under-represented in clinical services. An open-access service in the North of England provides a breadth of support to people affected by palliative diagnoses, without requiring clinical referral, with dedicated support to address some of these inequalities. We report on an evaluation of this service.

Method This study was conducted as a secondary data analysis of an annual service evaluation. Characteristic data of service users was collected through an anonymous cross-sectional survey. One-hundred and fifteen responses were acquired via convenience sampling over the period of one week. Data was compared against the characteristics of local specialist palliative care services, local census data and historical MDS data through descriptive and inferential techniques (chi-squared test).

Findings The open-access service was found to have a significantly higher proportion of non-cancer patients (75%) compared with clinical services (27%) and MDS data (24%), highlighting that this is a potentially valuable approach to improving access for this under-represented group ($p=0.05$). Conversely, attendees were more likely to be female (<0.001), under 75 (<0.001), live in the local area (<0.001) and have religious beliefs (<0.01), highlighting areas for further development.

Conclusion This service evaluation has highlighted a potential approach for improving access to specialist support for people with non-malignant disease and members of minority ethnic groups; formal research evaluation is recommended. Outstanding challenges include broadening access for men, older people, non-religious people and the wider area.

113 INTRODUCING A LEARNING FROM DEATHS MEETING IN A HOSPICE

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Introduction 'Learning from deaths' is a monthly meeting open to all clinical staff from across hospice services. It is a forum to discuss, reflect on and learn from the deaths of our patients.

Method The meeting was established as there was no formal forum to discuss deaths in the hospice and a positive experience attending a similar event gave the forward momentum and inspiration to create this meeting. Suggestions of deaths to be discussed can be made by any clinician and may include deaths which have been challenging or traumatic as well as deaths which have been examples of good practice. An overview of the case is presented including what happened, what went well and what could be improved. Senior clinicians are present to guide the discussion, ensuring a positive focus is maintained and assisting with identifying the learning for the future.

Results This meeting was launched in July 2019. There has been an encouraging turnout with an average of 22 attendees and positive feedback has been given. Particular comment has been made regarding the tone of the meeting and it being a safe, reflective non-judgmental space. Another strength is noted as learning being focused on improving future practice and care. A learning log is gathered during the meetings to ensure that discussion is put into action. For example following one discussion a series of educational sessions were organised about the withdrawal of non-invasive ventilation.

Conclusion Learning from deaths is now considered a vital part of clinical practice, support for staff and an opportunity

for learning. In the future invitations to attend the meeting could be extended to clinicians from outside the hospice who were involved in the individual's care e.g. General Practitioners, District Nurses.

114 APPROACHING THE END OF LIFE: ARE REFERRALS TO HOSPITAL SPECIALIST PALLIATIVE CARE TEAM ARRIVING TOO LATE?

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Introduction Late referrals to specialist palliative care teams (SPCT) limit the ability of and time for SPCTs to improve symptoms and reduce distress for patients and their families. We aimed to identify all patients referred to the hospital SPCT who died before being seen during 2018 to:

1. Assess if uncontrolled symptoms were present
2. Ensure SPCT responded rapidly
3. Identify ways to support wards with timely referrals and reduce late referrals.

Methods Design: Audit with case-notes review

Part 1: we identified all hospital patients referred to SPCT who died before being seen, and assessed the hospitals/wards/patient characteristics to identify patterns. We reviewed referral time and our response times/telephone advice.

Part 2: Detailed case-notes review of 15% (randomly selected) patients who died before being seen by the SPCT to assess recognition of dying, see if these dying patients had specialist palliative care needs and if symptoms/distress were controlled or not.

Results Part 1: In 2018, the SPCT reviewed 1520 patients across the acute trust. 87 (5.6%) patients died before being seen by the SPCT. Of those, 19 patients (21%) were referred and died outside SPCT working hours. Referrals came from 25 different wards. 42 (37%) patients died within 6 hours of referral. Telephone advice was given to healthcare professionals for 37 patients (42%). Most patients were over 65 years old; the common causes of death were pneumonia and cancer.

Part 2: 15 case-notes had a detailed review. Median length of stay was 9 days (range 2–40days). Most patients were documented as dying only in the last 2 days. 5 patients had no SPC needs whilst 10 patients had uncontrolled symptoms.

Conclusion Promoting earlier recognition of dying and a more integrated approach of palliative care alongside active interventions could optimise symptom management and reduce distress towards end of life for patients dying in hospitals.

115 COMPASSIONATE CARE BED IN PARTNERSHIP WITH INTERMEDIATE CARE SERVICES – NORTH MANCHESTER

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Background The North Manchester Palliative Care Support Service (MMSPCSNL) was introduced in April 2016 with a significant remodelling of the previous provision. The service