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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10.1136/bmjspcare-2017-hospice.228

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

- Over 10 months, 156 referrals, 78 of whom accessed the service
- Average 18 patients on waiting list
- 72% average attendance/week
- 71% malignancy; 29% non-malignant condition
- IPOS data shows mixed scores but tool clinically useful for identifying patients' unmet needs
- Quality of life increased from 3.0 to 4.3 despite overall deteriorating health
- Patients/carers report Day Hospice makes a significant difference with most saying it gives 'a lot of benefit'
- Patterns in phase of illness have emerged and may help to guide decision making regarding follow-up
- 100% patients discharged from hospice, had consecutive 'stable' status throughout care
- All patients needing specialist follow-up had 'deteriorating' or 'unstable' phase during programme.

Conclusions The redesign has been successful and patient feedback good. Measuring hospice outcomes remains challenging but our experience of the OACC suite has been positive and we are now implementing Karnofsky. A clearer pattern, particularly with IPOS may emerge with more data. However, we may need to wait to benchmark against other similar services or a baseline population.

P-205 THE POSITIVE IMPACT OF A LIVING WELL SERVICE OFFERED WITHIN A PALLIATIVE DAY HOSPICE SETTING

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10.1136/bmjspcare-2017-hospice.230

Background Patients attend Day Hospice for a limited period enabling monitoring and management of symptoms. Once symptoms are managed, the discharge process has proven difficult. The beneficial support and care patients receive mean they are reluctant to terminate attendance, causing anxiety and distress for patients and families.

Aims

- Initiate a structured programme for patients whose symptoms were stable and not requiring specialist medical palliative care
- Help facilitate discharge while empowering patients with information and education
- Utilise the service as a step up or step down tool, for patients that may deteriorate or stabilise, enabling us to offer a flexible, responsive service.

Methods Patients identified by the multi-disciplinary team from the cohort attending Day Hospice that no longer required specialist medical input. Programme is nurse-led with input from the multi-disciplinary team. These patients were reluctant to be discharged as felt they benefitted emotionally and psychologically from the social aspect of the service. A sixteen-week plan was devised which included optional education sessions and circulated to potential attendees. Activities were also available which patients could access if desired. A drop-in session is available on completion of the 16 week programme, ensuring an open door policy to hospice services or enabling people to access social contact. Patients can now join the programme at any point and can be referred directly from other professionals.

Results The pilot is still continuing and evaluation has been ongoing and positive. (Pilot completes 22/6/17). Everyone has benefitted from the education sessions. Patients seem reassured by the offer of drop-in sessions and expressed a desire to attend these.

Conclusion By offering information and tools needed to feel empowered to live well independently with the option of drop-in sessions, appears to be a successful way of supporting patients' discharge from the day hospice.

P-206

PROACTIVE DISCHARGE – A PERSON CENTRED APPROACH TO WELLBEING WITHIN A HOSPICE DAY SERVICE

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10.1136/bmjspcare-2017-hospice.231

Background Feedback demonstrated patients felt unprepared for discharge from a hospice Day-Service. Staff sought a more effective method to support patients to discharge. A Wellbeing Group (WG) was created focusing on enhancing knowledge and self-empowerment using a person-centred approach. This created an inclusive and positive discharge. This approach supports the Scottish Government's vision of Realistic Medicine, putting patients at the centre of decision-making.

Aim The WG aims to empower patients using self-management techniques, enabling patients to make shared decisions. This reduces dependency on hospice and statutory services and focuses on what matters most to the patient.

Methodology A prospective study was planned to identify outcomes of the WG. Sample size n=17, with 16 completing. Sample aged 54–74, female 80%, male 20%, analysis was carried out by two authors. Outcomes were evaluated through the use of evaluation, Patient Activation Measure – PAM (Hibbard & Gilbert, 2014) and Views on Care – VoC (Witt et al., 2015).

Results 100% felt benefit from attending WG.

92.3% increased confidence.

84.6% improvement in main problems and concerns.

84.6% learned techniques that enhanced physical and mental wellbeing.

73.3% improvement in the response to the question: 'when all is said and done, I am the person who is responsible for taking care of my health.'

69.2% improvement in quality of life.

Patient quote, 'This group has certainly improved my confidence and wellbeing.'

Conclusion Kilbryde Hospice has tailored service delivery according to patient feedback introducing a new and innovative WG. This has shown a positive impact on individuals. All nine PAM questions and evaluation results demonstrated improvement in many areas. Patients felt more prepared for discharge, confident they had the skills to take an active role in their own health and wellbeing. On reflection, PAM could be carried out earlier to ensure WG was the defining factor in improvement.