

Questionnaire (SGRQ) (Tsiligianni IG et al 2012). Although the CRQ and SGRQ were originally developed in patients with chronic airway obstruction, they are commonly used in clinical practise in chronic respiratory diseases other than COPD. We hypothesised that the CCQ would correlate with existing health status measures and exercise capacity in a survey of non-COPD patients

Methods 60 patients were recruited from respiratory outpatient clinics. Disease classifications included interstitial lung disease (n=23), asthma (n=10), bronchiectasis (n=17), extrathoracic restriction (n=8) and thoracic surgery for lung cancer (n=2). CCQ, CAT, CRQ, SGRQ and incremental shuttle walk (ISW) were recorded. Spearman's rank correlation was used to assess the relationship between CCQ and other outcome measures.

Results Baseline characteristics are presented as mean (standard deviation) or median (25th, 75th percentiles); Age 65 (58, 77), FEV₁% predicted 69.8 (24.4), BMI 28.0 (25.4, 32.3), MRC 3(1), CCQ 2.1 (1.5, 3.8) and ISW 210 (90, 320). There was a significant correlation between the total CCQ and CAT, SGRQ, CRDQ, MRC and ISW (all p<0.01 see Table. 1). In addition individual domains of the CCQ correlated significantly with MRC, CAT and individual domains of the CRQ (p<0.01).

Conclusions The CCQ correlates well with existing health status and functional outcome measures in non-COPD patients. CCQ may be a useful assessment tool to test the efficacy of interventions such as pulmonary rehabilitation in this population, but longitudinal studies are required to confirm.

P107 LONG-TERM ADHERENCE TO EXERCISE AFTER PULMONARY REHABILITATION: UNDERSTANDING THE MOTIVATIONS AND BARRIERS TO EXERCISE?

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Introduction Adherence to exercise after PR is known to be low and the role of motivation/barriers in this population remains unclear. This study aimed to further investigate the role of motivation and barriers to exercise and specifically profiling trends that may guide/assist maintenance strategies.

Method 112 (58=M) patients who completed >50% of a PR programme over a 3 year period, were sent a postal survey. Data collected included; demographics, co-morbidities, MRC, physical activity/exercise and motivation (21 items) and barriers (14 items) to exercise quantified along a 5 point-likert scale (Newson and Kemp, 2007).

Results 51.8% (n=58) responded; mean age 71.72, MRC dyspnoea 2.86 and co-morbidities 1.09, COPD=87.9%. Motivation and barriers were analysed separately, as mean motivation/barriers weren't significantly correlated. Mean barrier was significant correlated with MRC dyspnoea (p=0.003), co-morbidities (p<0.001) and intent to exercise (p<0.001), but not with motivation. Sub-analyses identified those who exercised regularly (currently at least once a week most weeks) rated motivations and barriers significantly different to those who didn't. Exercisers had significantly higher mean motivation (p=0.023) and deemed the following factors to be significantly more motivating reasons to exercise; 'I want to be

physically fit' (p=0.002); 'I exercise because a health professional advised me to' (p=0.029); 'I want to stay in shape' (p=0.019) and 'exercising gives me energy' (p=0.0210). Conversely the non-exercisers had significantly higher mean barrier score (p=0.003) and rated the following as significantly greater barriers; 'Shortness of breath' (p=0.013); 'lack of energy' (p=0.011); 'having a limited health/physical condition' (p=0.028); 'painful joints' (p=0.002); 'not knowing what you are capable of, or should be doing' (p=0.030); fear of, injury (p=0.032), falling (p=0.036) and safety (p=0.021). None of these factors changed over time since completing PR.

Conclusion This study quantified 21 motivating factors to exercise and 14 barriers that prevent exercise in the post-PR population. Some factors were rated significantly differently between exercisers and non-exercisers and did not significantly vary over time since completion of PR. Further research is required to establish if targeting specific factors could guide/assist maintenance strategies.

P108 HEALTHCARE PROFESSIONALS PERCEPTIONS OF SELF MANAGEMENT IN COPD – IMPORTANT, CHALLENGING AND MISUNDERSTOOD

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Introduction There is increasing focus on the importance of self management (SM) within COPD. Literature from other chronic diseases highlights the challenges of implementing SM and the lack of specialist training available. Currently we have no knowledge of what Health Care Professionals (HCP) understand by the term 'SM' and their perceptions of the challenges to successfully supporting SM strategies specifically with a COPD population. A greater awareness of HCP understanding and beliefs surrounding SM is likely to inform training, enhance professional development and improve delivery of SM to patients with COPD.

Aim To explore HCP understanding of SM and their perceptions of the challenges of supporting COPD patients with SM in order to identify education, training and resource needs.

Method A purposive sample of 14 respiratory HCP participated in semi-structured interviews. Interviews were transcribed verbatim and thematic analysis was performed. Two experienced researchers (SH, LA) analysed a sub-group of interviews to enhance rigour.

Results Three main themes emerged from the data: 1. *Understanding of SM* – meaning, importance. 2. *Supporting SM* – advising and working in partnership. 3. *Challenges to delivering SM* - service, cultural and perceived patient barriers.

Conclusion HCP demonstrate a lack of understanding regarding SM which subsequently impacts upon its successful delivery. In spite of this, all HCP agreed that SM is an important aspect of care for COPD patients. HCP feel apt in the delivery of advice and many worked in partnership with their patients but most failed to consistently address additional SM needs. HCP could improve their delivery of individualised SM by abandoning preconceptions about their patients and enhancing skills to assist patients with core SM strategies including: problem solving, decision making and taking action.

Abstract P106 Table 1 Relationship between CCQ and other outcome measures, r = Spearman's Correlation Coefficient

| | ISW (m) | MRC | CAT | CRQ-D | CRQ- F | CRQ-E | CRQ-M | SGRQ Symptom | SGRQ Activities | SGRQ Impact | SGRQ Total |
|----------------|---------|------|------|-------|--------|-------|-------|--------------|-----------------|-------------|------------|
| CCQ Symptoms | -0.41 | 0.54 | 0.63 | -0.46 | -0.42 | -0.50 | -0.58 | 0.47 | 0.61 | 0.55 | 0.63 |
| CCQ Functional | -0.44 | 0.52 | 0.65 | -0.42 | -0.67 | -0.78 | -0.72 | 0.21 | 0.58 | 0.75 | 0.66 |
| CCQ Mental | -0.59 | 0.64 | 0.67 | -0.64 | -0.63 | -0.62 | -0.76 | 0.27 | 0.81 | 0.71 | 0.77 |
| CCQ Total | -0.54 | 0.65 | 0.74 | -0.59 | -0.66 | -0.71 | -0.79 | 0.37 | 0.78 | 0.76 | 0.79 |