Discharge Summaries, Respiratory clinic letter database and the separate patient neurorehab notes was undertaken.

Results One patient has been managed by Basildon Hospital so excluded from the audit which focused on CHUFT services. Of the seven remaining patients, two have not been seen by respiratory services as yet and the reason is unclear. One patient was admitted to Colchester General Hospital with life threatening respiratory compromise two months after referral and started NIV therefore as an inpatient. The final four patients were seen at 13 days, 6 weeks and (2x) 4 months post referral.

Conclusion There is no standard best practice process for managing these referrals. The NICE quality standard does not advise the time by which these patients should be assessed by respiratory services post referral. The tests required also could be standardised. At present it is not clear whether they require an arterial blood gas or sleep study. It might also be possible to start NIV and assess symptomatic benefit without tests. Writing agreed local guidelines would therefore be beneficial. In light of the patients short prognosis with MND it might advisable to aim for review in <6 weeks.

107

EMAIL ALERTS ALLOW MORE RAPID ASSESSMENT BY PALLIATIVE CARE SERVICE AND DECREASE LENGTH OF HOSPITAL STAY FOR THOSE DISCHARGED HOME

Hannah Curtis, Rob Smith, Ruth England. *Derby Teaching Hospitals NHS Foundation Trust*

10.1136/bmjspcare-2018-ASPabstracts.134

Background The Hospital Palliative Care Team (HPCT) at Royal Derby Hospital identified a number of circumstances where previously known patients were readmitted, but not promptly re-referred, to HPCT. The average length of time between admission to hospital and referral to HPCT was 8 days. We believed earlier HPCT intervention might reduce length of stay.

Methods Through our electronic hospital database we attach an e-alert to a patient's clinical details which generates an email on each re-admission. HPCT apply e-alerts to the records of patients who have stated they would not want further hospital admissions or to those complex patients for whom we feel early involvement in future would be advantageous. We check the e-alert inbox daily and respond by telephoning the ward to ascertain whether HPCT input is required.

Results We report on data collected over 30 months relating to 627 unique patients with e-alerts. 213 patients had unplanned re-admissions to hospital. A total of 294 emails were received, on average 2.25 emails per week – which did not present an excessive new workload. HPCT response time to an e-alert averaged 0.6 days. For those patients whose preference was to be discharged, the use of an e-alert was associated with a reduced time in hospital of 7 days. When the patient died in hospital, the average length of stay was 15 days.

Conclusion Admit alerts allow HPCT to make a more prompt assessment of patients previously known to the service. For patients who go on to be discharged home, this is associated with a decreased length of hospital stay. We suggest this may improve patient experience.

108

TELEHEALTH PILOT: DEVELOPMENT AND SETTING UP OF A TELEHEALTH SERVICE FOR PALLIATIVE CARE PATIENTS

Emma Randall. *Weldmar HospiceCare, Macmillan*

10.1136/bmjspcare-2018-ASPabstracts.135

Weldmar HospiceCare has growing numbers of patients being referred to the service who want to be supported in their own homes for as long as possible. Weldmar are working in partnership with Macmillan who are providing funding for an 18 month secondment post to set up and lead a Telehealth pilot. Therefore enhancing the service offered to Weldmar patients and giving clinicians another tool to support and monitor patients. Telehealth is already being used in the UK for patients with long term conditions such as COPD and Heart failure but there is limited numbers of palliative care patients using a Telehealth service. The pilot consists of a POD which has a protocol uploaded to it that has been written using recognised palliative care outcome measures these are the Barthel Index and the IPOS scoring system. Patients log on daily completing the pre-set questions this will monitor changes in symptoms and also level of need. The results are stored on the POD so clinicians visiting the home can access these or clinicians can access these remotely from their PC to review the data the patient has inputted. The PODS have the capability for video conferencing and allow clinicians to use this to discuss with patients the data they have inputted and also carry out assessments of patients face to face via Skype. Patients have embraced the pilot and use of the POD. They report the POD is quick and easy to use, they like that clinicians can monitor them remotely. Clinicians are adapting to having another tool to use to support patients and having access to a wealth of data about patients. Also having the ability to monitor changes in symptoms without being reliant on patients relaying to them how they have been over a set period of time.

109

DEVELOPING AN ON-LINE TOOLKIT TO SUPPORT END OF LIFE CARE

Ruth England, Phil Shreeve. *Derby Teaching Hospitals NHS Foundation Trust, Treetops Hospice*

10.1136/bmjspcare-2018-ASPabstracts.136

Background When the Liverpool Care Pathway was removed, a range of materials and guidance required review; furthermore, revised practice needed a platform in order to be shared. We decided that our new approach to care might be supported by a novel on-line resource.

Methods A suite of tools that could be used by different providers across Derbyshire at different stages in a patient's end of life journey were collected together. Initially, these documents were held on a webpage hosted by a local community healthcare provider. An accompanying webpage contained details of upcoming educational events and contacts. In the first 6 months the pages were used regularly. However, feedback stated they were not easily accessible to all staff and were clumsy to use. Funding was obtained to build a more 'user friendly' resource. An improved platform (www.