49% reported worsening MHR. Senior nurses (band 6 or above) appeared most affected, with 83% reporting a decrease in mental health, followed by doctors (56%).

Abstract P179 Table 1

RHCU Data

Job role (%)

- Senior doctor (registrar and above)	8
- Junior doctor	9
- Senior nurse (band 6 and above)	11
- Staff nurse	25
- HCA	17
- Physio	11
- Other (pharmacist, ward clerk, housekeepers, students)	19

Time worked on RHCU (%):

- 1–4 months	25
- 4–8 months	13
- 8–12 months	62

Age of participants in years (%):

- 18–25	13.2
- 26–35	34.0
- 36–45	24.5
- 46–55	18.9
- 56–65	7.5
- >65	1.9

Analysis

**April
2020** **March
2021**

Overall MHR (%):

- Poor	4	11
- Fairly poor	10	19
- Average	25	26
- Fairly good	44	42
- Excellent	17	2

Mood symptoms – reported as half the time or more (%)

- Depressed	4	21
- Tearful	6	27
- Anxious	18	44
- Irritable	18	40

Anxiety coming into work experienced half the time or more (%) 14 45

Lack of motivation at work experienced half the time or more (%) 10 30

Work-life balance – reported as half the time or more (%)

- Worrying/thinking about patients outside of normal working hours	24	58
- Trouble falling asleep or sleeping too much	33	55
- Feeling overly tired after a shift	35	51
- Difficulty focusing on activities outside of work	20	43
- Strain on personal relationships	24	42
- Over/under eating	29	54
- Exercising regularly	52	50

Further analysis

Impact on physical health (%)

- No impact	10
- Unsure	15
- Little impact	49
- Significant impact	26

Would you continue in your current job role? (%)

- Yes	68
- Unsure	26
- No	6

There was an increase in negative mood symptoms (depressed, tearful, anxious and irritable) experienced half the time or more in 2021. Depressed mood had > 5 folds increase (4% in 2020, 21% in 2021). 44% staff reported feeling anxious half the time or more in 2021 (18% in 2020).

58% staff reported worrying about patients outside working hours half the time or more (20% in 2020).

75% reported some impact on their physical health. Worryingly, 67% senior nurses and 44% doctors were unsure or would not continue in their job role.

Overall, participants aged 36–45 were most affected, 54% reporting deterioration in MHR. Those aged 26–35 were most likely to consider leaving their current job role (39%).

Our survey highlighted the ongoing need for mental health support for staff working through the pandemic. Staff recruitment and retention is another challenge.

REFERENCE

1. British Medical Association. *Personal impact of the COVID-19 pandemic on doctors' wellbeing revealed in major BMA survey.*

P180

THE VIABILITY AND ACCEPTABILITY OF A RESPIRATORY PHYSIOTHERAPY WEEKEND LATE SHIFT SERVICE: A SERVICE EVALUATION

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10.1136/thorax-2021-BTSabstracts.289

Background From July to November 2020, Nottingham City Hospital trialled a respiratory physiotherapy weekend late shift (RWLS) service in response to the COVID-19 Pandemic, running on Saturday and Sunday from 16:00 to 21:00. It aimed to decrease emergency call-outs, improve patient flow and improve timeliness of assessment and treatment. Literature relating to the efficacy of emergency and weekend physiotherapy services in the UK is limited due to inter-service variation. Local factors serve as barriers and facilitators to the provision of these services, justifying the need to evaluate services individually.

Aims To determine the viability and staff acceptability of the RWLS. Viability was defined as the success of the RWLS in meeting its three main aims, staff acceptance was defined as its perceived success.

Method Mixed-methods design. Quantitative data was collected prospectively using a bespoke data collection form completed by staff at the end of their shift. Data included; number of patients seen, area of speciality, emergency calls attended and number of discharges per shift. An online semi-structured focus group with staff who worked the RWLS explored staff perceptions of the success and future acceptability of the RWLS, in depth.

Results The RWLS successfully reduced emergency call-outs by a mean of 1.06 call-outs per shift. Patient flow, measured by the number of interventions facilitating discharge was not directly improved, although staff felt discharge planning was initiated sooner. Staff felt the RWLS improved timeliness of assessment and treatment, but reported inefficiencies related to handover. The RWLS was well accepted by staff due to the shift's perceived benefits to patients, COVID-19 socialisation restrictions and overtime pay. Junior staff felt working the RWLS aided transition to emergency on-call work.

Concerns included maintaining staff commitment and lone-working.

Conclusion and Recommendations The RWLS appears viable, two of three main aims were met. Further investigations into patient benefit and flow, cost and handover efficiency would potentially improve the justification for implementing the service long-term. Staff accepted continuing the RWLS following the trial period. Maintenance of the service may require opt-in rostering, and promotion of the benefits to staff in light of the potential easing of COVID-19 restrictions.

P181 FINANCIAL BENEFITS OF A DEDICATED PULMONARY NODULE MULTIDISCIPLINARY TEAM MEETING: EXPERIENCE FROM A DISTRICT GENERAL HOSPITAL IN THE UNITED KINGDOM

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10.1136/thorax-2021-BTSabstracts.290

Introduction and Objectives Traditionally, pulmonary nodule surveillance was clinic-based with discussions of pulmonary nodule cases at lung cancer multi-disciplinary team meetings (MDTM). However, the increased burden of nodule discussions can increase workload when discussed at complex lung cancer MDTMs.¹ Thus, a dedicated pulmonary nodule MDTM was initiated at Ashford and St Peters Hospital (ASPH) NHS Trust with aim to determine its financial implications.

Methods We undertook a cost effectiveness analysis to compare the NHS cost of discussion of one nodule case at pulmonary nodule MDTM versus discussion at lung cancer MDTM at ASPH for 1 hour of time. We calculated the hourly cost for each member. The non-direct costs i.e., overheads of 21% were added to the total MDTM cost. Discussion of one case at MDTM takes 3 minutes on average i.e., 1 minute for radiology review, 1 minute for discussion and 1 minute for form filling and recording. The cost per case associated with discussion at nodule MDTM was compared to the costs per case at lung cancer MDTM and outpatient clinic review.

Abstract P181 Table 1 showing cost of each MDTM member for pulmonary nodule and lung cancer MDTM

Lung cancer MDTM			Pulmonary nodule MDTM	
MDTM member	MDTM members	Cost (£) per hour	MDTM members	Cost (£) per hour
Respiratory consultant	4	372.00	1	93.00
Radiologist	2	198.00	1	99.00
MDT coordinator	1	15.50	1	15.50
Thoracic surgeon	2	198.00	0	0.00
Oncologist	2	198.00		0.00
Palliative care consultant	1	87.00		0.00
Lung cancer CNS	1	28.00		0.00
Overhead allowance (21%)		230.27		43.58
Total cost of MDT/hour	£1326.77			£251.08

Results The cost to discuss one case at the lung cancer MDTM was £66.34, compared to £12.55 for discussion at pulmonary nodule MDTM. Therefore, the estimated cost saving was £53.79 per case if discussed at nodule MDTM as opposed to lung cancer MDTM. The pulmonary nodule MDTMs avoided the need for outpatient clinic review and was estimated to save £99.55 per follow up case [cost of follow outpatient clinic visit (112.10) minus cost of one nodule MDTM case (£12.55)] and £238.23 per new case [cost of new outpatient clinic visit (£250.78) minus cost of one nodule MDTM case (£12.55)].

Conclusion To conclude, the implementation of a pulmonary nodule MDTM has resulted in massive cost savings to our organisation. If this were to be formally implemented and adopted to a regular job planned activity, the cost savings to the NHS as a whole could be substantial.

REFERENCE

- Hardavella G, Desai S. Development of a pulmonary nodule service & clinical pathway: A pragmatic approach addressing an unmet need. *European Respiratory Journal* 2016;**48**:60. doi:10.1183/13993003.congress-2016.PA3079

P182 WHAT MAKES A HERO?

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National data has shown that the COVID-19 pandemic has drastically impacted the situation of poor mental health amongst NHS staff. Severe levels of anxiety have risen from 8% pre-pandemic to 36% during the pandemic and severe stress has increased from 11% to 46%¹.

From a targeted and anonymous survey of 125 healthcare professionals at a district general hospital 83% said that their mental health had been negatively impacted by the pandemic. Interestingly, although 72% were aware of support available for mental health just over half said that they would feel comfortable seeking this support.

Throughout the pandemic NHS workers have been praised for being 'heroes'. There are growing concerns that this label could actually be detrimental, making it more difficult for staff to seek help with their mental health and exacerbating the existing issue of mental health stigma among healthcare professionals². This issue is visibly evident with the vast majority of survey respondents reporting a decline in mental health, but a large proportion not feeling comfortable in seeking help.

Specific factors affecting mental health were evaluated (figure 1) and the factor with the greatest response was 'fear of spreading the virus to loved ones'. Conversely the lowest response was 'fear of catching the virus yourself'. This is an example of the inbuilt compassionate nature that healthcare professionals have, but the lack of self-compassion even in times of adversity.

There is no simple or quick fix to this issue. What is needed is a shift in culture. Putting an emphasis on wellbeing, kind communication, encouraging the use of available support and compassionate leadership are just some of the ways to managed this issue long term. This pandemic will have effects lasting long after the last case is reported and the heroes in years to come will be those who knew how to seek help and felt comfortable to do so when they needed it.