Introduction and Objectives Previous studies have shown that overall asthma care can vary greatly between practises. In this study we evaluate the recorded asthma prevalence and characterize asthma control and risk profiles of real-life asthma patients from 210 practises managed within UK primary care.
Methods Electronic practise data was extracted from patients with asthma from 210 practises across the UK Patients included in the analysis were ≥18 years, had clinician-diagnosed asthma (defined as a diagnostic Read code compatible with the UK Quality and Outcomes Framework [QoF] for asthma) and were receiving current asthma therapy (≥1 asthma prescriptions within the last 2 years). Eligible patients were sent asthma management questionnaires to capture patient-reported outcomes. Pooled practise and patient data were used to characterize patients in terms of their control status (as classified by the Global INitiative for Asthma [GINA] and Royal College of Physician three questions [RCP3]) and risk status (stratified according to exacerbation frequency [Read code defined acute exacerbations and number of courses of acute oral steroids in previous 12 months], with high risk defined as ≥2 exacerbations annually).
Results From 210 practises across the UK there was an asthma prevalence of 5.9%, comprising 80280 adult patients and comparing to a UK QoF-assessed prevalence of 5.8%. The percentage of patients per practise with uncontrolled asthma (Median [IQR]) was 18.8% (9.1, 26.7) while the percentage per practise with no recorded RCP3 data was 18.9 (12.4, 45.9). 3.2% (n=2594) of the patients were classified as being high risk.
Conclusions A high proportion of patients managed in routine UK primary care have sub-optimal asthma control. More patients at BTS management stages 4 and 5 have uncontrolled asthma and suffer from a greater number of exacerbations. RCP3 recording varies between practises, and can be poorly recorded.

P278 REASONS PROFFERED FOR NON-ATTENDANCE AT A DIFFICULT ASTHMA CLINIC

doi:10.1136/thoraxjnl-2012-202678.370

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Background Our weekly difficult asthma clinic consistently has a higher 'did not attend' (DNA) rate compared to the general respiratory clinics (32.6% v 23.7%). There is some evidence that DNA rates are particularly high for primary care asthma reviews[1]. Demand for our weekly difficult asthma clinic appointments is increasing such that routine appointments are at a premium. To explore reasons for non-attendance, our asthma specialist nurses attempted to interview patients that DNA over the telephone within a week of their scheduled appointment. The cause for non-attendance was ascertained in a non-confrontational manner and asthma control gauged.
Aim To determine reasons preferred for non-attendance at a difficult asthma clinic and to ascertain whether these differed between new and follow-up patients.
Methods Review of database generated from contacting patients that DNA asthma clinic between April 2011 and March 2012.
Results There were a total of 153 missed appointments. We attempted to contact the patient following their missed appointment in 101 cases and were able to succesfully complete a telephone interview in 51 cases. Of the DNA appointments, 8 were new-patient appointments and 43 were follow-up.

See Table 1. Reasons for non-attendance.

Conclusions Forgetfulness ('wrong day' and 'forgot') was the commonest reason for non-attendance amongst both new and follow-up patients. This is in keeping with work done in the general outpatient population.[2] One in 5 patients claimed not to have recieved their appointment. Attempts to telephone patients a week prior to their scheduled appointment may help to reduce DNA rates and/or make more appoinments available to patients that need them.

References

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Abstract P278 Table 1

Reason	Overall (n=51)	New (n=8)	Follow-up (n=43)
Didn't receive	10 (19.6%)	2 (25%)	8 (18.1%)
Forgot	12 (23.5%)	1 (12.5%)	11 (25.6%)
Wrong day	12 (23.5%)	3 (37.5%)	9 (20.9%)
Unwell	5 (9.8%)	0	5 (11.6%)
Family problems	2 (3.9%)	1 (12.5%)	1 (2.3%)
Pt says cancelled appointment	5 (9.8%)	1 (12.5%)	4 (9.3%)
No data	2 (3.9%)	0	2 (4.7%)
Inpatient	2(3.9%)	0	2 (4.7%)
Moved out of area	1(2.0%)	0	1 (2.3%)

P279 EVALUATION OF TREATMENT WITH FIXED DOSE COMBINATIONS IN ASTHMA PATIENTS IN PRIMARY CARE IN SWEDEN BY USING MANNITOL CHALLENGE TEST

doi:10.1136/thoraxjnl-2012-202678.371

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Background The mannitol challenge test is an indirect bronchial challenge test suitable for use in a primary-care setting. The test is most often used to diagnose asthma. In this pilot study the test was used to evaluate the effectiveness of ongoing treatment with ICS/LABA combination therapy in patients with asthma.
Objectives To explore the prevalence of optimal treated asthma patients in primary care in Sweden. The hypothesis was that not all patients are optimal treated.
Methods Male and female subjects, age 18–65 years with asthma, who were treated with a fixed dose combination (budesonide/formoterol or fluticasone/salmeterol) were included in the study. The subjects performed a mannitol challenge test (direct fall) followed by an inhalation of a β_2-agonist. A new spirometry (reversibility test) was performed 15 minutes later. The main explorative end-point was positive or negative response of mannitol challenge test and/or a reversibility of ≥15%.
Results The preliminary result of this pilot study (100 subjects) shows that an unexpected, surprisingly high proportion of the asthma patients had a positive response, either as a direct fall of FEV_1 ≥15% in the mannitol challenge test and/or a reversibility of ≥15%.
Conclusion The result of this study indicates that a large proportion of asthma patients in primary care, who are currently treated with fixed dose combination therapy, may not be optimally treated. Further research is needed to support these findings and to understand the reasons.

P280 REDUCING NON-ATTENDANCE AT A DIFFICULT ASTHMA CLINIC – ARE PHONE CALLS FUTILE?

doi:10.1136/thoraxjnl-2012-202678.372

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Background Missed outpatient appointment cost NHS hospitals in the region of £600 million per year.[1] There is some evidence that

'did-not-attend' (DNA) rates are particularly high for primary care asthma reviews[2]. Increasing demand for our weekly difficult asthma clinic means that routine appointments are at a premium. This led us to attempt to reduce the DNA rate. Our asthma specialist nurses began to interview patients that failed to attend over the telephone within a week of their scheduled appointment.

Aim To ascertain whether telephoning patients that DNA clinic leads to an attendance at the next scheduled clinic appointment.

Methods Review of database generated from contacting patients that DNA asthma clinic between April 2011 and March 2012.

Results There were a total of 153 missed appointments. We attempted to contact the patient following their missed appointment in 101 cases. We were able to contact 51 patients, of these 20 (39%) attended their next appointment. We tried but failed to contact 50 patients of whom 5 (10%) attended their next appointment. We did not contact 52 patients for various reasons, 10 (19%)attended their next appointment.

Conclusions Telephoning patients that DNA asthma clinic led to a two fold increase in attendance at subsequent clinics. Each phone call lasted approximately ten minutes and there were often several attempts required before contact was made. The patient's asthma control was assessed during the call and the outcome was recorded in the case notes.

Despite that fact that telephoning patients led to a reduction in subsequent missed appointments, this is a time consuming and therefore costly exercise and 24/51 (47%) of patients missed their subsequent appointment despite having been contacted. Non-attendance may be a reflection of poor concordance which in itself may be contributing to the patients' difficult asthma.

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COPD care bundles, IT systems, service analysis and beyond

P281 IMPACT OF AN ELECTRONIC CHRONIC DISEASE MANAGEMENT SYSTEM FOR CHRONIC OBSTRUCTIVE PULMONARY DISEASE

doi:10.1136/thoraxjnl-2012-202678.373

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Introduction and Objectives The chronic disease management system (CDMS) is an electronic patient record developed by healthcare professionals (HCP) across inner northwest London for care of patients with COPD. It was introduced across Imperial NHS and Central London Community Healthcare in January 2012. The aim was to improve patient management by promoting real time information sharing across and between organisations.

The objectives of this study were to assess:

1. The acceptability and use of the COPD CDMS by HCPs.
2. Whether healthcare professionals using the system felt it benefitted patient care.

Methods All healthcare professionals (42) in the integrated COPD MDT were asked to complete an anonymous questionnaire at month 3 after the introduction to paperless working and again four months (month 7) later to assess whether opinions had changed.

Results 35/42 members of the COPD MDT completed questionnaires in March 2012 and 28/42 in July 2012.

Initial questionnaire: 33 (94%) of healthcare professionals were using the COPD CDMS with 17 (52%) multiple times a day. The most frequent reasons for using the COPD CDMS was that it gave access to timely information pertinent to patient care (25/89%) and increasing information sharing across teams (25/89%). 19 (58%) felt it improved patient care and 10 (35%) users felt it improved the patient's experience. 18 (55%) rated the system as very or extremely useful.

Repeat Questionnaire: Responses in the follow up questionnaire were similar to the initial results with a similar number using it (89%) and rating it as very or extremely useful (52%). The system was also being used more out of hours (17% - 32%) and there were increases in the number of users who believe it improves patient experience (45%) and care (67%). Table 1 indicates factors influencing the use of COPD CDMS by HCP.

Conclusions Introduction of an electronic patient record is acceptable to the integrated COPD teams. The majority will use from day 1 with no drop off of use over 7 months. Over time, out of hours usage increases and the belief using the electronic record improves patient care increases. This information will help others who plan similar changes across their care communities.

Acknowledgements NW London CLAHRC.

P282 AN INTEGRATED IT SYSTEM FOR COPD BETWEEN PRIMARY, SECONDARY AND COMMUNITY CARE USING SYSTMONE

doi:10.1136/thoraxjnl-2012-202678.374

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Southend Hospital and South Essex PCT have been developing an integrated COPD service for over a decade. Information sharing between providers remained a barrier to improved services. SystmOne is a medical management system used by 70% of practises in our area and utilised by community services. We decided to develop a COPD system for primary, secondary and community care using SystmOne.

Development A business case was developed and agreed by the IT strategy groups of the PCT, hospital trust and community trust. A project manager was appointed who worked with clinical leads from the hospital and PCT. The clinicians who would utilise the system including hospital consultants, respiratory nurse specialists, GPs, community matrons, community oxygen team and early supported discharge team all contributed to the design of the template. The system records demographic information, respiratory and smoking history, pertinent respiratory investigations such as spirometry and blood gases as well as whether the patient has been referred for pulmonary rehabilitation, smoking cessation or has a self management plan. At each clinical consultation symptoms and management changes are recorded. Tasks can be sent between members of the team for example allowing community matrons to send queries to hospital consultants.

Implementation All GPs agreed to participate in the scheme. Patients were required to sign a form consenting to sharing of clinical information. The project manager undertook training of all the clinical groups involved as well as hospital secretarial and clinic staff. Community staff were provided with laptops enabling remote access. After a training period of 5 months the system went live in March 2011. We now have 1522 patients registered on the system. 13 patients refused consent to the sharing of information.