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CATCH ME IF YOU CAN

CHASING THE ELUSIVE GOAL OF GOOD HAND HYGIENE: 2

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HAND HYGIENE

Despite major campaigns in the past to eradicate the hazards of poor hand hygiene, problems in the NHS remain. Jennifer Trueland looks at the possible remedies and at two case studies showing how the issue can be tackled. Columnist Phil Spark offers thoughts on a cost-effective, electronic solution.
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Daloni Carlisle finds that seamless sharing across the health service could finally become a reality, and looks at two organisations which have used TPP's SystmOne for easy access to records. And columnist Dr John Parry sets out his arguments for why sharing must become standard practice in the NHS.
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PHIL SPARK
THE HI-TECH HAI BUSTER

IN ASSOCIATION WITH DEB UK

The World Health Organisation is calling for healthcare staff and managers across the world to focus on the importance of improving hand hygiene in hospitals through its Save Lives: Clean Your Hands campaign.

For this campaign, WHO is enlisting support from leading global suppliers of infection prevention solutions. Deb Group, creators of the DebMed Group Monitoring System and a range of hand hygiene and sanitising products, are among those signed up.

This campaign calls attention to something that is imperative 365 days a year for healthcare staff – effective hand hygiene behaviour according to the "WHO Five Moments of Hand Hygiene" recommendations. The campaign aims to empower healthcare staff, patients and ultimately all hospital visitors with the knowledge that can help prevent healthcare-associated infections.

To help with this process, individual hospitals and healthcare facilities around the world are encouraged by the WHO to register for the Save Lives: Clean Your Hands campaign and get access to a wide range of resources, including monitoring and feedback tools, self-assessment framework, action plan template and hand hygiene training films. The WHO resources can also be accessed at www.debgroup.com along with the "Clean Your Hands Pledge" which reinforces the "five moments" to healthcare staff and provides three important reminders to help maintain hand hygiene compliance.

Currently, across the world less than 1 per cent of hospitals abide by the WHO's "five moments" recommendation, yet at any time more than 1.4 million patients are suffering from healthcare associated infections. However, the WHO reports that after completing a systematic review of 77 peer-reviewed hand hygiene articles published between 1981 and 2008, the baseline hand hygiene compliance rate was only 38.7 per cent.

Evaluation and repeated monitoring of practices, knowledge and perceptions are vital components of any successful hand hygiene programme. Through the campaign, the WHO is actively encouraging hospitals to implement sustainable practices and to learn more about innovative electronic systems for the automatic monitoring of hand hygiene compliance.

"These new technologies present numerous advantages and may become the future approach to hand hygiene compliance monitoring when available resources permit, and provided that they can reflect the Five Moments for Hand Hygiene," the WHO has said.

The DebMed GMS electronically monitors healthcare workers' hand hygiene events and provides feedback on compliance rates in real time. It is an accurate, cost-effective solution for fighting HAIs and is the only electronic hand hygiene monitoring system that meets the WHO Five Moments recommendation.

Phil Spark is marketing director of Deb UK.

INFECTION CONTROL

GRASPING A VITAL SAFETY MESSAGE

At a time when many believe the issue of hand hygiene has been fixed, much work remains to be done to embed robust systems in UK healthcare, says Jennifer Trueland

As the senior nurse in the infection prevention and control team at Salisbury Foundation Trust, Fiona McCarthy is a regular at trust board meetings. It's important, she says, that board members are aware of their responsibilities towards infection prevention, and also that they are kept up to date with any issues.

"There are always a lot of questions – which means they are reading the report," she says with a smile. "Having said that, we don't wait for the trust board to meet – if there are any issues then directors will be informed at once."

Salisbury has a particularly proactive approach to infection control, which includes a frequently updated – and publicly available – hand hygiene policy, which incorporates the WHO "five moments" approach to reducing healthcare-associated infection. These identify key points during care when cleaning the hands is crucial:

- before patient contact;
- before an aseptic task;
- after body fluid exposure risk;
- after patient contact, and
- after contact with patient surroundings.

Salisbury is far from alone in taking on this approach. Earlier this month, on the WHO's annual global hand hygiene day, some 170 countries participated in events and campaigns to raise the profile of hand hygiene, up from 130 last year.

This growing spread was welcomed by Professor Didier Pittet, external programme lead for the WHO's first patient safety challenge: Clean Care is Safer Care.

"This year, once again, the global movement catalysed by WHO around hand hygiene in healthcare is showing its amazing vitality," he said ahead of 5 May.

"Many campaigns have organised activities and celebrations to respond to the WHO's call to action on hand hygiene monitoring and feedback and patient participation."

But is the hand hygiene message truly embedded in UK healthcare systems – or can we do better? According to the Infection Prevention Society, while hand hygiene has come a long way, more needs to be done. "It is clear that currently hand hygiene in healthcare is viewed as an important patient safety topic, but action comes in a sporadic way," says president Jules Storr.

"Recently there has been an attitude of 'the problem has been fixed', when we know avoidable harm is still being caused by healthcare associated infections, and poor hand hygiene compliance is a significant contributing factor in many of these infections, not to mention the public's waning confidence in this basic area of healthcare, as seen in the Francis report."

Taken seriously

England was the first country in the world to have a nationally funded, centrally co-ordinated ongoing campaign on hand hygiene, but this was closed down in 2010.

"What we know is that hand hygiene at the right time, every time can play a key role in preventing harm as well as reducing patient concern. The IPS acknowledges this and supports the continued need for hand hygiene to be taken seriously to achieve its vision that no person is harmed by a preventable infection. Our five-year strategy reflects this."

Ms Storr believes a multi-faceted approach is needed. "This is about changing behaviour and we know no single strategy works. Success requires sign-up from not just infection preventionists but policy makers, managers and all staff. Utilising the expertise of behavioural scientists on how to

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further enhance safe healthcare delivery is also needed to build on all that has been done to date and to ensure we get the systems and environment right, promote targeted training and education, market the topic in a way that will engage healthcare staff, provide meaningful, rapid feedback on hand hygiene compliance and address the culture – a culture that will ultimately facilitate the prevention of harm through avoidable infections."

She cites a paper published in the *BMJ* this month (of which she is a co-author) which also laments the closing of England's national hand hygiene programme in 2010. (www.bmj.com/content/346/bmj.f2699) "Hand hygiene is the most basic of all patient safety interventions," the paper reads. "Three years after the closure of the Cleanyourhands campaign we still need to ensure that hand hygiene really is an established part of clinical care."

The authors, led by Sheldon Stone, senior lecturer at the Royal Free Campus of University College London Medical School, describe a group set up to ensure the gains

'Hand hygiene performed at the right time, every time, saves lives: fact'

of the campaign are not lost. Made up of members of the Cleanyourhands campaign external reference group, the Independent Alliance of Patients and Health Care Workers for Hand Hygiene (www.idrn.org/alliance.php) it aims to make sure that "a high standard of hygiene, based on the best available evidence, continues to be observed by all healthcare workers".

It seeks to do this "through working with the agencies that emerge in the newly reconfigured NHS for commissioning, regulation and education".

There are, however, areas of good practice – such as Salisbury, where the "five moments" methodology is part of a wide-ranging approach to tackling hand hygiene.

"A lot of our education focuses on the five moments, but we also make sure we can audit all aspects," says Ms McCarthy. "We find it quite applicable in improving compliance in medical staff and in allied health professionals."

Engaging staff at all levels is crucial to a successful infection prevention strategy, she says. "We've had a lot of support from the trust board and it's been important to engage staff at a ward level. We've also made real efforts to improve hand hygiene in areas like outpatients."

The IPS would like to see all healthcare organisations, including commissioners, taking a proactive approach – and will continue to work at achieving this, in part as a member of the new hand hygiene alliance. "Hand hygiene performed at the right time, every time, save lives: fact," says Ms Storr. "Commitment must be given to ensure that the simple action of cleaning hands is not omitted." ●

FIND OUT MORE

Salisbury Foundation Trust's WHO-influenced approach to hygiene control
➔**http://tinyurl.com/d6q8xvb**

INFECTION CONTROL: CASE STUDIES

HANDS-ON TIPS TO BEAT BACTERIA

Jennifer Trueland talks to two trusts which have overturned the status quo to put in place systems which are aggressively driving up levels of good hand hygiene

NORTH EAST AMBULANCE SERVICE

Christine McManus reckons that when it comes to hand hygiene, ambulance services are around 10 years behind hospitals.

"The crews are out and about, they are in patients' homes, they are now doing quite invasive procedures – and have been doing cannulisation for years – but it was never seen as the same issue as it was in hospitals," she says. "It's been very challenging, and it still is."

Ms McManus is infection prevention and control manager at the North East Ambulance Service Trust. The NEAS covers a huge area of the country – 3,230 square miles, and a population of 2.55 million. The trust has around 2,000 staff, three quarters of whom are operational. In any one year, crews attend more than 125,000 incidents, carry out almost half a million patient transport service journeys, and almost 20,000 urgent care transport journeys.

That is a lot of patient contact, yet until Ms McManus came into post in 2008, the trust did not have anyone in an infection control role.

A hand hygiene awareness day demonstrates participants' bacteria levels

"I had worked in primary care before that, and the Cleanyourhands campaign had just come into the community," she says. "When I joined the trust I realised we were starting from scratch – there was nothing on the vehicles [in terms of gel dispensers] and staff tended to rely on gloves."

Ms McManus embarked on an ambitious programme to raise awareness of the importance of hand hygiene, and to make it easier for staff to comply. This included placing wall-mounted dispensers in all accident and emergency and patient transport service vehicles. Staff were also given personal issue alcohol hand rub so that they could decontaminate their hands in patients' homes, or wherever they happened to be.

Hand hygiene training was introduced and is now part of induction, and of mandatory training programmes. Emphasis has been put on the World Health Organisation's "five moments" approach, to get the message across that it's important to clean your hands before and after contact with patients.

Heated debate

"Changing the culture among ambulance staff has been very challenging. They had thought that gloves would protect them – getting their gloves off them has been very challenging indeed," she says. "There's been a lot of heated discussion and debate – we're getting there, but it's still a struggle."

One of the issues, she says, is that patients and the public do not particularly think of hand hygiene in connection with ambulance staff in the same way as many now do in hospitals. "They're so pleased that the ambulance is there that they don't particularly notice if the paramedic has cleaned his hands," she says.

"And, of course, there are times – dealing with a cardiac arrest, for example – where immediate patient care is the priority, but in the majority of cases good hand hygiene should be possible."

Ms McManus takes a direct role in measuring compliance with the policy – she actually stands in the region's various A&E departments and watches the crews go in and out. But she says that carrying out more thorough audit is the next step.

Initial monitoring has included checking how much alcohol gel is being ordered to ensure it is actually being ordered and used. The number of gloves ordered has also been monitored to see if glove use is falling. Early indications were that this was happening, but it is a constant effort to keep progress going, Ms McManus says.

As well as formal training, the trust embarked on a publicity drive. Cleanyourhands posters were distributed to team leaders and staff at all NEAS premises – with a reminder to change them every month. Hand-washing technique posters have been displayed at wash hand basins, and there have been articles and information published in the trust's in-house magazine.

Senior management support is a must. "The chief executive is really on board with this, and so is the board of the trust," she says. "And the heat is really on now with the new

One of the biggest challenges in the North East has been getting ambulance staff to ditch their gloves and wash their hands

zero tolerance target on preventable infections."

Although the ambulance trust itself is not subject to these targets, the hospitals that it works with are – which, in turn, puts pressure on the NEAS. "The last thing I want is for a bacteraemia to be traced back to a paramedic," she says.

CALDERDALE AND HUDDERSFIELD

It was a meeting over a rather nice cup of coffee and some strawberries which helped Carole Hallam make a big breakthrough on hand hygiene – by convincing a director of finance that it would have a real impact on the bottom line.

Ms Hallam, assistant director of infection prevention and control at Calderdale and Huddersfield Foundation Trust, was in the Zalau Emergency Hospital in Romania, where she has been instrumental in changing the practice and culture around hand hygiene.

Ms Hallam, who has been involved with Medical Support in Romania since 2005, has supported the hospital in running campaigns to boost awareness of infection control, and has successfully raised the profile of hand hygiene among staff and management.

'Patients are so pleased that the ambulance is there that they don't notice if the paramedic has washed his hands'

"The breakthrough was a very powerful meeting with the director of nursing and the director of finance. I was making the point that very simple hand hygiene had a big impact on healthcare-associated infection, that it reduced length of stay, and that it essentially saved money. When the finance director understood this, she really welcomed the idea and has been very supportive."

In 2010, a systematic approach to improving hand hygiene was introduced at the 800-bed hospital. This included an audit of hand hygiene facilities in clinical areas, training and education, observation and feedback, and awareness raising.

The audit found there were only 15 paper towel dispensers, and that nine were empty; there were 206 liquid soap dispensers, of which 39 (19 per cent) were broken. There were 62 alcohol containers and dispensers, which had all been provided since the previous year, but the most commonly used alcohol containers did not include a pump to control the amount dispensed. A cost-benefits analysis showed that in the A&E department alone, around £913 per year could be saved if wall-mounted dispensers applying a controlled amount of alcohol were fitted.

"Staff were really enthusiastic, and the director of nursing is really passionate about it – a real change agent," says Ms Hallam.

Having won an educational grant from Deb, Ms Hallam and colleagues were able to buy posters to raise awareness of hand hygiene, and also to buy an ultraviolet light box to aid with training.

"That's been a really successful training aid in Romania, because it's quite novel and people like it," she says, explaining that people can see how good their hand cleaning technique is by how well they manage to wash a special cream off their hands – any traces will show up under the UV light.

In 2010, the hospital was one of three in Romania to sign up to the WHO Save Lives – Clean Your Hands campaign. During the week-long visit from Ms Hallam and colleagues, ward sisters and other nurses were trained in the "five moments for hand hygiene" (before patient care, before aseptic technique, after contact with blood and body fluids, after direct contact with the patient, and after contact with the patient's immediate environment).

Great strides

Since then, momentum has been maintained by, for example, a competition to design appropriate posters, which attracted 27 high-quality entries within four days.

Next week, Ms Hallam will return to Romania to take part in a national conference to be held in Zalau. The two-day event on sterilisation and infection control will include the launch of an infection control text book – called *Preventing Patient Harm* – which has been written by Ms Hallam and colleagues, and translated into Romanian.

Back home in West Yorkshire and hand hygiene clearly remains high on Ms Hallam's agenda – and on that of her employers. An infection control nurse for 16 years, she has seen great strides in that time – partly due to top-down initiatives like targets, she says.

"I don't think I particularly welcomed targets when they first came out, but now I don't think we'd have achieved what we have without them," she says.

"Some initiatives have really helped to make a difference – such as the 'bare below the elbow' policy. I think that's a really visible statement and sends out the message to everyone – staff and visitors – that this is an issue that matters. It's really saying: 'I'm signed up to this' – and so we should be." ●

ALAMY

DR JOHN PARRY
A RECORDS REVAMP IS ESSENTIAL

The new Caldicott recommendations state that information sharing should be the norm whenever it is in the interest of the patient. Not only that, but information sharing should include the social care sector, and be in the full control of the patient.

The new guidance is undoubtedly very welcome and hopefully it will go far enough in easing the fears of those troubled by sharing. These concerns are valid and must be answered. Yet they should not, under any circumstance, disrupt the sharing of information where patients consent and where it directly enhances their care.

The NHS is now at a stage where it wants, and needs, more information sharing. We all know that patient safety, care quality, outcomes and user experience are enhanced by it.

Information sharing will drive improved efficiency by reducing the need for duplicate tests, providing the basis for consistent decision support and reducing uncertainty of diagnosis and care requirements.

Multidisciplinary care pathways require clinical record sharing. The detailed care record ensures that clinical elements are not missed, that episodes or diagnoses that may not seem relevant are available to support holistic care, and provides the mode of "transport" along integrated care pathways.

However, many recent initiatives for data sharing have focused on single conditions, which does not reflect real patients' real lives, and is an inadequate test of care for patients with multiple long-term conditions.

A more comprehensive approach to care planning, with a holistic view of the patient and greater accessibility to care records, is needed to drive change in the delivery of care.

We need to remember that sharing is not new. There are numerous proven examples of record sharing working in practice:

- **E-consultations have shown the success of using the detailed care record in lieu of patient referral for clinical advice.**
- **Acute hospital and pharmacy clinicians have reduced prescribing errors and improved medicines optimisation by viewing GP records.**
- **Acute and primary care providers using the same system have been able to utilise a longitudinal care record for patients.**
- **Prisons have been able to ensure the continuity of care as prisoners move around the system.**
- **To support end of life pathways.**

The time to empower patients to understand and control their records is now. It's necessary to support the legitimising of the shared record, and to enable patients to benefit directly from better information. Sharing of data for clinical care and for research must now become standard practice in NHS care.

Dr John Parry is a GP and clinical director, TPP. www.tpp-uk.com

PATIENT DATA

WHY CARING IS DESPERATE FOR SHARING

Dame Fiona Caldicott's information governance review could usher in a new era in which patient data is seamlessly available across the NHS, says Daloni Carlisle

When Graham Price's wife Maureen developed dementia on top of her existing Parkinson's disease in 2011, he asked her consultant to send over clinic letters by email. Graham, you see, is blind.

It took over a year of battling bureaucracy and an appeal to the ombudsman before the hospital agreed.

"My wife had advanced dementia and I had no help and felt suicidal. I could get no information from the hospital. They hid behind the smoke screen of privacy and patient confidentiality. They said email is not secure," he recalls.

"But as I pointed out, I have an email reader so I can read them myself. With letters, I have to take them to my neighbour or someone else to read. Then what about confidentiality? It is a nonsense. And when has the post been secure?

"The real issue for me was the indifference I met and how it keeps inequalities going. We have to challenge that. I am sure the consultant was a decent man and a good neurologist, but he was prepared to defend the indefensible."

With Mrs Price now in a nursing home, Mr Price campaigns for better information sharing and took an active role in Dame Fiona Caldicott's information governance review launched in April. His story serves to illustrate why health secretary Jeremy Hunt links information sharing to compassion, safety and quality in care.

"I was at Watford General Hospital recently," says Mr Hunt. "The nurses there talked to me about an elderly lady with dementia who had bruises all over her face. They knew nothing about her. There was no medical history available to them, no medications. That simply cannot be in people's interest."

He compared this with Airedale Hospital (see case study overleaf) where emergency department clinicians can see the GP record – as long as patients give their consent. If the patient is unconscious, they apply the same principle as they would to operating on someone who is unable to give consent.

"The doctors and nurses at Airedale told me that no-one has refused consent," he says. "This is part of the compassionate care agenda, the quality agenda and the safety agenda."

Mr Price's story is also, says Dame Fiona, a striking example of how the NHS has failed to get the balance right between protecting patient confidentiality and sharing information for the benefit of patients. This has to change.

Change of emphasis

"The review heard from citizens and they want more information sharing," she says. "In particular, they cannot understand why, if they appear at hospital, the record of that treatment is not available to the entire group of staff with whom they interact.

"They want more joining up of systems so that information is available to those looking after patients."

They also want their information kept safe; they want to be asked for their permission to share it; and despite supporting research, they have reservations about giving researchers carte blanche in using their information.

As Dame Fiona says: "There is antipathy to information being used for other purposes such as running the health service unless they are aware of that happening."

The information governance review, *Information: to share or not to share?* starts from the premise that citizens should feel confident their information is kept safe – and shared appropriately. As Dame Fiona's

CASE STUDIES OVERLEAF ▶

ALAMY

introduction notes: "Unfortunately, that is not currently the case." Too often, information governance is seen as an impediment to sharing. Perhaps, though, it would be more accurate to say that it is often not the case, as the case studies (overleaf) in this report show. When patients have a single record shared by GPs, hospitals and hospices, it can transform care.

But Dame Fiona does not underplay the important principles of data protection and patient confidentiality. Rather, she wants to see a change of balance between privacy and sharing.

So the review recommends a new Caldicott principle: the duty to share information can be as important as the duty to protect patient confidentiality.

This is an important change of emphasis and one that can only be achieved if staff feel supported by their employers, regulators and professional bodies and here Dame Fiona makes a plea: "We think the emphasis needs to be redrawn. If information governance could be part of clinical governance and not put on the side as a technical issue that would be a good thing."

'There is antipathy to information being used for other purposes unless they are aware of it'

This would bring to the forefront a better understanding of how information sharing can support good patient care but it needs to take place within clear frameworks that govern consent, for example, or access to data and audit trails of who has looked at patient records. She wants to see trust boards take a greater responsibility for information sharing.

There is also a large training and education agenda for healthcare professionals and managers.

"The review panel discovered that the mandatory training is often a 'tick-box exercise'," she says. "Health and social care professionals should be educated and not simply trained in effective policies and processes for sharing of information. This education should include a professional component explaining why there may be a duty to share information in the interests of the patient, as well as the legal aspects of the common law of confidentiality, the Data Protection Act and Human Rights Act."

Another strand is public understanding. "There is a big agenda for public education," says Dame Fiona. "We do not think the public is told nearly enough about how their health and social care information is used."

She would like to see notices in GP and outpatient departments, for example, explaining how consent works, how their personal health data might be used and what the sanctions are for breaching confidentiality.

Dame Fiona has given the government a year to respond fully to her report, especially on some of the more complex issues around secondary uses, safe havens, using information in commissioning and for research. But the principle – and with it the culture around information sharing – looks set to change. Are you ready? ●

PATIENT DATA: CASE STUDIES

MEET THE RECORD BREAKERS

TPP's SystmOne has allowed a foundation trust and a hospice easy access to all areas of the patient journey, transforming care, as Daloni Carlisle reports

AIREDALE FOUNDATION TRUST

Airedale Hospital has been using TPP's SystmOne to share primary and secondary care information for over six months and it has transformed care, allowing nurses and doctors in the emergency department to see patients' GP records.

Now the trust is going a step further to create a single record for patients accessible wherever they are, by whoever needs to see it – although always with patient consent.

The trust has now embarked on an ambitious project that involves four SystmOne acute modules: PAS, bed management, e-discharge summaries and e-prescribing.

Tim Rycroft, head of IT for the trust, says: "We are pretty much SystmOne territory up here in West Yorkshire so we are keen to explore how to exploit this." The acute trust, community providers and most GP practices now use SystmOne. The PAS went live last November and bed management and e-discharge summaries are now being rolled out gradually, starting with the emergency department and medical admissions unit.

Later this year will see the implementation of e-prescribing before other systems, such as the PACS and RIS, are interfaced with the PAS. Eventually this will create a single electronic patient record within SystmOne.

"Our job over the next year is to take the hospital product from an administrative system into a clinical system and to consider what a hospital electronic patient record will look like," he says.

It already exists in a nascent form. "We have the demographic details and now, with a bed management system in the ED and medical assessment unit, GPs can see where their patients are in the system and in terms of their treatment. Now we need to start to refine it," says Mr Rycroft.

The exchange of information is more comprehensive than ever

Offering reassurance

At the moment, the shared system is probably more use to the acute clinicians than it is to the GPs. "Hospital clinicians are able to view GP records from the hospital, with the caveat of permissions and consent," says Mr Rycroft. "They can see really useful information about medications, allergies, when the patient had the last consultation with the GP and so on."

The acute clinicians are not using the system as a CPOE (computerised physician order entry) because other systems, such as the PACS and RIS are not yet interfaced so no pathology or radiology results can yet appear.

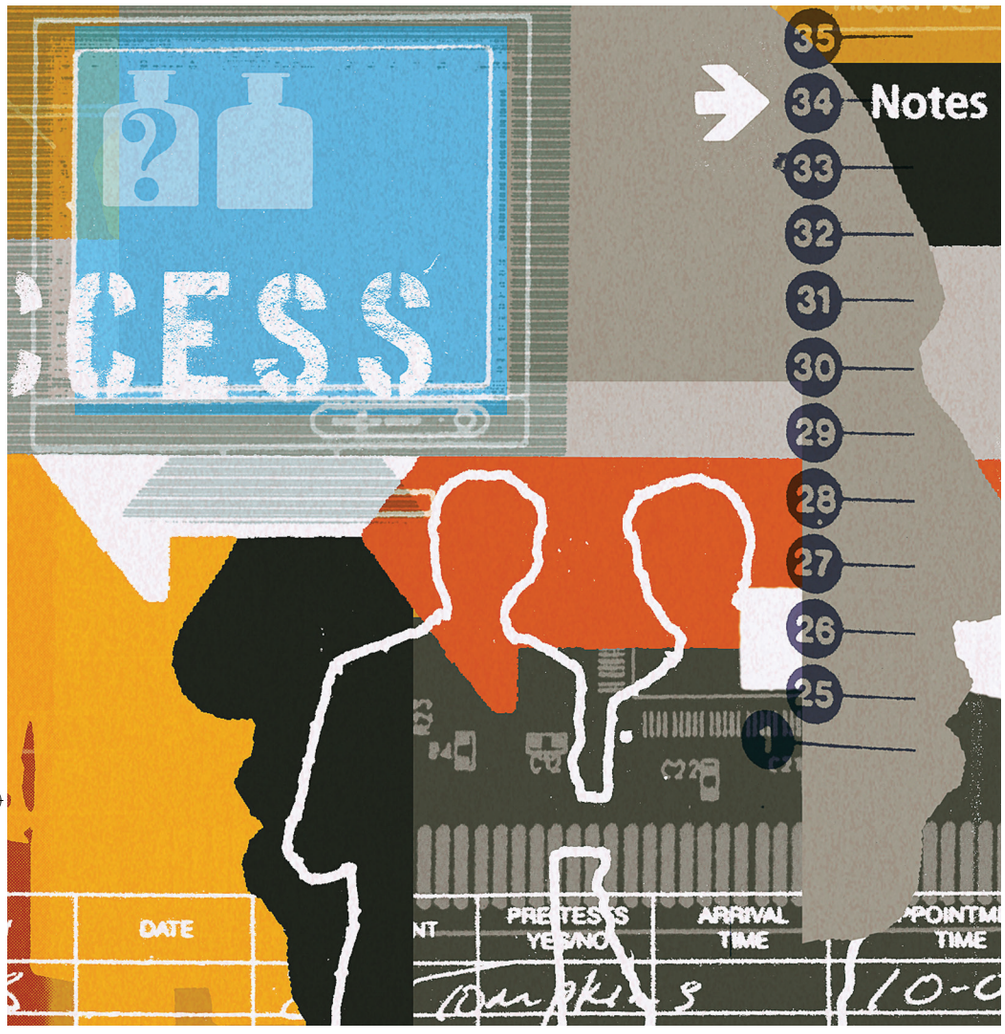
"We have started to do some electronic discharge summaries from the ED and MAU that go straight into the GP record but that is about the extent of it at the moment," says Mr Rycroft.

Clinicians locally are on board, he says. "The GPs have been very helpful and very supportive but they have needed some reassurance and I hope we have been able to give that. We are using a cloud-based system so it will put them in a good position for giving patients access to their records."

Paul Jennings, consultant in emergency medicine, says the system in place so far is easy to use. "We can get access to the GP record very easily and now we are able to pull allergies and drug histories and past medical history from the GP record into the A&E card so we can fill in our record here. It is not 100 per cent perfect yet but it is very useful."

Clinicians not only ask for permission but also check with patients that they have the right information. "We tend to trust the patients more than the IT at the moment," he says. "It is a work in progress. Some people like it; some people prefer to have a box they can fill in line by line. But everyone agrees that for patients who are not able to answer for themselves, whether it is because they are inebriated or have an injury or dementia, it is very useful."

He is looking forward to seeing how the full EPR will develop and what other clinical uses the system can support.



"One of the things I think is very exciting is the idea of GPs sending an email via SystmOne asking a hospital specialist for advice," he says. The combination of secure email coupled with access to the patient's notes could be very powerful in transforming how GPs and specialists work together to support patient care.

ST BARNABAS LINCOLNSHIRE HOSPICE

When St Barnabas Hospice in Lincolnshire first deployed TPP's SystmOne in 2006, it set the organisation on an information sharing journey.

"When I first started using it in 2007 it was really where we entered information about the patient," says Hospice at Home manager for North East Lincolnshire Jill Edwards. "Now it is much more about what we do every day. How we integrate the team around the patient, how we plan and prioritise our work and even how we communicate.

"If SystmOne goes down – which it very rarely does – we do have backup systems but we struggle. I cannot imagine life without it."

It is a system that has kept up with changes in end-of-life care as St Barnabas has moved from providing care in a hospice to care out in the community in this largely rural area.

The Hospice at Home team cares for patients who are in the last 16 weeks of their life with a team that brings in GPs, district nurses, out of hours doctors and Marie Curie nurses, community hospitals and acute trusts.

Of these, the St Barnabas team, the community nurses and hospitals and most of the GPs use SystmOne. This means that, with the patient's consent, each can see information from the others not just about the care delivered but also about the patients' wishes. It is all contained in a single electronic patient record.

"We do a lot of advanced care planning," says Ms Edwards. "It is recorded on SystmOne so the GP can see it, we can see it and the community nurses can see it."

It also helps the hospice at home nurses plan their care. "We come in at 8am and the first thing we do is look at activity overnight on our patients' SystmOne records," she explains.

"If there has been an out of hours visit by the Marie Curie nurses or the out of hours GP, it shows on the system. We can then call those patients and find out if there is anything they need and plan our visits accordingly."

Over at Northern Lincolnshire Goole and District Hospitals, the emergency department and medical admissions unit has deployed the TPP SystmOne clinical record viewer and so is able to access – but not write to – the patients' electronic record.

The system overall helps not just with information sharing but also with communication, adds Ms Edwards. "Sometimes, when we have not been able to reach a GP or district nurse by phone, we use 'tasking' in SystmOne," she says.

This means sending a secure message via SystmOne that pops up on the clinicians' screens when they log in. "It does not replace the phone call or the meeting but it is very useful."

'We tend to trust the patients more than the IT at the moment. It is a work in progress'

SystmOne also figures in future plans. St Barnabas Hospice recently bid for – and won – some funds from the Department of Health's capital grants scheme to refurbish part of United Lincolnshire Hospitals as a "hospice in the hospital" – thought to be the first of its kind.

Sarah Furley, head of strategic development for St Barnabas, explains: "We have a partnership between ourselves, the acute trust and commissioners to redesign end of life care in Lincolnshire and the hospice in a hospital is part of that. We hope to open it in January 2014."

The plan is for the hospice to use the acute TPP SystmOne module. This would link its patient record not just with GPs and the community but also with the hospital PAS.

This would create a record of care in the hospital that can move with the patient should they be discharged from the hospice. It would also allow the hospice to inform GPs very quickly should a patient die in the hospice.

"We would be able to alert the GP the same day. That is incredibly important from a carer point of view," says Mr Furley.

Like Ms Edwards, she says there has been an information sharing journey over the last seven years where the technology to support effective sharing has fostered a change in attitude.

"I do think the battle is being won," she says. "Our experience overall here in end of life care in Lincolnshire is that people are prepared to share." ●

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