

**Results** 30–40 people attending each month. Volunteers and people attending have been hugely positive and tell us the sessions provide a gentle introduction to the hospice. Many welcome using outdoor space in the summer.

Comments include: “Concerned for the future and outgrowing the space as the sessions are so popular”; “Thoroughly delighted with our first six months. We are learning that singing and music are an essential element”; “Some enjoy lunch afterwards. Not always so easy for them elsewhere”; “Carers benefit from having the opportunity to speak to other carers and volunteers”; “Feels safe, felt hugged by the experience”.

**Conclusion** These sessions are very popular and the venue has not put people off attending. It has created an opportunity for people to see and feel the hospice environment, creating opportunities for people to gain better access to our services.

**P-74** **KNOWLEDGE IS POWER? WHY COMMUNITY-CENTRIC LEARNING AND EXPLORATION OF DEATH, DYING AND LOSS COULD HELP TACKLE INEQUALITIES IN DEATH SYSTEMS**

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**Background** The public health call for public engagement around death, dying and loss has led to initiatives around community engagement to encourage greater community involvement in end of life. One part of this is public education and death literacy, the idea that we must generate knowledge, skills and confidence for people about the end of life. While there are many opportunities, this can also create a risk of only sharing knowledge that we know of as institutions, which may reproduce inequality or significant knowledge gaps.

**Aims** This presentation will outline how at St Christopher's we are supporting a type of learning experience and opportunity for members of the public that focuses on people with lived experience generating and sharing knowledge, and community members deciding what knowledge and skills they'd like to share and acquire.

**Methods** We have focused on using Community Development methods and strengths-based approaches to death literacy, including reframing public education into community learning and development opportunities. Our methods focus on peer-peer learning and exchange, and the assumption people have knowledge to share, rather than possess a knowledge deficit. We work in community settings with people with lived experience who become peer learning facilitators and engage in equitable exchanges based on reciprocity rather than hierarchy, to attempt to redress the balance of knowledge about the end of life and inequities of knowledge that exist. This also benefits St Christopher's as we reflect on greater change and challenge we must enact.

**Results** To date the learning courses, workshops and initiatives have created an opportunity for hundreds of people to explore death, dying and loss and to develop skills, confidence and capacity. This includes young people, people receiving support from local charity and voluntary sector, for example, people with learning disabilities, and different faith groups.

**P-75** **'THE GRIEFCASE': CREATING OPPORTUNITIES WITHIN COMMUNITIES TO TALK ABOUT DEATH AND DYING, USING TOOLS DESIGNED TO OPEN DISCUSSION**

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**Background** Globally the phrase 'death literacy' is becoming increasingly recognised, defined as 'knowledge about and understanding of the death system' (Primary Health Tasmania. Learning about death literacy, with Dr Kerrie Noonan. [internet]). Greater awareness about death and dying has been shown to reduce anxieties and enable a better experience around death. However, we struggle to engage with communities in a meaningful way to be a more death literate society (Sallnow, Smith, Ahmedzai, et al. *Lancet*. 2022; 399(10327):837–884). The Griefcase is an initiative inspired by the 'death-positive movement' (Koksvik & Richards. *Mortality*. 2023; 28(3): 349–366). It aims to facilitate thought-provoking conversations about death and dying. This includes both practical and emotional aspects at end-of-life, encouraging decisions to be made sooner rather than later (Marie Curie et al. *Creating a death literate society*. 2022). We created a 'toolkit' which is contained within the 'Griefcase', a physical case. Bespoke Griefcases include kin-aesthetic activities and cue cards to help encourage conversations and learning about end-of-life matters. These sessions are held in physical spaces called 'Departure Lounges', using the analogy of travel, connection and change to initiate engagement.

**Aim** To create, evaluate and refine an accessible bespoke toolkit for groups to use, encouraging death literacy learning including health (Mitchell, Nyatanga, Lillyman, et al. *Int J Palliat Nurs*. 2021; 27(7):352–360) and education settings.

**Methods** Phase 1 (Nov 2022 – Feb 2023). Stakeholder consultation, literature review. Phase 2 (Feb 2022). Pilot initial session using hospice workforce, collation of feedback. Phase 3 (April 2023 – May 2023). Second pilot involving staff, patients and their loved ones, collation of feedback. Phase 4 (July 2023 – ongoing). Six-month pilot with the community.

**Results** 25 people attending. Mode of delivery – face-to-face at hospice. Patients = 3, family member = 2, staff = 10, volunteers = 10. Evaluation forms (12 completed) with initial findings of (i) Increased confidence in conversations around death and dying (ii) Increased confidence in discussing practical issues sooner, (iii) Awareness of choices.

**Conclusions** Creating opportunities to engage communities' interest in death literacy (Noonan, Horsfall, Leonard, et al. *Prog Palliat Care*. 2016; 24(1): 31–35) will build capacity for both future caring and prevention of inappropriate treatment by building confidence in communities to make informed choices.

**P-76** **THE MAKING MEMORIES AND LASTING LEGACIES (MMELL) PROGRAMME: A PERSONALISED AND ART-BASED APPROACH TO MORE MEANINGFUL ADVANCE CARE PLANNING DISCUSSIONS**

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**Background** Storytelling has been established as an effective tool for supporting people with end-of-life care decision making (Youell, Ward. *ehospice* [UK ed]. 2016; Jan 4; Watson, Voss, Bloomer. *Res Pract Persons with Severe Disabilities*. 2019; 44(4):267–79). Through a process of personal evaluation and reflection, patients and their loved ones can come to terms with life-changing diagnosis and death (Youell, Ward, 2016; Watson et al, 2019). We observed that parts of our workforce had difficulties initiating and having important advance care planning (ACP) discussions with patients and their loved ones. We developed a Making MEMories and Lasting Legacies (MMELL) programme as a less clinical, neutral and personalised tool for promoting ACP discussions. With art-based therapies and personal narratives at its core, MMELL seeks to help the hospice workforce, patients, and their families to have meaningful ACP discussions for a better end-of-life care experience.

**Aims** To refine the MMELL programme and evaluate its impact on meaningful ACP discussions.

**Methods** Phase 1. Literature review, stakeholder consultation and hospice-wide roll out of the MMELL programme, development of feedback forms. Phase 2. Data collection and analysis (i) patient and family uptake of MMELL programme, (ii) clinical notes for ACP discussions before and after MMELL programme introduction, (iii) service user feedback forms. Phase 3. Programme refinement, expansion of the offer to the wider hospice community, stakeholder consultation, dissemination of preliminary findings.

**Preliminary results** Since May 2022, we have created 15 fingerprint jewellery items, nine hand casts, conducted seven family workshops, and recorded 10 life stories. Feedback forms show that patients enjoy the process of using art-based, creative methods to express what is important to them in ACP discussions. Families have also expressed that it has helped them to come to terms with their loved one's impending mortality.

**Conclusions** MMELL has improved uptake of ACP discussions for people accessing the hospice services. This service has emerged as a personalised offer during initial clinical assessments. Our MMELL programme shows that art-based methods of expressing what matters most are accessible, inclusive and personal (Watson et al, 2019; Jerwood, Allen. *BMJ Support Palliat Care*. 2022;12:A1-A2).

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#### EARLIER CONVERSATIONS ABOUT THE FUTURE: HEALTHCARE PROFESSIONALS BROACHING HOSPICE CARE AND OTHER END-OF-LIFE ISSUES

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**Background** Early conversations about the future benefits people with life-limiting conditions. Timely admission to a hospice service often provides the best outcomes (Brighton & Bristowe. *Postgrad Med J*. 2016; 92(1090): 466–470). However, patients are frequently not referred until near to death (Casarett & Quill. *Ann Intern Med*. 2007; 146(6): 443–449): 'at the beginning of the end.' There are multiple reasons for this. Healthcare practitioners (HCPs) may not want to relinquish their patients or to acknowledge that they cannot intervene to prolong the patient's life further.

Meanwhile, patients and families who received hospice care would have liked to have more information about the hospice when the illness was labelled terminal (Weckmann, *Family Practice Manage*. 2008; 18–22.). There are often negative connotations associated with the word 'hospice' (Friedman, Harwood, Shields. *J Palliat Med*. 2002; 5(1):73–84; Matthews, Peters, Lawson. *Health Mark Q*. 2017; 34(1): 48–61) which feeds into practitioners' reluctance to bring up the subject. We address these challenges by focusing on approaches and 'what words to use' when broaching conversations about referral to a hospice.

**Aim** Our aim is to explore the language used by HCPs who refer to a hospice service and the challenges in making earlier referrals. We identify specific language practices for encouraging these conversations.

**Method** We are interviewing HCPs (N=25) who talk to patients with life-limiting conditions and their family members about planning for the future, including referrals to a hospice. These HCPs include hospital consultants, GPs, occupational therapists, nurses and psychiatrists. Interviews are subjected to inductive thematic analysis based on six principles developed by Braun and Clarke (2006). Analysis is assisted by NVivo data analytic software.

**Results/conclusions** Our study is in progress. So far, thematic analysis has identified key signs of patient readiness for conversations, techniques for encouraging patient engagement (e.g., hypotheticals, framing around control), specific language and conversational approaches for starting a dialogue, ways into broaching these conversations through checking existing patient understanding, ideal timings for beginning these discussions, and supporting HCPs' confidence in having these conversations through training.

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#### PALLIATIVE COMMUNITY NURSES' LIVED EXPERIENCES WHEN COMPLETING ADVANCE CARE PLANNING FACE-TO-FACE COMPARED TO TELEPHONE

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**Background** COVID-19 changed healthcare working practices. Communication with patients and their families moved from face-to-face to primarily remote contact; communication skills had to adapt.

**Aim** To understand palliative community nurses' lived experiences when completing advance care planning (ACP) face-to-face, compared to telephone.

**Method** Using reflective stories, the author attempted to understand what influences the way ACP is raised both face-to-face and over the telephone. Themes were then compared to understand if one approach is more effective. University and organisational ethical approval was obtained prior to commencing the study. Written consent from participants was obtained prior to the interviews being undertaken. The sample consisted of community nursing team staff, with ward-based staff and those with less than two years' organisational experience excluded.

**Results** Seven semi-structured interviews were conducted, three face-to-face and four conducted virtually over a meetings platform. Face-to-face ACP is preferred, as the telephone can be a barrier to the discussion, with a lack of non-verbal prompts