Administration of as needed subcutaneous medication for common breakthrough symptoms in home-based dying people in Wales.) if services were overwhelmed and help support the predicted strain on the NHS.
Results Patients' and health professionals were able to access 24-hour palliative care advice and a network of community pharmacies supported by the local Commissioning Support Unit (CSU) linked together to make finding and accessing medicines easier. Clinical Commissioning Group (CCG) pharmacists provided delivery services to those who were vulnerable, shielding or just needed help. Hospice teams worked together to provide cover, other professions utilised this support too, calls from paramedics resulted in patients staying at home rather than being transferred to hospital. A local NHS Trust provided back up supplies to enable around the clock dispensing in urgent circumstances.
Conclusion Only by working collaboratively across the area and sectors were we able to provide a safety net. The pandemic removed some of the financial and organisational barriers to make this happen. Some of this work is now established and continues. Other aspects have highlighted an ongoing need for future commissioning and improved patient and care giver experience (Wilson, Caswell, Turner et al., 2018. J Pain Symptom Manage. 56:962).

P-13 CREATING EQUALITY IN END-OF-LIFE DOMICILIARY CARE AT HOME ACROSS CHESHIRE

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10.1136/spcare-2022-HUNC.35

Background Due to disparity in commissioned end-of-life domiciliary care at home, poor communication and the variation of the quality of care being delivered, the collaboration project's aim was to improve service delivery, patient experience and reduce unwanted admissions during the final months of life.

As a consequence of this fragmented approach, there is duplication of commissioned services. The Continuing Health Care [CHC] model uses multiple independent care providers, at varying costs, and is dependent on availability at the time of request (NHS CHC Strategic Improvement Programme [Internet] Accessed 04 May 2022).

The proposal for commissioning change identified the need for a consistent approach to delivering high level patient outcomes from this service across Cheshire. All the partner organisations involved worked together to support the patients' full provision of home care packages within the remit of the CHC fast track criteria, including out of hours support, night care, pre- and post- bereavement support for both patients and their primary carers and ongoing review of the service.

The aim of the collaboration between NHS services and third sector organisations was to support people whose Preferred Place of Care and Death [PPC/D] is their own home and who require a planned or urgent package of care to enable this to happen (Leadership Alliance for the Care of Dying People, 2014; Ambitions for Palliative and End of Life Care, 2021).

The three Partnership Hubs now provide a rapid, planned and unplanned care response, which is supported by a single point of access, delivering a consistent step up and step down care model across all Cheshire localities.
Results Results in first month (patients referred):

- 100% recorded on GSF and local palliative register.
- 100% completed advance care planning.
- 100% patients care facilitated within 48hours of referral.
- 88.9% patients achieving their PPD.

Conclusion This new way of working provides significant opportunity to reshape existing services and to strengthen integration and coordination. The integration of services allows for shared learning, service sustainability and the opportunity for further future developments, linking into emerging programmes such as Place-based care and the Digital First agenda.

P-14 CANCER CARE COORDINATION – INNOVATIVE PARTNERSHIP WORKING BETWEEN A HOSPICE AND PRIMARY CARE NETWORK

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Background Cancer Care coordination is one of a range of roles that is recommended to ensure holistic patient care and improved access to services (NHS England and Improvement. 2020). In a collaboration, St Giles Hospice is working with Sutton Coldfield Group Practice (SCGP) Primary Care Network (PCN) to provide a cancer care coordinator to enable coordination and navigation of care and support across health and care services (NHS England and Improvement. 2021).
Aim To embed a cancer coordinator within a PCN network and improve patients' access to care and health services through coordination and navigation.
Method The cancer care coordinator will alleviate pressures on GPs by picking up duties that free up clinical time. This might include chasing up referrals, proactively signposting to relevant local services, answering queries from patients and their carers, organising and facilitating GSF meetings.

This dedicated resource would provide patients with the time for conversations around their diagnosis and treatment and would support advance care planning discussions. The cancer care coordinator would work closely with other health and social care services and professionals, creating a network that is able to support patients in a number of ways including organisation of GSF meetings and review of cancer screening engagement and barriers. In addition the cancer care coordinator will be key in navigating a path for patients who are no longer curable but imminently end of life.
Results Results that will be evaluated as part of this collaboration include:

- Increased participation in Gold Standards Framework (GSF) meetings.
- Increase in patients accessing cancer screening.
- Improved patient outcomes and quality of life.

Conclusion This innovative new role will improve patient navigation through a complex health and social care system thus improving patient outcomes and releasing time to care.