Innovation in service design

M1 ASSERTIVE OUTREACH FOR PERSISTENT FREQUENT ATTENDERS WITH COPD IN THE COMMUNITY: REDUCING ATTENDANCE BY MEETING THEIR UNMET PSYCHOLOGICAL NEEDS

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10.1136/thoraxjnl-2017-210983.423

Introduction and Objectives Co-morbid mental health problems in COPD can result in maladaptive and inappropriate utilisation of healthcare services (e.g., panic attacks cause attendance at A and E and acute hospital admission). Research evidence shows that COPD patients with co-morbid mental health problems have a higher rate of persistent A and E attendance and unplanned hospital admissions and on average incur an additional 80%–102% of medical treatment cost (Makek & Norris, 2008). Conventional models of mental health service provisions (e.g., Improving Access to Psychological Therapies (IAPT), secondary care mental health services) have proved ineffective in accessing and treating this subgroup of COPD patients. As such, there is a financial incentive for health services to develop more person-centred and cost-effective service models to address this issue. The current study investigates the effect of an Assertive Outreach Model of psychological interventions as applied to COPD patients with histories of frequent attendances to A and E and unplanned short-term hospital admissions. Attendance behaviours, depression and anxiety symptoms, and treatment costs were investigated.

Methods 19 COPD patients with persistently high attendance behaviours (i.e., three or more A and E attendances and/or two or more unplanned hospital admissions in a 12 month period) were identified from cross-referencing data from Electronic Patients Record (EPR) and the clinical knowledge of the community COPD team. They were then proactively engaged in an assertive outreach model within two weeks of identification, and offered four to 12 sessions of community-based psychological intervention during a 24 month period.

Results Compared to their 12 month pre- psychological intervention baseline, a total reduction of 40% (n=56) A and E attendances and 33% (n=32) short-term inpatient admissions was seen which amounts to approximately £30 000 of cost savings on treatment per year. 16% (n=6) and 21% (n=8) of patients reported a significant reduction in their depression and anxiety.

Conclusions An Assertive Outreach model of psychological intervention for COPD and co-morbid mental health problems providing responsive community-based treatment is highly effective in reducing attendance behaviours, achieving cost-savings, and by implication improving quality of life. However, it does not significantly improve patients' mental health symptoms which is likely due to the complex and multiple needs of this patient group.

M2 ADULT INTEGRATED RESPIRATORY CARE; STAFFING, POPULATIONS SERVED AND PATHWAYS OF CARE IN THE UK IN 2017

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10.1136/thoraxjnl-2017-210983.424

Introduction and objectives NHS England has defined integrated care as services that are patient centred, coordinated and tailored to the needs and preferences of the individual, their carers and family. An integrated care service also is one that has moved away from episodic care to a more holistic approach to health. The aims of the British Thoracic Society (BTS) Models of Care Committee (MoCC) are to identify current integrated respiratory services, gain a better understanding of the models and components of integrated respiratory care and to share learning.

Methods An electronic survey was designed to determine workforce involvement, populations served and interventions offered by respiratory integrated services. This was emailed directly to all BTS members and via a link to Primary Care Respiratory Society-UK, Association of Chartered Physiotherapists in Respiratory Care and Association of Respiratory Nurse Specialists members.

Results 113 clinicians participated in the survey: 64 nurses, 29 consultants, 14 physiotherapists and 6 others. 59/113 (52%) reported working in an integrated service.

44 adult integrated respiratory care services were identified: Scotland (1), Northern Ireland (2), North of England (10), Midlands/East of England (12), London (10), South of England (9).

- 75% teams were consultant-led, 54% nurse-led and 27% physiotherapist-led
- All teams included nurses, 93% physiotherapists and 90% consultants
- 95% accepted patients with COPD, 72% bronchiectasis, 68% asthma, 61% interstitial lung disease
- A wide range of services were offered; see Table 1
- 65% described care co-ordination involving primary, secondary and community care
- 45% reported using a shared care record
- 50% offered a 7 day service.

Conclusion With at least 44 services across the UK in 2017, adult integrated respiratory care is already an established model of care, in particular, but not only for COPD in the UK. Leadership and delivery is largely by a respiratory nurse specialist, physiotherapist and consultant workforce. While a wide and varying range of services are offered, the majority focus on chronic disease management, pulmonary rehabilitation, oxygen therapy and advanced disease care. The Results from this survey will be used by the BTS MoCC to create a directory of integrated respiratory services as a resource for the respiratory community.