programming to an adult audience. This is the first time MCP has been offered in the UK to adults with life-limiting illness and has evaluated very well with very little if no expense to the hospice. One provider can stream to unlimited patients/locations.

P-212 HOSPICE WALKS FOR HEALTH – INTRODUCING A ‘WALKING FOR HEALTH’ SERVICE AT A PRO-ACTIVE HOSPICE

Nicola MacKinnon, Chris Herman, Diane Baldwin. *Willen Hospice, Milton Keynes, UK*

10.1136/bmjspcare-2018-hospiceabs.237

Background Following a recent relaunch of the user group at the hospice, users requested the opportunity to participate in regular walks linked to the hospice. Armed with this request we designed a service to complement this and three other key considerations:

- Increasing evidence that people benefit both physically and psychologically from pursuing as active a lifestyle as possible
- The hospice is located by two beautiful lakes in an area with a network of well-maintained footpaths
- There is an already established national ‘Walking for Health’ (WfH) programme across the city but service users did not have the confidence to use the other walks.

Aims To work in collaboration with our staff, volunteers, local council and users to develop a cost-effective, regular programme to empower service users to be physically active.

Methods Volunteers were recruited, attended training organised by the local Council and were supported by the hospice team to start a weekly WfH program based at the hospice. The walks finish at the main hospice lounge with refreshments and opportunity to socialise. A service user who attends the walks designed a questionnaire to gain qualitative feedback about the walks.

Results Within six weeks, seven patients have regularly attended the weekly walks. Patients describe the benefits of attending the walks as ‘companionship, togetherness, friendships, confidence, fitness, strength and stamina’. One patient said, ‘I can walk further every week, now I can manage two miles’.

Conclusions Within six weeks, having worked in collaboration with our local Council to have seen six patients and two volunteers go for an hour long walk every week is something to celebrate and share. The Council are now planning to promote the walk in their WfH publications. We now plan to increase the range of these walks and promote them to all users of our services.

P-213 GROWING FORWARDS

Lucy Heaps. *Garden House Hospice Care, Letchworth, UK*

10.1136/bmjspcare-2018-hospiceabs.238

Background The hospice Occupational Therapist (OT) had read a poster regarding Social Therapeutic Horticulture (STH) within palliative care (Leckie & Pilgrem, 2016). With low level experience of gardening, the OT was given the challenge of starting up STH within day services.

Aims

- To liaise with the fundraising team to access funding for training and equipment needs
- To develop skills and knowledge to lead STH sessions via networking and training
- To run STH sessions with support from the rehab assistant and a volunteer.

Method June 2017 – started researching what was involved in running a weekly STH session. September 2017 – funding gained from Santander. September 2017 – became a member of the STH for palliative care (STH4PC) specialist interest group. October 2017 – attend the Thrive ‘Award Access course’ on STH (endorsed by the Royal College of Occupational Therapists). November 2017 – Attended training day at Phyllis Tuckwell Hospice – setting up a STH session. April 2018 – started weekly STH sessions at the Hawthorne Centre.

Results

- OT has increased knowledge and skills in STH
- Gained fantastic peer support and guidance face to face, attending specialist interest groups and via social media channels
- Weekly STH sessions are in place and patients are giving good feedback. They have a reduction in their anxiety and stress as a result of attending a sessions
- Patients are proud to be growing plants and vegetables to be used by the kitchen, and also sold at our annual hospice open garden event.

Conclusion It has been a rewarding personal development experience to come into a new post and set up a successful STH session to patients. We have future plans ahead to increase the overall access to the garden by patients, families and staff.

P-214 THE TWINING RELATIONSHIP BETWEEN LOROS HOSPICE AND NDI MOYO HOSPICE

Gemma Miller, Agnes Rupango. *LOROS Hospice, Leicester, UK*

10.1136/bmjspcare-2018-hospiceabs.239

Background In 2015 LOROS Hospice was approached by a doctor about a possible twinning with Ndi Moyo Hospice in Malawi. The doctor is a retired GP who had previously witnessed the good work that they were doing and their need for support. The LOROS Ndi Moyo Hospice Steering Group is responsible for fundraising, managing monies and planning visits. A patient legacy has enabled LOROS to set up a bursary fund which enables a limited number of LOROS staff across all services to visit Ndi Moyo Hospice annually.

Aims It has been agreed that LOROS staff will visit Ndi Moyo to:

- Share ideas, innovation, and best working practice
- Enhance and broaden palliative care training for the benefit of patient care and personal development
- To experience palliative care in a different cultural setting
- Support the acquisition of medical supplies for Ndi Moyo
- Provide opportunities for staff to experience palliative care in diverse environments.

Methods LOROS staff spent seven days visiting Ndi Moyo getting actively involved with daily tasks. They provided

feedback on their return and shared new ideas based on their individual experiences. LOROS staff presented relevant topics to Ndi Moyo staff to share palliative care methods and ideologies. Enabling them to identify practical resource needs.

Results LOROS has been able to share knowledge which in turn has improved confidence levels at Ndi Moyo. On a practical level LOROS has provided some basic medical supplies and resources. LOROS has implemented new working processes learnt at Ndi Moyo to improve team working across the hospice. Overall it has enhanced cultural awareness and diversity.

Conclusion The twinning has helped to transform patient care within both organisations through the sharing of skills and knowledge. For LOROS staff the twinning has brought a new level of appreciation for our standards and values.

P-215 TWINNED: SIMILAR TRAITS BUT NOT IDENTICAL

Peter Gilliam, Dee Curless, Jackie Whiller. *Mountbatten, Isle of Wight, UK*

10.1136/bmjspcare-2018-hospiceabs.240

Background In 2015, after 20 years in preparation, a hospice in Cyprus opened its doors. As the only hospice on the Island of Cyprus, they were challenging the norms of culture and expectations for palliative and end of life care. Many residents of Cyprus have strong Christian faith which influences their views, a culture where 'life is precious beyond all means'. Many did not understand what a hospice is or does, as there is no word in the Greek language for hospice. Delivering palliative and end of life care to an island community with a shared geographical isolation was familiar to us; given our longevity and stability as an organisation meant that we were uniquely placed to offer the support being sought.

Aims The aim of the Cypriot hospice was to twin with a partner UK hospice to aid in its development, having a shared sense of purpose.

Methods Support included sharing and development of practice and policies along with advice on retail and fundraising activities. Nursing documentation to support the delivery of care and education, training and practical development for staff has been well received. This has been achieved through ongoing exchange visits in both directions.

Results We have seen an increased confidence in the Cypriot hospice staff along with developments and improvements in patient care and practice.

Conclusion What has emerged has been a relationship that is proving to be mutually beneficial to both organisations. It has enabled us to think beyond the realms of our own service, having a greater understanding of the challenges faced in delivering care in a different cultural setting, sharing and learning to improve patient care which is at the heart of what palliative care is all about.

P-216 HOW HOSPICES CAN ADD VALUE TO THE DELIVERY OF LOCAL SUSTAINABILITY AND TRANSFORMATION PLANS (STP)

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Frailty is recognised as a long term condition. However, the syndromes of frailty are often viewed by older people, professionals and society alike as an inevitable part of aging. As a consequence, opportunities are missed to identify people's underlying complex needs including palliative and end of life care needs. This results in people with frailty, often presenting in crisis to health services with conditions that ostensibly appear to have been avoidable.

Lincolnshire has implemented Neighbourhood Team working, underpinned by the principles of the 'House of Care' (HoC) policy: a proactive model of self-care that encourages a move away from the traditional health care delivery model that is single condition specific to one that has a person-centred approach and promotes an integrated model of care. A model that is familiar to providers of specialist palliative and end of life care. Therefore, St Barnabas Lincolnshire Hospice has worked collaboratively with the members of the Neighbourhood Teams to develop a Frailty Pathway to inform the Neighbourhood Teams priorities.

The Frailty Pathway works as a boundary object to facilitate a whole systems approach by the Neighbourhood Teams, thus ensuring people with frailty, wherever they present are able to have their needs recognised, and assessed resulting in personal support and care plans reflecting their outcomes including when appropriate, advance care planning and timely access to palliative and end of life care.

We would like to present our experiences in collaboration with a Neighbourhood Team Lead, to share how hospices can support generalists to improve the health and well-being outcomes for people with multi-comorbidity and frailty, by widening access to palliative and end of life care. Thus enabling people to achieve person-centred outcomes including, preferred place of care, and supporting the STP aspiration of reducing avoidable admissions by 30%.

P-217 COLLABORATIVE NEIGHBOURHOOD TEAM WORKING ENABLING IMPROVED USE OF RESOURCES AND PERSON-CENTRED CARE

Kerry Bareham, Anita Miller, Karen McCay. *St Barnabas Lincolnshire Hospice, Lincoln, UK*

10.1136/bmjspcare-2018-hospiceabs.242

The challenge for Lincolnshire reflects that of most of the NHS. In spite of our best efforts our current model does not always deliver the highest quality safe services. Demand for services are increasing, associated with an increasingly aged population with multiple comorbidities and associated complexities. There is a national shortage of appropriately trained and skilled staff, compounded in Lincolnshire with increased challenges in recruitment. We need to look at a way of delivering services that is less reliant on secondary care. We need to stop duplication of services and move away from the traditional reactive model of care the NHS was designed to deliver, to a service model that recognises the biopsychosocial determinants of health and is therefore a more holistic proactive model. Delivered seamlessly by a multi-agency, multidisciplinary team working together to achieve person centred outcomes.

Lincolnshire has adopted a Neighbourhood Team (NHT) model of working that reflects the proactive model of care described by NHS England's House of Care policy – A framework for long term conditions. One of the priorities has been