**Problem** While renal teams are well practiced at discussing extension of life through renal replacement therapy, discussions about advance care planning and end of life care are more varied, with a smaller body of evidence and data to draw upon.

**Purpose** To evaluate the standard of advance care planning and end of life care provision in our large renal service we examined when, where and how patients with established renal disease died during 2016, seeking the views of bereaved family members or friends.

**Design** We identified patients under our care with established renal disease on RRT for more than 90 days who died in 2016 (n=125). We identified the location, date and cause of death via a variety of approaches. In those who died following planned treatment withdrawal, we assessed approaches to advance care planning by looking for evidence of components of the Gold Standard Framework in clinic/ review letters and inpatient notes. We sought the views of bereaved carers and relatives via postal questionnaire, and by telephone interview where agreement was provided.

**Findings** Of 125 patients who died in 2016, 63 were undergoing haemodialysis, 11 were on peritoneal dialysis, 20 had a functioning renal transplant, and 31 died following withdrawal of treatment.

Causes of death was identified in 106 patients; treatment withdrawal being most common (24.8%), followed by infection (19.2%), cardiovascular disease (17.6%), malignancy (4.8%), cerebrovascular disease (3.2%), and other (15.2%). Mean survival from day of withdrawal of RRT was 9.7 days. Patients who withdrew from treatment were twice as likely to die at home versus haemodialysis patients, 5x more likely than those on peritoneal dialysis, and 1.5x more likely than those with a transplant. Evidence of advance care planning in those who withdrew from treatment was identified in 51.6% of cases in the 7 days before death, 83.9% in the last 8-30 days of life, and 19.6% in the last 31 days to 1 year of life.

25 of 125 postal questionnaires were returned. 64.0-76.0% of next of kin were satisfied with involvement in decisions, the standard of communication, and that their next of kin was treated with dignity and respect, but only 44.0% felt that their next of kin had the opportunity to express their wishes at the end of life. We also found that even several months after bereavement, many relatives still had unresolved issues causing distress, and a number requested formal bereavement support.

**Conclusion** We found that significantly more patients under the care of our team died following treatment withdrawal than published nationally. We found that the mean time until death following withdrawal of treatment was 9.7 days, and that a decision to withdraw from treatment meant that patients were more likely to die at home. Quality of advance care planning was assessed in accordance with recognised guidelines and found to be good overall. A need for earlier initiation of advance care planning was identified. Perhaps most importantly, we found that the bereaved still had distressing unresolved concerns several months after death.

**Relevance** We developed a body of evidence which is useful in counselling those who are considering withdrawal of RRT; particularly our own data on survival from withdrawal of treatment of 9.7 days, and that those who have a planned withdrawal of treatment are more likely to have a planned death at home. We also found that although the standard of end of life care provided to patients was very good that there was room for improvement and that the bereaved were not supported sufficiently – an important consideration and further challenge to how we should approach end of life care.