infarction, STEMI, diagnostic code) or their angiography was not identified as an emergency. Hospital data documented that 187 patients had CMR but, in the HES/PEDW data (inpatient and outpatient), CMR was recorded for only 53 of these (28%). We are currently exploring algorithms to identify specific subgroups of particular interest with respect to CMR; early results suggest that we can identify patients who have had cardiac arrest or who have unobstructed arteries but not those with multivessel disease.

Conclusion It is possible to identify patients who activate the PPCI pathway from routinely collected HES/PEDW data. We conclude that it is not currently feasible to document the use of CMR in patients who activate the PPCI pathway from HES/PEDW data although the integration of the Diagnostic Imaging Dataset with inpatient and outpatient HES datasets may make it feasible soon. We are exploring the reasons for the discordance between CMR scans reported in the prospective cohort study and those identified in HES.

P37 BARRIERS TO AND FACILITATORS OF EFFECTIVE DIABETES SELF-MANAGEMENT AMONG PEOPLE NEWLY DIAGNOSED WITH TYPE 2 DIABETES MELLITUS (T2DM): A QUALITATIVE STUDY FROM MALAYSIA

¹AM Mohamed*, ²J Romli, ¹K Ismail, ¹K Winkley. ¹Department of Psychological Medicine, Institute of Psychiatry, Psychology and Neuroscience, King's College London, London, UK; ²Non-Communicable Disease Unit, Primary Care Clinic Tampoi, Johor Bahru, Malaysia

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Background To determine the views and experiences of people with Type 2 diabetes (T2DM) in relation to their diabetes self-management and to understand what additional support is required to support lifestyle changes.

Methods A qualitative study using semi-structured face-to-face and audio/telephone interviews. All interviews were audio-recorded, transcribed verbatim and analysed using a thematic approach. Seventeen people with newly diagnosed T2DM (less than 3 years of diagnosis) were recruited from a primary care clinic in the southern region of Malaysia (Johor Bahru).

Results Qualitative analysis revealed three major barriers to diabetes self-management: (i) psychological issues, e.g. depression and anxiety, such as feeling sad about the diagnosis and worried about the future; (ii) social factors e.g. shame and stigma of T2DM, feeling ashamed have diabetes at a young age and being different from peers; (iii) perceived barriers e.g. environment and culture, such as ineffective support from healthcare providers, beliefs and use of herbal medicine, and the importance of eating rice and feast culture. Facilitators of diabetes self-management included greater perceived self-efficacy such as being disciplined about eating well, good support from immediate family members and religiosity.

Conclusion This study represents novel findings describing barriers and facilitators of effective T2DM self-management in Malaysia. It identifies specific cultural factors that are unique to the Malaysian population that have not been reported in western studies. If diabetes self-management education is to meet people's needs within this region factors such as these need to be considered when developing new T2DM education programmes.

P38 DECISION REGRET IN MEN TREATED FOR LOCALISED PROSTATE CANCER: RESULTS FROM THE LIFE AFTER PROSTATE CANCER DIAGNOSIS STUDY

¹A Downing*, ¹P Wright, ²E Watson, ³R Wagland, ⁴L Hounsom, ¹H Butcher, ⁵A Gavin, ¹AW Glaser. ¹Leeds Institute of Cancer and Pathology, University of Leeds, Leeds, UK; ²Department of Applied Health and Professional Development, Oxford Brookes University, Oxford, UK; ³Faculty of Health Sciences, University of Southampton, Southampton, UK; ⁴National Cancer Registration and Analysis Service, Public Health England, London, UK; ⁵Northern Ireland Cancer Registry, Queens University Belfast, Belfast, UK

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Background Men with localised prostate cancer have a number of treatment options. Treatments carry associated benefits and side- and late-effects. The Life After Prostate Cancer Diagnosis study is a UK-wide survey of men 18–42 months post-diagnosis of prostate cancer. The survey included treatment questions, the Decision Regret Scale (DRS) and a single item on decision-making participation. The aim of this sub-study is to explore the association of decision regret with prostate cancer treatment and patient perception of participation in decision making.

Methods The English arm of the survey achieved a 60.3% response rate (30 465 respondents). Men diagnosed with stage 1–3 disease were included in this sub-study (n=16,808). Descriptive statistics were used to explore associations between DRS scores (0–100), self-reported treatments and perceived participation in decision-making.

Results 12 600 (75.0%) men completed the DRS. Due to the skewed nature of the data, decision regret was categorised as 'None' (score=0; 36.5%), 'Low' (score=5–20; 31.6%) and 'High' (score=≥25; 31.8%). Levels of regret were lowest in men who underwent brachytherapy alone and surgery alone (25.8% and 27.5% respectively reporting 'High' regret). Men who received combination therapy (e.g. radiotherapy and hormones) reported higher levels of regret compared to men having a single therapy (34.8% vs. 28.3% reporting 'High' regret). 28.6% of men on active surveillance reported a high level of regret. 74.2% of men said their views were definitely taken into account in treatment decisions: 22.6% of these reported high regret. 2.8% of men said their views were not taken into account; 62.8% reported high regret.

Conclusion These preliminary analyses show a strong association between perceived involvement in treatment decision making and subsequent decision regret in men with prostate cancer. Levels of regret also vary according to the type of treatment received. Interestingly, men on active surveillance who receive no treatment report similar levels of regret to those who undergo surgery. Further analysis will investigate the impact of patient characteristics and functional outcomes (urinary, bowel and sexual) on levels of regret.

P39 EMERGENCY ADMISSIONS TO HOSPITAL FOR OLDER PEOPLE WITH COPD DURING THE RESHAPING CARE FOR OLDER PEOPLE PROGRAMME (RCOPP): AN ECOLOGICAL STUDY

KA Levin*, EM Crighton. Public Health Directorate, NHS GGC, Glasgow, UK

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Background The RCOPP was a national programme aimed at enabling older people to stay independent and well at home. Three of the interventions funded by the RCOPP in Glasgow City targeted COPD. This study aims to describe emergency admissions (EAs) for those with COPD in Glasgow City during the RCOPP.

Methods COPD EAs were defined using a primary diagnosis of COPD, while EAs for those with COPD were defined using any of the 6 diagnostic fields. Monthly standardised rates of emergency admission between April 2011 and March 2015 were calculated, for residents of Glasgow City aged 65 years+. Multilevel Zero-inflated Negative Binomial models for EAs nested by datazone adjusted for sex, 5 year agegroup, area-level deprivation (SIMD quintile), season, month and month squared. Relevant interventions were entered into the models, to test association with the two outcomes by time and location.

Results COPD EAs first rose, from April 2011 until October 2012, then fell until March 2015. When modelled, both month (RR for month 12 relative to month 1% and 95% CI=1.08 (0.996, 1.17)) and month squared (RR=0.998 (0.996, 0.999)) were significant, with risk of admission falling below the baseline figures by October 2013 and continuing to reduce thereafter. EAs for COPD patients, however, had the opposite trend, first falling between April 2011 and February 2013, then rising until March 2015, although never reaching the level of April 2011. Under the model, month (RR=0.92 (0.87, 0.97)) and month squared (RR=1.002 (1.001, 1.003)) were both significant. However, this increase was only in the North East and North West sectors of Glasgow. EA for COPD patients reduced in the South, with particularly large reductions from July 2012. When included in the model, the Community Respiratory Team, in the North West, was associated with reductions in COPD EAs (RR=0.89 (0.82, 0.97)) from the point of full staffing) and increases in EAs for COPD patients (RR=1.11 (1.03, 1.20)). Two other projects were also potentially associated with increases in EAs for COPD.

Conclusion COPD EAs reduced from the end of 2012, in line with all-cause EAs shown previously. The timing and geography suggest these reductions may be due to the Community Respiratory project which helps people to manage their symptoms at home. EAs for COPD patients, however, increased from around the same time. This or another RCOPP service may have raised awareness of other health concerns or health more generally, increasing EAs for these patients.

P40 EXPERIENCES AND ILLNESS PERCEPTIONS OF WORKING-AGE CARDIAC REHABILITATION ATTENDEES

R Nutt*, G Ozakinci. School of Medicine, University of St Andrews, St Andrews, UK

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Background Cardiac rehabilitation (CR) research often focuses on older individuals. With particular pressures faced by working-age individuals (<65 years), such as work and family responsibilities, it is important to consider how this group engages with cardiac rehabilitation. We present here a synthesis of qualitative literature and initial results of a longitudinal qualitative study.

Methods We conducted thematic synthesis of studies (2006–2016) describing CR experiences of 18–65's. Synthesis was

gender-sensitive and guided by Leventhal's Self-Regulation Model of Illness. Results informed development of the qualitative study.

The longitudinal qualitative study recruited participants aged 18–65, following MI, from a Phase IV CR programme in Scotland. Semi-structured interviews occur at commencement and completion of the 12 week programme. Participants complete a questionnaire (Illness Perceptions Questionnaire-Revised and health behaviour questions) plus a family member is interviewed at both time points. Questionnaire data contextualises qualitative data (analysed using theoretical thematic analysis).

Results Review Nine studies were included. Heterogeneity existed in CR setting, participant numbers and gender. Thematic synthesis identified themes including illness perceptions, emotional representations and behaviour for illness control i.e. diet change. Some themes appear specific to the 'working-age' group. The influence of gender featured across all themes.

Study (At time of submission) Five participants and two family members interviewed, three baseline and follow-up, two baseline only. Participants are male, aged 41–61, all married and employed. Family members are female spouses. All participants had MI. Genetics or bad luck were often seen as cause of their MI, leading to limited behaviour change. Participants and family valued CR as a place of safety and reassurance due to monitoring and advice provided by staff. Participants identified themselves as fit and active, and therefore not 'old', suggesting recovering function/fitness may be particularly important for this age group. Following completion of CR, participants felt they could now exert themselves without causing their body or heart harm. Participants also described a lack of age-relevant support material that addressed issues like returning to work, family demands such as elderly parents, and exercise advice accounting for their greater pre-MI fitness.

Conclusion It is important to consider how working-age individuals experience CR, as it impacts on engagement and behaviour. Existing literature regarding this group that also includes gender is limited and heterogeneous. Our study thus far indicates male working-age CR attendees and their family value the reassurance monitoring provides and allowing them to regain confidence in their bodies.

P41 MENTAL HEALTH COMPETENCE IN ELEVEN YEAR OLDS AND ITS ASSOCIATION WITH POOR PHYSICAL HEALTH AND MENTAL WELL-BEING: FINDINGS FROM THE UK MILLENNIUM COHORT STUDY

¹E Rougeaux*, ¹A Pearce, ²J Deighton, ¹C Law, ¹S Hope. ¹Great Ormond Street Institute of Child Health, UCL, London, UK; ²Evidence Based Practice Unit, UCL and the Anna Freud Centre, London, UK

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Background Positive mental health (not simply absence of mental disorder) may hold potential for fostering resilience and reducing risks of poor health and well-being. However, it is challenging to define and measure. One promising conceptualisation is mental health competence (MHC), comprising age-relevant developmental tasks and abilities. To date MHC has not been investigated in UK children.

Methods We developed a measure of MHC in the UK Millennium Cohort Study (MCS) (~18 000 children born 2000–2002) using seven items addressing learning skills and prosocial behaviours, reported by mothers at age 11 (n=12082).