

is valued by relatives, whilst health care professionals liaise and seek advice. The delivery of telephone support is complex and can be a catalyst for stress, anxiety and a source of overwhelming responsibility for the CNSs. The challenges that the team face, are balancing different aspects of their roles and having unmet training needs.

Conclusion This study has provided a “snap shot” of the day-to-day telephone support that is offered by the community palliative care team. Furthermore, this study has highlighted areas of potential development for the team, for example, by reviewing processes, logistics and administration, related to the ongoing delivery of telephone support.

P-170 HERTS NEIGHBOURS VOLUNTEERING SERVICE

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Context This volunteering service supports patients and families coping with a life-limiting illness. It was established in 2015 following a study evaluated by Lancaster University, funded by the Centre for Social Action, Cabinet Office. It was one of six project sites to set up a pilot service to evaluate support for end of life patients by social action volunteers.

In collaboration with local partners volunteers were recruited and completed training following a thorough recruitment process. Patients were recruited onto pilot and consented to an assessment of their support needs. Patients and carers were asked by the University to complete questionnaires on carer burden, quality of life, loneliness and social support whilst being supported for twelve weeks by volunteers.

Aim To provide practical and emotional support for isolated individuals and their families, within their home who have a palliative diagnosis.

The project is managed by a co-coordinator who visits individuals at home and completes assessments to discuss the support required. Interests and background are taken into account to match with an appropriate volunteer. Regular reviews are held to ensure the partnership is working.

Weekly 1–3 hours of support provides:

- Befriending, companionship
- Shopping or social outings
- Daily errands and chores
- Accompanying individuals to hospital and GP appointments
- Assisting with social media to keep in touch with distant relatives.

Evaluation and sustainability The study is evaluated by Lancaster University by end of June 2016. It is hoped that this will provide favourable evidence for CCGs to future fund. The hospice carried out its own evaluation, a user survey which was presented to the board of trustees which resulted in backed funding for a permanent coordinator post.

Development of the service and role of the Herts Neighbour is being progressed to provide enablement and bereavement support.

P-171 HOME VOLUNTEERING – THE NEED, THE CHALLENGE AND THE IMPACT

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We hope to share our experiences of home volunteering through a hospice for children and young adults, exploring the need, the challenges (and how we deal with these), and initial thoughts about impact. Volunteering *outside* the hospice offers new solutions to key questions around people, partnerships and potential.

Children and young people visit our hospices for respite, symptom management, stepped discharge and end-of-life care. Their visits are brief and infrequent. One way to bridge these gaps and address the practical and emotional challenges children, young people and their families face is through volunteers.

Home volunteering has two distinct strands:

Support for families For many families, their lives are dominated by supporting a child with a life-limiting condition, particularly where that child also has physical and/or learning disabilities. On top of this they face the same day to day challenges as others – looking after other children, getting to work, managing the home. Families often find that there is a ‘last straw’ – a pile of ironing or a weed-filled garden. Small, frequent help from a volunteer can have a big impact.

Befriending for young adults Like families, young adults can be overwhelmed by their situations, but instead of being overloaded with things to do, they are more often socially isolated, physically dependent and lacking things to do. Volunteer befrienders seem symbolically important because they aren’t paid to be with the young adults, nor are they there to perform a functional task for them. They simply spend time with them.

Though these two strands look very different in practice, we have observed a similar impact, with parents and young adults alike experiencing reduced stress, increased confidence and – perhaps most crucially – a level of control in their lives, no matter how small. Both strands provide a crucial link between hospice support and life outside.

P-172 TRAINED VOLUNTEERS: EMPOWERING AND SUPPORTING DYING HOSPITAL PATIENTS AND THEIR CARERS

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Background Dying patients in hospital may have little emotional support at the end of their life and may die alone. Alongside this, family and friends can feel isolated and overwhelmed by the experience. A key challenge for hospitals is how to provide emotional support when staff are needed to provide nursing care on busy wards.

A charity trained 28 volunteer “companions” to accompany, advocate and support people during this difficult time. Supported by a service manager, the “companions” deliver emotional comfort 12 hours a day, every day of the year.

Aims The main objectives of this innovative service are:

- to provide emotional support to the dying and their families
- to facilitate increased understanding about the emotional and social needs of the dying, and their families, within the community and across the hospital environment.

Methods On the whole, healthcare professionals refer patients/families to the service manager who then meets the patients/families to understand their needs. An appropriate “companion” is allocated by the service manager and the “companion” is then introduced to the patient/family to provide face-to-face support tailored to their needs.

The service is evaluated on a continuous basis, using:

- Stakeholder feedback: from patients/families, staff and “companions” to explore the impact of the service on improving emotional support
- Activity data: completed by the “companions” capturing what support was delivered.

Results An earlier review suggested that hospital staff, dying patients and their families had very positive experiences of the service, with nursing staff seeing benefits in terms of patient and family wellbeing and their own stress levels.

The initial pilot has increased from three adult wards to supporting all 20, and has received over 250 referrals since launch in August 2014.

The service is the only one of its kind in the country, and was outlined in the Care Quality Commission report as an example of outstanding practice.

P-173 THE HOSPICE FRIENDLY HOSPITALS PROGRAMME IN IRELAND

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Background Almost 30,000 people die in Ireland each year. 43% of people in Ireland die in acute hospitals; that’s around 35 people every day. The Irish Hospice Foundation identified a deficit in the care of patients and their families at the end of life and in 2007 established the Hospice Friendly Hospitals (HFH) Programme in partnership with Ireland’s National Health Service Executive. The programme was established in order to introduce hospice principles into hospital practice

Aim The HFH Programme seeks to ensure that end of life, palliative and bereavement care is central to the everyday business of Irish hospitals.

Methods The HFH Programme designed a suite of quality improvement interventions for hospital staff. The programme

- Developed the *Quality Standards for End of Life Care* and a suite of guidance documents for hospital staff.
- Improved the culture of end-of-life care through education initiatives, a national nurse practice development programme and promotion of symbolic resources.
- Influenced the health system to raise the profile of end of life care by establishing.
 - End-of-Life Care Coordinator posts.
 - End-of-Life Care/Bereavement Care Committees in hospitals.
 - Three national leadership networks for hospital staff.

Results

- Over 40 public and private hospitals are linked to the HFH Programme. This represents over 90% of public hospitals in Ireland.
- Palliative, end-of-life and bereavement care is a core component of hospital operational plans.
- Hospitals have established a governance structure (committee) to oversee quality improvement projects.
- Symbolic resources e.g. the end-of-life symbol are used widely.
- Over 20 refurbishment projects complete e.g. mortuaries, family rooms, bereavement suites through the Design & Dignity Grants Scheme.
- The Quality Standards for End of Life Care underpin new national standards for bereavement care in maternity settings.
- The HFH Programme is working with organisations in Northern Ireland, the UK and Canada to disseminate learning.

P-174 TRANSFORMING END OF LIFE CARE IN THE COMMUNITY AND ACUTE HOSPITAL

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Background The Transforming End of Life Care in the Community Programme was based on the success of the Transform Acute Hospitals programme. Both programmes aim to promote multi-professional team communication and to improve end of life care. Two local Clinical Commissioning Groups provided funding for the community programme, which launched in April 2015, following introduction of the programme to health-professionals by means of masterclasses.

Aim The hospital programme aims to accommodate patients *going back* to their preferred place of care/death. The community programme aims to *keep* people in their preferred place of care/death. It intends to promote the use of supportive care registers and improve the incidence, quality and recording of future wishes, preferences, wishes and values – Advance Care Planning (ACP).

Jointly, both programmes are facilitating implementation of the new Electronic Palliative Care Co-ordination System.

Methods The hospital programme utilises teaching time with hospital staff. In the community, Protected Education Training time in GP practices is used, incorporating district nursing teams.

Training covers ACP, DNACPR and end-of-life care, and has extended to community therapy teams and nursing/care homes, with stand-alone sessions for NWS and PTS. It incorporates the ‘One Chance to Get it Right’ and the ‘NICE Guidance for the Care of the Dying Adult’ documents. The education is measured with both pre and post impact and evaluation.

Results The number of people trained as of 31/03/16 is 628. Completed figures from cohort one indicate a 56% increase in the number of people identified as being in their last year of life. Records of ACP and DNACPR discussions have increased by almost 21%.

In 2008, average local DiUPR figures were 33.8% (England 37.8%). In 2014, these figures were 39.2% and 44.7% respectively. We wait to see whether this education initiative, in combination with other aspects of local strategy will lead to a further improvement in DiUPR.