The End of Life Care strategy promotes choice of place of care and of death for all patients, yet research continues to show more people die in hospital than anywhere else, despite home being the place of choice for the majority. (ONS 2014). Individuals who have no partner or family support, and are over 75 have almost no chance of achieving this goal (Gao *et al*., 2013).

A one-year pilot project, funded by St. James's Place Foundation planned, recruited, and trained volunteers with a health care background to be companions to lone patients who wanted to die at home. They offered sessions of around four hours duration to patients referred by primary care teams and who fulfilled agreed criteria. Volunteers were mainly available during evenings and at weekends, when most services are at their least well-staffed. They offered a calm, reassuring and supportive presence to the patient and any family present.

Achieving choice of place of death for this specific patient group and deflecting inappropriate admissions were initial objectives. However, poor uptake resulted in wider geographic location, and extension of the service to patients in community hospitals and the hospice, and earlier, additional support, including to families.

Focus on this specific patient group is recommended as a national strategic objective, to offer equity in end of life care choices (NEoLCIN 2014). This is a complex issue, involving willingness to advance care plan, changing priorities as health deteriorates, and the human element of loneliness. More people, of a greater age, will live in single-person households in the future, and are likely to die alone. (housinglin.org.uk, 2012). Is this a service that is before its time? Statistics show that patients in areas of greater deprivation are less likely to die at home – thus should such a service be located by demographic need?

P-165 VOLUNTEER CARE NAVIGATORS: ENRICHING PATIENT NETWORKS

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Background The hospice's strategic model of care review in 2014 found that patients wanted sustained face-to-face contact from their clinical nurse specialist. This is expensive so we developed the volunteer care navigator role. These are trained volunteers who develop trusting relationships with patients and their families, offer sustained emotional and practical support; signpost to relevant agencies and help with navigating the local health and social care system. The project was supported by a grant from the St James's Place Foundation.

Aims

- To care for more people at home, giving the hospice's palliative care nurse specialists more time to support more complex needs
- To support more people to access and benefit from local statutory or voluntary services
- To develop a new high-level volunteer model that can be shared and replicated.

Our approach

- Volunteering Manager recruited and trained a team of volunteer care navigators (25 as at 1 June 2016)
- Appointed an Assistant Practitioner to co-ordinate the service
- Developed comprehensive training programme for the volunteers
- Ensured the volunteer team were integrated with the hospice's community palliative care team
- Supported the volunteers through regular supervision sessions.

Outcomes

- 51 patient referrals, 1512 volunteering hours (nine months' data)
- Map developed and shared of local community agencies and activities
- Project shared with Association of Volunteer Managers.

Impact

- Improved emotional and practical support evidenced by patient and carer feedback
- Enriched patient networks evidenced by mapping
- Clinical nurse specialists' value enhanced support for patients that enables them to focus on more complex patients.

Learning

- Important service is integrated/co-located with the hospice's community palliative care nursing team
- Value of regular volunteer peer learning, support and sharing local knowledge
- Value of initial and continuing training
- Important to include dementia awareness in training.

P-166 EMPOWERING VOLUNTEERS TO SUPPORT CARERS AND PATIENTS AT THE END OF LIFE

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Background An End of Life Support Service set up in 2014 as a pilot project funded by Staffordshire County Council, was developed, to engage and assess the needs of carers. A service was developed providing: information, advice and volunteer support. The volunteers provide emotional and practical support to help end of life carers cope with demands and difficulties they faced.

Development The Carers Support Service proved to be a great success, reviews and feedback regularly sought from carers, patients, medical staff and volunteers, showed the support assisted in helping carers continue in their caring role as well as enabling the patient to remain at home.

Funding ended in 2015, the hospice used the learning from this project to inform the ongoing development of its services.

The hospice decided to develop this into a new service including those patients in need of additional home support, the service has now become Carer & Patient Support Service.

One full time co-ordinator organises a team of volunteers to visit carers and patients known to the hospice in their own homes.

Volunteers Volunteers all received training *et al*., communication and listening, boundaries, confidentiality, safeguarding, and end-of-life care, ongoing training and qualifications are offered.

Outcomes Carers report that they feel more able to cope, less isolated, their sense of well-being increased, more able to sustain their caring role.

Patients report that they feel less of a burden, knowing someone is visiting just for them, giving their carer a break, and when

there is no carer the patient said knowing someone is voluntarily visiting them they felt valued, less alone.

In a world where care has become increasingly professionalised, volunteers offering home support provide a valuable link between the medical needs of the patient, the physical and emotional needs of carers and patients.

P-167 QUANTITATIVE, QUALITATIVE AND ECONOMIC REVIEW OF MARIE CURIE INTEGRATED PALLIATIVE CARE SERVICE

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Introduction The pilot service delivered tailored care and support at home for terminally ill people and their families. Locally coordinated support included nursing care, personal care, emotional support and practical information delivered by a team of registered nurses, healthcare assistants, health and personal care assistants and trained volunteers. An anticipated benefit was a changed pattern of use across health and social care, reducing the use of acute services and increasing the number of patients able to die at home.

Aim The evaluation aimed to address patient and carer experience, quality and costs of the service.

Methods A mixed-methods methodology was used to analyse service use and outcomes across the pilot. Stakeholder, healthcare professional and service user surveys and interviews were carried out to create case studies and analyse service quality. Data linkage was carried out between 153 patients supported by the pilot and their matched controls (who died before the start of the pilot service) to assess the impact of the integrated service on hospital use and place of death. Finally, economic analysis used cost per activity from NHS Scotland Health Services to estimate potential savings.

Results The evaluation evidenced improved quality outcomes for patients and a changed pattern of hospital use. Significantly fewer patients in the pilot group experienced a hospital admission (27%), compared to their matched controls (40%) with a shorter average stay in hospital (2.5 days less per admission) and more time in the community (15.8%). Furthermore, significantly more patients in the pilot group (73.7%) died at home, compared to their matched controls (29.1%). The economic analysis showed a potential annual reduction in the costs of end-of-life care in Fife of £182,283.

Conclusion The integrated service model demonstrates that investment in coordinated palliative care services delivers positive outcomes in quality of care and health economics.

P-168 A REVIEW OF OUT OF HOURS (OOH) CALLS MADE TO A COMMUNITY PALLIATIVE CARE SERVICE

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10.1136/bmjspcare-2016-001245.190

The National Institute for Health and Clinical Excellence published the 'Quality Standard for End of Life Care for Adults' in 2011 (updated 2013).

Four of the standards make specific reference to provision of a care across the 24/7 period.

Currently all patients under the community palliative care service, their families and any professionals supporting them can access out-of-hours (OOH) specialist palliative care support from a clinical nurse specialist (CNS) via the telephone. It is widely considered that the optimal service provision would include access to face to face visits 24/7.

In order to understand the scope of local need for access to a 24/7 visiting service, a review of all OOH calls received over a one-month period was undertaken.

A retrospective review was undertaken examining the clinical records relating to 34 OOH calls in an attempt to understand whether an OOH face to face visit by a CNS would have led to a more favourable patient outcome.

The reviewers felt that on the following four occasions, face to face assessment carried out by a CNS may have led to a more favourable patient outcome:

1. No contact was made with the OOH CNS. Patient was transferred to hospital with no assessed clinical need.
2. Patient had multiple symptoms which made telephone assessment difficult.
3. Patient suffering from breathing difficulties with known social complexities
4. Patient had no recent CNS input and had uncontrolled symptoms.

Next steps include Increased promotion of the OOH CNS service and when and how to access it.

Provision of written guidance for patients and carers about the potential for changes in the patient's condition and instruction on how to proactively manage symptoms to avoid crises.

P-169 WHAT ARE THE PERCEPTIONS OF THE COMMUNITY PALLIATIVE CARE TEAM REGARDING THE CURRENT PROVISION OF TELEPHONE SUPPORT?

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Aim The aim of this study is firstly to understand the form and content of telephone support delivered by the community palliative care team (single inner-city hospice). Secondly, to explore the perspectives of the team members, regarding their lived experience of providing telephone support.

Background The role of the community clinical nurse specialist in palliative care, is pivotal to supporting patients with complex needs. There is limited literature acknowledging and quantifying, the clinical and supportive role of day-to-day telephone advice, provided by the team.

Method A two phase method was adopted. Firstly, a contact analysis table, logging incoming calls and messages received by the team, provided a picture of the current provision of telephone advice. Secondly, adopting a phenomenological approach, in-depth interviews enabled the researcher, to explore the perceptions of the community palliative care team, on the current provision of telephone support.

Findings Relatives of patients utilise the telephone advice from the CNSs, for both symptom management and emotional support. The average length of a call for a CNS is eight minutes and two minutes for the administration team. The CPCT perceive that the availability and accessibility for advice over the telephone