Benefits The system has allowed improved communication between members of the team. The template has served as a management checklist ensuring that important components of COPD care are not forgotten. The system has been used to identify patients with very severe disease for discussion at a severe disease MDT and been associated with a 5% reduction in outpatient attendances.

Methods Examined this in the EoE. i) outcomes and ii) the quality standards that deliver them. As generally low interest in COPD and poor attendance at educational programmes where practice improvement plans, a COPD management tool (POINTS) was introduced into most practices.

Financial incentives (QP 8 and QP 11) were used to drive key elements, in particular improved recording of exacerbations, the use of rescue packs and self-management plans. Plan for Primary Care Nurses was made “user-friendly” and delivered as monthly ‘bite size’ education sessions, with GP reimbursement for nurse time.

Results There has been a high level of support and engagement from primary and secondary care. COPD is now the top local LTC priority. During the first year admissions and re-admissions have reduced by approximately 15%. More than 90% of COPD outpatient activity is now in the community (including post discharge follow up).

Patient surveys have shown very high levels of satisfaction.

The project has been cost neutral in its first year (including savings from Oxygen Register cleansing but excluding savings from moving outpatient care to the community team) and the CCGs project savings of approximately £300,000 and £600,000 at 24 and 36 months.

Discussion This demonstrates that service redesign can deliver rapid improvements in the quality of care with significant cost savings potential.

Conclusion We had expected to find a relationship but these results suggest that the existence of various services cannot be used as a surrogate for outcome measures. It would be expected that the existence of these services would improve the outcomes. The services were present in April 2012 but may have been introduced after or during 2010–11 when outcomes were measured. Auditing is also necessary to show that services are effective. Outcomes may also have improved in some areas after the introduction of services but those PCTs may still be ranked below others. In future trend analysis will be more useful than simple ranking.

Quality Improvements and Cost Savings Associated with the Integration of COPD Care in Coventry

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Hospital admission for acute respiratory disease accounts for 40% of the cost of managing respiratory disease in the UK. Data from national and European respiratory audits suggest the quality of care received is highly variable, and in the UK only 50% of people admitted for exacerbation of COPD will be managed by respiratory physicians. Admission to hospital is a significant event for someone with respiratory disease and represents an opportunity for the patient to receive a comprehensive and high quality respiratory review and interventions. Through project work with five project sites a structured admission model was developed and implemented through service improvement and process redesign. The components of the model include:

- Appropriate and timely (within 3 hours of admission) access to non-invasive ventilation (NIV)
- Access to respiratory specialist within 24 hours
- Proactive identification and management of high impact service users
- Ensuring every patient receives the key aspects of care during their admission (e.g. smoking cessation, inhaler technique check, self-management plan)