management plans, inhaler technique checks and influenza vaccination. However, small UK studies have suggested there is often a suboptimal level of implementation. The objective of this study was to use nationally representative data to describe the annual incidence of receiving GCPA and determine which children are at risk of not receiving them.

Methods
Data was obtained from nationwide UK primary care records (Clinical Practice Research Datalink), including children with asthma aged 5–16 years old, from January 2004 to January 2021. The annual incidence of each GCPA (annual asthma review, management plan, inhaler technique check and influenza vaccination) were measured. The association between children’s clinical characteristics and receiving each GCPA within three-years from diagnosis, was estimated using mixed effects (GP practice was the random effect) multivariable logistic regression. Age was categorised as 5–8 years, 9–11 years and 12–16 years.

Results
One year post-diagnosis: 56% of children received an asthma review, decreasing to around 45% in subsequent years, 42% received an asthma management plan, decreasing to around 30% thereafter, and 59% received an inhaler technique check, decreasing to around 40% thereafter. Only 7% of children received influenza vaccination through their GP practice.

Factors associated with non-receipt of a GCPA were younger age, higher social deprivation, and higher BMI (figure 1). Factors increasing the odds of receiving a GCPA were 4 or more inhaled corticosteroids (ICS) or short-acting beta-agonist (SABA) prescriptions one year before diagnosis (figure 1).

Conclusion
The incidence of GCPA appears to match the minimum required for financial reward by QOF (45% for annual reviews). There are significant disparities in the provision of GCPA, where younger, more deprived, and overweight or obese children are at highest risk of not receiving them. Low influenza vaccination rates were likely due to vaccinations being offered at school or by local pharmacists.

A RETROSPECTIVE STUDY EXPLORING NUTRITIONAL STATUS OF CHILDREN WITH BRONCHIECTASIS AND PRIMARY CILIARY DYSKINESIA

Introduction
Primary Ciliary Dyskinesia (PCD) and paediatric bronchiectasis (PB) unrelated to Cystic Fibrosis are chronic lung diseases affecting lung function and quality of life in childhood. There is limited understanding of the nutritional status in these children.

Aim
To investigate nutritional status and change over time in children with PB and PCD.

Methods
Patient records of children with PB and/or PCD were audited (2007–2023) for weight, height and BMI at 6 age points: 3, 5, 7, 9, 11, and 15 years. BMI z-scores were calculated based on age, gender and UK reference data and used to categorise nutritional status according to WHO definitions for undernutrition, overweight and obesity (–2SD,
+2SD and +3SD respectively) and expressed as% of the available data for each age group. Change in BMI between ages was recorded as deviation by ≥±1 centile over time.

**Results** Data was collected for 52 patients (76% PB, 12% PCD, 12% PB and PCD; 52% male). Z-scores revealed that most individuals were of a healthy BMI (≥80%). There was no undernutrition at any of the age points except at age 7 (5%). There was higher frequency of overweight at ages 3 & 15 (12% and 16%). Obesity levels were low compared to the general population (age3:4%, age5:0%, age7:2%, age9&11:3%, age15:7%). The frequency of children crossing down ≥1centiles was most pronounced between age 3 to 5 years (60%, n=23). Between the ages of 7–9, 9–11 and 11–15 most children had no major change in BMI (58%, 66% and 41%) but went up ≥1centiles in around a third (30%, 24%, 37%).

**Conclusion** Most children had healthy weight for height. However, between age 3–5 a high portion showed a decline in nutritional status that may be linked with clinical respiratory symptoms at the time and needs further exploration. An increase in BMI is most notable in teenage years that may or may not be related to their respiratory health and early intervention is indicated. BMI may also not be the most sensitive indicator of nutritional undernutrition in this age group.

---

**Poster sessions**

**P70** EVALUATION OF PATIENT EXPERIENCE OF A SELF-REFERRAL CHEST XRAY SERVICE PILOTED IN AREAS OF GREATER MANCHESTER

S Taylor, D Brickhill, L Brown, L Dunn, M Edson, Galligan-Davison, S Grundy, E Harris, Lyon, A Smith, N Rehan. The Christie NHS Foundation Trust, Manchester, UK; Northern Care Alliance NHS Foundation Trust, Manchester, UK; Manchester Foundation Trust, Manchester, UK; Manchester University NHS Foundation Trust, Manchester, UK; Greater Manchester Cancer Alliance, Manchester, UK.

**Introduction** Increasing the uptake chest X-rays (CXRs) in patients with the common symptoms of lung cancer might lead to a stage-shift towards early diagnosis of lung cancer. However, symptomatic patients experience numerous barriers to accessing CXRs. A self-referral CXR (SRCXR) service was launched in July 2022 allowing symptomatic members of the public to attend for a CXR at one of three Greater Manchester (GM) hospitals without the need for a primary care appointment (if specific criteria were met). Outcomes of this pilot service have been published previously. This project aims to

---

**Abstract P70 Figure 1** Patient experiences and how they relate to the health belief model

- **Perceived Susceptibility:** family history of lung cancer or other condition
  - “Family history of lung cancer so always at the back of my mind’ P2

- **Perceived Seriousness:** worry that health concern is something serious
  - “Never know with chest if it’s something and nothing or could be something serious’ P38

- **Perceived Benefits:** reassurance, peace of mind, early diagnosis
  - "Peace of mind that everything was okay’ P25
  - "Yes certainly recommend, puts your mind at rest if nothing else. ‘If they find something then early diagnosis is always the best way isn’t it?’ P38
  - "At least I know what I’ve got now, I wouldn’t have known’ P42

- **Perceived Barriers:** location and accessibility, parking, wait times, fear of outcome or hospital, limited information
  - "I don’t know if it was bad timing but went at lunch time and all staff walked out at same time and we were kept waiting for over on hour. Once they resumed service it was very quick’ P45
  - "People’s worries about hospitals and how long they have to wait’ P4
  - "The outcome, if they didn’t want bad news’ P10

- **Self Efficacy:** High due to walk-in appointments
  - "Skips the whole first layer, didn’t have to worry the GP at all, anxiety levels came down and couple of weeks later the cough had gone’ P55

- **Cues to action:** knowledge of the service through advertisements and recommendations, experience of a symptoms
  - "Playing on my mind’ because it was so long and I couldn’t get rid of it I was a bit worried’ P55
  - "Wife suggested I attend as she’d seen an advertisement’ P42

'I still haven’t found what I’m looking for’ – Cancer diagnosis: imaging and bronchoscopy