project will be run as a three year pilot funded by the Issa Medical Group.

**Method** CNS is based at the practice hub. Referrals are now taken directly from primary care staff to the CNS. CNS has access to practices’ electronic systems to streamline communication and ensure timely treatment and prescribing. CNS maintains place in week-end rota, line management, clinical supervision and multi-disciplinary team input from the hospice.

**Results** Challenges we encountered were:

- I.T.; ensuring access to two electronic patient records in two locations;
- Establishing working relationships within a large two–centred practice;
- Adapting prescribing policy and practice to that used by the Group;
- Changing practice to enable greater flexibility and responsiveness;
- Acquiring enhanced skills, such as verification of death.

**Initial benefits**

- Joint ward rounds held at large nursing homes;
- Waiting time now less than 48hrs compared to the current CNs wait of 4 weeks;
- Wider referral criteria, including early intervention. 23 patients seen who would not have been seen in the old model of which 14 were for end of life care;
- GPs appreciate being able to see entries put directly onto EMIS rather than in traditional letter format;
- Cancer care reviews undertaken on palliative patients.

**Results**

- Physical assessments increased on average by 1.83 points;
- Grip test scores increased on average by 2.85 kg (left hand) and 2.4 kg (right hand);
- Participants reported new friendships made and told us that they ’learnt something new’ during the course.

**Client feedback** ‘I had knee surgery 18 months ago and it’s not been right, but it’s feeling stronger. I’m doing exercises at home too’.

‘You have a good chat with the friends that you’ve made. I really look forward to coming’.

‘It’s been interesting. I enjoyed the talk on being prepared for when you ‘fall off the twig’ - putting everything in order for those left behind’.

**Conclusion** Our assessments and client feedback demonstrate that wellbeing programmes improve the health, wellbeing and social connectedness of participants. The course has been replicated at several locations within our locality with similar results.

---

**P-219**  **LIVING WELL PROGRAMME: SUPPORTING OUR COMMUNITY TO LIVE INDEPENDENT AND HEALTHIER LIVES**

1Michelle Vodden, 1Ian Leech. 1Uttoxeter Cares, Uttoxeter, UK; 2St Giles Hospice, Whittington, UK

10.1136/bmjspcare-2019-HUKNC.241

Background As part of our aim to support our wider community and help people live independent and healthier lives, we worked with a local GP surgery to provide a Living Well Programme for identified patients with long term health conditions.

**Aims**

- Improve overall health, wellbeing and independence;
- Help participants’ flexibility and muscle strength;
- Increase access to supportive advice and information;
- Provide social opportunities.

**Method** The Living Well Programme comprises 13 sessions. During Session One we complete baseline physical assessments: balance test, gait speed, sit to stand and grip strength. These were repeated at the end of the programme.

All other sessions began with a 45 minute seated exercise class, followed by a short break to socialise, then 45 minutes from a speaker. Speakers covered a variety of topics including assistive technology, dementia awareness, personal safety, nutrition, benefits advice and advance care planning. Client feedback was sought at regular intervals throughout the programme.