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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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

Samantha Edward. *North London Hospice, London, UK*

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.

Conclusion To achieve digital change multiple enablers need to be undertaken to achieve change and the success is reflective of the multiple-pronged response.

P-98 A MODERN VIEW OF HOSPICE DATA

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10.1136/bmjspcare-2019-HUKNC.121

Background St. Cuthbert's Hospice manages their patients' records through SystmOne, a known patient record software. All the care services, in-patient and out-patient, are managed through the software, therefore it was possible to register outcome data and link it to a particular user, service, spell of care and phase of illness. This opened the path for developing an information system containing online-cloud interactive dashboards, all done with open source technologies, making it an affordable option. The system takes a patient-centred approach, which includes outcome scores per patient and their 'journey' across all services, having spells shared across the entire organisation and not by service, everything in one interface and accessible from any device with internet connection.

Methods The information system works with the data structure of SystmOne, allowing the inclusion of any validated outcome measurement, not only limited to IPOS. The system is made entirely with the R programming language, using the Rstudio ecosystem and is intended to centralise all the data that a hospice produces from every patient.

Conclusions Having a centralised information system allows hospices to see patients from every perspective, either if an in-patient or out-patient service was delivered. By having spells shared across all services it is possible to see sequentially how the patient has improved or deteriorated and how every department had an impact on the outcome. As most of the technology is open source, any hospice that currently uses SystmOne could make use of the system with little investment. Also, being able to see the data from any device connected to the internet can allow practitioners to access the patient's outcome even when they are performing a home visit.

P-99 DRIVING BY THE DASHBOARD LIGHTS

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10.1136/bmjspcare-2019-HUKNC.122

Background There was a need identified that data we had used and displayed historically didn't give a true picture of the complexity and diverse nature of the care and support we offered.

Aims

- To develop a dashboard as a single source of reporting for all different meetings, stakeholders and teams, from the Clinical Commissioning Group through to teams on the frontline;
- To have a consistent approach and method of reporting for all teams;
- To make sure all teams were represented;
- To highlight the importance of good recording.

Method When we moved to a new electronic patient record (EPR), this was an ideal opportunity to change the way we reported and demonstrated our work. A new role was

recruited and an application called Power BI was used to analyse data from the EPR.

Results We found that the new dashboards promoted discussion in all the situations it was displayed and that staff engaged with data and recording at all levels of the organisation. Being able to see the data for individual teams has helped staff to understand the importance of recording accurately. Team leaders have fed back that they have a clear understanding of their caseloads and the complexity of patients referred to them using outcome measures.

The dashboard data acts as a single source of information for team and organisation reports, and sections of the dashboard have been used for delivering messages to the public. Having a dedicated member of staff has meant that changes can be made to the dashboard quickly as new data is requested.

Conclusion The development of our dashboards has allowed the organisation to give a clear picture of what we do. Feedback has been positive at all levels with engagement driving healthy discussion and improvements in practice.

P-100 EVALUATION OF THE USE OF HEALTH INFORMATION EXCHANGE AT ST JOSEPH'S HOSPICE, LONDON

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10.1136/bmjspcare-2019-HUKNC.123

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). Following many years of engagement with the IT Enabler Board in Hackney, St Joseph's Hospice gained access to the Health Information Exchange (HIE) in July 2017. The King's Fund in their review of successful digital change projects identified this link with the voluntary sector services provided at St Joseph's Hospice, as the first link of its kind (Maguire, Evans, Honeyman & Omojomolo, 2018). The evaluation was undertaken after the first 1000 accesses.

Method During December 2018–January 2019, email questionnaires based on the benefits study (Redman *et al.*) were circulated to the 34 users. Follow-up reminder emails were sent. 12 respondents (seven nurses, five doctors) submitted between December 2018 and March 2019 (excluding the author). The completed questionnaires were evaluated.

Results The respondents identified that they used HIE to access a range of clinical information. Over 80% of the responding doctors and nurses used it to source information when taking a history. Nurses particularly reported this being a 'much easier' way to source information. 100% of nurses and 80% of doctors felt it had a 'positive' or 'very positive' effect on their working day.

Conclusion The benefits of access to the eLPR (east London Patient Record) have been suggested in this small sample of the first users of HIE in a hospice setting. The overwhelming weight of the responses regarding the benefits of access to information were positive. The results were limited by a low response rate. The findings do suggest that hospices could have considerable benefits with reference to access to information, reduction in administration and efficiency of gathering clinical information from other providers. The author recommends that hospices should explore the digital networks in