

measured the success of the cafés by recording attendance rates and through conducting qualitative surveys.

**Results** Attendance rates: 2016: 19, 2017: 43, 2018: 82.

**Conclusion** During the three years of death cafés at Ashgate Hospicecare, there has been an evident growth in attendance rates. To complement this, the surveys have shown more positive feedback from death café attendees and growing interest from outside organisations who want to be involved in future events. Moving forward, Ashgate Hospicecare aims to run death cafés throughout the year, working in partnership with other community groups, such as schools and clinical organisations. We strongly believe in the importance of raising awareness around death and dying and helping people plan for their future.

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### LEARNING FROM BEFRIENDERS IN COMPASSIONATE COMMUNITIES – SERVICE CO-PRODUCTION WITH VOLUNTEERS

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‘Compassionate Communities help to reduce isolation and loneliness and bring a sense of belonging into what is sometimes a disconnected society.’ (Abel & Kingston, 2018).

Nightingale House Hospice in Wrexham, North Wales covers a diverse catchment area including urban, coastal and rural communities, and includes areas of significant deprivation (Jones, Atenstaedt & Charles, 2014).

During 2015, following the pilot of a day unit outreach service within a local, rural community, the hospice supported the community to develop a compassionate communities befriending project, and this was followed by two further befriending groups in other communities within our catchment area.

Our presentation describes a service evaluation undertaken with our volunteers from these three compassionate communities groups to identify the motivation for volunteers to become befrienders, their own social circumstances and households and how to improve the establishment of compassionate communities from the perspective of the volunteers delivering the service. The presentation identifies the enthusiasm from the volunteers to deliver a service to others and also the challenges of ensuring systems to ensure befriender safety are in place. The presentation concludes by demonstrating how the feedback from volunteers has impacted on the training delivered, in a demonstration of co-production and the systems for establishing new groups with ten active groups now in development or operation.

## Generating research, knowledge and outcomes

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### TRANSFORMING PALLIATIVE CARE SERVICE THROUGH DATA COLLECTION, ANALYSIS AND SHARING

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**Background** How is data used to really understand the service that we provide, help target service delivery and assist the development of a clinical strategy to enhance care provision?

**Aims** Review historical data for gaps in service provision. Identify meaningful data to inform hospice strategy and vision of supporting more people, earlier. Monitor, benchmark our progress and share with staff.

**Method** We undertook a review of historical data and health needs analysis to identify gaps in service provision. Analysis showed a diverse palliative service user population with patients being referred late in their diagnosis and a small cohort of non-cancer patient referrals, highlighting a gap in specialist palliative intervention. With OACC measures fully embedded in clinical practice, we asked how patient reported outcomes could be used to improve patient care and reflected on IPOS scores quarterly, which showed patients scoring highly in relation to the psychological impact of their illness. We introduced specialist link nurses and expanded our day services to encourage early referrals; a daily morning community meeting to identify, discuss and prioritise those patients with an unstable phase of illness and increased provision of psychological and spiritual support in our family support team.

**Results** Increased non-cancer referrals into the hospice from 19% to 40%; reduction of cancer patients dying within one month of referral from 39% to 35%; 10% reduction in the percentage of patients scoring severely or overwhelmingly for psychological concerns at the end of spell of care; 18 day average for a patient to move from unstable to stable phase following CNS intervention.

**Conclusion** Clinical data acts as a vital tool for identifying where action may be needed to address gaps in care delivery. Sharing these outcomes with clinical managers and staff helps everyone to understand the importance of accurate and meaningful data.

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### TRANSFORMING SPECIALIST PALLIATIVE CARE WITH DATA

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**Background** Interprofessional working is vital in the delivery of specialist palliative care (Dawson, 2007); both between and within organisations. Funding bodies require ever stronger evidence before and after gifting monies, and technology is showing potential for the identifying patients in need of palliative care (Tanuseputro, 2017). Use of data has proved problematic in palliative care, leading some to highlight the importance of making the most of routine data (Hanratty, Goldacre, Griffith, *et al.*, 2008).

**Aims** To evaluate how data are being generated, gathered and used in different areas of the hospice, and the role of technology in this (Nwosu, Collins & Mason, 2018).

**Methods** A Clinical Support Analyst position has been created to collate data. To demonstrate the range of educator activity, the Clinical Practice Facilitator (CPF) has been using an app (WonderApps AB, 2018) to collate data about his time division. Registrations onto courses are made through an electronic booking system (Eventbrite). Education evaluation data is collated electronically and brought

together to report on the educational and financial value of education plans.

**Results** The work of the Clinical Support Analyst is enabling standardisation of the data collection. The CPF has collated four months of activity data, manipulating visual representations of the data to analyse his time allocation. Using an electronic booking system gives a streamlined process for the organisers and attendees, making more efficient use of administration time.

**Conclusions** The work is ongoing, initial conclusions are as follows. The Clinical Support Analyst prompted a formalisation of data requests and rigorous recording of the time work takes him to complete. It has also highlighted that the data from the electronic patient notes does not match the data collected locally. The CPF has found that the App has to be used with rigour to ensure full data capture. Not all members of staff are confident enough to book their own training and do not read their emails in a timely way.

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### DEVELOPMENT OF PERSON-CENTRED CARE AT A HOSPICE

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**Background** We have had an electronic patient record (SystemOne) at the hospice for the past five years. This is our tool for documenting the care that we provide, viewing and reviewing these notes and reporting on this data. Our patients and families have input from many members of the multi-disciplinary team to ensure that they receive person-centred holistic care. Our electronic patient record, SystemOne was structured so each discipline completed initial assessments within a communal template but ongoing care tended to be written as separate reviews and action plans. The result of this was silos of information and staff not reading each others notes and using the information obtained from patients and families to the optimum. We recognised that the crucial bits of information from patients that make a huge difference to their experience were not being captured and communicated well.

**Aims** To put people at the centre of their care and support and maximise their involvement through development of person-centred templates on SystemOne.

**Methods** Multidisciplinary team meetings explored the current methods of documentation. Using patient journeys, a gold standard method of documentation was designed within SystemOne. Generic nursing care plans were removed and replaced with a multi-disciplinary 'About me' Care plan.

**Results** An 'About me' care plan pops up as soon as an electronic record is opened. It is completed by all members of the MDT and tells us how to care for a patient. It is divided into seven domains of care. It includes phrases like 'Julie likes to have a Baileys in the early evening'. All other elements of care are documented in a person-centred care template by all disciplines.

**Conclusions** The new method of documentation puts the patient at the centre of their care and ensures their care and support is completely individualised.

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### DO ELECTRONIC PALLIATIVE CARE COORDINATION SYSTEMS (EPaCCS) INCREASE THE CHANCES OF A GOOD DEATH?

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**Background** People at the end of life frequently receive care from a variety of teams and organisations. Continuity of care is particularly important for patients at the end of life and a lack of information sharing is often cited as a barrier to the provision of good quality end of life care.

Nationally, the policy drive to address this has been the development of electronic palliative care coordination systems (EPaCCS). The purpose of EPaCCS are to provide a shared local record for health and social care professionals, with key information about an individual approaching the end of life, including their expressed preferences for care.

Quantitative studies have shown striking differences in place of death with EPaCCS, but are potentially biased and confounded. Technology in isolation is not guaranteed to bring benefit and the initiation of an EPaCCS relies on healthcare professionals opening conversations about death and dying. Whether EPaCCS facilitate such conversations is unclear.

We do not know if EPaCCS improve practice or simply document what is already taking place. Little research has been undertaken to understand how, and by whom, EPaCCS are being used and whether EPaCCS support patients' end of life wishes. Rigorous evaluation and research is needed to investigate to what extent EPaCCS influence services working together to support 'a good death'.

**Aims** Describe the socio-demographic characteristics of patients who die with an EPaCCS record, their cause and place of death and compare these with patients who die without an EPaCCS record. Explore the impact of an EPaCCS on the experience of receiving end of life care for patients and carers, and understand healthcare professionals' views and experiences of utilising an EPaCCS to provide coordinate care.

**Methods** This is a mixed-methods study, taking place in the Bristol, North Somerset and South Gloucestershire area, within a realist evaluation paradigm.

**Results and conclusions** Work in progress – data collection starting September 2018.

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### MOVING FROM PAPER TO ELECTRONIC RECORD KEEPING WITHIN A CHILDREN'S HOSPICE

Andrew Beaumont. *Brian House Children's Hospice, Blackpool, UK*

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The aim of the work was to enhance patient safety in the following ways:

- Ability to remotely access a patient record enabling advice or queries to be addressed without finding a set of case notes
- Reduced amount of telephone traffic between the multi-disciplinary team and hospice staff around episodes of care – enabling more timely and appropriate interventions to be offered to the children and their families