

clinic was planned by the specialist respiratory team, this feedback was sought to understand if these clinics are useful and how they might be improved. The following areas were reviewed in the clinics:

1. Home oxygen prescribing
2. Pulmonary rehabilitation utilisation
3. Inhaled corticosteroid prescribing for patients with COPD
4. Management of frequent COPD exacerbations
5. Excessive salbutamol prescribing in Asthma
6. General advice as requested by the General Practice

Methods Satisfaction questionnaires were completed by the General Practice clinicians (GPs and Nurses) upon completion of the clinic. The questionnaire consisted of; six questions scored on a Likert scale, one multiple choice question regarding preferred frequency of repeat clinics, and an area for general comments. The Likert scale options were; definitely not, probably not, not sure, probably, definitely.

Results Initial feedback from 8 primary care clinicians indicates high level of satisfaction (figure 1). Most clinicians (n=6) wanted a repeat clinic in 6 months, a minority requested a repeat clinic quarterly (n=2). Free text comments were broadly positive and some areas for improvement were identified. Broadly positive quotes: 'great to talk about tricky cases', 'this clinic has avoided nine hospital referrals', 'improves networking with specialist team', 'good to review asthma and beta-blocker use', 'useful meeting'. Comments suggesting areas for improvement: 'helpful to have an agenda and prescribing data sent in advance', 'possibly a longer session to look at more patients'. Figure 1 only shows answers of probably and definitely, because no clinicians indicated any lower degree of satisfaction.

Conclusion This small sample supports a continued use of respiratory virtual clinic in general practices. It is reassuring every questionnaire indicated a repeat clinic would be welcomed and overall there is a perception this helps with general respiratory care. Ensuring GP practices receive information about their prescribing in advance is important and clinic processes have been changed accordingly.

P173 THE GRENFELL FIRE: EXPERIENCE OF A COMMUNITY CLINIC

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Introduction The Grenfell Tower fire in 2017 claimed 72 lives and hospitalised a further 74. Following this disaster a rapid access respiratory outpatient service was offered to all primary care patients affected by the fire. We aim to identify the symptoms leading to referrals and any new diagnoses made.

Methods The patient records were reviewed for all those referred to the rapid access respiratory clinic between 14/07/2017 and 1/7/2019. Data was collected on demographics, smoking status, co-morbidities, reason for referral, respiratory diagnosis and ongoing management.

Results 77 patients were referred. 21/77 (27%) lived in Grenfell Tower on the night of the fire, the others were from the surrounding area. 8/77 (10%) had been admitted on the night of the fire. Patients were 18–83 years (median 50 years) with a slight female (61%) predominance. 46/77 (60%) had a

smoking history. The main symptoms resulting in referral were cough (64%), dyspnoea (39%) and wheeze (19%). Of the patients referred, 13/77 (17%) did not attend their appointment and 5/77 (6%) currently are awaiting a first appointment.

Of the 59 patients reviewed, all patients were offered spirometry and 44/59 (75%) had thoracic imaging (CT or chest radiograph). Respiratory physicians had access to further tests from clinic including: lung volumes, gas transfer, bronchodilator reversibility, exhaled nitric oxide, histamine challenges and echocardiograms.

12/59 (20%) patients had pre-existing respiratory conditions confirmed. A further 12/59 were diagnosed with a new chronic respiratory disease: 6 asthma, 3 COPD, 2 ILD, 1 bronchiectasis. Of these 6/12 (50%) had respiratory symptoms pre-dating but exacerbated by the fire.

7/59 (12%) had temporary symptoms due to smoke/dust inhalation which either self-resolved or improved with inhaled corticosteroids. There was overlap between respiratory symptoms and anxiety after the fire. 7/59 (12%) patients were referred to dyspnoea clinic for breathing pattern disorders, meanwhile 35/59 (59%) patients received simultaneous support from the mental health team.

Conclusion The Grenfell Fire resulted in a local increase in respiratory symptoms and an increase in new respiratory diagnosis. A rapid access respiratory service helped optimise pre-existing respiratory conditions and identify patients with previously undiagnosed respiratory disease exacerbated by the fire.

P174 INITIAL PROCESS EVALUATION FINDINGS FROM THE AT-RISK REGISTERS INTEGRATED INTO PRIMARY CARE TO STOP ASTHMA CRISES IN THE UK (ARRISA-UK) TRIAL: PRACTICE CHARACTERISTICS, ENGAGEMENT AND EARLY EXPERIENCES OF THE INTERVENTION

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Introduction The ARRISA-UK trial is investigating whether, compared to usual care, a GP practice-level complex intervention decreases the proportion of 'at-risk' asthma patients who experience asthma-related A&E attendances, hospitalisations or death over 12 months. This presentation reports initial findings from a nested process evaluation.

Methods ARRISA-UK is a nationwide cluster-randomised controlled trial of an intervention involving identification and flagging of at-risk asthma patients' electronic records and web-based training of practice staff to support implementation of actions in response to the flags (e.g. improved access and opportunistic care). A mixed-methods process evaluation is exploring intervention implementation, mechanisms of action and the influence of contextual factors (e.g. practice characteristics). Quantitative and qualitative data from questionnaires, training software, practice-specific action plans and staff focus groups/interviews were analysed to describe practice characteristics, and their engagement with, and initial implementation and experiences of, the ARRISA-UK approach.

Results The 275 recruited practices, from across 14 English Clinical Research Network Regions, 7 Welsh and 5 Scottish Health Boards, had a median list size of 8801 (range 1667–

Abstract P174 Table 1 Characteristics of ARRISA-UK intervention practices (N=139)

	N (%)
Practice software EMIS	65 (47)
SystmOne	55 (40)
VISION	19 (14)
Urban practices	103 (74)
Dispensing practices	35 (25)
English practices (n=116) in two most deprived quintiles	20 (34)
Practices with asthma/respiratory lead GP	36 (26)
Practices with asthma diploma trained nurse	96 (69)

37800) and identified 10,000+ at-risk asthma patients in total, representing an average of 33 (range 1–197) and 6% (range 0.2–13%) of registered asthma patients per practice. There was considerable variation in the characteristics of the 139 intervention practices (Table 1). Despite some early documented difficulties with technology and staff turnover, at least 409 staff (GPs, nurses, receptionists/administrators, dispensers/pharmacists) from 131 (94%) practices completed at least minimum individual on-line training, reflecting a median of 3 (maximum of 9) staff per practice. 128 (92%) practices also completed group training to prepare Action Plans, attended a webinar and activated flagging. Action plans varied in content and detail but illustrated ways for staff to enhance access to, and uptake of, asthma-related services by at-risk patients. Questionnaires suggested the training was generally well-received. Analyses of staff focus groups/interviews are underway.

Conclusions The ARRISA-UK intervention represents a pragmatic, practice-wide approach to targeting at-risk asthma patients which has been successfully implemented across a variety of GP practices and generally engaged and been well-received by all practice staff groups. Initial findings have informed ongoing quantitative and qualitative data collection.

P175 **DOMICILIARY VISITS BY SPECIALIST RESPIRATORY CLINICIANS FOR PATIENTS WITH COPD: PATIENT EXPERIENCE, OUTCOMES AND PREDICTING THOSE THAT MAY BENEFIT MOST**

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Introduction and objectives The Integrated Respiratory Team aims to provide holistic individualised care for patients with COPD. Patients who are housebound, frail, or assessed as needing intensive 1:1 support for self-management, receive domiciliary visits, with the aims of improving patient self-management, and preventing admission to hospital.

Methods Patients (n=20) were assessed with PHQ9, GAD7 and EQ5D5L questionnaires during the visit, followed by a structured telephone interview within one week. Patients were excluded if they were unable to complete telephone interview.

Results Participants: 9 female: 11 male, mean age 74 years (range 62 to 91), mean MRC score 4.7. 5 patients were GOLD II, 12 patients GOLD III and 3 patients GOLD IV.

Patient-reported experience: 100% of patients reported the visit took place at a suitable time; 90% reported they felt

they definitely had enough time to discuss what was required; and 93% felt that the right amount of information was provided.

Patient-reported outcome: 95% of patients rated the domiciliary visit as 'Very useful'. When asked if they 'felt confident they could self-manage their condition' after domiciliary visit, 50% of patients responded 'Yes definitely', 45% responded 'Yes to some extent', and 5% responded 'No'. Qualitative answers also provided strongly positive responses.

Predicting benefit: matched Wilcoxon signed rank test was used to investigate correlation between PHQ9, GAD 7 and EQ5D5L scores and patient reported confidence in their ability to self-manage their condition after domiciliary visit.

GAD7 and PHQ9 scores did not correlate with the patients' self-reported confidence in self-managing their condition. Higher EQ5D5L score did show significant correlation with self-reported confidence in their ability to self-manage after domiciliary visit $p < 0.001$.

Conclusion Patients with poorer health-related quality of life were most likely to feel confident in their ability to self-manage after a domiciliary visit. Interventions that improve self-management have been concluded to reduce respiratory-related and all-cause admissions, reduce dyspnoea and improve quality of life [1]. Models of care that allow specialist domiciliary visits may be important in improving outcomes for patients with poorer health-related quality of life.

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P176 **THE CHANGING FACE OF HOME OXYGEN THERAPY; SEAMLESS COMMUNICATION BETWEEN HOSPITAL, PRIMARY, AND COMMUNITY CARE IS ESSENTIAL**

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Introduction Long term oxygen therapy for home use was introduced after trials which showed it worked in COPD and oxygen concentrator development. Some services are hospital based, but some patients too ill to attend; others community based often without full data on hospital blood gases and treatments in the primary care record. We have examined the primary care notes on all patients on our oxygen register to see why they are on it, and identify issues to improve care.

Methods We carried out audits on source/diagnosis for referral and examined primary care notes for all those on the oxygen register We have looked for issues that needed addressing for each patient.

Results We took over the service in April 2015; 109 patients receiving oxygen were alive 1.2.19. 59 with COPD, 7 on NIV, 42LTOT, 10 ambulatory oxygen alone. 19 with OHS/OSA, 6 ILD, 5 on LTOT, 1 ambulatory. Audits in 2018 (345) and 1.1.19–26.6.19 (202) show 56% of referrals with COPD, 12% ILD.

Of 538 patients on the oxygen register, 322 COPD, of which 20 NIV, 38 ambulatory, 237 LTOT, 52OHS/OSA, 9 PAH, 18LVF, 26 palliative.

65 had $PCO_2 > 7$, 19 on NIV/CPAP, 4 who refused it, 7 referred for NIV, 41/46COPD LTOT. Where $\uparrow PCO_2$ (16), 2 sent to A&E, 2 referred NIV, 5 already on NIV, 1 refused