'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.

References

1. www.drfosterhealth.co.uk/features/outpatient-appointment-no-shows.aspx
2. van Baar JD, Joosten H, Car J, Freeman, GK, Partridge MR, van Weel C, Sheikh A. Understanding reasons for asthma outpatient (non)-attendance and exploring the role of telephone and e-consulting in facilitating access to care: exploratory qualitative study Qual Saf Health Care 2006; 15:191–195.

COPD care bundles, IT systems, service analysis and beyond

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

A Sykes, M Nyadzayo, S Elkin. *Imperial Healthcare NHS Trust and Imperial College London, London, UK*

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.

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

[1]DJ Powrie, [1]R Goodwin, [2]D Allan-Smith, [2]E Paddison, [1]M Ali, [1]S Ansari, [1]KG Lingam, [1]AG Davison. *[1]Southend University Hospital, Westcliff on Sea, UK; [2]South Essex PCT*

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.