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

P Ayuen, A Khan, C Butter, R Davies, C Ashwin, S Saikia. *St Peters Hospital, Chertsey, Surrey, UK*

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?

K Crowley, I Du Rand. *Hereford County Hospital, Hereford, UK*

10.1136/thorax-2021-BTSAbstracts.291

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.

Common Factors affecting mental health related to Covid-19

Abstract P182 Figure 1

P183 ACUTE NIV: A SIMULATION BASED QIP FOR INTERNAL MEDICAL TRAINEES

W Hassan, D Sagar, A Hamad. *Sheffield Teaching Hospitals, Sheffield, UK*

10.1136/thorax-2021-BTSabstracts.292

Background The use of Non-invasive ventilation (NIV) became popular over the last years.¹ BTS guidelines state that all staff involved in the use of NIV should have evidence of acute NIV training.¹ At the local level, the scale of the problem was identified by a survey sent to all the general medical registrars in our region. This questionnaire identified the shortcoming in the knowledge that surrounds NIV and the majority of the non-respiratory trainees identified a lack of training in this area.²

Objective Purpose of this QIP was to set up a simulation based NIV course for internal medical trainees which would lead to improvement in knowledge and management of the use of NIV.

Methods Simulation based training sessions were organized which and run on a monthly basis at the SIM suite at our teaching hospital. The candidates were asked to complete a pre and post course questionnaire. The sessions consisted of a presentation on the basics of NIV followed by simulation based scenarios.

Results On a scale of 1 to 10, the confidence level of the candidates was assessed via the questionnaire. The pre and post course mean confidence levels for selecting patients for acute NIV were 5.7/10 and 8.3/10 respectively whereas

managing patients on NIV and adjusting the settings were 4.6/10 and 7.8/10 respectively. After attending the course, 95% of the candidates were able to correctly identify the absolute contra-indications of acute NIV compared to 85% prior to the course. In 2 different clinical scenarios, after attending the course, 100% and 93% of the candidates were able to identify when acute NIV is not indicated compared to 77% and 82% prior to the course.

Conclusion Our QIP was able to provide the acute NIV training recommended by the BTS. It also demonstrated that supervised training led to increased knowledge and confidence level of managing patients on NIV.

REFERENCES

1. Davies M, et al. BTS Quality standards for acute NIV in adults. *BMJ open Respiratory Research*. Feb 2018.
2. Sagar D, et al. Acute NIV: Survey of medical Registrars. BTS, 2017.

Fighting back: optimising treatment for COVID-19

P184 IS CONTINUOUS POSITIVE AIRWAY PRESSURE (CPAP) EFFECTIVE IN THE MANAGEMENT OF COVID-19 IN PATIENTS AGED 75 AND OVER? A RETROSPECTIVE OBSERVATIONAL STUDY OF A RESPIRATORY COVID-19 CPAP UNIT THROUGH ITS SECOND WAVE

H Alexander, R McGow, S Makwana, S Al-Hakeem, A Adeyeye, A Ashish. *Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust, Wigan, UK*

10.1136/thorax-2021-BTSabstracts.293

Introduction There remains significant variation in treatment of COVID-19 associated respiratory failure. Although Continuous Positive Airway Pressure (CPAP) has shown to improve outcome in single centre studies, inclusion criteria for commencement of CPAP varies significantly (Ashish et al., 2020; Nightingale et al., 2020). This respiratory-led ward-level dedicated CPAP unit provided CPAP to COVID-19 patients through the 'second wave'. This study aims to evaluate the efficacy and appropriateness of CPAP for COVID-19 management in an elderly population.

Methods This retrospective observational study included all patients aged 75 and over who received CPAP for COVID-19 infection, admitted to a district general hospital between 1 October 2020 and 16 February 2021. Fifty-seven patients

Correctly identifying indications for NIV

Abstract P183 Figure 1