+2SD and +3SD respectively) and expressed as% of the available data for each age group. Change in BMI between ages was recorded as deviation by ≥±1 centile over time.

**Results** Data was collected for 52 patients (76% PB, 12% PCD, 12% PB and PCD; 52% male). Z-scores revealed that most individuals were of a healthy BMI (≥80%). There was no undernutrition at any of the age points except at age 7 (5%). There was higher frequency of overweight at ages 3 & 15 (12% and 16%). Obesity levels were low compared to the general population (age3:4%, age5:0%, age7:2%, age9&11:3%, age15:7%). The frequency of children crossing down ≥1centiles was most pronounced between age 3 to 5 years (60%, n=23). Between the ages of 7–9, 9–11 and 11–15 most children had no major change in BMI (58%, 66% and 41%) but went up ≥1centiles in around a third (30%, 24%, 37%).

**Conclusion** Most children had healthy weight for height. However, between age 3–5 a high portion showed a decline in nutritional status that may be linked with clinical respiratory symptoms at the time and needs further exploration. An increase in BMI is most notable in teenage years that may or may not be related to their respiratory health and early intervention is indicated. BMI may also not be the most sensitive indicator of nutritional undernutrition in this age group.

### Abstract P70 Figure 1

Patient experiences and how they relate to the health belief model

- **Perceived Susceptibility: family history of lung cancer or other condition**
  - "Family history of lung cancer so always at the back of my mind" P2

- **Perceived Seriousness: worry that health concern is something serious**
  - "Never know with chest if it’s something and nothing or could be something serious" P38

- **Perceived Benefits: Reassurance, peace of mind, early diagnosis**
  - "Peace of mind that everything was okay" P25
  - "Yes certainly recommend, puts your mind at rest if nothing else. If they find something then early diagnosis is always the best way isn’t it?" P38
  - "At least I know what I’ve got now, I wouldn’t have known" P42

- **Perceived Barriers: location and accessibility, parking, wait times, fear of outcome or hospital, limited information**
  - "I don’t know if it was bad timing but went at lunch time and all staff walked out at same time and we were kept waiting for over an hour. Once they resumed service it was very quick" P45
  - "People’s worries about hospitals and how long they have to wait" P4
  - "The outcome, if they didn’t want bad news" P10

- **Self Efficacy: High due to walk-in appointments**
  - "Skips the whole first layer, didn’t have to worry the GP at all, anxiety levels came down and couple of weeks later the cough had gone" P55

- **Clues to action: knowledge of the service through advertisements and recommendations, experience of a symptoms**
  - "Playing on my mind because it was so long and I couldn’t get rid of it I was a bit worried" P55
  - "Wife suggested I attend as she’d seen an advertisement" P42

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**I still haven’t found what I’m looking for** – Cancer diagnosis: imaging and bronchoscopy
to understand patient motivations for attending the service to determine how uptake could be increased and to facilitate service expansion.

**Methods** Deductive thematic content analysis of semi-structured qualitative interviews with a sample of attendees.

**Results** Fifty-one attendees were interviewed. Respondents were from a wide range of age groups and postcodes within the included areas. The majority of participants were female (57%) and White British (94%). Overall, participants ‘couldn’t fault the service’ and would recommend it to others. Most participants heard about the service through word of mouth and advertisement (35%) or through their GP surgery (22%). The majority (86%) attended due to a concerning health issue (i.e. cough or chest complaints). Twenty-two percent had tried to see their GP but were unable to get an appointment. Qualitative findings are interpreted within the Health Belief Model (figure 1). Demographic factors may influence engagement. Some forms of advertising may be more suitable to people of different ages, concerns were raised that social media ‘may not reach older people’. Ethnicity barriers such as language or cultural issues were also highlighted. If the chest X-ray self-referral service wasn’t available, most participants would contact their GP, but highlighted the difficulties, e.g. contacting the surgery, long waits for appointments/referrals. Others would not have done anything if this service was not available.

**Conclusion** This work provides assurances that the GM SRCXR service is providing a good experience of care and helping to break down barriers to accessing CXRs in patients with the common symptoms of lung cancer and provides guidance for future service enhancements.

**Abstract P71 Table 1** Comparison of diagnostic accuracy between MDT decisions and Herder scores

<table>
<thead>
<tr>
<th></th>
<th>MDT decision to investigate for all patients</th>
<th>MDT decision to investigate in patients with Herder score 10–70%</th>
<th>Herder score alone at ≥ 10%</th>
<th>Herder score alone at ≥ 70%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accuracy</td>
<td>79.7%</td>
<td>82.4%</td>
<td>67.6%</td>
<td>67.3%</td>
</tr>
<tr>
<td>Sensitivity</td>
<td>88.2%</td>
<td>81.5%</td>
<td>96.5%</td>
<td>67.1%</td>
</tr>
<tr>
<td>Specificity</td>
<td>69.1%</td>
<td>83.3%</td>
<td>29.4%</td>
<td>67.6%</td>
</tr>
<tr>
<td>Positive predictive value</td>
<td>78.1%</td>
<td>84.6%</td>
<td>63.1%</td>
<td>72.2%</td>
</tr>
<tr>
<td>Negative predictive value</td>
<td>82.5%</td>
<td>80%</td>
<td>87%</td>
<td>62.2%</td>
</tr>
</tbody>
</table>

**Results** 186 patients underwent a PET-CT scan for a suspicious nodule. 33 patients were excluded owing to loss to follow-up, awaiting a 12-month surveillance scan or being discharged after PET-CT scan; 153 subjects were included in the final analysis. The mean age was 68.6 years (range 56 to 76) with 76 female subjects and 104 ex-smokers. The mean size of nodules was 17.4mm (range 7.7 to 30mm). 85 out of 153 nodules (55.3%) were malignant. Sensitivity, specificity, positive and negative predictive values for identifying malignant nodules are outlined in Table 1.

**Conclusion** An MDT decision to further investigate nodules using a combination of the Herder score between 10–70% as well as imaging and clinical factors provided the greatest overall diagnostic accuracy compared to Herder alone.

**P72 THE ROLE OF THE HISTORICAL CLINICAL AND IMAGING DATA IN TARGETED LUNG HEALTH CHECK SCREENING REVIEW MEETINGS**

**Introduction** The Somerset, Wiltshire, Avon and Gloucester (SWAG) Cancer Alliance are undertaking a Phase 3 Pilot in the National TLHC programme. SWAG covers a population of 2.6 million with an estimated 366,500 eligible participants. Weekly Screening Review Meetings (SRM) are undertaken to review actionable cases. The SWAG SRM has established access to local PACS imaging databases to enable review of relevant historical imaging.

**Methods** TLHC participant data were captured for participants in the West Bath and Bridgewater regions between August 2022 and June 2023. SRM outcomes were scrutinised and pathway changes were categorised. Actionable incidental findings were downgraded according to additional available clinical information and historical imaging. Pulmonary nodule follow-up recommendations were downgraded on the basis of historical imaging.

**Results** 3133 screening participants underwent a baseline low dose CT scan. 874/3133 (27.9%) participants were discussed in an SRM with 95/874 (10.9%) undergoing pathway change.