**Abstract P120 Table 1**

| Shared Decision Making Descriptor | Result |
|---|---|
| % of patients felt that the clinician addressed what was important to them at their appointment | 90% |
| % of patients felt that their expectations were met during their appointment | 90% |
| % of patients felt able to make a decision that was right for them with their clinician | 90% |
| % of patients felt that the clinician shared their expertise with them enough to help the patient feel that they were making the right choice for them | 90% |
| % of patients felt that they fully understood the pros and cons of each treatment option | 88% |
| % of patients were happy that there was enough time to help them feel confident in making their treatment choice | 90% |
| % of patients reported that the information they received led to them changing their decision regarding treatment choices | 45% |
| % of patients felt more confident to manage their condition after attending an education and self-management group | 90% |
| % of patients reporting that they now do things differently as a result of their consultations showing changes in lifestyle and health behaviours | 95% |
| % of patients reporting high confidence scores in self-managing their condition at the start of the group | 5% |
| % of patients reporting high confidence scores in self-managing their condition at the end of the group. | 90% |

shared decision making within group education for COPD patients to date.

**Methods** 20 semi-structured interviews were performed to obtain quantitative and qualitative data from COPD patients who had recently attended an education and supported self-management group held over six weeks. Data collection was performed by allied health professionals who do not work in the COPD clinic. Questionnaires were reviewed and amended by a Questionnaire Users, Interviews and Surveys group prior to use.

**Results** (see Table) Qualitative feedback provided by patients supported the quantitative results and ranged from neutral to highly positive in nature, with several patients reporting significant impact on their quality of life, confidence in supported self-management, increased exercise participation, physical function, and social participation.

**Conclusion** COPD patients attending a six weeks education and supported self-management group reported significant understanding of information, increased understanding of treatment options, and increased education and ability to self-manage.

## REFERENCES

Collins A (2011)The Kings Fund Report: 'Making shared decision-making a reality: No decision about me, without me'

Coulter A (2009) 'Implementing Shared Decision Making in the UK': A Report for The Health Foundation

## P121 SPEECH AND LANGUAGE THERAPY IN PULMONARY REHABILITATION: THE IMPLICATION OF EDUCATION SESSIONS ON DYSPHAGIA MANAGEMENT

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**Introduction** Pulmonary rehabilitation (PR) programs use multidisciplinary teams to optimise physical and social functioning of patients with chronic respiratory impairment. Such patients demonstrate an increased prevalence of oropharyngeal dysphagia as a consequence of impaired co-ordination between respiration and swallowing function. Often patients will not be aware of the warning signs of dysphagia and unfortunately will not be seen by a speech and language therapist until they are admitted to hospital. We report the outcomes of a pilot scheme whereby such patients underwent education, assessment and treatment for dysphagia as part of their PR programme..

**Methods** The pilot scheme ran between June 2013 and May 2014. Intervention consisted of: (1) a one hour group education session on the signs, symptoms and risks of dysphagia; (2) screening for oropharyngeal dysphagia; and (3) individual outpatient management in Airways Clinic. The majority of patients attending the education sessions had a diagnosis of Chronic Obstructive Pulmonary Disease (COPD).

**Results** The education programme was delivered to 72 patients, and resulted in a significant improvement in dysphagia knowledge. The average score pre education was 3/11 and post education was 8/11. Fourteen patients (19%) exhibited or reported symptoms of dysphagia. Of these two patients were overtly aspirating and required food/fluid modification and seven patient's required instrumental assessment in the form of fibre endoscopic evaluation of swallowing (FEES). During FEES, three patients showed penetration of food/ fluids and were at risk of silent aspiration. These patients attended for further SLT where diet/ fluids were modified, posture was assessed and dysphagia therapy was introduced.

**Conclusions** Dysphagia education and management of patients in PR can contribute the early identification, patient awareness and self-management of dysphagia. We have confirmed that undiagnosed but clinically important dysphagia is present in patients undergoing PR. We are investigating whether improved dysphagia knowledge and early identification of dysphagia symptoms leads to reduced exacerbations and improved quality of life.

## P122 A SURVEY OF PULMONARY REHABILITATION (PR) SERVICES IN KENT, SURREY, SUSSEX (KSS)

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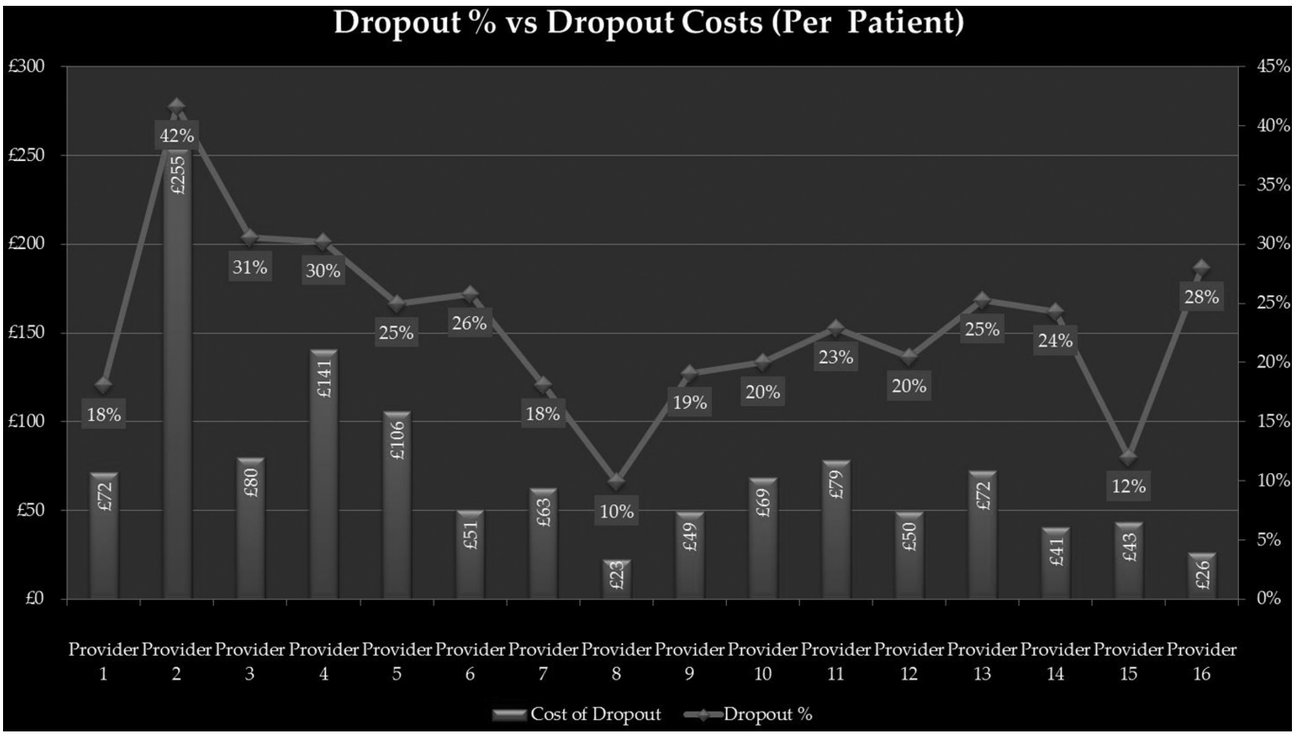
**Introduction and objectives** There is no agreed model for Pulmonary Rehabilitation (PR) and wide variation in services exists. A regional PR network was established 4 years ago, with the aim to drive up standards and reduce variation. An audit was undertaken of all PR services in the region to determine costs of services and factors influencing variance.

**Method** In June 2013 e-questionnaires were sent to all 16 known PR providers; fifty questions requested average annual/ weekly data including: staff pay bands, time spent on exercise, education, administration, travel and other identifiable costs, numbers failing to complete (drop-out) and clinical outcomes. All costs were calculated in terms of cost-per-patient. Providers




**Abstract P122 Figure 1** Dropout% vs Dropout Costs (Per Patient)

were assured actual costs and their identity would not be revealed.

**Results**

1. PR regionally serviced 3712 patients annually
2. Many providers total per patient costs were above the national tariff
3. Administration formed the highest share of providers total cost (24%),
4. Administration time per patient per course varied widely (1 – 14 h)
5. There was a wide range of drop-out, 10–42%, mean 23%
6. The mean (£76) and range (£23-£255) of drop-out cost per patient was high, rising at an ever increasing rate for every dropout (Figure)
7. Both larger patient numbers and rolling programmes were associated with higher per patient cost, the latter accountable to higher admin costs surpassing savings in exercise session costs.
8. Inconsistent reporting of clinical outcome data by providers.

**Conclusion** Our analysis demonstrates significant variation in the makeup of providers' individual costs, with the majority of the variation between providers' total cost per patient attributed to dropouts. Administration and drop-out were the greatest contributory factors to higher service costs. Higher cost was associated with larger patient numbers and rolling programmes.

**Discussion** Insufficient clinical outcome data were received to make any meaningful comparison of cost with outcome. Further work in this area is therefore required. Providers expected that providing services for larger numbers of patients and using rolling programmes would have lower costs, but the reverse was true. Administration costs for PR are very significant and may frequently be the key driver behind cost differences.

## P123 THE BENEFITS OF PULMONARY REHABILITATION (PR) IN INTERSTITIAL LUNG DISEASE (ILD): OBSERVATIONS FROM OXFORDSHIRE'S MIXED RESPIRATORY DISEASE, COMMUNITY BASED PR PROGRAMME

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**Introduction** The benefits of increased exercise capacity and health related quality of life after PR are well documented in chronic obstructive pulmonary disease (COPD). Interest is growing in whether other respiratory diseases benefit from PR interventions. Limited research is available to demonstrate benefit to patients with ILD (Holland *et al*., 2008). No published studies examine the relative performance of ILD patients in a PR programme compared with a mixed disease cohort.

**Objective** To establish whether ILD patients benefit from participation in an established PR programme.

**Methods** Pre- and post-PR data for patients with ILD who took part in a 6-week PR programme compliant with BTS guidelines (Bolton *et al*., 2013), were examined alongside similar data for all patients who had participated in the PR programmes over an 18 month period.

**Results** Data was available for 21 patients with ILD, and 344 patients with other respiratory diseases. Median MRC grade of both groups of patients was 4. Mean baseline lung function of ILD patients was $FEV_1$ 2.06 (84.6% predicted), FVC 2.59 (82.81% predicted), $FEV_1$ /FVC 78.37, $TL_{CO}$ 46% predicted. Incremental Shuttle Walk Test (ISWT) and St Georges Respiratory Questionnaire (SGRQ) data for ILD patients, and the whole cohort is shown in the attached table.