with chronic respiratory disease. A range of potential roles for a respiratory GPwSI, working as part of a multi-disciplinary team, were suggested, and a number of practical issues were highlighted. For the role to succeed, the GPwSI needs to have the trust of their primary and secondary care colleagues as well as the patients, to be a credible practitioner, and to be politically astute potentially enabling them to act as a champion supporting the transition process within the local health service. *Conclusions:* The introduction of a respiratory GPwSI service represents a challenge to traditional roles which, whilst broadly acceptable, raised a number of important issues for the stakeholders in our study. These perspectives need to be taken into account if workforce change is to be implemented successfully.

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ABS52: Organisation of asthma and COPD care in primary health care in Mid-Sweden

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Objective: To investigate the organisation of primary health care with regard to management of asthma and COPD and relate it to the guidelines and quality indicators for organisation stated by the Swedish National Board of Health and Welfare and to an earlier study in the area. *Background:* The Swedish National Board of Health and Welfare assessed quality indicators for the organisation and equipment for asthma and COPD in primary health care in 2004. These are spirometer, pulse oximeter for assessing respiratory impairment, nebuliser for emergency treatment and an asthma/COPD clinic for patient education. *Method:* A postal survey in 2005 to 56 randomly selected primary health care centres in Mid-Sweden. The survey included questions about access to an asthma/COPD clinic, spirometer, pulse oximeter, nebuliser, organisation for smoking cessation and rehabilitation. *Results:* All centres answered the survey. 93% had a spirometer, 83% pulse oximeter, 90% nebuliser and 64% asthma/COPD clinic. 65% had access to a program for smoking cessation within primary care. Regarding resources for COPD patients 63% centres had access to physiotherapy, 71% to occupational therapy, 41% to a dietitian and 93% to a social welfare official or psychologist. *Conclusion:* The possibilities to offer patients with asthma and COPD sufficient care is good regarding access to diagnostic tools as spirometers and pulse oximeters and nebulisers, while access to education through an asthma/COPD clinic is insufficient. Compared to the results from the AIM-study in 2000 primary health care centres with asthma clinics have increased from 52% to 64% and access to spirometer from 76% to 93%. Only two-thirds of the centres can offer a program for smoking cessation which is insufficient. The study shows that many centres have the resources to start pulmonary rehabilitation for patients with COPD.

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ABS53: Does the clinical COPD questionnaire (CCQ) score reflect reality in individual patients?

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Introduction: Patient Reported Outcome(PRO) measures are important in assessing effectiveness in clinical trials. The use of PROs could also provide valuable information for health care professionals in routine clinical practice. The Clinical COPD Questionnaire (CCQ) is a validated 10-item PRO assessing the health status of COPD patients (Health Qual Life Outcomes. 2003 Apr 28;1(1):13). *Aims and objectives:* To assess the validity of the CCQ on individual level. *Subjects and methods:* COPD patients visiting two out-patient clinics completed the CCQ before consulting their pulmonologist. These CCQ scores were compared with (i) the CCQ score completed about the patient by the blinded pulmonologist directly after the consultation in the first half of the patients and (ii) data from a semi-structured interview with the patient. The interviews were transcribed, analyzed and converted to CCQ scores by the researcher. Differences in CCQ scores between patient and (i) doctor and (ii) interview were analyzed. The number of differences exceeding the Minimal Clinically Important Differences (MCID) of the CCQ (0.4) were counted. *Results:* 44 patients (mean age 66 (±7) yr; 72% male; FEV1% predicted 44 (±14); mean total CCQ score 2.2 (±0.9)) were included. The correlation between the doctor vs patient CCQ score (method i) was $r = 0.87$, $n = 22$. The correlation between the interview and the patient (method ii) CCQ score was $r = 0.93$, $n = 44$. The number (%) of times the difference in total CCQ score exceeded the MCID was 8 (36) and 4 (9) respectively between patient and doctor and patient and interview. The interviews suggest that differences in scores between interview based CCQ score and patient CCQ score can be explained by patients' cognitive level and multiple co-morbidity. *Conclusion:* The CCQ can be trusted in routine clinical practice to assess COPD related health status, because of the high agreement between measurements, and the low number of differences exceeding the MCID between CCQ scores based on the interview and completed by the patient.

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ABS54: Patients' experience of an exacerbation of COPD. Lessons for primary health professionals

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Introduction: Patients are at the centre of managing their own disease but need the skills and support from health professionals to do so. An exacerbation is an unwelcome interruption to self management though is rarely sudden in onset. Helping to support self care in COPD is poorly developed in primary care and research has focused on the physical parameters of exacerbations using quantitative methods rather than the patient experience. *Aims:* The project aimed to gain insight into people with experience of an acute exacerbation of COPD. *Objectives:* For participants to recount their story of their most recent exacerbation which required admission to hospital. To identify implications for health professionals practice particularly in supporting self care strategies in patients living with COPD.

Subjects and method:

8 patients (5 men, 3 female) Age range 59–73