

**Methods** A robust volunteer recruitment, selection, training and support programme was created. Referrals were taken from health and social care professionals and from families. Trained volunteers were matched to clients to begin weekly visits. The service was evaluated on a continuous basis, using stakeholder feedback from the terminally ill person, their informal carers and the referrers. Every episode of support is recorded for analysis.

**Results** There are now 18 Helper Services across the country. Since 2009: 3,081 people have been supported 1180 volunteers have been trained.

**Conclusion** This is a highly valued service that has had a huge impact on a large number of people living with a terminal illness and their families. A more in-depth evaluation is underway which will lead to developments in the scope of the service.

**P-202** A PALLIATIVE CARE MODEL FOR ADVANCE CARE PLANNING: A HOSPITAL2HOME APPROACH

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**Background** Patients with life-limiting disease often do not achieve their preferred place of care and death. The Hospital2Home service (H2H) has been created to enable patients whose treatment has moved to palliation only, to leave hospital and safely achieve their priorities and preferences. The H2H service is facilitated by a team of palliative care Clinical Nurse Specialists and is based on a successful research project undertaken in Australia (Abernethy, 2006).

**Aim** To demonstrate the effectiveness and impact of the Hospital2Home telephone case conference model. This service delivery model coordinates advance care planning, transition of care, enhances communication between the hospital and specialist community services, and where appropriate, establishes a shared digital Urgent Care Plan (Co-ordinate My Care). Conversations with the patient and those close to them form the agenda of the telephone case conference with community teams and GP. Symptoms, social needs, family issues and preferences are discussed.

**Methods** The data for this evaluation have been retrospectively extracted from the Hospital2Home database between January 2015 to June 2017. Demographics, diagnoses, preferences and service data have been analysed.

**Results** The data demonstrates that by establishing patient preferences, and sharing priorities via telephone case conferences, 76% of 544 patients were enabled to achieve their preferred place of death ie home or hospice and only 20.4% died in hospitals.

**Conclusion** Telephone case conferencing is an effective tool to promote safer complex discharges.

**P-203** ORANGELINE: MUCH MORE THAN EXPECTED

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**Background** OrangeLine, launched in April 2016, is a telephone helpline for local people seeking information, friendship

and support. Callers do not have to be known to the hospice. OrangeLine addresses loneliness and isolation, and signposts to internal and external services. It was anticipated OrangeLine would run simply as a telephone helpline. Interventions are recorded and include all telephone and face to face contacts. In 2017 April recorded 122 interventions, and 186 in May.

**Aim** To gain feedback from service users after the first three months of the helpline, establish if OrangeLine is meeting their needs and make appropriate changes.

To explore the impact of OrangeLine on service users.

**Method** Telephone user satisfaction surveys on the quality of the service, sought from each service user approximately two weeks after each call.

Focus group participants, recruited from families who used family support services or OrangeLine. Thirty service users attended, diverse in age, gender and ethnicity, and feedback on quality of their experience was collected.

**Findings** Unanticipated needs were highlighted and included i) earlier and regular contact with OrangeLine, ii) immediate assistance with death certificate processes and iii) social contact with others in similar situations. Service design now includes a monthly social contact Friendly Faces group. Data from the satisfaction survey and the Friendly Faces group is analysed monthly and shows 92% feel less isolated and 83% feel their mood has improved. Condolence cards are sent out one week post bereavement to initiate earlier contact, followed by a welfare call one week later. Referrals from the inpatient unit are made immediately after death, to assist with death certificate administration.

**Conclusion** One year on, OrangeLine is much more than a telephone helpline. Service user feedback has directly impacted on redesign and delivery. The need for a formal service evaluation is being explored.

**P-204** DAY HOSPICE – SERVICE REDESIGN AND OUTCOME MEASUREMENT

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**Background** Day Hospice underwent review and subsequent service redesign as referrals and attendance had dropped and new models of care were emerging. The redesign incorporated implementation of outcome measures to evaluate impact.

**Aim** Move from a social model to a therapeutic programme to:

- empower patients to 'live well' with their illness
- improve symptom control and self-management
- offer education, exercise, relaxation and support
- reach more people.
- Start measuring outcomes using the OACC suite.

**Methods** The Day Hospice therapeutic programme runs weekly for 20 patients over 12 weeks. Patients have individualised assessment with nurse/physiotherapist, then embark on a structured programme with ongoing 1:1 support from the MDT. Measures recorded: IPOS and 'views on care' 0 and 6 weeks, Barthel and phase of illness every visit. Patients are discussed at MDT meeting at 0 and 12 weeks

**Results**