documentation of outcome (100% vs 80%) and rationale for this (85.7% vs 40%). Decisions on prophylaxis were deemed to be appropriate. The study was limited by its small sample size (n=8 for each single day snapshot audit of cases). Further work will need to be done on: the appropriateness and timing of re-assessment of VTE risk; and discussion about decision-making around VTE prophylaxis with patients and their relatives.

**Abstracts**

**117 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, Rannie Nahas. East Sussex Healthcare Trust

10.1136/spcare-2023-PCC.137

**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 participant discussion informed next steps required.

**Results**

Response rate 32%. Majority of respondents were Consultant (7/20)/CNS (6/20). Positives to MM included SJR process was either ‘understood’/’partly understood’ by 75%. MDT nature of learning widely valued. 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 notice of cases. Following feedback of results to MM, the selection process was clarified as were plans to develop cross site participation.

**Conclusions**

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

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

Jaya Jaitly, Rosie Bronnert. University Hospitals of Leicester

10.1136/spcare-2023-PCC.138

**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.

**119 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

10.1136/spcare-2023-PCC.139

**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.

**Method(s)**

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