the sexual assault to formal support providers (e.g., health care providers). The literature suggests there are several factors associated with reduced disclosure to formal support providers (e.g., self-blame). If survivors do disclose to formal support providers, they receive more negative social reactions (e.g., victim blame) than if they disclose to informal support providers (e.g., friends). Furthermore, survivors holding marginalized identities (e.g., sexual minority) appear more likely to receive negative reactions from formal support providers than those holding more dominant identities (e.g., white, heterosexual). To date, little work has provided a theoretical examination of how sexual assault stigmatization impacts the disclosure experiences of survivors or how those effects may be compounded for those who hold (multiple) marginalized identities.

Objectives Grounded in intersectionality (e.g., intersection of racism, sexism), this study explores the role of stigma in the decision to disclose to formal support providers and how stigma shapes the disclosure encounter.

Methods This study employs a computer-mediated discourse analysis of posts by sexual assault survivors to the website *Reddit*.

Results This study is currently in the data analysis stage. Preliminary results suggest that being a sexual assault survivor constitutes a concealable, stigmatized identity. Survivors experience stigma (e.g., internal, cultural) in both the decision to disclose to formal support providers and during the disclosure encounter, and holding (multiple) marginalized identities impacts how this stigma is experienced. Emergent themes include the seeking of help in online communities for those whom (intersectional) stigma acts as a barrier to seeking in-person help from formal support providers, the use of online support concomitantly with formal help-seeking, and the influence of the #metoo movement on (non)disclosure to formal support providers.

Parallel session – Healthcare Improvement and Knowledge Mobilisation (22 March 14:00 –15:15)

023 PATIENT EXPERIENCE IN ACUTE CARE SETTINGS: MAKING SENSE OF THE DATA OR MAKING DATA OF THE SENSE?

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Background Patient experience is identified by NHS England as a key component in improving care quality. Although several indicators have been developed to measure patient experience and provide institutional benchmarks, comparatively little is known about the range of sources of information about patient experience within healthcare, or about how staff interpret and use experiential data to enhance knowledge and improve care.

Aims To understand more clearly the breadth of patient experience data which is currently available and how it is being responded to by healthcare professionals to improve patient care.

Methods We conducted ethnographic observations and interviews with a purposive sample of healthcare staff in Intensive Care Units and Acute Medical Units in three NHS hospital

sites, involving over 100 hours of observations and 45 interviews.

Results We identified a spectrum of types of information about patient experience, including written feedback from surveys and complaints; 'bedside' conversations or patients returning to speak about their experiences; and information received in a sensory way such as a hug, or gifts of chocolates or flowers. Some types of data were codified and used as intelligence within organisations to monitor and improve services, but much of the information about patient experience remained 'below the line': it was recognised by staff and used to shape their practice informally, but never entered the formal economy of data for improvement.

Conclusions We suggest that, rather than trying to convert this 'soft' information into hard data that can be counted at an organisational level, there is value in recognising the different ways in which different types of information about the patient experience can be harnessed to drive improvement. Soft data can promote grass-roots improvement through reinforcing good practice and facilitating reflection.

024 THE FIVE 'ES' OF HOLISTIC CARE FOR ADOLESCENTS AND YOUNG ADULTS WITH CANCER

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Introduction One of the 'arts' of age-appropriate care for adolescents and young adults (AYA) with cancer is a holistic approach to delivering care, which relies on the knowledge, skills and attitudes of all healthcare professionals (HCP).

Aim The paper aims to describe the five 'Es' enabling holistic competence.

Methods Data were collected across four specialist AYA services (21 hospitals) in a multi-site case study; using semi-structured interviews with 29 AYA and 40 HCPs, focussed ethnography and observation (120 hours). Data were analysed through thematic and framework analysis.

Results HCP holistic competence was enabled by the five 'Es':

- Exposure to experience continuum: dependent on the AYA case load of the care setting. More contact with AYA facilitated knowledge in needs beyond clinical treatment.
- Enthusiasm: vital with smaller caseloads of AYA. Interest in the speciality heightened holistic knowledge, often created through leadership.
- Environment: a specialist environment to meet AYA psychosocial needs increased HCPs ability to support AYA holistically.
- Education: occurred on three levels: raising awareness of AYA needs, in-house education, and formal training in AYA care.
- Ethos: core to culture of care was a whole-team approach recognising individuality, empowering, and promoting normality for AYA.

Discussion and conclusion HCP holistic competence was dependent on the level of contact with AYA: a continuum from infrequent exposure to AYA, to substantial experience in specialist services. This contact level was related to the care environment (non-specialist or specialist) and together with

enthusiasm for the speciality, was a key factor in the creation of a holistic, AYA-focussed ethos of care. Centralising AYA cancer services would increase the experience HCPs have of working with AYA, within age-appropriate environments of care, thus fostering an ethos of care sensitive to AYA holistic needs. Whether this impacts outcome will become evident in early 2019 when the results of BRIGHTLIGHT are released.

025 USING QUALITATIVE SYNTHESIS DATA TO INFORM INTERVENTIONS IN PALLIATIVE CARE: A MULTILEVEL APPROACH

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Introduction Complex interventions are common in palliative care (PC), but the data from quantitative and qualitative research can be contrasting. For example, systematic reviews found trial evidence on effectiveness was uncertain in complementary therapies (CTs) in PC; however, based on qualitative evidence patients' perceived CT to be highly beneficial for their well-being and highlighted ways in which they wished CT were delivered.

Aim To develop an exemplar in PC that draws together the findings from quantitative and qualitative systematic reviews to inform reasons for discrepancies between the two and suggest directions for future intervention development.

Methods We sought trials on the effectiveness of CT and qualitative studies on patients' perspectives about CTs. Our primary outcomes for trials included anxiety, pain, and quality of life. Eight databases were searched in 2018. Citations and full-text papers were reviewed independently to identify relevant studies. Meta-analyses to pool trial data were considered and a thematic synthesis was conducted to understand patients' experiences as presented in primary qualitative analysis. The individual review findings were combined in matrices to explore similarities and differences.

Results Twenty-two trials and five qualitative studies were included. A matrix table explored the (lack of) overlap between items on a commonly used quality of life measure from the review of trials and the themes from the thematic synthesis. A table was also created to explore the variations between how patients want CT to be delivered and how it is being delivered in trials.

Conclusions This combining of qualitative and quantitative data has highlighted outcome measures in trials may be inappropriate and the interventions may not be delivered how patients wish. Our approach demonstrates a potential way in PC to enhance development of practice appropriate complex interventions.

026 OPTIMAL INVOLVEMENT OF PATIENTS IN THE MORBIDITY AND MORTALITY MEETING (OPTIMA STUDY)

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Background Different research has suggested that involving patients during meetings, normally intended for doctors, is beneficial: not only to inform patients, but also to integrate the patient's perspective in the discussions on future cure and care. However, inviting the patient to join such a meeting, is a new field. In general, surgical departments worldwide hold a Morbidity and Mortality (M and M) meeting to discuss medical errors, (unexpected) adverse events or near misses. The healthcare professionals discuss what happened, why and what they can do to prevent this in the future. It can be challenging to discuss this openly in front of the patient.

In 2016 a pilot has been started to invite the patient to join the monthly M and M meeting at the department of gynecological oncology (Radboudumc, Nijmegen, the Netherlands).

We evaluated the M and M meetings with patient participation since its pilot. What are the burdens and benefits for patients and healthcare professionals, in order to improve the M and M meeting?

Methods We conducted in-depth interviews with 10 patients and 15–20 healthcare professionals. Two M and M meetings were observed. The analyses were done by thematic coding using the program Atlas.ti, but framed in order to choose next methodological steps and ways to implement this format in other departments.

Preliminary results Patients feel safe to share their experience during the discussion and feel fully informed. Healthcare professionals gain new insights from the patient and their partners' perspective. However, it is more difficult to choose the right words and communicate open and honest during the discussion.

Conclusion The current M and M meeting format with patient participation is improved and next methodological steps are chosen.

027 KNOWLEDGE-TO-ACTION: PROMOTING BEST PRACTICES FOR MATERNAL OPIOID USE

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10.1136/bmjopen-2019-QHRN.27

Background An increase in opioid use during pregnancy fuelled concerns among reproductive health advocates, policy-makers, and providers in North Carolina, USA. Stakeholder groups joined together to address these concerns. A knowledge transfer (KT) intervention, which provided specialized education and training for frontline providers, in an effort to increase evidence-based practices became the primary goal of their response. Qualitative methodology can provide critical insight on the process of KT interventions and the contexts in which KT activities occur.

Methods Data from a grounded theory study on care provision for perinatal substance use was used to examine a naturalistic KT intervention that emerged from stakeholder concerns. Data was collected over a six-year period and include observations of KT activities (conferences, workshops, and community meetings), focus groups and interviews conducted with stakeholders, and a review of publicly available documents developed as part of KT activities. Identified KT activities were mapped onto a theoretical framework detailing the Knowledge-to-Action (KTA) process and a thick, rich description of the intervention was developed. Additional