• 56 hospital admissions were avoided
• 53 were referred on to the hospice Community Clinical Nurse Specialist Team
• two were admitted to hospital
• Only three people needed personal care.

Conclusion
The project supported people to die where they wished to be cared for. It prevented a number of hospital admissions due to the rapid and skilled support of trained staff. The care component was not needed as the present provider was able to support within an appropriate timeframe. Feedback from families and carers was overwhelmingly positive.

Findings and Conclusions
On average per month there were 156 calls made to the night service triage service and eight nursing visits. Of the 140 visits by the inpatient nursing team:
• 92 were primarily to administer medication for pain or end of life care
• 8 were for assistance with catheterisation issues
• 40 visits were for various other issues ranging from assessment of new symptoms, fixing O2 tubing, other hygiene issues and general nursing and repositioning issues.

All visits were assessed as appropriate use of this emergency support service, with the aim of supporting community patients at home and avoiding hospital admissions. The new service did not impact on medical on call support.
Decline’ tool. Referrals were made by telephone to the Hospice Coordination Team. Band 3 carers were available to provide up to 24 hours care in patients’ own homes dependant on need. There was ongoing review of care needs in liaison with the district nurse and hospice nurse specialists.

Results The service was effective and timely, supporting same or next day discharge. The service was responsive to patient and family need. The care provided was flexible, supporting patients in the last days of life alongside those awaiting a CHC Fast Track package of care. Good communication was fostered between the partner organisations. In one quarter 18 patients were discharged saving a total of 148 acute bed days.

Conclusions The service has demonstrated a reduction in patient length of stay in the acute trust, improving patient flow in the wider health community. Funding has been secured for a further year and access will be extended to Discharge Liaison teams. Plans are now in place to address inequity across the patch and provide the service across other local authority areas.