

Results The cause of death for the vast majority of families was accident or illness. Death of a father was experienced by 41% of CYP. Six months after the end of support, improvements were shown for the following areas: peer relationship difficulties, emotional difficulties, behavioural difficulties, overall stress and impact of difficulties on the child's life.

Conclusions CYP with multiple needs who were supported through this programme experienced fewer mental health difficulties in the medium-term. Tailored psychosocial support can promote adaptive developmental outcomes after bereavement and it can be particularly helpful for CYP who face school or social adjustment difficulties.

Free papers 4–6 | End of life care in hospitals

4 BUILDING ON THE BEST QUALITY IMPROVEMENT PROGRAMME – SUPPORTING IMPROVEMENTS IN END OF LIFE CARE IN ACUTE HOSPITALS

A Hayes, I Carey, R Hill, M Kennedy, K Nash, D Wakefield, M James, L Ison, D Wood, C Henry, P Hayes. *Hospice UK, Guys and St Thomas' NHS Foundation Trust, Macmillan Cancer Support*

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Background Building on the best (Botb), a 24 month partnership quality improvement (QI) programme delivered by Hospice UK aims to improve the quality of end of life care in acute hospitals. The programme design uses a collaborative methodology with flexibility for teams to work in alignment with local priorities.

Methods Four Improvement areas were prioritised for the collaborative by a clinical reference group: outpatient setting, communication of transfer, shared decision making, pain and symptom management. Teams received structured improvement coaching, monthly Webex, and the development of a community of practice. In addition to headline outcome and process measures, key outputs include teams' improvement case studies sharing impact and learning.

Results Botb currently encompasses 13 Trusts across England and Scotland. The collaborative has had 9 face to face community of practice learning events plus 18 monthly webinars. An example case study from Guy's and St Thomas' outlines testing on an acute admissions ward of a symptom observation chart and care planning guide for dying patients. A working group including the clinical lead and matron for acute medicine identified alignment of a local priority with Botb. Staff surveys and clinical audit demonstrated a positive impact on care planning and delivery. A positive feedback loop strengthened staff pride in the work of the ward. Success was boosted by a focus on influencing culture and delivery of flexible on the job education. These staff will now champion and support roll out within elderly care wards. The materials have been shared within the community of practice.

Conclusions Building on the best programme collaborative enables improvements by embedding systematic QI change methodology, supporting a mature community of practice to democratise knowledge and deliver results within complex systems by peer to peer learning.

5 IMPROVING CARE FOR PATIENTS WHO HAVE CLINICAL UNCERTAINTY OF RECOVERY: THE LENS OF ACUTE ADMISSIONS

C Hayle, A Jayachandran, H Kerss, A Waites, A Hopper, V Connolly, A Hayes, C Henry, S Shouls, G Purewal. *Wirral University Teaching Hospital Foundation Trust, NHS Improvement, NCPC/Hospice UK, Guy's and St. Thomas' Foundation Trust*

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Background Acute Trusts are an important provider of care for patients who may be in their last months of life; emergency admission may indicate underlying clinical decline. Acute admission processes are not generally designed to manage care for this group.

Wirral University Teaching Hospitals NHS Foundation Trust participated in an ECIP-funded End of Life Care Project in 2016/2017 to improve quality of care for this group of patients.

Method An acute physician and a consultant in palliative medicine reviewed 26 deceased patient records using a method designed to uncover clinical system issues and to create a 'common language' between the specialities. This review included focus on patients with clinical uncertainty of recovery. An acute and an elderly care physician carried out 'Plan Do Study Act' tests of change using the AMBER care bundle in the AMU and an elderly care ward for a total of 26 patients.

Results Qualitatively, the review showed that doctors struggled to recognise patients at risk of dying and viewed palliation as an 'all or nothing' approach to care. Tests of change showed an improvement from 75% to 100% recognition of expected deaths; 15% to 42% awareness of what is important to the patient; 53% to 78% preferred place of care recorded; 85% record of what family feels is important. 96% of patients had ceilings of treatment documented. 62% of patients were discharged.

Discussion The numbers are small. Qualitative feedback is initial conversations in AMU set the scene for the whole admission. Feedback was positive however time implications at the 'front door' can present a challenge. Redesign of the process to 'protect' time may be required.

Conclusions This is an important topic. Early recognition of clinical uncertainty, honest conversations can set the scene for the whole admission potentially resulting in improved patient and staff experience.

6 END OF LIFE CARE ON ACUTE HOSPITAL WARDS: THE IMPORTANCE OF DIALOGUE AND DECISION MAKING

Fiona MacCormick, Catherine Exley, Paul Paes, Julian C Hughes. *Newcastle University*

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Background shared decision-making (SDM) has been recommended as the gold standard for decision making in end of life care when decisions may be complex and involve multiple possible courses of action. The perspectives of patients, relatives and staff members about decision making at the end of life on hospital wards have been little researched in reaching this recommendation. This presentation analyses the practice

of end of life care decision making on hospital wards from the perspectives of patients, relatives and healthcare staff.

Methods data collection comprised ethnographic non-participant observation of 280 hours on two acute hospital wards and 36 semi-structured interviews with staff members, relatives, and patients thought to be approaching the end of life. Data were analysed using a constructivist grounded theory approach.

Results decision making is an important part of end of life care. However, this research suggests that decision making *per se* is not the priority of patients and relatives. Instead, the crucial thing is taking part in discussion and being kept informed by staff members. Ongoing dialogue to establish and maintain a shared understanding between healthcare professionals and those who receive care is often the real priority for patients and relatives.

Conclusions discussion between patients, relatives and healthcare professionals must be prioritised in clinical practice. Without shared understanding, gained through ongoing dialogue, shared decision making is impossible. Senior healthcare staff must demonstrate such behaviour to their junior colleagues. An environment that supports ongoing dialogue is also needed. Recommendations for clinical practice and future research will be made.

Free papers 7–9 | Palliative care in the community I

7 REALIST EVALUATION OF A COORDINATED END-OF-LIFE CARE SERVICE

Nikolaos Efsthathiou, Anna Lock, Suha Ahmed, Linda Parkes, Susan Law, Tammy Davies. *University of Birmingham, Sandwell and West Birmingham Hospitals NHS Trust*

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Background Dying at home or in a hospice are the most preferred options among the population in England. However, the lack of co-ordinated End-of-Life (EoL) services means that most patients will not die in their preferred place of death. Following the development of a new service that consisted of a single point of contact (hub) to coordinate care, EoL facilitators and rapid response teams, we developed an hypothesis that the provision of co-ordinated EoL services would increase supporting patients being cared or dying in their preferred place. Evaluating this new service would be challenging using traditional research methods.

Methods This mixed-method study used a realist evaluation approach to examine ‘what works for whom, how, in what circumstances and why’. Multiple data were reviewed, including activity/performance indicators, observations of management meetings, documents and 29 individual interviews with the service providers and users. Framework analysis was used to synthesise the findings.

Results During the first year of operation 1000 patients were registered on the service register. 99% of callers had a service contact within one working day of urgent referral and transfers to hospice care if required were organised quickly.

Advanced Care Planning progressively increased through the year and 70% of patients received their preferred choice of care and 64% were able to achieve preferred place of death. The mechanisms identified as driving forces of the service included: one point of access; coordinating services across providers; recruiting and developing the workforce; understanding and clarifying new roles; and managing expectations.

Conclusions The use of realist evaluation allowed us to understand how specific preconditions made some outcomes more likely to occur. The identified mechanisms appear to have improved coordination of EoL services, communication between service providers, and service user’s experiences; this was made possible through challenging conceptions about pre-existing services and traditional roles.

8 ‘PALLIATIVE CRITICAL CARE’: EVOLUTION OF A HOSPITAL PALLIATIVE CARE SERVICE IN THE INTENSIVE CARE UNIT SETTING

HK Crispin, K Haynes, A Cran, E Murphy, R Chambers, CL Davis. *University Hospital Southampton NHS FT*

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Introduction A collaborative approach between the General Intensive Care Unit (GICU) and the Hospital Specialist Palliative Care Team (HSPCT) can promote optimisation of patient physiology and symptom burden, aid clinical decision making, expedite transfer or discharge plans and provide additional support to patients, families and staff.

In 2014 we created 4 hours of intensivist time for palliative care and developed joint working, named ‘Palliative Critical Care’. In 2016 a weekly combined Palliative Medicine and GICU ward round was established. Here, we detail the impact of this intervention on the activity of the HSPCT and associated patient outcomes.

Methods A retrospective review of HSPCT records of GICU referrals between March 2013 and March 2017.

Results There has been a sustained increase in referrals from GICU to the HSPCT since 2013; 6 in 2013/2014, 57 in 2014/2015, 99 in 2015/16, 89 in 2016/17. Timeliness of referrals has improved. The proportion of patients who died before HSPCT review has reduced, 15.8% in 2014/2015, 7.6% in 2015/16, 10.1% in 2016/2017. Collaborative working has supported patient preferences, enabling direct discharge from GICU to home or hospice in a number of cases (0% prior to intervention, 13.3% in 2014/2015, 2% in 2015/2016, 6.4% in 2016/2017). Over the years, of those transferred to wards 12.5%–22% are discharged home and 13.6%–20.8% to a hospice. The majority of patients seen by the HSPCT are kept under review whilst in hospital, even if discharged from GICU (66.0%–89.7%).

Patient and family feedback has been ‘excellent’.

Conclusion This intervention has resulted in sustained improvements in collaborative working between the GICU and the HSPCT as indicated by the number and timeliness of referrals. It has supported patient preferences, enabling a significant proportion to be discharged either to home or hospice, including some directly from GICU.