Robust data collection and reporting on Fast Track discharges.

Implementation The audit data for this time period revealed a reduction in length of stay (LOS) from baseline data of six days (from 22 days to 16 days) and a reduction in admission to clinical decision to Fast Track by two days (from 15 days to 13 days) and the Fast Track process time has reduced from 7 days to 2.5 days.

Cost savings This equates to a saving of £615,600 based on the average cost of an acute bed price of £300 per day and 2052 beds saved (11 beds).

Conclusion Improvements have been made in the consistency and quality of data collection which is informing performance and evaluation of the process. Initial audit has shown that changes to how we approach Fast Track discharges have shown good progress in reduction in average length of stay and clinical decision making.

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P-209 DEVELOPMENT OF A COMMISSIONED FAST TRACK CONTINUING HEALTH CARE (CHC) SERVICE DELIVERED BY A HOSPICE

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Background A review has identified the strength of the existing Hospice at Home service but weakness of contractual arrangements. The service has evolved from providing bridging to one which provides the initiation of all fast track care packages. The hospice has thus invested time and finance to support delivery of statutory CHC services.

Aims Pilot a dedicated hospice-led fast track brokerage service retaining current responsiveness and quality but delivered with 100% cost recovery for the hospice.

Method Twelve month pilot will explore the:

1. timeliness, quality and equity of access of a hospice-led service (Marie Curie, 2017; Marie Curie, 2019);
2. interface between this service and a traditional hospice at home service;
3. benefits of co-location with other hospice services;
4. impact upon locality expenditure.

The service will receive, triage and assess all referrals for fast track CHC and initiate care.

Out of hours referrals will be picked up by the Hospice in the Home Service which will bridge care for a maximum of 72 hours.

Results A set of key performance indicators including the following will be used to measure outcomes:

1. Range of packages delivered;
2. % of referrals which have not been able to receive care;
3. % of referrals that require Hospice in the Home Service to bridge care;
4. % of patients utilising Personal Health Budgets.

Our intention is to demonstrate that timeliness and quality is best delivered by a hospice-led service and that this can be positively impact equity of access and expenditure.

Conclusion The pilot demonstrates collaboration, has potential to positively impact patient outcomes, responds to policy requirements and could inform future commissioning recommendations. Since commencement of the pilot, initial results have identified potentially some significant benefits to patients, providers and commissioners. Therefore the poster presentation will focus on perceived outcomes.