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

1. [https://doi.org/10.1016/S0140-6736\(20\)31043-6](https://doi.org/10.1016/S0140-6736(20)31043-6)
2. <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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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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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.

REFERENCE

1. Callister M, et al. British thoracic society guidelines for the investigation and management of pulmonary nodules. *Thorax* 2015;70(S2):ii1–ii54.

P129 GETTING IT RIGHT IN A DIGITAL AGE – ROBUST PATIENT SELECTION TO AN EARLY SUPPORTED DISCHARGE SERVICE

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Introduction and Objectives Digital technology with capability for virtual ward consultant clinical supervision, DECAF scoring and a trusted assessor model was used to select patients for early supported discharge (ESD). We present here data on the initial three months of the pilot ESD service.

Methods ESD was a joint venture with the combined workforce of established hospital respiratory specialists (Respiratory Support Team; RST) and an expanded community respiratory team (CRT). A robust alert system linked to our electronic prescribing system identified potential patients to the RST (Colclough, 2014). Consultant clinical supervision screened all COPD admissions virtually from the hospital COPD virtual ward; established when an electronic bundle is opened by the RST. The DECAF score 0–1 was used to establish a cohort of patients assessed as safe for ESD (Steer, 2012). DECAF >2 required respiratory consultant approval for discharge to ESD. Advice and guidance was given to support the clinical team decision for suitability to be discharged.

Results In quarter 1 2020 29 patients were referred to ESD out of 161 patients admitted with COPD.

Conclusions ESD is safe and effective using a trusted assessor model supported by digital technology and consultant virtual supervision to screen into this service.

REFERENCES

1. Colclough R. P32 A Novel automated referral system using the electronic prescription of prednisolone ≥ 30 Mg And nebulised bronchodilators to the respiratory specialist team is robust and effective. *Thorax* 2014;69(Suppl 2):A91–A91.

2. Steer J, Gibson J, Bourke S. The DECAF score: predicting hospital mortality in exacerbations of chronic obstructive pulmonary disease. <http://dx.doi.org/10.1136/thoraxjnl-2012-202103>

COVID-19 recovery: predicting long term outcomes

P130 PROGNOSTIC VALUE OF THE INITIAL CHEST COMPUTERISED TOMOGRAPHY SCAN AT ONE YEAR FOLLOWING INFECTION IN AN ETHNICALLY DIVERSE COHORT OF PATIENTS ADMITTED TO HOSPITAL FOR COVID-19

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Background Little is known about computed tomography thorax (CTT) findings in hospitalised patients with COVID-19 of different ethnic groups, as well as their prognostic value following hospitalisation.

Methods Clinical data and the CTTs of patients admitted with COVID-19 between 9th March and 27th April 2020 to University Hospitals of Leicester NHS Trust were recorded and reviewed. CTTs were reviewed by two independent radiologists, blind to clinical data for ground glass opacities (absent, mild, moderate and severe), consolidation (absent, present) and pulmonary emboli (PE; absent, present). The main outcome of interest was all-cause mortality by April 12th 2021. Cox proportional hazards regression was used to investigate the relation between variables and all-cause mortality.

Results 312 patients were enrolled; median age 65 (IQR 51–77); 234 (75%) were White; 42 (14%) Asian; 9 (6%) Black and 17 (5%) were from other ethnic minority groups. 195 (63%) of patients had multifocal ground glass changes on

Abstract P130 Figure 1 Features of COVID-19 on the CT were very common in hospitalised patients and were related to all-cause mortality one year following hospitalisation