

recorded for 143 (71.5%) patients, religion for 82 (41%), and nationality for 136 (68.0%). Where it was documented, 88.1% were white and 98.5% were British. Discussions were only documented in 34 (17.0%) cases. If specialist palliative care input was sought, cultural preferences were more likely to be discussed ($p < 0.001$). When discussions were documented, patients were more likely to be referred to chaplaincy ($p < 0.001$).

Conclusion/Discussion In this service evaluation, cultural preferences at the end-of-life were often not documented and possibly not being discussed with patients and families. Education is needed on the importance of assessing and addressing these needs.

Poster Nos 90–144: Service Development

90 EYE DONATION IN THE HOSPICE SETTING: PERSONAL AND SYSTEM-BASED BARRIERS TO DISCUSSING THIS END OF LIFE OPTION WITH PATIENTS AND FAMILY MEMBERS: AN EXPLORATORY QUALITATIVE STUDY

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Background In the UK there is a national shortage of corneas available for transplantation. Up to 50% of patients within a palliative care setting may be eligible to donate corneas, yet donation rates from this environment are low. Studies have indicated that healthcare professionals are reluctant to initiate conversations. Doctors views on donation are poorly represented in the literature.

Aim To identify and explore barriers to clinicians initiating conversations about the option of eye donation as part of end of life care planning in a hospice setting.

Methods An exploratory qualitative design was adopted using focus groups. The study was based from palliative care services in the South of England and was conducted between 15th and 22nd February 2017. Participants included 14 doctors holding registrar, specialty doctor or consultant posts. Qualitative content analysis was the data analysis method chosen.

Results Despite holding positive views towards corneal donation, doctors are unlikely to initial conversations. Barriers identified included 1) lack of knowledge around eye donation, principally involving eligibility 2) attitudes, influenced by personal beliefs but also clinical experiences and the perception of patient and public views on donation in a hospice setting 3) professional concerns about workload and the prioritisation of significant conversations, and 4) a lack of confidence in the process of eye donation which directly impacted on an individual initiating a discussion. Findings indicate that level of clinical experience does not influence the likelihood of initiating conversations, but individual experiences do shape attitudes. The hospice was viewed as a unique entity with specific challenges to implementing corneal donation services.

Conclusions Despite positive views toward eye donation, many barriers contribute to a lack of confidence in the system and low donation rates. Improvements could be made by education and support for staff members and appointing a designated lead staff member.

91 MAPPING THE SPECIALIST PALLIATIVE CARE WORKFORCE IN LONDON'S ACUTE HOSPITALS – A POSTCODE LOTTERY?

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Introduction An estimated 75% of people who die each year could benefit from receiving palliative care. Little data exists on the specialist palliative care workforce and service provision and whether this meets defined standards.

Aims To map the specialist palliative care workforce across London and identify any differences in staffing levels and out-of-hours cover, to inform workforce planning discussions across the London Palliative and End-of-Life Care Strategic Clinical Network.

Method Service evaluation of 27 specialist palliative care teams within 19 London NHS Hospital Trusts (August-December 2022). The following data were collected: numbers of whole-time-equivalent establishment and staff-in-post for clinical and non-clinical roles; hospital bed numbers, annual service referral numbers, and annual deaths (surrogate markers of service demand). Descriptive statistical analysis compared staff establishment levels per 1000 beds, referrals, and deaths. Also, data on vacancy rates and out-of-hours cover for each team were analysed.

Results All 27 teams provided data. The median ratio of medical staff to 1000 beds/referrals/deaths was 5.5, 2.5 and 3.2 respectively; the median ratio of nursing staff to 1000 beds/referrals/deaths was 14.9, 6.1 and 7.5 respectively, with wide variation across services. 48% of teams had an underfilled staffing establishment; the median vacancy rate was 10.2% (range 0.5%-42%). 44% of teams provided a 7-day face-to-face service with 24/7 telephone support. The proportion of teams with specialist social workers and psychologists in their establishment was 37% and 26% respectively. Results are subject to final verification.

Conclusion Our results demonstrate wide variation in hospital specialist palliative care workforce levels across London, and levels of out-of-hours cover. Whilst the heterogeneous nature of hospitals make comparisons challenging, our findings indicate inequity in provision. Replication of this mapping exercise across wider Strategic Clinical Networks in England is important to understand variation in workforce and service provision at a national level.

92 TRANSFERRING THE CARE OF PATIENTS WHO ARE APPROACHING THE END OF THEIR LIVES – A RE-AUDIT OF HOSPITAL DISCHARGE SUMMARIES

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Introduction Discharge summaries are fundamental in transferring care from hospital to community. However, our GP colleagues tell us these vital letters require improvement.¹ Since 2014, junior doctors from Royal Derby Hospital have examined the quality of discharge summaries written about patients who are reaching their last weeks of life. These patients are eligible for immediate access to NHS continuing