intervention phase with 75% of inpatients having DNACPR decisions and 46% escalation plans documented. Safety huddles helped improve ward culture and spread lessons learnt from debriefing of the last 3 events.

Conclusion Early results show there has been a reduction in total 2222 calls in the pilot ward compared to the other wards. We believe this is through improved decision making and empowering frontline staff. This could be scaled-up in other wards to have greater impact on patient care.

All 2222 calls on pilot ward
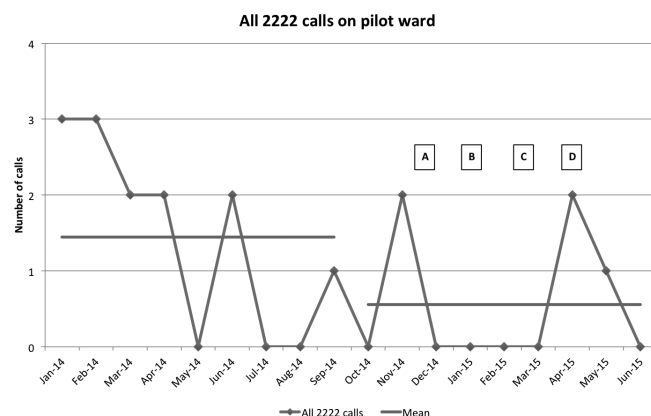
Abstract M7 Figure 1 Total number of 2222 calls on pilot ward. Interventions indicated by lettering (A): Staff survey, (B): Introduction of "deteriorating patient stamp", (C): Debriefing following any arrests, (D): Introduction of "Safety huddle". Mean of pre-intervention and intervention data, 1.44 and 0.56 respectively

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| M8 | PREVALENCE OF RESPIRATORY DISEASE IN SEVERE MORBID OBESITY |

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Introduction It is well established that asthma and obstructive sleep apnoea (OSA) are significantly more prevalent in obese vs. non-obese populations. To date however there is limited data on whether this risk is increased with severity of obesity as most studies classify all patients >30 Kg/m^2 simply as 'obese'. In addition, many existing studies' obese cohorts have fairly low BMI scores compared to patients attending specialist medical obesity services. Our study aims to examine the prevalence of these diseases in higher BMI groups, compare the relative risk of increasing obesity on prevalence of respiratory disease and investigate whether there is a synergistic effect of multiple demographic factors and severity of obesity.

Methods Data was collected from a total of 367 (of whom 159 had a BMI recorded) patient records attending a tier 4 obesity clinic over an 8 month period. Patients were divided into three groups according to severity of obesity, BMI 30–40, 40–50 and >50 Kg/m^2. Index of multiple deprivation (IMD) scores (mapped to postcodes) were used as a proxy of socioeconomic status.

Results 43% of our total cohort had OSA, including 75.7% of those with a BMI >50 (Multivariate logistic regression OR 10.4 (95% CI 3.33 – 32.7, p < 0.001). In a chi-square analysis, this association was significant in both genders but stronger in males (Cramer's V 0.481 vs 0.305) and was significantly associated

with a worse IMD score, being white and increasing age. 11.6% of the cohort were asthmatic however there was no difference in prevalence between the groups OR 0.175 (95% CI 0.019 – 1.631, p = 0.126). There was however a significant co-effect of being male and increasing BMI in a multi-layer chi-square analysis p = 0.044.

Conclusions Our study highlights a very high prevalence of major respiratory diseases as co-morbidities in a severely obese population. Early data suggests a synergistic effect of Caucasian ethnicity, male gender and IMD score with increasing BMI on the risk of developing OSA (and Asthma for male gender). This is in contrast with our initial findings for Diabetes and Cardiovascular disease where the association is with Asian ethnicity.

| M9 | LUNG HEALTH OF OPIATE USERS (LHOP): A PILOT STUDY TO ASSESS THE RESPIRATORY HEALTH OF OPIATE MISUSERS ATTENDING A COMMUNITY SUBSTANCE MISUSE CLINIC |

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Introduction MDTs promote harm reduction in the care of opiate misusers (OMUs) through the prescription of opiate substitute medication and by encouraging smoking rather than injecting (to reduce the risk of blood-bourne virus transmission and venous thromboembolism). The average life expectancy for a male OMU is 41 years and whilst evidence suggests that the current cohort of older OMUs are dying prematurely from non-drug related deaths, all-cause mortality studies rarely report the prevalence of chronic health problems. A recent case-controlled study reported a higher prevalence of asthma and COPD in OMUs after adjusting for tobacco consumption and other factors.

The study objective was to investigate the prevalence and illness burden of respiratory problems (asthma, COPD, symptomatic but undiagnosed lung disease) in patients with a history of current and/or past opiate misuse.

Methods Opportunistic clinic-based participant recruitment. Resting spirometry and researcher administered socio-demographic, inhaled drug use and validated respiratory patient reported outcome questionnaires: 1) prior diagnosis of asthma (ACT; mini-ARQoL) or COPD (CCQ); 2) respiratory health screening if no prior diagnosis (LFQ).

Results There were 36 participants (26 male; 10 female; aged 24–53). Only 8 had a diagnosis (all asthmatics); 35/36 smoked tobacco; 34/36 smoked heroin; 33/36 smoked cocaine; and 31/36 smoked cannabis. All asthmatics had poor control (<13) on the ACT (median score 8) and frequent beta-agonist use (none used inhaled corticosteroids). Of the others, 22/28 scored ≤18 on LFQ suggesting high symptom burden and three of these had obstructive resting spirometry increasing the possibility of COPD.

Conclusions Chronic respiratory health in drug users is an under-researched area with few screening or high quality intervention studies evident. We identified a significant respiratory symptom burden within this OMU cohort. Most smoked tobacco, heroin, cocaine and cannabis. Asthmatics reported poor