

highlighted that most evidence about the use of PROMs in palliative care populations is in the outpatient oncology setting. There is little evidence about the completion of PROMs in the inpatient palliative care setting. St Christopher's Index of Patient Priorities (SKIPP) 2 is a validated questionnaire exploring symptoms and quality-of-life and given to all patients on their third and tenth day of hospice stay. The completion of one SKIPP on the third day has been used as a PROM as it enquires about the patients' symptoms and quality of life prior to, and after contact/admission to the hospice service.

Methods A retrospective analysis from 150 consecutive admissions lasting four or more days across two hospice sites in the South West of England to determine the completion rates of SKIPP.

Results Of 150 admissions, 61 stayed less than 10 days (and thus expected to complete one SKIPP) and 89 stayed longer than 10 days (and thus expected to complete two SKIPPs). One SKIPP form was completed by 57.3% of all patients. Of the patients who stayed for 10 days or greater, 33.7% completed a second SKIPP form. The most common reasons for non-completion were the patient was too unwell (44.3%), or the form was not able to be completed on day three (21.4%) and therefore deemed an inappropriate outcome measure.

Discussion Nearly 60% of patients managed to complete one SKIPP questionnaire which can be used alone as a PROM for patients in an inpatient palliative care setting. This suggests PROM can be routinely embedded into clinical practice within a hospice setting.

P-79

REMOVING TECHNICAL BARRIERS: IPOS TIMELINE TOOL AND IPOS REPORT WITH ST BARNABAS HOSPICE AND LOROS

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10.1136/bmjspcare-2017-hospice.106

Aims Two tools are now in use across St Barnabas and LOROS sites, which support clinicians in getting the best outcomes from IPOS and OACC measures. These are the IPOS Timeline tool and IPOS Report. The IPOS Timeline tool generates a series of graphs about a single patient. The IPOS Report provides a comprehensive assessment of a service's performance for a given time frame. These aim to help services to make the best use of all their IPOS data, by automating processes and removing any technical barriers.

Results The IPOS Timeline has been designed for clinicians. By pressing a single button in a SystmOne extract, it creates a set of graphs showing all IPOS information about the patient. Using this, the clinician can see trends, current and past problems at a glance. This saves time with the patient, or in explaining the patient's history to other clinicians. The IPOS Report has automated the task of analysing all IPOS data across an entire organisation. It uses this information to create an in depth report of service performance, and a full suite of graphs and measures for each IPOS indicator. No data analysis or advanced computer skills are required. The IPOS Report shows where teams are performing well and what can be improved. It contains graphs of service trends over time, and visualises the current level of patient care and how patients needs are changing. A summary shows all this at service level, with a simple rating system. Together, these tools have

removed the barrier of technical knowledge and analytical skills needed to handle large amounts of IPOS data. This has enabled services to become more responsive and improve their delivery of patient care.

P-80

SCOPING THE LOCAL LANDSCAPE OF END OF LIFE CARE WITH ROUTINE DATA AND QUALITATIVE RESEARCH

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10.1136/bmjspcare-2017-hospice.107

Background Hospices need to engage in research to ensure provision of the highest possible quality of palliative and end of life care for patients and families. A hospice collaborated with researchers at a world-leading university on a research project to scope the current landscape of palliative and end of life care needs within their geographical area. A postdoctoral research fellow was recruited in May 2017 to conduct and deliver the research over a period of six months.

Aim(s) The research aims to identify what is happening in the hospice's catchment area, and establish why these trends are happening.

Methods Routinely collected health and social care data provide an efficient and useful opportunity for evaluating and improving palliative and end of life care services (Davies et al., 2016). Data from ONS, Public Health England and the primary care network will be used to establish:

- How many people have died in the hospice's catchment area since 2014
- What these people died from
- How many of these deaths did and did not have hospice involvement.

Empirical data collected via qualitative and quantitative research tools will then be used to understand why these trends are happening. Data will be collected from multiple stakeholders and then subjected to systematic thematic analysis. Stakeholders include:

- Health care professionals (n=20)
- Hospice service users (n=20)
- Non-hospice users (n=20)
- Wider population (questionnaires accessed via GP practices).

Results Once the research is complete, these findings will inform the hospice's clinical strategy by providing robust evidence of where direction, activity and resources are most needed. It is anticipated the project will also generate future opportunities for the hospice and research team to develop practical and academic outputs.

Conclusions Hospices and universities can work in partnership to learn about the landscape of end of life care needs in different localities using routine data and qualitative research.

P-81

LEARNING TO FLY: EXPERIENCES OF A FLEDGLING RESEARCH HOSPICE

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10.1136/bmjspcare-2017-hospice.108

Background As a small hospice, whose only research activity had been individual staff undertaking Masters degrees or local university collaborative service evaluation, opportunity of a national multicentre trial of short specialist palliative care intervention (SSPCI) in advanced neurological disease (AND) was exciting and daunting. The local neurological centre identified suitable patients, explained, consented, randomised and undertook research questionnaires. The hospice delivered intervention, following required training for involved staff.

Method Collation staff/patient comments about study involvement.

Results Staff reported pride at being involved with high calibre institutions; anxious and keen to get it right; initially saw trial patients as different and lacked confidence assessing and evaluating their care; positive experience following patient (with long standing diagnoses, and excellent existing care/support at home) from admission to discharge; keen to demonstrate impact of SSPCI in AND patients; having named clinical lead nurse responsible for overall supervision of study proved beneficial and necessary; challenges talking to patients with long standing diagnoses about preferred place of care and future care planning. Patients reported feeling proud to take part; initial reluctance to attend hospice due to pre conceived ideas, but all now state look forward to coming. One participant decided participating was not for him and withdrew.

Conclusion Significant multiprofessional staff time and effort involved in delivering intervention – more than expected for a similar number of usual referrals. Staff recognised the vital importance of thorough initial clinical assessment on admission; used some new educational and inspirational outcome measures; further educated in whole ‘research process’ and realise importance of adhering to strict requirements; frustrated that unable to signpost patients elsewhere for support at end of interventions due to lack of available resources and/or funding.

P-82

BECOMING A RESEARCH ACTIVE HOSPICE: INTRODUCING RESEARCH INTO A DAY HOSPICE ENVIRONMENT

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10.1136/bmjspcare-2017-hospice.109

Background Despite the many perceived benefits of research in palliative care, hospices have historically not engaged with research to any significant degree (Payne et al., 2013). With the exception of small projects initiated by staff undertaking postgraduate studies, this hospice undertook no research until 2016. The Research Framework for Hospices was designed to start addressing this, encouraging Hospices to become Research Active.

Aims To become a Research Active hospice, with the knowledge, skills processes and organisational culture required to take part in research to commence recruitment to a multi-centre trial within day hospice.

Methods A research governance framework was established, led by the hospice medical director with support from the Clinical Research Network (CRN) and neighbouring hospices who shared experience and policies. A study was identified

from the National Institute for Health Research (NIHR) portfolio. It was decided to commence recruitment in day hospice. A number of hospice staff, including day hospice staff, undertook Good Clinical Practice training. Research awareness sessions were held, which included an introduction to the study.

Results The hospice opened to recruitment in November 2016. By 25 May 2017, 95 day hospice patients have been screened, 45 were eligible and 26 have enrolled. Informal feedback has been positive, with staff appreciating the importance of research and being able to incorporate it within their clinical duties, and many patients being willing to take part.

Conclusions In under two years, the hospice has moved from a position where research was not ‘something we do’ to being actively involved in recruiting to a NIHR portfolio study. Key factors to success have included senior hospice leadership, the support of the CRN, and the involvement and enthusiasm of clinical staff. The next step is to widen involvement in research to other hospice clinical teams.

P-83

THE JOURNEY BEGINS. TAKING THE FIRST STEPS INTO PORTFOLIO STUDIES. A HOSPICE PERSPECTIVE

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10.1136/bmjspcare-2017-hospice.110

Hospice UK (2013) acknowledged that research is not universally welcomed, encouraged or embedded within hospice care and highlighted the need for hospices to become more involved in research in the future. St Giles Hospice set out in 2014 to become a research active hospice. As a hospice that covers a wide geographical area providing a comprehensive service that includes two inpatient units, day hospice, specialist community team, hospice at home, family support and bereavement services, we are ideally placed to have access to hundreds of potential participants for clinical and non-clinical research studies.

How did St Giles Hospice become research active? A research operational policy was developed that set out a clear process for undertaking research within the hospice and led to the set up of a Research Forum which includes a research ethics committee. The research forum was set up with the following purpose: To develop and oversee the effective implementation of research at St Giles Hospice as part of the clinical governance process. To review all research proposals in accordance with the Operational Research Policy and Procedure. To ensure the protection of patients, carers, staff and volunteers through appropriate research governance processes which comply with the principles of The Research Governance Framework.

What St Giles Hospice has learnt from being part of portfolio studies: With the support from lead sites and the NIHR Clinical Research Network the hospice was able to learn the processes that are involved in conducting research. The organisational skills and time required to maintain records such as site files. The organisation was able to explore the research culture within the hospice. Patient engagement and appetite for research has been high. A better understanding about how high quality evidence is generated.