Two data streams were collected: a) pathway time log, b) patient qualitative data 12 months pre biologics and at the end of the 12 month treatment trial. The West Midlands Applied Research Collaboration conducted the project evaluation.

Conclusion The enhanced pathway was associated with increased number of patients on biologics with substantial reductions in patient waiting times, significant reductions in Prednisolone use, bronchodilator prescribing rates, hospital admissions and significant improvements in asthma control.

REFERENCE

Introduction and Objectives
The Severe Asthma Service (SAS) covers the Integrated Care Board footprint (ICB) with 128,811 patients on the asthma register. Evidence suggests that 5% (6,440) have severe asthma, of these 18% (1,180) are eligible for biologic therapies, which could have a significant impact on patients’ quality of life.

Before the project, only 50% patients were established on severe asthma therapies.

Methods
One Place was selected within the ICB as a target for this project.

A flow diagram illustrating the severe asthma pathway is included as figure 1. The redesigned elements are highlighted on the key.

The revised pathway aimed to provide specialist in-reach support into PCNs to:
- Provide primary care with education on improving adherence and optimising inhaler therapy
- Expedite biologic initiation for those eligible
- Improve optimisation of therapies and use of technology (NuvoAir) to enhance the care experience and remotely monitor patients prior to biologic therapy initiation
The pathway also included in-reach into secondary care to support MDTs and expedite referrals to the SAS.

To address the lack of knowledge in primary care around severe asthma and how to make a good quality referral into the severe asthma service, an educational package, comprising 2 videos and a podcast, was produced.

Results The re-designed pathway released resource to reduce waiting times from referral to review, from 70 to 18 days and improved access to biologics. Moving some of the LSAS asthma confirmation process, adherence checking and biologic counselling, into the community reduced waiting times from referral to first injection, in eligible patients, from 167 to 53 days.

In-reach into one secondary care Trust will result in it becoming a prescribing site for biologics.

Conclusions
- The work has highlighted a proof of concept re rolling the pathway out to a wider population which includes innovation and partnership working
- The project has formed the basis for a funding bid to spread this approach across the ICB footprint.
- Written/recorded guidance is vital to support education
- Wider staff such roles such as Physician Associates and Clinical Pharmacists can support specialist areas such as asthma
- Remote review works

M31 BRIDGING THE GAP: EMPOWERING COMMUNITIES THROUGH ADVANCED PHARMACIST-LED SPECIALIST ASTHMA CLINICS IN PRIMARY CARE


10.1136/thorax-2023-BTSabstracts.420

Introduction The project aimed to utilise the skills of highly advanced respiratory pharmacists, usually based in tertiary care, who provided outreach clinics in general practices serving populations of highest deprivation.

Objectives
1. Identify uncontrolled severe asthma patients, including biologics candidates.
2. Optimise treatment with a focus on immediate SABA reduction and environmental inhaler switches.
3. Upskill primary care colleagues to improve diagnosis and management of asthma patients.

Methods Pilot study assessing the effectiveness of a digital risk stratification tool to identify uncontrolled severe asthma patients. Between January and December 2022, three project pharmacists analysed 2000 primary care notes across 8 recruited PCNs (26 general practices) from across 3 CCGs (now 1 ICS). They subsequently reviewed consultation notes, test results, admissions and medication history before inviting patients to 30-40-minute clinics. Each patient was provided with medicines review and, where appropriate, optimisation, adherence and inhaler technique check, asthma education (including risks and benefits of oral steroids use) and FeNO testing. Patients who required a referral to a tertiary centre were fast-tracked to a consultant collaborating on this project. The consultant also provided clinical supervision to the project pharmacists.

Results
- 241 patients offered a pharmacist-led clinic and 149 attended
  - 100% had medicines reviewed, adherence checked and bespoke education provided
  - 55 referred to tertiary centre (78% referrals rated as excellent vs. 20% pre-project)
  - 40 patients started on biologics.
  - 35 patients switched to MART and SABA stopped
  - 45 environmental inhaler switches
- Primary care teams surveyed rated the project highly and would recommend delivered educational sessions to colleagues
- 25 randomly selected patients provided service feedback
  - 96% found project pharmacists good/very good at shared decision-making and the consultation helpful/very helpful
  - 92% considered seeing a specialist pharmacist important.

Conclusion The project successfully utilised highly advanced respiratory pharmacists to provide outreach clinics in deprived general practices, achieving its objectives. We demonstrated positive outcomes with a high attendance rate, successful referrals to tertiary centres, medication optimisations, and positive patient and clinician feedback, highlighting the importance and effectiveness of involving specialist pharmacists in improving asthma management in underserved populations.

Please refer to page A295 for declarations of interest related to this abstract.