Conclusion Evaluation data and feedback demonstrated benefits to patients, referrers and increased awareness of services. Single point of referral enabled accurate data gathering and efficient use of service resources.

Demonstrated effective collaborative working. We learnt increased GP awareness across the locality may increase earlier referrals and clear feedback was required to referrers regarding priority of triage.

P-205 WORKING AT SCALE... NOT TIPPING THE SCALES

Bev Behmer, Duncan Fleming. *Mountbatten, Isle of Wight, UK*

10.1136/bmjspcare-2019-HUKNC.227

Background The Mountbatten Coordination Centre is central to our strategy moving forward. It is becoming the catalyst for working in different ways to future proof services, supporting people at scale with the services they need.

Aims Our coordination centre referral criteria of anyone with a life limiting disease or within their last five years of life, means we can reach more of our population earlier, preventing inappropriate admissions to the acute setting and enabling a planned approach to care. Our desire is to give the correct dose of care to each person at the right time, meaning our finite resources are used effectively and people aren't smothered in a blanket of care becoming 'a patient'.

Method The criterion for referral into our coordination centre is the last five years of life. All people referred are assessed and a plan put in place. The plan can range from light touch support, including access to our 24/7 support line, social programme and rapid response service, to the assignment of a specialist nurse. Our vision is that more people will fit in to the criteria of the former, enabling a planned approach, with patients' wishes achieved and stress and anxiety managed.

Results We have recently undertaken an evaluation of the Coordination Centre, this has resulted in some interesting findings. There is some evidence that it has had a positive impact on primary care with the amount of contacts decreasing after referral to the Coordination Centre. There have also been many pieces of anecdotal feedback from patients, family and professionals.

Conclusion We are using our limited resource to reach more people, when they need us; an increase of 50% in the past year. Helping them wherever, whenever and however is appropriate, to make the final years of their lives as rewarding as possible, giving all hope.

P-206 CONTINUING HEALTHCARE FAST TRACK PROJECT – ONE YEAR ON

Jane Baumeister, Gail Ewins, Lisa Morris. *Garden House Hospice Care, Letchworth, UK*

10.1136/bmjspcare-2019-HUKNC.228

Background In April 2018, the hospice was commissioned to deliver care packages to patients who qualified for continuing healthcare (CHC) funding under fast track provision. Initially the project offered five virtual beds which enabled patients with a deteriorating and life limiting illness to remain at home by preventing avoidable admissions to hospital and

facilitating early discharge from in-patient care, either hospital or hospice.

Aims of the service

- Ability to provide rapid discharge from acute sector;
- To deliver a comprehensive fast track CHC service for service users with palliative and end of life care needs based on their clinical need rather than diagnosis;
- To support people to live and die in their preferred place of care especially where this is identified as their own home;
- To prevent avoidable admission to hospital.

Method Commenced provision of five virtual beds in April 2018 and the level of care was based upon clinical need rather than being time specific. Care was provided by Health Care Assistants (HCAs) with the necessary skills to support this vulnerable group of people with specialist assessment being carried out by Registered Nurses. Care was offered up to a maximum of four times per day and was personalised and tailored to meet the needs of patients.

Results The service demonstrated:

- The ability to be responsive to patients' preferred place of care/death;
- The ability to support Community Teams;
- feedback from both patients and carers has been overwhelmingly positive;
- The smooth transition between hospice services including in-patient and day service.

Conclusion Following evaluation of the service and the positive feedback received from both staff, patients and relatives, the CCG have commissioned a further five virtual beds.

As of the 1 April 2019 the service can now provide care for 10 patients with a maximum of four visits per day.

P-207 FAST TRACK IMPROVEMENT PROJECT: SIX MONTH REPORT (SEPT 2018 – MARCH 2019)

Jane Moreland. *University Hospitals of Derby and Burton NHS Foundation Trust, Derby, UK*

10.1136/bmjspcare-2019-HUKNC.229

Introduction Fast Track Continuing Healthcare (CHC) is a care package, funded and arranged by the NHS when a person is identified as having a 'rapidly deteriorating condition that may be entering a terminal phase of life' (National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care, 2018).

Methodology Various initiatives were developed and implemented to provide guidance and improve the process:

- Direct electronic referral to CHC;
- Fast Track Operational guidelines detailing roles and responsibilities of staff;
- Integrated Discharge Team accountable for Fast Track referrals and discharge;
- Patient information leaflet;
- *End of Life care: a guide* – a booklet for people in the final stages of life and their carers (Macmillan Cancer Support and Mare Curie, 2015);
- Community services leaflet with contact telephone numbers;
- Discharge toolkit on the hospital intranet;
- Discharge prompt stickers for medical notes;
- End of life care facilitator attendance at daily ward board rounds;