

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.

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

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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

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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.