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

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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

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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

to look at the provision of very end of life care in the last 12 weeks of life. To enable improved use of resources and coordination between services, to deliver care that is truly person-centred. At the end of life, time is precious. Loved ones' feedback is that services often feel uncoordinated, and the numbers of seemingly duplicated visits by different services can be overwhelming.

One Neighbourhood Team has chosen to audit and review the delivery and coordination of end of life services in the last 12 weeks of life, with a view that this will also positively influence closer collaboration and improved outcomes for all people. The poster presentation outlines our work and achievements.

P-218 STAND TOGETHER TO BE OUTSTANDING

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10.1136/bmjspcare-2018-hospiceabs.243

Background With over 120 local care providers, more than a quarter are currently rated by the Care Quality Commission (CQC) as Inadequate or Requires Improvement. Following our own Outstanding inspection we, as the sole provider of specialist end of life care, now have a unique role to play sharing our knowledge and skills.

Aim The key to a successful CQC inspection is to work in partnership with other organisations with the aim of improving or maintaining CQC ratings to 'Good'. A shift in culture and leadership will improve the lives and experiences of some of our most vulnerable people and place them at the centre of their care.

Methods The programme aims to provide information and tools to help the proprietors and managers both produce and take forward robust quality assurance and action plans, focusing on culture and leadership based on the Key Lines of Enquiry, but particularly 'Safe' and 'Well Led'. A five-day classroom based education delivered to four cohorts per year; access to an online 'Share-point' of information for all participating providers; and ongoing support visits to help implement the tools.

Results With a rapidly subscribed programme extending over three years, there is already evidence of improved relationships and communication between Statutory Authorities and providers. Ratings are already improving as we share this hospice's mission, vision and values to support each other.

Conclusion With support and improved CQC inspections there will be fewer closures which result in the local area losing essential care provision. Working in partnership with an open and honest culture is the only sustainable model to ensure the future delivery of high quality care. Highlighting gaps in training and education this project has led to further programmes of training which we are now coordinating as a partnership to ensure the delivery of quality standardised education to all.

P-219 IMPROVING THE EFFECTIVENESS OF HOSPICE NURSING HANDOVERS

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10.1136/bmjspcare-2018-hospiceabs.244

Introduction The quality of nursing handover is important to ensure safe and effective care of patients and to reduce health

care errors by ensuring patient information is correct and understood. Review of evidence shows a number of models used in clinical practice but none felt to be appropriate for a hospice care environment. Staff comments were sought and identified that a more structured and meaningful approach was needed.

Aims Provide a more structured and consistent approach to nursing handover. To utilise a team approach to change in practice. New approach to be user friendly

Method A fishbone analysis was conducted to provide a systemic perspective of current practice of nursing handover on the in-patient unit. Staff comments and ideas collected through group discussions, ideas shower, observations, interviews, dotting voting and audit.

HOSPICE mnemonic created: H – History; O – Overall care needs; S – Symptoms; P – Psychological needs and support; I – In/Output and Infection prevention; C – Controlled medication; E – Evaluation of care.

Nursing champions within the team identified to facilitate implementation.

Implementation Colourful prompt cards detailing 'HOSPICE' handover mnemonic, provided to all staff. Four-week trial period of using new approach, showed existing handover sheet required review. Documentation changed to match the structure of the 'HOSPICE' mnemonic. Ongoing implementation using new approach.

Evaluation Data will be gathered three months post-implementation and will include staff comments and experience, review of clinical incidents and audit of documentation.

P-220 SOCIAL SUPPORT: DEVELOPING SUPPORT ROLES FROM WITHIN THE WORKFORCE

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10.1136/bmjspcare-2018-hospiceabs.245

Background Increasing workload of palliative care social worker recognised. Employed by hospice but funding for post shared by hospice, local authority and Clinical Commissioning Group with responsibility to attend meetings, training and supervision away from hospice base.

Aims In order to facilitate a timely discharge to preferred place of care, we need to be able to respond and meet the demands of the complex and challenging needs of patients and improve the accessibility of social work advice to patients and their families in a timely manner.

Methods Empower existing staff in a developmental role by recognising ambition, skills and knowledge in a current staff member, whilst acknowledging limitations of this and respecting specialist social worker role. Shadowing of palliative care social worker on ward rounds, outpatient clinic and day services; communication skills training undertaken. Developing existing knowledge for application of Continuing Healthcare Funding and placements with further training planned for benefits and welfare advice. Work closely with social work administration support.

Results Access to social work advice from health professional at time suitable to patient and family means no waiting. Discussions and administration around discharge planning can be commenced in a timely way and followed up with specialist input from social worker. Better use of health professional skills; palliative care social worker can undertake joint