lower levels of ACP in people from Black, Asian and Minority Ethnic (BAME) communities. BAME groups are also more likely to desire invasive medical interventions, regardless of prognosis and impact on quality of life. Little is known about how the model of resuscitation decision-making fits with the social, cultural and religious values and beliefs of BAME groups. Evidence also suggests that health care professionals (HCPs) report a lack of confidence in having culturally appropriate discussions with BAME patients and their families. Equipping professionals to be more confident about such ACP discussions with BAME patients may lead to achieving patient preferences.

Aims With a focus on making decisions about resuscitation, this study explores professional views and experiences of ACP with patients from BAME backgrounds. It aims to identify barriers and enablers and person-centred outcomes to such discussions and provide evidence for training professionals.

Methods Thematic analysis of qualitative semi-structured interviews with HCPs across primary, secondary and tertiary care in Leicester, including GPs, hospital doctors and nurses.

Results There was an emphasis on the significance of building rapport, the timing of discussions and navigating communication barriers. Barriers to decision-making included: patients' and their families understanding of both prognosis and resuscitation; and differing values amongst generations of migrants. Professionals struggled with how to find a balance between acting in a non-discriminatory way whilst respecting cultural differences. Most HCPs highlight the need for further training and/or support.

Conclusion There are significant barriers for HCPs when discussing resuscitation decisions with people from BAME communities. This increases the complexity of navigating ACP and achieving patients' preferences. HCPs would benefit from further training and support.

P-16 | **CONVERSATIONS ON LIVING AND DYING: FACILITATING ADVANCE CARE PLANNING FOR OLDER PEOPLE WITH FRAILTY**

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Background Older people living with frailty (older people) often receive suboptimal end-of-life care (Lloyd et al., 2016). Frequently under- or over-treated, older people experience inappropriate hospital admissions and procedures (Houben et al., 2014; Hunt et al., 2014). Most die in hospital despite 81% wishing to die at home (Office for National Statistics 2016). Advance care planning (ACP), a structured conversation between professionals and someone nearing the end-of-life, enables people to discuss and document what matters to them regarding their future care (Thomas & Lobo, 2011) Facilitating informed decision-making regarding ACP means people are more likely to receive person-centred end-of-life care (National Council for Palliative Care, 2011). Multiple challenges mean that ACP is relatively uncommon for older people (Musa et al., 2015; Pollock & Wilson, 2015). Consequently, priorities are often not discussed prior to significant deterioration (Sharp et al., 2013). leading to crisis decision-making which older people may not have capacity for (Clegg, 2013). Current initiatives encompass aspects of ACP.

However, there is no systematic, agreed format or training for health and social care professionals (professionals) that supports older people to articulate their broader end-of-life wishes on an ongoing basis (Brinkman-Stoppelenburg et al., 2014; Johnson et al., 2015; Weathers et al., 2016).

Aims This four-phase study aims to develop a relevant ACP intervention in collaboration with older people, their carers and professionals. Phase one, presented here, aims to establish current evidence regarding the components and implementation of ACP for community-dwelling older people, and use this to develop a theoretical model which will underpin the remaining study phases.

Methods An integrative review will be conducted using CINAHL, Embase, Ovid Medline, PsycINFO, and NHS Evidence databases, grey literature, and hand-searching. Paper selection will be verified by the research team and critically appraised using relevant systematic tools. Whittemore and Knafl's (2005) method will be used to develop an integrated, theoretical model. This will include data mapping against COM-B, a model of behaviour change often used in intervention development, to identify relevant target behaviours. (Michie et al., 2011)

Results and Conclusions The study began in January 2017. Phase one is currently underway and its results, conclusions and recommendations will be presented at this conference.

P-17 | **WE DON'T TALK ANYMORE – IMPROVING COMMUNICATION OF ADVANCE CARE PLANNING ON DISCHARGE FROM HOSPITAL**

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Background Research shows that more than 30% of hospital inpatients over 85 may die within the next year. Advance Care Planning (ACP) has been shown to increase achievement of preferred place of death and decrease unnecessary hospital admissions in the last year of life. Accordingly, local Elderly Care discharge summaries include a mandatory ACP section. As part of the 'Building on the Best' quality improvement programme, our Trust is focusing on improving handover of ACP information as people move between healthcare settings.

Aims To determine best practice in sharing information on ACP between hospital and community services

To review current transfer of information about ACP on discharge from an Elderly Care ward.

Method We reviewed relevant literature about transfer of information on discharge summaries and retrospectively audited 30 discharges from an elderly care ward. We recorded inclusion of key ACP topics, such as cardiopulmonary resuscitation status and preferred place of death, as well as deaths within the subsequent six months.

Results Literature review highlighted importance of high quality information in discharge summaries to decrease inappropriate readmission in last year of life. No discharge summaries audited included any information in the 'mandatory' ACP section

50% documented DNAR status separately

53% of patients were readmitted to our hospital within six months

30% died within six months.

Conclusion Although a significant proportion of patients on elderly care wards are in the last year of life, there was minimal sharing of ACP information with community services. The 'process' change of including a mandatory ACP section on discharge summaries has not improved outcomes. Future quality improvement will focus on staff engagement and raising awareness of the importance of ACP. We have developed a blended learning programme to support the implementation of routine identification of patient in their last year of life in multi-disciplinary meetings, thereby triggering ACP and communication across organisations.

P-18   ADVANCE CARE PLANNING ACROSS ENGLAND AND WALES

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Background Last year Byw Nawr commissioned the research and development of a new public facing website. The resource drew on expertise from Dying Matters, Hospice UK, the Digital Legacy Association and a number of healthcare professionals.
Aim The aim of the website is to make Advance Care Planning accessible to the general public though a clear information architecture and videos.
Methods By working collaboratively, a website containing over 10 000 words was created in English. It was then translated into Welsh. A small stakeholder group provided ongoing advice and a wider stakeholder group was called upon at the end of the website's build for review.
Results and Conclusion Later this year Byw Nawr will evaluate the impact of the resource. It is hoped that the results will be displayed as a poster or through a presentation at the Hospice UK conference in November.

P-19   HIGHLIGHT 5 – 5 MINUTES TO DELIVER MESSAGES ON PATIENT CARE

Charles Hyland, Susan Schofield, Paula Powell. *Willowbrook Hospice Merseyside, UK*

At any one time in a health organisation there are important messages on patient care that staff need to be informed of but disseminating that information such that all staff see and hear those messages and respond appropriately is very challenging. E-mails, team briefs, written policies and procedures may be left unread and even verbal information can be missed by some. HIGHLIGHT 5 describes an initiative developed to improve communication and ensure that as many staff as possible hear important messages about patient care. Each week has a defined topic that can be covered in 5 min by a member of the clinical staff. The ward manager and practice development nurse plan the topics in advance but all staff can contribute ideas. Examples so far are cost effective prescribing of laxatives, opioid brand prescribing and introduction of a sepsis care bundle. The Highlight topic is delivered at every handover throughout the seven days so all members of staff as far as possible are aware. Feedback is very positive from staff who feel that it is very effective at ensuring important messages are highlighted.

P-20   RELEASING TIME TO CARE – A BOARD AT A GLANCE!

Augustina Ebiredelu, Edith Simfukwe, Michelle Hatcher, Christine Johnson. *Garden House Hospice Care, Letchworth Garden City, UK*

Background Devising a new patient information board for the nurses' office was to improve the efficiency of the nurse in charge and reduce time spent on handover. Due to a variety of shift patterns worked on the in-patient unit, handovers became a long and laborious task that would occur up to eight times a day to cater for all the staff starting their shifts at different times including MDT. This in turn meant that the nurse in charge would be spending long periods out of their day handing over the same information to different staff which took them away from being able to carry out patient care and take charge of their shift.
Aim Decrease the time of handovers by having useful information available at a glance and to reduce the risk of delays in (OACC) Outcome Assessment and Complexity Collaboration assessments and relevant tasks being carried out by the designated date.
Method HotBoard company was contacted to devise and design a bespoke information board to meet the requirement of the information necessary to reduce handover times. Between the nursing and medical team, a collaborative effort was made to decide what information was to be included on the board to streamline the handovers. The designers incorporated the hospice care logo and colour scheme to give a unified look and the designs were regularly amended until everyone was satisfied with the information on the board.
Results There has already been a marked improvement in the effectiveness of handovers. There are two handovers which take 30 min each. Bank staff working short shifts can read the information rather than take a nurse away from caring for patient to carry out handover. Team members can quickly check the board for OACC and dates that assessments are due for patients and this has noticeably reduced the delays in these being completed for patients.
Conclusion We are due to carry out an audit soon to evaluate the time efficiency of the board and how delays have been reduced and hour many hours have been released for nurses to spend with patients per nurse.

P-21   WHAT DOES OUR COMMUNITY KNOW? RESEARCHING PUBLIC PERCEPTIONS TO DIRECT THE FUTURE OF COMMUNICATIONS

Alice Spearing. *St Richard's Hospice, Worcester, UK*

Background The hospice has a strategic aim to develop and maintain its profile across the county as an essential charity to support. The messages we communicate to the community forms their understanding of our care. Past communications have been guided by assumptions of what the community does and does not know. Market research was an opportunity to produce evidence on our community's awareness.