

data suggests a difficulty in maintaining improved screening rates and therefore we will need, in addition to the 4AT, strategies to ensure consistent increased screening rates.

#### P-104 CHC FAST TRACK FUNDING: WHO, WHAT, WHEN?

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**Background** NHS Continuing healthcare [CHC] is the name given to funding of care which is arranged and funded solely by the NHS for individuals outside of hospital who have ongoing health care needs; the 'fast track CHC pathway' is a tool to enable the immediate provision of this care for patients who are deteriorating rapidly or who are actively dying (NHS Website). There is no timeframe for prognosis in the National Framework when considering eligibility for NHS Fast Track Funding.

**Aims** To review diagnostic trends in patients referred for fast track funding, the appropriateness of applications made by the hospice community team and the impact on place of death.

**Method** We recorded all fast track CHC funding requests made by the hospice community team between 1st June 2017 and 31st May 2018, recording date of request, date of death, place of death and diagnosis. We compared this to the whole population of patients referred to the service in that time.

**Results** 71 patients had a fast track CHC funding request made. 68 had a cancer diagnosis. 63 have died. Of those who have died, the range [in days] from application to death was 1–109 days. 36 [57%] died within two weeks of the application, and four were still alive at 12 weeks. 36 died at home, 17 in the hospice inpatient unit, three in an acute hospital, one in a community hospital and six in a nursing home.

**Conclusions and discussion** When compared with our annual data, more patients died at home [57% vs 44%] and fewer died in hospital [6% vs 17%]. Nearly all of the patients had died within 12 weeks [the standard review period] indicating an excellent assessment of likely prognosis. However, with over half dying within two weeks of completing the request this raises the question: should we be requesting funding earlier?

#### P-105 DEVELOPMENT OF A SINGLE ASSESSMENT PROCESS FOR INITIAL PATIENT CONTACT WITH A HOSPICE

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**Background** Feedback from patients indicated that they were often seen by multiple different people after referral to the hospice, with duplication of processes. To address this, the hospice wanted to develop a 'single point of access' for patients and clients, to reduce duplication and provide more co-ordinated care for our patients. Part of this included developing a single assessment form for initial patient contact with the hospice.

**Aim** The primary aim was to develop a single assessment process for patients for their first point of contact with the hospice, in order to streamline and improve patient care and experience.

**Methods** A 'task to finish' group was set up in February 2017 to review the hospice referral form, and develop a single assessment process to be used for patient referrals. The group consisted of representatives from different departments within the hospice, including an independent group member from Healthwatch and a critical friend. A new referral form was developed with basic demographic details, including patient consent, any safety concerns, and six main questions (an initial question of 'what has prompted you to phone today' and questions covering physical, social, psychological, spiritual and functional domains). After a successful pilot with several local GP surgeries, and hospital nurse specialists, it was introduced to all referrers in April 2018. Referrals now come in to a dedicated co-ordination centre via telephone, email or the electronic notes system.

**Results** Feedback about the new referral form has been good. Referral information is of a higher quality, particularly for telephone referrals. The process for patients is more streamlined with less duplication.

**Conclusion** Higher quality information is obtained from the referrer, which supports MDT decision making over who is the most appropriate first point of contact. Patient experience of the hospice is improved.

#### P-106 RECOGNISING DISTRESS AND BODILY CHANGES IN THE LAST HOURS OR DAYS OF LIFE

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**Background** Between 56%–74% of the Great British public report their preference is to die at home (National Audit Office, 2008). Around half of all deaths occur in hospital although there are few clinical reasons for admission, (National Audit Office, 2008; Berry, Brink, Harris *et al.*, 2017) suggesting the need for greater community support to avoid inappropriate hospital admission.

**Aims** Ambitions for Palliative and End of Life Care (National Palliative and End of Life Care Partnership, 2015) set a framework for action; six ambitions to urge change at the end of life for individuals and those important to them to enable a good home death.

**Method** The leaflet guides them through symptoms which their loved one may experience. It offers education and practical information; helping the relative feel useful at a time when they perhaps feel helpless. The subjects cover those 'normal' symptoms considered to be the most distressing in the dying process.

**Results** The patient information leaflet will support and educate all those involved in the care of the dying person. The Community Palliative Care Specialist Nurse focus on prevention and relief of symptoms, in a prompt and timely manner to improve the quality of life for the patient and their family (World Health Organization, 2002). Continually assessing the signs and symptoms which may suggest that a person is in the last days of life will allow for compassionate and responsive care provision (NICE, 2015).

**Conclusion** There is scope for more people to die at home by improving training and understanding of end of life care needs. In May 2015, The Parliamentary and Health Service Ombudsman identified palliative care failings in the report 'Dying without dignity' suggesting that the ability of health