P142 A DECREASE IN REFERRALS TO SECONDARY CARE FOLLOWING THE IMPLEMENTATION OF A NOVEL INTEGRATED CARE SYSTEM IN THE NORTH WEST OF ENGLAND

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Promoting integrated care is a key goal of the NHS long term plan to improve population respiratory health. In the Morecambe Bay Clinical Commissioning Group we have built an integrated care system called the Morecambe Bay Respiratory Network (MBRN). The network involves funding Primary Care teams to develop in-house specialist respiratory clinics which are supported by a monthly multi-disciplinary meeting (MDT) with support from secondary care and community teams. Patients are discussed from both diagnostic and management perspectives. This is backed up by a rolling programme of education for all local primary, community and secondary care staff.

This was implemented in 4 practices in North Lancashire in 2016, with a further 10 practices from Barrow-in-Furness joining in 2019. All practices have a designated clinician who leads on respiratory integrated care for their practice. They have direct access to appropriate blood test panels, pulmonary function testing and thoracic CT scanning. Two secondary care consultants provide advice at all MDTs.

Compared to a baseline of 2017/18, in 2019/20 there was an overall reduction in referrals to Respiratory outpatients from MBRN practices of -36%. By contrast referrals from local practices outside the MBRN structure increased by +12% over the same period. The observed reduction in referral to secondary care was not associated with increased non-elective admissions from participating practices (-7% in 2019/20 vs 2017/18 baseline) suggesting that disease control was not adversely affected. Evidence of improved quality of care is reflected in a significant increase in referrals for pulmonary rehabilitation for patients with eligible criteria in March 2020 compared to March 2019 (80% vs 54% in North Lancashire and 71% vs 35% in Furness).

This data from our novel integrated system demonstrates a significant reduction in secondary care referrals and improved patient care within the primary care setting. The data is supported by excellent patient feedback and staff satisfaction surveys.

P143 USING HOSPITAL ADMISSION TO OFFER INFLUENZA VACCINATION TO CLINICALLY AT-RISK ELIGIBLE INPATIENTS; WHAT IS THE NEED AND WHAT IS THE UPTAKE? TWO YEARS EXPERIENCE IN ONE ACUTE TRUST

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Background All Hospital Trusts in England are expected to offer influenza vaccination to eligible inpatients during Winter 2020–21. There is currently no data on which to model need and uptake of this approach by clinicians and patients.

Abstract P143 Table 1 Inpatient influenza vaccinations administered October 2018–19 and 2019–20 in one Acute Trust; patient characteristics, indication for vaccination, reason for admission, specialty ward and snapshot mortality June 2020

	2018–2019	2019–2020	Total
Inpatient vaccinations n	71	88	159
Mean age [range] years	61 (19 – 94)	63 (18 – 94)	62 (18–94)
Mortality at June 2020 n (%)	20 (28%)	12 (14%)	-
INDICATION FOR INFLUENZA VACCINATION			
COPD	28	41	69
Asthma	22	14	36
Bronchiectasis	1	1	2
Interstitial Lung Disease (ILD)	1	4	5
Heart Failure	2	5	7
Diabetes Mellitus	1	6	7
Sickle Cell disease	1	1	2
Immunosuppression	3	5	8
Cancer	4	2	6
Chronic neurological condition	3	7	10
Age alone	5	2	7
REASON FOR ADMISSION			
Exacerbation of COPD	15	24	39
Exacerbation of Asthma	18	12	30
Exacerbation of Bronchiectasis	1	1	2
Exacerbation of ILD	3	2	5
Pneumonia on background of COPD	7	11	18
Pneumonia on background of asthma	2	1	3
Pneumonia (without known respiratory disease)	6	9	15
Lung Cancer complication	5	1	6
Pulmonary Embolism	1	2	3
Pleural Effusion	0	1	1
Pneumothorax	0	1	1
Immunosuppression	1	2	3
Heart Failure	3	3	6
Acute Kidney Injury	2	2	4
Frailty complications	6	12	18
Sickle Cell Crisis	1	2	3
Other	0	2	2
WARD OF ADMISSION	n=71	n=88	n=159
Respiratory	54	60	114
Care of the Older Person	6	16	22
Cardiology	4	1	5
Acute Medicine	3	3	6
Gastroenterology	1	4	5
Surgery	3	4	7

In 2018 addressing vaccination status was added to the COPD 'Bundle' used in our hospital, electronic influenza vaccine prescription was introduced following NICE guidance recommending offering vaccination to eligible inpatients and checking vaccination status and offering to appropriate patients was included in respiratory ward reviews.

Aim To evaluate the uptake and characteristics of inpatients offered and accepting influenza vaccination over Winter 2018–19 and 2019–20 in one Acute Trust.

Methods Data on inpatient influenza vaccine prescriptions between October-March 2018–19 and 2019–20 was obtained from our electronic prescribing system. Electronic records of each admission were reviewed and analysed for patient demographics, reason for admission, indication for vaccination, ward and mortality at June 2020.

Results See table 1 for results. 159 inpatient vaccinations were administered over 2 years. Mean (range) age was 62 (18–94) years and mortality at 1+ year was 28%. 114 (72%) were on our 23-bed respiratory ward. By year 2, 32% (28/88) vaccines were administered on other wards. 2/3 vaccines were for patients with COPD or asthma.

Discussion Our data suggests that offering influenza vaccination to inpatients is a feasible and sustainable intervention for which there is patient demand. Approximately 2 vaccinations/week were administered on a 23-bed respiratory ward. Inpatients were also vaccinated on other wards; with >60% increase on elderly-care wards in year 2. This was largely due to prescribing by trainees who had completed a respiratory rotation and continued to offer vaccination in subsequent roles.

The high snap-shot mortality at June 2020 (28% 1 year+) is a reminder of the high risk of death for inpatients eligible for influenza vaccination. Our findings suggest that clinicians want to offer vaccination and that there are groups of unvaccinated inpatients who take up the offer of influenza vaccination. In the era of COVID-19, it is particularly important this population is vaccinated. Face-to-face contact during admission is an opportunity we should be using to do this.

P144 STANDARDISING FOLLOW UP OF SYMPTOMS, TESTS, AND OUTCOME ASSESSMENT AFTER HOSPITALISATION FOR EXACERBATION OF COPD – A DELPHI SURVEY

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Introduction and Objectives Hospitalised exacerbations of COPD lead to significant morbidity and mortality. Unlike most other common conditions treated in hospital (eg. pulmonary embolism and myocardial infarction), international guidelines do not define clinical characteristics, tests and outcomes to be assessed at time of follow up. We sought to evaluate the current Europe-wide expert view on demographic, clinical characteristics, comorbidities, investigations, and clinical outcomes to be assessed at follow up after a hospitalised exacerbation of COPD.

Methods A modified online Delphi survey of COPD experts was performed. 3 iterative rounds were undertaken. Importance and feasibility of items were assessed. Consensus and stability criteria were pre-defined.

Results 25 COPD experts from 18 European countries completed all 3 rounds of the Delphi survey. Of the 31 clinical signs assessed, 13 (42%) clinical signs achieved consensus as important to capture at time of follow up after hospitalised exacerbation of COPD. Similarly, only five clinical scores and questionnaires were thought to be important to capture at time of follow up after hospitalisation. These were the modified Medical Research Council (mMRC) dyspnoea index, COPD Assessment Test (CAT), the BODE index (BMI, Obstruction, Dyspnoea and Exercise Capacity), the Global initiative for chronic obstructive lung disease (GOLD) I-IV and A-D classifications. Experts agreed by consensus that they would consider most of the scores at time of follow up but would not suggest including them routinely.

Abstract P144 Table 1 Tests at time of follow up after hospitalisation for exacerbation of COPD

Must include	Consider inclusion	Exclude
Arterial Blood Gas	Urea, electrolytes, and creatinine	Liver function tests
Full blood count	Brain Natriuretic Peptide	Phosphate, calcium, magnesium
Spirometry	Sputum microscopy & culture	Lactate Dehydrogenase
Inspiratory capacity	Glucose	Fibrinogen
Diffusion capacity of lung for carbon monoxide	C-reactive protein	D-Dimer
Plethysmography	Electrocardiogram	Immunoglobulins
	Chest X-Ray	Procalcitonin
	Sit to stand	Urine dipstick
	Patient symptom diaries	Urine microscopy and culture
		Viral throat swabs
		Glycated Haemoglobin
		Exhaled Nitric Oxide
		Frequency oscillometry testing

Conclusion Hospitalised exacerbations of COPD are managed and followed up differently throughout Europe. Standardisation will help guide research to improve outcomes

P145 IMPROVING THE FOLLOW-UP OF PATIENTS WITH EXACERBATIONS OF ASTHMA AFTER DISCHARGE FROM THE EMERGENCY DEPARTMENT

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