

Abstract P199 Figure 1 Flow of patients through our COPD Hyperinflation service in 2015. MDT: multidisciplinary team; EBV: endobronchial valve; LVRS: Lung volume reduction surgery.* Endobronchial coil was offered as part of a clinical trial

REFERENCE

1 McNulty W, et al. *BMJ Open Respir Res* 2014;1:e000023.

P200 LARGE SCALE IMPLEMENTATION OF COPD DISCHARGE BUNDLE

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Introduction COPD Discharge Bundles have been associated with reduction in 30 day re-admission rates.¹ Kent, Surrey, Sussex Respiratory Programme aims to improve respiratory care by spreading good practice and reducing variation. We monitor outcomes via our regional COPD Dashboard. In 2014 we decided to start a project to support acute hospital trusts to deliver a COPD discharge bundle

Methods We held twice yearly collaborative meetings with respiratory clinicians establishing region wide support for implementation of the bundle. By consensus working the teams agreed wording for a KSS bundle, based on the BTS bundle. A data dictionary and a data collection tool were created to standardise collection of data. Results are fed back to teams monthly via a bespoke reporting tool. Educational sessions on improving quality and delivery of the bundles are part of the collaborative meetings, e.g. ‘train the trainers’ inhaler technique.

Results 10 of 11 acute trusts in the region now deliver the COPD discharge bundle. 8 of those submit data to the regional reporting tool. Prior to the project only one trust in the region was systematically delivering the COPD discharge bundle.

At the start of the programme in October 2014, for the trusts reporting data, 222 patients per month (45% of HES recorded COPD admissions) were receiving at least some elements of the tool. By October 2015 the number had increased to 330 (66% of HES recorded COPD admissions).

The percentage of recorded patients documented as receiving each element of the bundle in KSS is shown in Table 1.

By October 2015, the percentage of AECOPD patients recorded as receiving every element of the discharge bundle had increased from a baseline of 4% to 25%. We aim to assess impact of bundle compliance on outcome measures. Data to Q4 2015/16 show a regional reducing 30 day readmission rate trend compared to prior to the project .

Conclusion With strong clinical networks and collaborative working it is possible to implement a more unified approach to delivery across a large geographical area.

Abstract P200 Table 1

	Oct 2014	Oct 2015
Inhaler technique checked	24%	49%*
Written Information given	9%	40%
Rescue Pack Prescribed	27%	40%
Referred for smoking cessation	59%	72%*
Referred for PR	27%	47%
Follow up arranged	27%	47%*

*significant at P = 0.05 level, paired t test on individual trust data.

REFERENCE

1 Hopkinson NS, et al. Designing and implementing a COPD care bundle. *Thorax* 2012;67(1):90–2.

P201 INTEGRATING PATIENT SUPPORT GROUPS INTO RESPIRATORY CARE PATHWAYS

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Strategy for change The British Lung Foundation wanted to test if integrating respiratory support groups into the local pathway produced a better understanding of health care services available and lung disease; increased medicine management and compliance; increased patient confidence and development of new skills. Did it also impact on control of health and demand on NHS services including unplanned hospital admissions?

Assessment The aim of this evaluation was two-fold:

1. A process evaluation: to look at the barriers and facilitators to integrating a support group into a respiratory care pathway.
2. An outcome, impact and economic evaluation: to measure impact on both physical and mental wellbeing and the benefits to NHS services, clinicians and commissioners

Methodology We employed validated questionnaires to measure physical, psychological and general wellbeing outcomes in participants. These were disseminated to control and test group at baseline and at 6 monthly intervals. Impact on NHS services was self-reported via telephone interviews with patients.

Effects of changes There was a self-reported 42% reduction in unplanned GP visits and a 57% reduction in unplanned hospital admissions compared to standard support groups.

People living with a lung condition who attended any type of support group had significantly greater quality of life at 6 months compared to control.

Those attending groups maintained quality of life throughout the study whereas quality of life decreased by more than 20% for patients in control group.

Those attending standard groups maintained self-efficacy whereas there was a decrease of 17% for those in control group.

For each pound invested in the integrated support groups there is a return of a minimum £3.43 and a maximum of £9.36.

For each pound invested in the integrated groups, there is a net gain of £8.01 in social return.

Lessons learnt Integrated respiratory patient support groups is a cost effective programme which has positive outcomes in terms of self-efficacy, health outcomes and wellbeing for attendees, providing cost savings and wider social benefits to local communities.

P202 OPTIMISING SERVICE DELIVERY IN ASTHMA AND COPD: CONSENSUS-DRIVEN RECOMMENDATIONS FOR FUTURE SERVICE DEVELOPMENT

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Introduction and objectives Asthma and COPD present a significant resource impact to the NHS. Earlier diagnosis may reduce morbidity and improve quality of life. In the UK, premature mortality from COPD is almost twice the European average and for asthma over 1.5 times the European average. This project sponsored by Teva Respiratory aims to identify differences in perceptions of various stakeholder groups regarding effective outcome improvements in asthma and COPD and make relevant recommendations.

Methods This group met with the objective of defining consensus statements for the future development of services in asthma and COPD. These statements were tested across a broad respondent sample by questionnaire. A Delphi methodology was used to assess levels of agreement with each statement. Questionnaires were offered to health care professionals across specialties

reflecting the roles of this group for completion as paper documents at Teva Respiratory sponsored UK meetings between June 2015 and January 2016.

Results 184 respondents, split across varied professional roles, completed questionnaires. 24 out of 42 statement scores (57%) exceeded the 66% agreement threshold and are thus regarded as supportive of the statements. Some variance was seen in responses between care settings (Figure 1), with primary care respondents commonly indicating lower levels of agreement than their secondary care colleagues (24 out of 42 statements (57%)).

Conclusions Most respondents indicate that it is possible to deliver effective care across all care settings that the patient will encounter. The need for further development of local integrated care approaches is well recognised. Respondents are ambivalent regarding the prioritisation of asthma and COPD, the variance may reflect differences in prioritisation between localities. There is strong agreement that definition of appropriate outcomes will support value-based care models and that interaction between professions is critical to effective integration of care. Respondents agreed there is a sound rationale for the use of branded inhaler therapies in asthma and COPD, which may liberate finite resources for other areas.

Based on this consensus exercise, 10 key recommendations for optimising outcomes in asthma and COPD are offered.

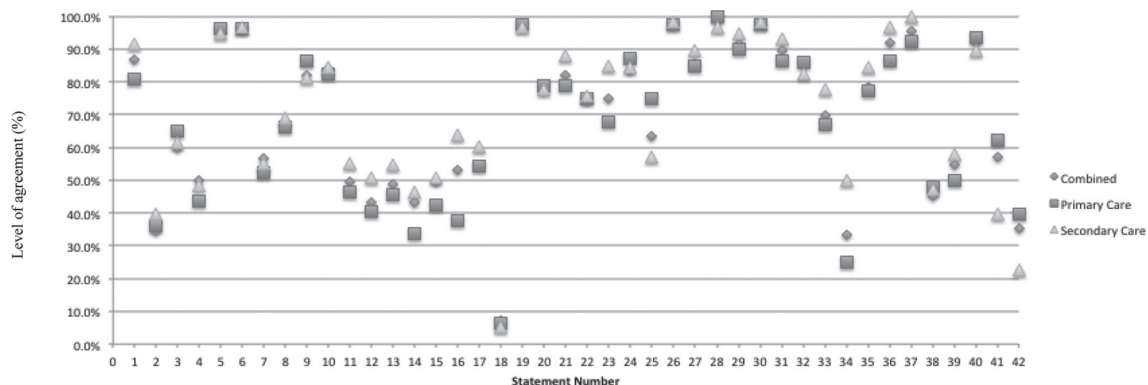
P203 ACUTE ONCOLOGY SERVICES AND THE CHEST PHYSICIAN

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Background At our trust (Popn 289400, x2 district general hospitals,) the Acute Oncology Service (AOS) began formally in June 2015. The team consists of 6 members, 3 consultants (1 session per week each ; x1 clinical lead at both sites and one clinical lead for metastatic spinal cord compression across both sites,) 2 clinical nurse specialists full time, 1 data coordinator full time. One of the 3 consultants is a chest physician (author.)

- In September 2014 a formal expression of need for AOS development was accepted and supported by Macmillan for a 3 year fixed term project.



Abstract P202 Figure 1 Care settings comparison