Abstract P126 Table 2

Adverse events (total)	PSP (12)	SSP (2)	Was a change in intervention required?
Description of adverse events			
Re-expansion pulmonary oedema (REPE)	1		No
Pain	5		1 vent was removed, and patient observed
Allergic reaction to dressing	1		ICD inserted
Surgical emphysema (SE) with no kinks or blockage	2	1	3 required ICD
Blockage of PV with fibrin or secretions or kinked on rib, causing SE	3	1	PV in patient with SSP replaced with another. All 2 PSP patients required an ICD

pneumothoraces secondary to image guided biopsies. Table 2 shows the adverse events related to those vents. Total number of bed days saved are 267.

Conclusions Complication rates are comparable RAMPP trial and commoner with PSP patients. There is no indication of the PV being unsafe in SSP, but our cohort is highly selective and thus at risk of significant bias. Our protocol works locally and we are happy to share it if needed.

REFERENCES

- https://doi.org/10.1016/S0140-6736(20)31043-6
- https://erj.ersjournals.com/content/early/2020/11/26/13993003.03375-2020

P127 LANCASHIRE AND SOUTH CUMBRIA REGIONAL TRACHEOSTOMY TEAM: ANNUAL IMPACT OF A SPECIALIST COMMISSIONED SERVICE

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10.1136/thorax-2021-BTSAbstracts.236

Evidenced annual impact of a specialist commissioned regional tracheostomy team aiming to reduce the risk of community tracheostomies.

There are an increasing number of tracheostomies being inserted nationally with no national framework for ongoing review following discharge to the community setting. This has the potential to result in poor clinical outcomes and ongoing dependence on acute care services and high cost packages of care. Prior to this service innovation, community tracheostomy patients were managed primarily by GP's with very few patients receiving specialist input. We found that this was resulting in repeated hospital admissions, lack of specialist review to assess for weaning potential and due to the lack of tracheostomy competent placements, was causing individuals to be relocated away from their families. £301,000 investment from regional Clinical Commissioning Groups (CCG's) was secured in April 2020 to create a specialist Nurse/Allied Health Professional led team consisting of 2.5 team members: Nurse (Clinical Lead), Physiotherapist and Speech and Language Therapist. Quantitative and qualitative data was collected during the first year of substantive funding to evidence service impact including: number of community decannulations with associated continuing health-care cost saving, reduced dependence on secondary care,

improved access to community placements, hospital admission avoidances and lived patient experiences. A total cost saving of £405,050.68 with an additional cost avoidance of £2,700,000 from acute in-reach decannulations during the first 6-month COVID-19 wave was achieved over this 12-month period. We have demonstrated the positive impact specialist tracheostomy services can have across primary and secondary care with the aim of this service model being used for national service provision pathway developments. Specialist tracheostomy services can achieve huge impact within the community setting both to improve clinical outcomes for this vulnerable patient group and to achieve substantial annual cost saving to the NHS.

P128 DEVELOPMENT OF A PULMONARY NODULE VIRTUAL PATHWAY

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10.1136/thorax-2021-BTSAbstracts.237

Introduction Pulmonary nodules are monitored at our hospital as per BTS guidance.¹ Previously, most patients were seen for a new patient appointment and follow-up appointments were planned in anticipation of interval CT scan results. Results would be acted on when the report reached the requesting consultant, with the follow-up appointment postponed if CT findings were stable.

This system had several flaws. The volume of nodules detected made it difficult to see all patients in clinic. Follow-up appointments would often be out of sync with scans leading to unnecessary appointments. As follow-up demand often outstripped capacity, outpatient follow-up did not act as an effective safety-net for problems with reports reaching requestors.

Development of a Virtual Pathway We developed a new pathway, improving several aspects of the system. Patients suitable for the Virtual Pathway are identified by Respiratory consultants based on referrals, CT results or via MDT. Patients are sent an information leaflet about pulmonary nodules with the option of requesting further information, rather than routinely offering new patient appointments. Interval scans are tracked by a database managed by a Specialty Doctor who ensures that scans have been requested, acted on, and patients notified of results.

Outcomes In the first year we tracked 244 follow-up scans, including 136 for nodule surveillance. Other reasons included follow-up of inflammatory change, lymph nodes and anterior mediastinal abnormalities. Only three nodule patients requested a new patient telephone consultation for further information. The database identified several 'near misses', including (1) a requesting consultant name being incorrectly transcribed, leading to the report not reaching the requesting consultant; (2) one overdue scan due to a radiology booking error, and (3) one scan that was not requested. No follow-up appointments were required for patients with stable findings.

Conclusion Development of a Pulmonary Nodule Virtual Pathway, utilising an interval scan database, reduced outpatient appointments whilst improving safety netting of pulmonary nodule surveillance.