

the responsibility for asthma control on themselves and not their HCP (Table), even among those with average or poor symptom control. Many respondents believed that lack of asthma control was inevitable, with 81% accepting that they would experience symptoms and 86% acknowledging that asthma would have an impact on their life.

Conclusions Patients have low expectations of the level of asthma control that can be achieved. Despite a good relationship with their HCP, many individuals do not attend regular asthma reviews, and awareness and use of Personal Asthma Action Plans is low. There is a clear need for continued education and initiatives to increase awareness among both HCPs and patients about asthma management plans and supported self-management.

Abstract P241 Table 1 Patient beliefs regarding the main responsibility for the management of their asthma

	Level of perceived control		
	All patients (n = 1083)	Very good or good (n = 859)	Average or poor (n = 224)
Responsibility			
Myself	70%	73%	58%
Myself and HCP	29%	26%	38%
HCP	1%	1%	3%

HCP, healthcare professional.

P242 PATIENTS OVERESTIMATE THEIR DEGREE OF ASTHMA CONTROL DESPITE THE PRESENCE OF SYMPTOMS: A UK SURVEY

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Introduction and Objectives Many patients with asthma overestimate the extent to which their symptoms are controlled, which may suggest that the real-world burden of the disease is greater than reported. This abstract reports data from a UK-based survey assessing the variation between patients' perceptions of asthma control and their symptoms.

Methods This was a cross-sectional online survey administered by YouGov plc (November 2011) to a panel of over 350,000 individuals. Panellists who had previously identified themselves as having asthma were invited by e-mail to participate in the survey. Responses were collated and analysed by YouGov and Insight Research Group. Overall, 1083 individuals completed the survey; 49% of respondents were aged over 55 years and 45% were male. Almost two-thirds (64%) of patients were using both reliever and preventer therapy and 17% were using reliever medication only.

Results Most respondents reported that their asthma control was 'very good' (37%) or 'good' (42%). However, 19% of respondents described having uncontrolled asthma (i.e. 'symptoms not very well managed') at least once a month and 10% reported lack of asthma control at least once a week. In the 2 years prior to the survey, 12%

of individuals had visited an accident-and-emergency department due to their asthma (ranging from 1 to 5 visits). Moreover, 41% of individuals used reliever medication at least once a day, and almost two-thirds experienced frequent (at least 'sometimes') day-time symptoms and over one-third had frequent night-time symptoms (Table). The most common day-time symptoms were coughing (experienced by 65% of individuals at least 'sometimes'), wheezing (62%) and breathlessness (58%). Despite this, 91% of respondents were 'very satisfied' or 'fairly satisfied' (44% and 47%, respectively) with their level of asthma control, and 59% did not believe it was possible to improve control.

Conclusions Patients are generally satisfied with their level of asthma control despite evidence of poor symptom control, suggesting a disconnection between patient perception of asthma control and actual asthma control. This suggests a need for further education to help patients better recognize the symptoms of poor asthma control and how this can help them aspire to greater asthma control.

P243 ARE HEALTHCARE PROFESSIONALS AWARE OF COSTS OF RESPIRATORY INHALERS?

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Introduction In 2011, 3 of the top 5 most expensive drugs to the NHS were respiratory inhalers, the most expensive being Seretide 250 evohaler. To achieve best value from our respiratory spend, healthcare professionals (HCPs) should know the relative costs of inhalers, and that their patients are using these devices appropriately. We undertook a survey of HCPs to test their knowledge of respiratory inhaler cost and how well the devices are used.

Methods We created a Survey Monkey questionnaire concerning the costs of commonly prescribed respiratory inhalers (see table) allowing respondents to click on an approximate range of costs for one month's treatment at normal recommended dose. We also asked about awareness of the evidence for effective use of metered dose inhalers (MDIs) by patients and HCPs. The survey was disseminated by email from various databases in community and hospital care within NHS London and beyond, especially to those involved in respiratory care.

Results There were 1274 respondents, 21% were doctors, 38% nurses, 21% pharmacists and 15% allied healthcare professionals (AHPs), 70% had a respiratory interest and 89% were clinicians. Overall, the correct price range was identified by fewer than 50% of all respondents for the inhalers tested (except generic salbutamol), the worst being for Seretide 250 evohaler and Ventol in evohaler (see table). 76% of respondents were not aware that fewer than 10% of patients can use an MDI effectively and 87% were not aware that fewer than 10% of HCPs can demonstrate the correct use of an MDI. Having attended a London Respiratory Team (LRT) event significantly improved the correct response rate (see table).

Conclusions Most HCPs are not aware of the costs of inhalers and how poorly some inhalers are used. Increasing awareness of cost

Abstract P242 Table 1 Frequency of reliever medication use and asthma symptoms

Use of reliever medication	Never	<1/day	1-2/day	3-4/day	5-6/day	7-8/day
% of respondents	3%	56%	26%	12%	3%	1%
Day-time and night-time asthma symptoms	Never	Rarely	Sometimes	Often	Everyday	
Day-time, % of respondents	4%	31%	35%	20%	10%	
Night-time, % of respondents	20%	43%	19%	12%	6%	

Abstract P243 Table 1

	% Correct answers		Respiratory interest n=976	Attended LRT Event n=168	Overall
	Community N=813	Hospital n=532			
Generic Salbutamol MDI	51.0	50.9	49.0	58.9	51.1
Ventolin Evohaler	36.5	18.6*	29.9	33.5	29.2
Symbicort 200 turbohaler	50.2	45.7	50.4	66.5 [#]	47.7
Seretide 250 evohaler	36.9	36.5	38.6	58.2 [#]	36.0
Seretide 500 accuhaler	50.6	50.4	53.1 ⁺	62.7 [#]	49.8
Fostair 100 MDI	52.4	43.6*	51.9 ⁺	50.6	48.7
Spiriva Handihaler	49.9	49.4	52.6 ⁺	55.7	49.3

*p<0.05 Hospital vs Community

⁺p<0.05 Respiratory interest vs no Respiratory interest[#]p<0.05 Attended LRT event vs no attendance to LRT event

could add a sense of value and improve responsible prescribing, including renewed focus on stepping down patients on high potency treatments when they are stable or have experienced no benefit, and always using a spacer with an MDI. Knowledge of which inhalers provide best value is also important for prescribers when choosing between evidenced based alternatives.

P244 ASSESSING TRAINING VALUE AND EDUCATIONAL SUPERVISION IN SP R POSTS

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Both the ongoing evaluation of training and the possible reduction in SpR training numbers makes it imperative to identify which SpR training posts offer the best educational value. Consultants may overestimate or overstate the training opportunities at their hospital. The JRCPTB "Post Assessment" form is rather non-specific and poorly used. The Respiratory STC in our region undertook to obtain feedback from respiratory SpR's about the diversity and quality of training and educational supervision. A questionnaire was e-mailed to all SpR's asking about training opportunities in clinical areas defined by the respiratory curriculum and the JRCPTB Respiratory PYA form; asking about exposure to a given service or specialty rather than just its presence in the hospital (e.g. domiciliary NIV, sleep medicine, thoracoscopy), and the quality of training in that area, (score 1–5, poor - excellent), and how they rated their educational supervision overall. Responses were to include posts previously and currently worked. Trainees sent 40 evaluations on the 14 training hospital in our region, (range 1–6 per hospital). A composite score for training opportunities was derived (maximum possible score for specialty and service areas 71). Scores for individual hospitals ranged from 17.3–43.6 (median 32) and the score for supervision at those sites ranged from 3.3–5 (median 4.3). Hospital identifiable results were tabulated and circulated firstly to trainers and later to trainees. Free text comments were handled more confidentially. Despite some reservations, (e.g. the perspective held by a junior SpR in completing the survey and a possible bias away from broad based DGH training), the STC regarded this as a useful exercise and the questionnaire will be modified by iteration and trainees will complete one after each post. Consultants will be asked to complete the same questionnaire for cross reference. Anecdotally, some units have already begun addressing some issue raised, perhaps in response to a need to "compete". These results may motivate hospitals to improve their training of SpR's as well as informing decisions on which posts should be retained and which should not.

P245 STANDARDISATION OF BRONCHOSCOPY TRAINING ACROSS YORKSHIRE AND HUMBER DEANERY

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Background Reduced exposure to bronchoscopy is a key issue for respiratory trainees with effect on their confidence in undertaking the procedure and thus patient safety. Studies have shown that simulation improves confidence in bronchoscopy skills but do not explore the most optimal teaching methods.

Aim To assess two different methods of delivering bronchoscopy simulation training

Methods Two half day simulation bronchoscopy courses were designed independently within the Yorkshire and Humber Deanery. Course 1 concentrated on providing a knowledge based training consisting of a didactic lecture followed by equal time spent on a Symbionix simulator and on the BTS e-learning hub website. Course 2 provided pre-course material in the form of BTS guidelines and bronchoscopy procedure pocketbook. The course focused on hands-on simulation training using a bronchoscopy manikin and the Symbionix simulator. All candidates completed pre and post course Likert scale questionnaires in six areas relating to participant knowledge and confidence in using a bronchoscope.

Results Overall 30 trainees; 15 in each course were evaluated. Candidates had performed between 0 to >300 previous bronchoscopies and were from across the SpR years. Both courses delivered significant improvement in confidence scores in all of the six areas assessed. The greatest improvement was found in confidence levels in technical ability (see table 1). Course 1 candidates showed a greater confidence improvement in factual skills (such as knowledge of contra-indications of the procedure and anatomy). Course 2 demonstrated that 93% of candidates agreed that the simulator helped to improve technical ability in contrast to 100% with manikin exposure. 100% of candidates found the pocketbook was a useful adjunct to the course with 93% agreeing that they would find this useful to complement their training.

Conclusions A combined and standardised bronchoscopy simulation course incorporating lectures and pre-course materials but focusing on hands on experience on both a manikin and a simulator is therefore considered to provide greatest educational benefit. This course is now active in Yorkshire and the Humber and is to be mandated for all new trainees to the programme. Each SpR will also be re-assessed after a 3-month period incorporating a competency-based assessment approach.