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.

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 efficiently and enabling a planned approach to care. 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.

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 Marie Curie, 2015);
- Community services leaflet with contact telephone numbers;
- Discharge toolkit on the hospital intranet;
- Discharge prompt stickers for medical notes;
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