Aims To understand the correlation between the patients who had been remembered with in memoriam donations and their personal circumstances/support from us. To identify if in memoriam fundraising could be at risk. To align care ambitions and fundraising potential in our next strategy.

Methodology Donation information from our fundraising database was exported. It was traced back to patient records by a specialist research colleague. They overlaid the donation information with a set of pre-determined patient criteria including age, illness, team contact, time on caseload and place of death. We also looked at the time-period loved-ones donated for, after their loss.

Results We will use this research to:

- Deepen the relationship between our clinical teams and fundraisers.
- Inform our future financial planning, aligning it with anticipated care-need trajectories.
- Invest hospice resources in areas which are likely to support our financial sustainability.

Conclusions Most in memoriam donations are for people who have died from cancer and stayed on our Inpatient Unit. However, the giving behaviour of loved ones who have lost someone to other illnesses is different, they are giving less, for shorter periods. We must incorporate these insights into our future plans.

Results Interview transcripts provide a rich narrative of participants’ direct and indirect experiences. Data analysis is in progress and findings will be presented at the Hospice UK conference.

Conclusions This project develops evidence-based explanations of ‘what worked for whom’ during the first year of implementing the service redesign at Dorothy House Hospice. Improved understanding of the contexts and mechanisms of change within hospices could help to inform future implementation projects.

P-230 SERVICE AND PATHWAYS DESIGN IN A HOSPICE SETTING

Konstantina Chatziargyriou, Natalie Carroll-Woods, Sarah Fidler, Megha Jain, Sophia Monastirioti, Andrew Wigley. Princess Alice Hospice, Esher, UK

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Background Continuous quality improvement requires commitment to constantly improve operations, processes, and activities (Varkey, Reller, Resar. Mayo Clin Proc. 2007;82(6):735–9). Clinical pathways allow us to reduce variation, improve quality of care, and maximise patient outcomes (Lawal, Rotter, Kinsman, et al. BMC Med. 2016;14, 35). We believe in continuous improvement, and recognise that one of the biggest barriers to delivering even better care and support is the overall design of our frontline services and the processes that deliver those services.

Aims To review the design of our service user touch points from the point of referral to the hospice until completion of bereavement support. To deliver service design and pathways that create an optimum, inclusive service user experience fully involving the user to choose their services and support. To optimise the use of resources across the organisation, improving the efficiency of pathways, removing duplication and silo working.


Results Development of an Organisational Service Design identified pathways to be reviewed whilst customer engagement work provided context. Three clinical pathways were redesigned: Referral to the Hospice; Bereavement; Pre-bereavement/Carer Support. In-house team was skilled in Lean Principles and tools, service and pathway design.

Conclusions Pathways are crucial to our ongoing pursuit for optimal care, seamless navigation and person-centred experience. By linking evidence to practice (Rotter, Kinsman, James, et al. Cochrane Database Syst Rev. 2010 Mar 17;(3):CD006632), our approach allowed us to develop the skills and a structured way to continuously review and improve our services.