- Conducted an internal communications drive to encourage the flexing of volunteer roles around skills and/or creating roles requiring specialist skills.

Results Funded by the Health Innovation Network (HIN), we recruited six volunteers with training backgrounds to co-produce a training course for local non-hospice volunteers on talking about death, dying and loss. All volunteers reported high satisfaction levels with using their skills in this project. We have recruited 16 people with professional coaching qualifications to coach senior staff in their ongoing development on a voluntary basis. Volunteers are joining staff working groups to provide new perspective.

Conclusions Every successful role and initiative is breathing more confidence in staff to focus their volunteer involvement around assets rather than boundaries.

Limitations to consider:

- Ensuring potential volunteers are not put off by roles that may feel too much like a paid job;
- Ensuring that skills are welcomed whilst being mindful of focusing on organisational need.

Acknowledgments With thanks to the HIN for funding some of this work.

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IGNORE VOLUNTEER CARERS AT YOUR PERIL – YOUNG ADULTS TO RETIRED ADULTS; DEVELOPING SKILLS TO CARE

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Background Staff shortages are a reality, training is not keeping pace with increasing demand for care, fuelling skill shortages, increasing agency costs (The Health Foundation, Nuffield Trust & The King's Fund, 2018) and increasing pressure on existing staff (Triggle, 2019).

Volunteers are an essential but under-utilised support for hospices (Help the Hospices Commission into the Future of Hospice Care, 2012; Together for Short Lives & Help the Hospices, 2014). In our hospice volunteers recognised they could do more to help, asking to be trained to support clinical staff in a more practical way (Marshall & Wilcocks, 2018).

Aim Enable a team of Care Volunteers with skills and experiences to work alongside clinical staff across all care settings.

Methods A pilot project to train Care Volunteers in the ward setting was quickly extended to offer Care Volunteers experience to work in the Day Hospice and Community teams. See Table 1 (Training and support provided for care volunteers).

Results

- Demand for Care Volunteers is increasing across the organisation;
- Increased care hours provided;
- Reduced stress levels on clinical staff;
- Reduced agency costs;
- Dementia patients are supported whilst carers attend training or support groups;
- Increased provision of respite care in community;
- Recruitment to Healthcare Assistants roles from Care Volunteers.

Abstract P-94 Table 1 Training and support provided for care volunteers

Training	Support
Induction in statutory and mandatory topics	Trained Assessors support, advise, and monitor progress
Care Certificate standards workbook	Weekly tutorials and observations of competencies
An overview of palliative care	Mobile messaging application enables communication and support
Practical competencies: moving and handling, personal care, nutrition and hydration, catheter care	Flexibility of work hours, including weekend and evening training

Case studies Community crisis: A patient's wife was the main carer but became acutely ill, needing hospital admission. A Care Volunteer responded immediately, staying with the patient until a respite bed could be found.

Recognising dying: Care Volunteer providing personal care recognised signs of end of life, alerted staff, enabling family to be with the patient as they died.

Conclusion We need to recognise that these Care Volunteers are a viable alternative to overstretched staff, providing added value to end of life care.

Generating Research, Knowledge and Outcomes

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AN EVALUATION OF THE FIRST FIVE YEARS OF AN ELECTRONIC PALLIATIVE CARE CO-ORDINATION SYSTEM (EPACCS)

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Background UK government policy supports advance care planning and recording of patient preferences on EPaCCs (Department of Health, 2008). EPaCCs have been developed across the country but there is no consensus on evaluation (Allsop, Kite, McDermott, Penn *et al.*, 2017) and assessments are urgently required (Petrova, Riley, Abel & Barclay, 2016; Callender, Riley, Broadhurst, Wiggins *et al.*, 2017).

Aim This evaluation reviews the first five years of EPaCCS in North East Essex, locally called the My Care Choices register (MCCR) including; uptake of the register; the process of register entry before death and preferred place of care choices and outcomes. This is to contribute to the discussion about how EPaCCs should be evaluated and developed.

Method Data was extracted from MCCR from the date of inception in September 2013 to September 2018. Data recorded on the EPaCCS for residents of North East Essex were compared to Office for National Statistics mortality data to calculate what proportion of deaths had a register entry. The mean number of days prior to death that the register entry was created was calculated. Extraction of data included preferred place of care and subsequent achievement.

Results 8978 people in North East Essex recorded a register entry in the first five years of My Care Choices. The mean number of days to death from the initiation of a MCCR entry increased from 65 in year one, to 316 in year five. The proportion of people in North East Essex who died with a MCCR record increased from 20% in year one to 46% in year five. Preferred places of care were recorded for 81% of register entries. Of these 52% were home, 36% care home, 8% hospice, 3.5% hospital, 0.5% community hospital. Achievement of first choice preferred place of care was 70%.

Conclusion EPaCCs have potential to promote care consistent with peoples' preferences towards the end of life. Opportunities should be taken to develop systematic evaluations to drive improvement.

P-96 MY CARE CHOICES REGISTER – BUILDING AN EPACCS FOR THE FUTURE

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10.1136/bmjspcare-2019-HUKNC.119

Background In 2013, St Helena was commissioned to implement an EPaCCS (National End of Life Care Intelligence Network, 2013) solution across North East Essex that would be used to capture the choices of patients deemed to be in the last 12 months of life. These would be made available at point of care.

St Helena launched the My Care Choices Register (MCCR). It quickly became nested within the locality. However, the system procured had limitations and following stakeholder consultation it was decided that a bespoke solution was required.

Aims

- Reduce administrative overheads;
- Create a solution that provides value for money, has scope for future development and integrates with GPSoC;
- Ensure this system can be expanded for use across the healthcare system and aligns with LDR Universal Capabilities.

Method March 2017- after engaging stakeholders, St Helena created a specification for a new solution. Care IS, a clinical solutions developer with a large user base in North East Essex, was approached. Care IS agreed to develop the solution and offer this to other localities in the UK to aid commercial viability. September 2018 – New integrated MCCR is launched.

Results Record duplication issues have been eliminated. The replacement system is now utilised by more health care professionals and areas such as the Ambulance Service. The increased usage has led to a larger number of people dying in their preferred place of care.

Conclusion The integrated nature of MCCR and the increased usage have made it one of the success stories for North East Essex CCG. This is only the start. Phase Two will see MCCR expanded into social care, along with other localities currently in the planning stages to use MCCR across their footprint.

P-97 DIGITAL CHANGE PROJECT: THE USE OF COORDINATE MY CARE (CMC) AT NORTH LONDON HOSPICE

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10.1136/bmjspcare-2019-HUKNC.120

Background Shared care records is identified as one of the foundations to achieving the Ambitions for Palliative and End of Life Care (National Palliative and End of Life Care Partnership, 2015). Electronic Palliative Care Co-ordination Systems (EPaCCS) are one vehicle which enable the recording and sharing of people's care preferences and key details about their care at the end of life. In North Central London (NCL) Coordinate My Care (CMC) has been adopted as the EPaCCs used across services and providers. Since January 2019 the community teams in the Boroughs of Barnet, Enfield and Haringey have undertaken a digital change project to improve use of CMC.

Objective To identify the challenges and enablers to achieving digital change.

Method Activity data provided by CMC was reviewed and evaluation of the ways in which digital change had been achieved is presented.

Results Since January 2019 for the Borough of Barnet the records created have more than tripled compared with the same time in 2018. Key themes in digital change management were explored according to the model suggested by the King's Fund (Maguire, Evans, Honeyman & Omojomolo, 2018).

Leadership and management: strategic leadership:

- Commissioning– LPoL (Last Phase of Life) Programme;
- Key Performance Indicator;
- Objective setting: Teams and individual;
- Project management;
- Barriers or enablers for change identified;
- Clinical Leaders identified;
- Data – close the loop – identify individual champions and individual support needs.

Resourcing and skills:

- Financial investment;
- Technical access and support;
- Working with CMC access issues.

Information governance:

- Information Governance Framework;
- Consent – Information leaflets;
- Communication skills around data sharing and benefits;
- New starters, transfers and leavers;
- Legitimate access;
- Auditing.

User engagement:

- Clinical champions;
- Celebration of successes – Data;
- Considering less successful outcomes – what can be improved (multi-agency);
- Incentivisation;
- Whole team – multidisciplinary team, colleagues;
- Patient engagement – MyCMC (My Coordinate My Care).

Partnerships:

- Urgent care system: London Ambulance Service, GP Out of Hours, local Palliative Care Support Service and acute sector;
- Patient engagement – MyCMC.