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

Fernando Torres. *St. Cuthbert's Hospice, Durham, UK*

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

Duncan Fleming, John Sharman. *Mountbatten, Isle of Wight, UK*

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

^{1,2}Samantha Edward. ¹North London Hospice, London, UK; ²St Joseph's Hospice, London, UK

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

their local areas to enable future access to shared care record systems as the benefits to hospices are considerable.

P-101 IMPLEMENTING THE THERAPY OUTCOME MEASURE (TOM) IN A DAY HOSPICE

Sally Boa, Gill Foster, Mandy Malcomson. *Strathcarron Hospice, Denny, UK*

10.1136/bmjspcare-2019-HUKNC.124

Background Hospice Day Services provide support to people to enable them to live with life limiting illness. The focus is on enhancing well-being and supporting people to continue to participate in activities that are important to them. Commonly used palliative care outcome measures tend to focus on problems and symptoms rather than well-being, activity and participation. The Therapy Outcome Measure (TOM) has been developed using the World Health Organization's *International Classification of Functioning, Disability and Health* and allows professionals to rate the person against descriptors which relate to four different domains: Impairment, Activity, Participation and Well-being.

Aim We aimed to find out if the TOM Palliative Care Scale could be used reliably and on a routine basis in Day Hospice by the multidisciplinary team to measure the impact of their interventions.

Methods Staff working in Day Hospice received training to become familiar with the TOM scales and use the scales reliably.

TOM was used with every patient referred to Day Hospice at two points during their episode of care; within the first two weeks and 12 weeks later. Patients were also assessed using the Australian Karnofsky Performance Status (AKPS), which provided information about functional status.

Findings Over a 22 week period, initial TOMs were used with 70 patients. Thirteen patients had TOM scores at 1 and 12 weeks as many patients deteriorated or stopped attending before the 12 week review. Changes in TOMs scores at these time points showed improvements in patients' well-being, activity and participation whilst impairment stayed the same. No changes were seen in AKPS level for this group.

Conclusions TOM scoring was readily adopted by those who received training. It was relatively quick to complete and provided meaningful information that reflected the impact of the interventions. Reducing the length of time between scores may enable collection of comparative scores for more patients.

P-102 USING OUTCOME ASSESSMENT AND COMPLEXITY COLLABORATIVE MEASURES TO REDESIGN HOSPICE COMMUNITY TEAM

Oliver-Jon Tidball, Christina Eldridge. *Heart of Kent Hospice, Maidstone, UK*

10.1136/bmjspcare-2019-HUKNC.125

Previous team composed of static level of Clinical Nurse Specialists (CNSs), increasing caseloads, limited prioritisation, silo working, resistance to change/new opportunities, and static budget. This led to high demand and high pressures with a rigid workforce. The need for change was identified to make the service fit for the present and incorporate future-proofing.

OACC was identified and developed as a means to achieve a skill mix team: right person, right place, right time, to

improve caseload management. The existing team were put at risk of redundancy and given the opportunity to apply for a position with the new structure.

March 2018 – the majority of the existing team decided to take redundancy reducing the Hospice Community Team (HCT) to a few remaining team members along with some agency and bank staff during the recruitment phase. HCT were not fully staffed until October/November 2018 with geographical 'zones' and 'urgent response' teams introduced in December 2018.

Three OACC tools (IPOS, AKPS, Phase of Illness) are being used with Views On Care due to be introduced shortly.

OACC impacts:

- Re-design of the hospice referral form;
- Using OACC as part of admissions and discharges from IPU and clinical assessment process;
- Development of Clinical Drop-In Day;
- New MDT process focussed around 'unstable' and inactivating;
- Prioritisation of assessments in zones between Registered Nurses and Clinical Nurse Specialists/Advance Nurse Practitioners;
- Utilisation of Paramedic role in 'urgent response' team to assess unstable/crisis situations;
- HCA role to manage more 'stable' patients and support carers at end of life;
- Good communication essential between roles, zones and urgent response teams.

Abstract P-102 Table 1

	February 2018	February 2019
Improved caseload management (total caseload)	392	367
Improved caseload management (average duration on caseload)	382 days	274 days
Improved patient management (face to face assessments)	233	291
Improved speed of response (referral to 1st assessment)	6 days	4.5 days

P-103 IMPLEMENTING THE INTEGRATED PALLIATIVE OUTCOME SCALE (IPOS) IN A SPECIALIST PALLIATIVE CARE SERVICE

Mary Holloway, Victoria Barrett. *Northamptonshire Healthcare NHS Foundation Trust, Northampton, UK*

10.1136/bmjspcare-2019-HUKNC.126

Background Evidence shows that routine measurement of patient-reported outcomes (PROMs) is important in palliative care (Bausewein, Daveson, Currow, Downing *et al.*, 2016; Collins, Witt, Bausewein, Daveson *et al.*, 2015). Increasing emphasis is placed on PROMs by those who commission services (Bausewein, Schildmann, Rosenbruch, Haberland *et al.*, 2018).

IPOS is a patient-reported outcome questionnaire in a suite of six palliative care-specific measures developed by the Outcome Assessment and Complexity Collaborative (OACC). OACC recommend a phased implementation (Witt, de Wolf-Linder, Dawkins, Daveson *et al.*, 2015; Dawkins & de Wolf-Linder, 2015).