- Ensure patients whose admission is their first presentation receive a quality assured diagnosis
- Ensure medicines optimisation during the in-patient stay
- Ensure every patient who has an admission for exacerbation of COPD has active follow-up and case management.
- Ensure every patient admitted for exacerbation of COPD receives pulmonary rehabilitation following discharge.

Many of these principles have long been accepted as best practise in respiratory care however the limited adoption of these factors indicates that barriers to implementation still exist. The project sites demonstrated that care bundles and checklists can be an effective way of achieving elements of the structured admission model with up to 80% of COPD admissions being managed through a care bundle approach. In addition the effective prioritisation of workloads to better match case load and demand on the service allowed more patients to receive high quality care and increased job satisfaction for staff. The achievement of high quality care for all patients requires organisational change and an integrated systems approach within hospital organisations.

P286   **IMPLEMENTING A COPD DISCHARGE CARE BUNDLE: THE CHALLENGES AND FACILITATORS REVEALED**

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Introductions/Objectives The National Institute for Health Research (NIHR) Collaboration for Applied Health Research and Care (CLAHRC) for Northwest London worked with clinicians and patients to develop a COPD discharge care bundle, which has been implemented across 7 acute hospitals using quality improvement (QI) methodology. The aim of this study is to identify the challenges encountered by teams in implementing the care bundle and the associated solutions and facilitators which will inform future implementation across other sites.

Methods An initial retrospective documentary analysis of data from the clinical implementation teams was undertaken. Data sources included minutes from 6, 12 and 18 month review meetings as well as contemporaneous records documented by the implementation team. The second stage involved collaborative learning workshops with 4 implementation teams. These workshops focused on reviewing the challenges identified in the first stage of analysis and identifying any challenges that had been missed. A discussion followed where the teams identified the solutions and facilitators that were developed during the project.

Results The first stage of analysis identified a number of challenges, some of which were common to all sites. The most common challenges related to the 5 following high-level themes: staffing, infrastructure, process, QI methodology and patient and public involvement. Within these themes 28 key challenges were identified. In the second stage of analysis teams demonstrated that they had developed solutions to address specific challenges. For example, a project team shared their experience of a mapping session which helped them better understand the flow of patients in their setting and led to improvements in compliance to the COPD discharge care bundle.

Conclusions There has been increasing enthusiasm to adopt the COPD bundle across the region but the implementation of new interventions poses challenges to both those planning and delivering such initiatives. Understanding and learning from the challenges faced by previous endeavours and the facilitators to overcoming these barriers provides an opportunity to mitigate issues that cost time and resource and ensure training tailored to the anticipated challenges.

Abstract P286 Table 1

High Level Themes	Key Challenges
Staffing	• Staff shortages • High staff turnover • Training of staff on bundle implementation • Training of staff on inhaler technique and smoking cessation • Staff not following the whole patient journey • Capability to make COPD referral-A&E nurse/doctor not referring to appropriate ward • Lack of staff engagement • Low buy in from pharmacists • Staff too busy
Process	1. Lack of prompt data capture 2. Patient coding issues 3. Lack of prompt feedback to staff on the progress of the project 4. Poor quality of spirometry 5. Completion status unsure because of community bundle end point
Infrastructure	1. Added workload of bundle 2. Bed shortages 3. Ward moves 4. Lack of pulmonary rehab service 5. Issues with government plans 6. GP involvement 7. Sustainability and costs of BLS booklet 8. Lack of communication and collaboration across sites
Patient and Public Involvement	1. Patient involvement declined over time 2. Patient 's focused on own interest and not the projects' 3. Patient illness 4. Patient engagement poor-amount or quality?
QI Methodology	1. Issues using PDSAs-not completed 2. Sustainability tool-Too generic not context specific 3. Unfamiliarity with tools

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P287   **IS YOUR COPD SERVICE IMPROVING OR DETERIORATING? TREND ANALYSIS OF MORTALITY, BED-DAYS AND READMISSIONS SHOWS GREAT VARIABILITY ACROSS ENGLAND DURING THE LAST DECADE**

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The White Paper "Equity and Excellence. Liberating the health service "stated that health service must focus on outcomes and quality standards. The aim must be to improve. Comparison of a trend in improvement/deterioration of over time of outcomes would be beneficial to both clinicians and commissioners.

Methods Trend was analysed in 3 key outcome measures for COPD for all 153 PTCs in England. The 3 outcome measures are COPD mortality per 1000 PCT population for 1993–2010, bed-days per 1000 PCT population for 2006/7–2010/11, and re-admission at 28 days for 2004/5–2010/11. Data from INHALE (www.inhale.nhs. uk) has been used and Dr Foster Intelligence for readmissions. Linear regression lines were fitted to the annual data for each PCT. An upward trend scored +1 (deterioration), no trend 0, downward trend –1(improvement). The scores were summated for each PCT resulting in a possible range of scores of +3 to –3.

Results The Table shows summated results. PCT mortality data was available for 152, bed-days for 151 and readmissions for 150 PCTs. Newham was the only PCT to improve in all 3 outcomes (score –3). 23 PCTs (15%)scored –2, of these 21 improved in one outcome, 2 improved in two outcomes but deteriorated in one; 78 PCTs (52%) scored –1, of these 74 improved in one outcome and 4 improved in two but deteriorated in one as well; 41 PCTs (27%) scored 0, of these 15 had improved in one outcome but deteriorated in another; 8 PCTs (0.5%) scored +1. There were no scores of +2 or +3.