patients to reach diagnosis and treatment however because of multiple referral sources, non 2 week [N2WW] patients follow a different journey. Our aim was to find out whether there is significant difference in patient outcome in these two groups in a multisite NHS Trust.

Method Between January 2008 & December 2011 all patients who had a radiological & or histological diagnosis (n=996) made in LCMDT were included in this study. Demography, time to diagnosis, time & number of deaths, staging & histology were compared.

Results In 2WW group 439 [Age 71(35–95)years, 177 female and In N2WW group 557 [Age 72(22–95), 232 female were compared. No significant difference in age, however significant difference were noticed in time to diagnosis [referral to diagnosis] 24.9 (0–167) in 2WW & 27.4(0–176) days in N2WW group [p=0.029]. 313 died in 2WW group and 451 in N2WW till June 2012. The time between date of referral to date of death was also significant between 2WW and N2WW group 258 [15–1328] days to 185[3–1271] days respectively (p=0.001)). In the 2WW group 62% [74%NSCLC, 15%SCLC, Others 10%] vs. 46% CLC 17% others 17%. 124(28%) of 2WW and 163(29%) of N2WW presented with metastatic disease [p=ns], 149(33.9%) of 2WW and 142(26%) of N2WW presented with T4 disease. Median PS was 1 and 2 respectively.

Conclusion The data suggests there is a significant difference between patient journey and outcome between two groups despite no significant difference in staging. Poor documentation and use of upgrading to 2WW made it difficult to find out why so many were under N2WW. Physicians are encouraged to review and alter patient pathway for N2WW group to ensure equal access to health care and appropriate outcome for all patients with LC diagnosis.

P32 DOES DISEASE SEVERITY AFFECT PATIENT ACTIVATION SCORES IN COPD?

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Background As part of the NHS Plan patients are encouraged to manage their own health. Healthcare professionals have a responsibility to ensure that patients have the right tools and education to self-manage their conditions. Hibbard *et al* have developed a patient activation measure (PAM) which measures the extent to which individuals have the attributes and skills to manage their condition. The PAM determines how "activated" an individual is and can highlight what help an individual needs to improve self-management skills. For example, Level 2 indicates when patients lack confidence/knowledge to take action, whereas Level 3 is where individuals start to take action.

Methods 18 patients attending consultations or pulmonary rehabilitation(PR) during a one-week period in June 2012 were recruited to participate in this observational study.

Results We recruited 18 COPD patients [8 Females, 10Males, Mean age 68 yrs ±8], eleven with moderate COPD, 5 had severe COPD and 2 had very severe COPD. The group had a mean percent predicted FEV1 of 53% and a mean MRC Score of 3±0.8. Five were current smokers and 12 were ex-smokers. In total there had been 10 respiratory admissions and 45 exacerbations in the last 12 months. The group mean PAM score was 66.9±21, and the mean level of activation was 2.89±1.13. Those who had more hospitalisations in the last 12 months had a lower PAM score (Pearsons correlation= –0.456, p=0.066). There was no correlation between COPD stratification and PAM Score (Pearsons correlation= –0.343, p=0.164). Sub-analysis (Table 1) showed 6 patients who had not received PR [mean age 66±5.6, mean MRC Score 2.62±0.48], 8 who were currently doing PR [mean age 71±11, mean MRC Score 3±0.75] and 4 who were post-PR [mean age 67.3±3.6, mean MRC Score 3.38±1.10].

Conclusions Pilot results show that there was no correlation between COPD severity and PAM Scores. Differences in PAM scores were found between those in current PR, as well as those with more hospitalisations. Further work is needed to evaluate the PAM as a tool for multiple points in an individual's journey such as at diagnosis, after a first or repeat admission and as part of PR programmes.

Abstract P32 Table 1

	Mean PAM activation score	Mean PAM level	PAM Level (frequency, Level 1–4)	P value
Pre- Pulmonary rehabilitation (n=6)	66.4 ±21.3*	2.83±1.0 (Level 2)	1=0, 2=3, 3=1, 4=2	No significant difference in PAM scores P=0.308
Currently undertaking Pulmonary Rehabilitation (n=8)	74.0±23.3*	3.25±1.03 (Level 3)	1=1, 2=0, 3=3, 4=4	
Post – Pulmonary rehabilitation (n=4)	53.4±13.0*	2.25±1.5 (Level 2)	1=2, 2=0, 3=1, 4=1	

P33 IMPROVING MEDICINES MANAGEMENT IN COPD: IDENTIFYING AND ADDRESSING SUB-OPTIMAL TREATMENT

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Medicines for Chronic Obstructive Pulmonary Disease (COPD) cost the NHS £317m pa. A national improvement programme worked with primary care sites to test practical ways to identify and address potentially sub-optimal prescribing, with a view to improving outcomes and containing cost.

Building on learning from initial test sites, selected practises in three CCG areas were supported to analyse primary care data for patients on the COPD disease register and optimise care for these patients. Practises process mapped their current system for managing COPD patients to identify potential improvements. Different methods for data extraction were used to audit diagnosis, disease severity and treatment in relation to NICE guidance. Patients identified as potentially sub optimally treated were called in for review with support of local nurse specialists. Data was collected on respiratory chapter prescribing costs per month per practize, patients reviewed, reasons and outcome. At CCG level, appropriate tools, training and support were developed to help sustain and spread improvement.

Early findings from data analysis and patient review identified up to 20% of patients with scope for optimisation of treatment, for reasons including inaccurate diagnosis, poor interpretation of spirometry, and over- or under-treatment in relation to assessment of disease severity. Detailed analysis of patient records required significant input of time and skills, but data extraction tools allowed groups of patients to be targeted more quickly. Review of patients is ongoing.

Conclusions Data analysis and practical support at practise level can identify and address existing problems of misdiagnosis and sub optimal treatment, but are labour intensive and reactive. It is essential to develop a reliable pathway to ensure accurate and timely diagnosis and treatment are maintained for the future. Tools, guidelines, and ongoing education and support can help sustain this.

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