Abstract M4 Table 1

Risk (Definition)	Mean PAR (%)	(Range)
Tobacco (Smoking and passive smoking)	3.52	(0 to 10.8)
Social indicators (Poor education and low BMI)	1.9	(0.3 to 6.2)
Dusty work	0.6	(0 to 1.6)
TB	0.2	(0 to 2.6)

5% expected from this definition were in Salzburg (+2.5%) and Maastricht (+2.0%). The most important causes were (figure 1):

Conclusions Most CAO can be explained. The most important risk factors after tobacco are associated with social conditions. The mechanistic explanation for these remains unclear.

M5 DEVELOPING IMPROVED MODELS OF CARE FOR COPD THROUGH PARTNERSHIP BETWEEN A GP FEDERATION 'QUALITY IMPROVEMENT SUPPORT TEAM' (QIST) AND A CONSULTANT SUPPORTED COMMUNITY RESPIRATORY SERVICE IN AN INNER CITY BOROUGH

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Introduction and objectives Local integrated respiratory services are well developed with a successful primary care enhanced service scheme for COPD and commissioned integrated respiratory consultant roles. However, hospital admission data suggests some patients still do not receive high value COPD interventions and pulmonary rehab completion rates in this group were low. Evolution of the GP Federation QIST (in affiliation with the Care closer to Home Integrated Networks 'CHIN') presented an opportunity to pilot a novel model of care to improve access to high-risk patients. It was proposed that proactively searching for such patients using primary and secondary care data with subsequent invite to an enhanced respiratory review would improve pulmonary rehab completion and admission rates.

Methods Seven G.P practices formed a CHIN network during 2017. Four planning meetings were held between the consultant led community respiratory team and the QIST. Criteria for patient selection were: lack of annual review; ³4 courses of prednisolone and/or acute admission with AECOPD during the previous 12 months. Patients were invited for a 45 min review with a respiratory nurse specialist in a G.P practice. This replaced the need for usual COPD annual review.

Results 96 patients were identified. 20 patients with an AECOPD admission were not on QOF registers but were included. 13 were already known to community respiratory services. 71 patients were offered either respiratory nurse clinic or home visit review. 10 patients were uncontactable, 15 declined, 9 did not attend. Initial contact by a clinician improved uptake. 36 patients were reviewed: 6 had their diagnosis modified, 20 required consultant MDT discussion, 9 were referred to pulmonary rehab, 3 were referred to stop smoking services and inhaled therapy was modified in 13 individuals.

Conclusions The model increased delivery of high-value COPD care. Combining secondary and primary care data improved patient selection. The CHIN structure facilitated project management and strengthened relationships. The model has been modified to improve efficiency to include initial virtual review by the integrated respiratory consultant to guide management and triage onward referral. 12 further practice reviews are now underway and pulmonary rehab completion and admission data will be analysed.

M6 EXPLORING THE RELATIONSHIP BETWEEN EOSINOPHILIA AND ASTHMA SYMPTOMS

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Background Asthma is a heterogenous disease characterised by chronic airway inflammation and variable airflow obstruction. We use surrogate markers of inflammation and evidence of atopy to help aid the diagnosis and monitor disease.

The aim of this project was to explore the relationship of markers of eosinophilia to asthma symptoms in new patients presenting to difficult asthma clinics.

To date, there is very limited data linking eosinophilic inflammation and the severity of asthma symptoms.

Objective To investigate the relationship between sputum and blood eosinophilia, exhaled nitric oxide and asthma symptoms as measured using asthma control test (ACT).

Method This was a prospective cohort study. Data was collected from patients attending difficult asthma clinics fulfilling the following criteria:

New patients, a diagnosis of asthma and a complete data set from initial clinic work-up (FeNO, Blood and sputum eosinophils, ACT on the same day). Patients were excluded if they were on oral steroids at the time of presentation.

Results A total of 25 patients were included in the study. The ratio of female to male was 4:1. The mean age of the patients was 39. All patients were step 4+of the BTS asthma management. The was no correlation between any of the markers of eosinophilic inflammation and ACT scores.

Discussion The lack of robust data looking into the relationship between markers of eosinophilia and symptom control poses a question as to whether we are measuring the right outcomes. With the known adverse effects of steroids, a degree of certainty that driving down markers of eosinophilia provides benefit to the patient is crucial. Asthma is such a clinical disease with a broad spectrum of symptoms. Therefore, the patients' subjective level of symptom control should be paramount in managing the disease and tailoring their treatment. Work is ongoing to expand across multiple sites to explore this further.

M7 NATIONAL PATTERNS IN THE TREATMENT OF CHILDREN WITH ASTHMA: A DESCRIPTIVE STUDY USING DATA FROM THE CLINICAL PRACTICE RESEARCH DATALINK

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Background Little is known about prescribing patterns in children with asthma in the UK, including how they compare with recommendations in clinical guidelines.

Withdrawn: *M6 Exploring the relationship between eosinophilia and asthma symptoms*

George K, Khurana S, Vyas A. M6 Exploring the relationship between eosinophilia and asthma symptoms. *Thorax* 2018;73:A248. doi: 10.1136/thorax-2018-212555.426

This abstract has been withdrawn. It was not presented at the meeting.

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