Making a common ‘Discharge Letter Preparation Table’ Template, 2. ‘UP-TO-DATE’ Whiteboard, 3. Changing to an electronic system for discharge letters.

**Results** After the first and second interventions the percentages of discharge letters meeting the target was 28% and 69% respectively. By the end of the 3rd intervention, this had increased to 78%.

**Conclusion** There has been a significant improvement in the percentage of discharge letters being sent to community teams within or at 24hrs of discharge, hence improving patient continuity of care. These changes are relevant to and could be replicated across clinical settings.

**WHAT’S THE DEMAND? DEVELOPING PALLIATIVE CARE RAPID RESPONSE SERVICE**

Helen Mullins, Hazel Coop. Coventry and Warwickshire Partnership Trust

10.1136/spcare-2023-PCC.134

**Background** Coventry and Warwickshire Partnership Trust Community Nursing had manned an urgent access phone to respond to people requiring just in case medication or have a syringe driver. The Integrated Palliative Care Team, following investment, took ownership daily between 8am-8pm. The use and need of this phone had not been monitored previously.

**Method** We created a proforma to document the calls being received detailing date, time, patient demographic details, caller details, reason for call, response needed and whether the call was appropriate. The data for September 2022 were analysed on excel.

**Results** There were 130 calls to the phone in the month, between 8am and 8pm 7 days per week. 117 (90%) were deemed appropriate. The most frequent callers were family members, 66 (51%), the next most common group was health and social care professionals, 48 (37%). The phone was busiest between 4pm and 8pm with this accounting for 56 calls (43%), the quietest time was between 12–4pm accounting for 28 (22%) of calls. 69 (53%) of appropriate calls were related to symptom needs, the second most common reason for calls was for palliative support care, 13 (11%). 96 (82%) required a 2-hour response, 3 (3%) a 24-hour response and 18 (15%) advice was given.

**Conclusion** This review shows there is a demand for this service and it is on the whole used appropriately by service users and professionals. The data has supported the team arranging and managing with primary prophylaxis, and documentation of this.

**IMPROVING VTE RISK ASSESSMENT FOR HOSPICE INPATIENTS**

Serena Chew, Francesca Aquilina, Debbie Adams, Helen Lock. Hospiscare

10.1136/spcare-2023-PCC.136

**Background & Aims** Hospice inpatients are often at higher risk of developing venous thromboembolic (VTE) events, but also often have various contra-indications to VTE prophylaxis. Careful assessment based on a risk-benefit balance is important to ensure that decisions are made that support patients’ quality of life and symptom control. A project was carried out to review the local hospice’s practices on VTE risk assessment and management with primary prophylaxis, and documentation of this.

**Methods** An audit was conducted in February 2021, prompted by participation in the data collection for the national UK Palliative trainees Research Collaborative (UKPRC) VTE audit. A local VTE assessment tool was then developed based on NICE guidance and practices from hospices in other regions of England.1–2 The tool was then embedded into the electronic SystmOne software used by the inpatient hospice team. A re-audit of local practice was then performed in May 2022 to assess the impact of this intervention.

**Findings and Discussion** The electronic VTE assessment tool led to greater percentage of patients having a documented VTE risk assessment (87.5% vs 62.5%), and better understanding regarding healthcare professionals’ (HCP) experiences in translating their care to this modality.

**Aim** Exploration of oncology and palliative care HCP perspectives on VTE, the role of VTE in varying stages of the treatment and management of patient care, and the future role of VTE in patient care.

**Method** A cross-sectional study of oncology and palliative care HCPs, analysed via an inductive thematic approach.

**Results** 87 surveys completed within a one-month period. Three master themes were identified. Personal, professional, and familial factors included factors of patient age, illness and VTE skill in influencing HCPs’ experience of VTE. Relationships and connection highlighted the influence of VTE in empowering patients, the importance of a therapeutic relationship. Here, there was a perceived loss in these domains with VTE. Significant challenges were felt in sharing bad news and having challenging conversations. Many survey respondents emphasized that they preferred to have first-time consultations face-to-face, and not virtually. Within the domain of logistical and practical implications reduced travel and increased accessibility were seen as a benefit of VTE. The inability to examine patients and concerns regarding missing clinical signs was emphasised as a significant barrier, alongside the challenges faced with sometimes failing technology.

**Conclusion** VCs have a stronger role for those patients who are already known to professionals, when prior relationships have already been developed, and here they are perceived as practical and beneficial. VTE for difficult discussions and for unstable patients were felt to be inadequate. Triaging patients with regard to suitability prior to offering VCs, with emphasis on the importance of patient choice, were seen as priority areas in this new era of VCs.
ARE WE LEARNING FROM DEATHS? EVALUATING A NEW ACUTE HOSPITAL FRAILTY, STROKE MEDICINE AND SUPPORTIVE & PALLIATIVE CARE (SPCT) TEAMS MORTALITY MEETING

Hilary Williams, Farida Malik, Rennie Nahas. East Sussex Healthcare Trust

Background A new monthly mortality meeting (MM) between SPCT/Frailty/Stroke Medicine teams was launched to review & learn from selected hospital deaths. Learning from deaths is a key aspect of medical education, registration, ethical obligation and contributes to meaning derived from our roles. However, few organisations use a validated approach despite availability of toolkits. The aim was to evaluate the effectiveness & utility of the MM.

Methods MM attendees were invited by email to complete an anonymised, semi-structured cross-sectional online survey twelve months after MM inception. Questions covered practical aspects surrounding MM access plus understanding of process. Results were fed back to the MM where joint participation informed next steps required.

Results Response rate 32%. Majority of respondents were Consultant (7/20)/CNS (6/20). Positives to MM included – 85% reported meeting had positively impacted their reflective learning. However, 65% unaware of case selection criteria, 40% unfamiliar with SJR process/wanted to understand more. 35% participants preferred advance learning. However, 65% unaware of case selection criteria, 40% unfamiliar with SJR process/wanted to understand more. 35% participants preferred advance learning.

Conclusions The meeting was seen as a beneficial intervention. Operational and content aspects have been incorporated to improve future MM effectiveness and utility.

SPOKEN LANGUAGES OF PATIENTS KNOWN TO A HOSPITAL SPECIALIST PALLIATIVE CARE TEAM AND ACCESS TO INTERPRETING SERVICES

Jaya Jaitly, Rosie Bromert. University Hospitals of Leicester

Background Conversations that are ‘honest, informed and timely’ are essential to achieving good end of life and palliative care. The 2011 CENSUS highlighted that 1 million people living in the UK could not speak English well or at all. In 2021–22, 74.7% of people who died within this large, 3 site city based hospital trust had their ‘ethnicity’ identified as White British. This project aims to describe the ‘ethnicity’ and primary spoken language for patients seen by the hospital specialist palliative care team (HSPCT) and establish areas for detailed audit and quality improvement work.

Methods Patients were included if they were referred to the HSPCT and died or were discharged in August 2022. Paper notes of HSPCT activity and electronic clinical systems were reviewed. The whole clinical record was not reviewed. Information collected included the persons’ documented primary language, whether interpreting services were used and ‘ethnicity.’

Results 227 people died or were discharged following referral to the HSPCT in August 2022. 77% had their ‘ethnicity’ identified as White British. The primary languages spoken were Gujarati (4%), Punjabi (2.21%), Hindi (0.44%), Persian (0.44%), Romanian (0.44%), Turkish (0.44%) and English (91.6%). Spoken language information was missing for 1 person. 2 people whose primary language wasn’t English died or were discharged before seeing the HSPCT. For people who spoke a primary language other than English, 15% (2/13) had reviews with an independent interpreter, 77% (9/13) with family members translating and 7.5% (1/13) with a staff member translating.

Conclusions The HSPCT sees people who speak a range of languages but communication must improve with those who speak a primary language other than English. An immediate change in practice has taken place to ensure that the HSPCT can book interpreters directly, removing the step of relying on ward teams to do this.

LET’S TALK: ADVANCE CARE PLANNING. HOW CAN WE IMPROVE THE QUALITY OF ADVANCE CARE PLANNING BOTH IN HOSPITAL AND COMMUNITY?

Joanna Bate, Marsha Dawkins, Irene Carey. Guys and St Thomas NHS Foundation Trust

Background End of life care (EoLC) and advance care planning (ACP) conversations can be challenging for staff and patients. Drawing on published guidance and building on previous local work1–4 this Trustwide project aims to improve the experience of patients, carers and staff in engaging with ACP discussions and to measure progress.

Methods This project is led by an ACP Nurse Specialist, overseen by the EoLC clinical lead and Deputy Head of Nursing. NHS Quality improvement methodology underpins the work which is supported by a steering group and governance structure.

Implementation of our previously developed ‘Let’s Talk’ resources (supporting information to aid understanding of ACP: videos, leaflet, website5), building stakeholder relationships, staff education, clinical visibility and role modelling were undertaken to increase engagement in ACP. A Gap Analysis Action Plan (GAAP) was developed by benchmarking against recommendations from the Care Quality Commission (2) and used at strategic and governance meetings to engage key stakeholders and agree measurable actions.

Data were collated from audits, patient and staff surveys and website viewing clicks.

Results Over 900 staff have received bespoke training. Changes from pre- to post-implementation include: increased