Background In the UK, 20–32% of children experience atopic eczema (AE), a chronic inflammatory skin condition typically diagnosed and treated in primary care. Emollient is effective for preventing flare-ups of inflammation and itchiness, topical corticosteroids (TCS) are used for flare-ups. The 2007 National Institute of Health and Clinical Excellence (NICE) guidelines for childhood AE diagnosis and treatment recommend all children presenting with AE in primary care are prescribed emollient; TCS are co-prescribed if indicated by the severity. The proportion of children receiving recommended treatment and NICE guideline impact on prescribing practices is unknown. This study was the first to access SystmOne routine data about UK-wide dermatology consultations in primary care.

We aimed to evaluate treatment patterns of childhood AE against NICE recommendations using routinely collected primary care data from SystmOne.

Methods Secondary analysis of retrospective, longitudinal primary care data for childhood (<12 yo) AE-related consultations from 2004 to 2013. Difference in proportion of consultations per month documenting 4 treatment scenarios was calculated (Wilson Score Method): 1) emollient and TCS co-prescribed (NICE-recommended for moderate or high severity presentation), 2) emollient only (NICE-recommended for mild severity presentation), 3) TCS only (not recommended), or 4) no topical treatment prescribed (not recommended if AE suspected). ARIMA used to examine step and trend-change in prescribing towards NICE-recommended treatment following guideline release.

Results We identified 130,106 children with AE documented at a consultation during the study period. After guideline was released, NICE-recommended treatments increased: emollient and TCS increased 8% (95%CI 7.7,8.7%); emollient only increased 8% (95%CI 7.8,8.8%); TCS only decreased 5% (95%CI -4.2,-5.1%); and no topical treatment decreased 11% (95%CI -11.3,-12.3%).

However, longitudinal analysis revealed there were underlying trends where NICE-recommended prescribing was increasing over time (scenarios 1 and 2), and prescribing not supported by NICE guidelines was decreasing (scenarios 3 and 4). These trends were not significantly affected by the guideline release. Despite these trends, at the end of 2013 ~334 children per month were still not receiving recommended AE treatment (37% of ~900 first-time AE consultations/month).

Conclusion Adherence to best practice guidelines for treatment and management of childhood atopic eczema could be improved. UK routine data can provide insights into the management of chronic conditions in primary care. Improving design of data input interfaces used by health professionals would remove significant barriers to optimal use of the data to answer pressing research questions.

P39 THE CHIPPS STUDY: A CLUSTER RANDOMISED CONTROLLED TRIAL TO DETERMINE THE EFFECTIVENESS AND COST-EFFECTIVENESS OF INDEPENDENT PHARMACIST PRESCRIBING IN CARE HOMES

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Background Prescribing, monitoring and administration of medicines in care homes could be significantly improved. Research has identified the need for one person to assume overall responsibility for medicines management within care homes. The advent of pharmacist independent prescribers (PIPs) provides an opportunity for pharmacists to assume this role. Although this approach is already being implemented, there has been no testing of effectiveness. This cluster randomised controlled trial (RCT) sets out to establish effectiveness and cost-effectiveness of PIPs.

Methods A cluster RCT across 90 care homes in England, Scotland and Northern Ireland with an internal pilot. The trial was designed following a programme of developmental and feasibility work in accordance with the MRC framework for developing and evaluating a complex intervention. The unit of randomisation is a triad (a PIP, a GP practice and a care home(s)). In the intervention group, the PIP is responsible for providing medication review, pharmaceutical care planning, prescribing and deprescribing for care home residents; supports the care home and optimises communication between GPs, care homes, and supplying pharmacy. The primary outcome is resident falls at 6 months. Secondary outcomes include resident health-related quality of life, medication burden, mortality and hospitalisation. Sample size is 880 residents across 44 triads to provide 80% power to detect a 20% decrease in fall rate from 1.5/resident to 1.178 with an ICC of 0.05 or less. We have conducted a parallel process evaluation including in-depth qualitative interviews with stakeholders.

Results The internal pilot study confirmed feasibility of the RCT with no significant adverse events. The trial completed recruitment to its sample size in October 2019, and follow-up will complete in March 2020. Characteristics of all residents recruited are: mean age 85 years; 70% female; 13% had capacity to consent; median number medications 7; fall rate 0.55/three months; mean Drug Burden Index 0.64; Charlson Morbidity Index 5.98; proxy EQ-5D 0.32; Barthel index 7.51. Full trial results will be available at the SSM Annual Scientific Meeting. Preliminary analysis of qualitative stakeholder interviews suggests changing professional roles need to be actively managed and effective communication systems implemented.

Conclusion As yet we do not know the trial outcome. A positive finding would support the provision of PIP-type interventions in care homes, whilst a negative finding would imply pharmacist resources may be better directed elsewhere. Either will be of great significance for UK pharmacy practice.

On behalf of CHIPPS investigators.

P40 A SYSTEMATIC REVIEW OF FACE TO FACE MEDICATION ADHERENCE INTERVENTIONS FOR PATIENTS WITH LONG TERM HEALTH CONDITIONS

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Background This review aimed to (i) identify efficacy of face to face interventions on medication adherence behaviour in adults with Long Term Health Conditions (LTHCs) and (ii) identify Behaviour Change Techniques (BCTs) and study