; close partnership working; and flexible teamwork. Following a successful introduction, the model was implemented in six further sites across England. This article reports a mixed methods evaluation of the implementation across these ‘Innovation Centres’.

Aim To assess the process and impact on staff, patients and carers of providing Macmillan Specialist Care at Home services across the six sites.

Methods A longitudinal, mixed methods research design. Data collection over 15 months (2014–2016) included: Quantitative outcome measures:- Palliative Performance Scale [PPS]; Palliative Prognostic Index [PPI] (n=2,711); Integrated Palliative Outcome Scales [IPOS] (n=1,157); Carers Support Needs Assessment Tool [CSNAT] (n=241); Views of Informal Carers – Evaluation of Services [VOICES-SF] (n=102); a custom-designed Service Data Tool [SDT] (n=88). Qualitative data methods:- focus groups with project team and staff (n=32 groups, [n=190 participants]), and, volunteers (n=6 groups, [n=32 participants]). Quantitative data analysis – SPSS vs 21; Qualitative data – thematic analysis.

Results Comparison across the different sites revealed contrasting modes of implementation. PPS, PPI and IPOS data exposed disparity in early referral criteria, complicated by conflicting interpretations of palliative care. The qualitative analysis, CSNAT and VOICES-SF data confirmed the value of the Macmillan model of care but uptake of the specialist home-

based clinical intervention component was limited. Significant findings included better co-ordination of palliative care through project management and a single referral point and multi-disciplinary teamwork including leadership from consultants in palliative medicine, the role of health care assistants in rapid referral, and volunteer support.

Discussion Specialist palliative care teams enhance the quality of palliative and end of life care in the community setting and should form an integral part of future policy in this area.

26 DESIGNING SAFER SERVICES FOR PATIENTS NEEDING PALLIATIVE CARE IN GP OUT OF HOURS SERVICES: A NATIONAL ANALYSIS OF PATIENT SAFETY DATA TO IDENTIFY PRIORITIES FOR SYSTEMS IMPROVEMENT

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Background Patients receiving OOH palliative care are at increased risk of unsafe care (Mazzocato & Stiefe, 1997; Dietz *et al.* 2010). The identification of improved ways of delivering palliative care outside working hours is a priority area for policy makers. (Best *et al.* 2015) To allow service redesign to provide safer care for patients, a means of identifying priority areas for systems improvement is needed.

Aims

- Explore the nature and causes of unsafe care delivered to patients receiving palliative care from primary care services outside normal working hours.
- Review literature to identify existing interventions addressing causes of unsafe care.
- Engage a stakeholder group in a large healthcare organisation in Wales to identify priority areas within the out-of-hours GP service.

Methods We characterised patient safety incident (PSI) reports submitted to the National Reporting and Learning System, using codes to describe what happened, underlying causes, harm outcome, and severity of harm. Exploratory descriptive and thematic analyses identified factors underpinning unsafe care. Results of this analysis informed a scoping review of the literature (Tricco *et al.* 2016), and findings were presented as a driver diagram (a one-page summary of where and how to improve the system).

Results 1072 reports of suboptimal care, described: medication-related issues (n=613); access to timely care (n=123); and non-medical management of pressure ulcers or urinary catheters. (n=102). Almost two thirds of reports (n=695) described harm with outcomes including increased pain, distress and dying in a place not of their choosing. A scoping review identified interventions to improve confidence of staff around end of life medications, improve advanced care planning and improve documentation across providers. The driver diagram facilitated discussions amongst stakeholders (lay and professional) to contextualise findings and identify priorities for service improvement.

Conclusions Analysis of PSI reports and associated literature review can be used to inform service improvement initiatives.