($r = 0.82$, $p = 0.123$), nor presence of PT ($\chi^2(2) = 2.305$, $p = 0.129$).

Conclusions RV dilatation and PT were prevalent in this multi-centre cohort of COVID-19 patients, but were not associated with mortality or parenchymal disease severity. PT is frequently low burden and, in contrast to PT outside the context of COVID-19, RV:LV >1 is not discriminatory for prognosis.

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P97 DISEASE SEVERITY AND PATIENT RECOVERY IN COVID-19: AN OBSERVATIONAL STUDY COMPARING FIRST AND SECOND WAVE ADMISSIONS IN LONDON

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Background The COVID-19 global pandemic presents with waves of infection. International studies report key demographic and outcome differences with younger patients, lower co-morbidity and mortality reported amongst second wave patients.¹ Less is known about observed differences, subsequent recovery and 'Long covid' development. We therefore sought to explore differences in clinical severity at 8–10 week follow-up for adult discharges following acute admission with COVID-19 during London's first two waves.

Methods This prospective observational cohort study compared in each wave the first 400 patients' admission trajectory and recovery after discharge. We excluded hospital acquired cases and included unreachable patients with available admission records.

Results Groups admitted between 27/2/2020 - 05/04/2020 (first wave) and 10/12/2020 - 08/02/2021 (second wave) demonstrated similar median age 61 years (IQR: 50 - 74 vs. 51 - 74); $p = 0.59$; and male sex (61.8% vs. 59.3%; $p = 0.47$); but higher BMI in second wave admissions (26.8 vs. 27.7 kg/m²; $p = 0.015$). Co-morbidity prevalence was similar, other than chronic kidney disease being more prevalent in first wave admissions (18% vs. 9.3%; $p < 0.0001$).

On admission, second wave patients demonstrated: higher Clinical Frailty Score, lower NEWS score with more patients deemed suitable for full treatment escalation. A significant number received more: novel agents, non-invasive treatment and less invasive ventilation (table 1). Length of stay was lower (5 vs. 8 days, $p < 0.0001$).

322 (first) vs. 365 participants (second wave) completed follow-up at 74 vs. 54 days; $p < 0.0001$, post discharge. Second wave patients reported less mental health burden, greater self-reported recovery and symptom trajectory other than fatigue. A greater proportion had improved radiological changes. Many patients had not returned to work in both waves.

Conclusion These data suggest second wave patients, although frailer, presented with fewer symptoms and experienced improved hospital admission trajectory. They demonstrated

improved self-reported mental health and physical recovery outcomes despite earlier follow-up, possibly attributed to improved in-hospital treatment. Supporting recovery remains a clinical priority given many patients had not returned to work.

Abstract P97 Table 1 Demographics and clinical characteristics of participants at hospital admission and follow up for wave 1 and 2 admissions

	Wave 1	Wave 2	p-value
	N = 400	N = 400	
Demographics and Lifestyle			
Age (years) (Median, IQR)	61 (50 - 74)	61 (51 - 74)	0.59
Male gender (N,%)	247 (61.8%)	237 (59.3%)	0.47
Ethnicity (White) (N,%)	200 (50.0%)	195 (48.8%)	0.001*
Smoking status – Never smoker (N,%)	215 (53.8%)	219 (54.8%)	0.58
BMI (kg/m ²) (Median, IQR)	26.8 (24.1 - 29.4)	27.7 (24.3 - 31.6)	0.015
Underlying clinical status			
Clinical Frailty Score (Median, IQR)	2 (2, 4) N = 332	3 (2, 3) N = 384	0.001
Shielding Status (N,%)	32 (10.1%)	39 (11.2%)	0.001
Extremely vulnerable	23 (7.2%)	5 (1.4%)	
HCP issued letter			
Covid Admission Severity Parameters			
Total number of symptoms (Median, IQR)	4 (3 - 6)	3 (2 - 3)	<0.0001
NEWS2 score (Median, IQR)	5 (2 - 7) N = 372	4 (3 - 6) N = 379	0.60
TEP status – For full escalation (N,%)	284/365 (77.8%)	361/400 (90.3%)	<0.0001
Maximum respiratory support (N,%)	N= 377	N = 400	<0.0001
CPAP	10 (2.7%)	32 (8.0%)	
NIV	2 (0.5%)	5 (1.3%)	
Received anti-viral or immunosuppressive drugs (N,%)	23/374 (6.2%)	127/400 (31.8%)	<0.0001
ITU admission (N,%)	62/377 (16.5%)	43/400 (10.8%)	0.02
Intubation (N,%)	49/364 (13.5%)	19/400 (4.8%)	<0.0001
Pulmonary Embolus (N,%)	22/360 (6.1%)	24/395 (6.1%)	0.98
Follow-up Outcomes			
	N = 322	N = 365	
Mental Health Outcomes			
PHQ2 score ≥ 3 (N,%)	47 (15.4%)	34 (9.9%)	0.04
TSQ score ≥ 5 (N,%)	44 (14.9%)	12 (3.3%)	<0.0001
Physical Recovery and Symptoms			
Not returned to work (N,%)	76 (24.8%)	114 (33.6%)	0.03
Improved Sleep quality (N,%)	168 (61.5%)	265 (78.4%)	<0.0001
Improved Fatigue (N,%)	241 (87.6%)	307 (88.7%)	0.91
Improved Cough (N,%)	194 (69.5%)	291 (84.8%)	<0.0001
Improved Breathlessness (N,%)	213 (76.1%)	311 (89.6%)	<0.0001
Total Number of Symptoms (Median, IQR)	1 (0 - 2) N=314	0 (0 - 1) N=364	
Radiology outcomes			
(N,%)	N=309	N=279	<0.0001
Normalised	211 (68.3%)	187 (67.0%)	
Significantly Improved	55 (17.8%)	65 (23.3%)	
Not significantly improved	2 (0.7%)	13 (4.7%)	
Worsened	30 (9.7%)	14 (5.0%)	

*p value likely attributable to differences in unknown ethnicity

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The wider impact of the pandemic

P99 COPD PATIENTS' KNOWLEDGE, TRAINING AND ADHERENCE WITH INHALATION THERAPIES DURING COVID-19

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Introduction and Objectives Effective management of chronic obstructive pulmonary disease (COPD) necessitates inhalation treatment at all disease stages. A previous UK Inhaler Group survey identified patient training and knowledge of their inhaler devices as key factors contributing to inhaler misuse and non-adherence, both known to impact clinical and economic burden. Coronavirus disease 2019 (COVID-19) potentially presents a significant risk of worsening disease management due to virtual consultations, patient shielding and self-isolation. We assessed patient engagement with inhalation therapies by understanding their treatment beliefs, knowledge, training received, and device-related concerns in pre-pandemic and pandemic periods.

Abstract P99 Table 1 Changes in self-reported knowledge, training, and adherence regarding inhaled therapies during COVID-19. Pattern analysis of participants reporting change in adherence indicates the role of patient emotions, beliefs, and experiences. Six reasons inducing adherence-promoting or adherence-limiting behaviour were identified.

Participant identifier	Change in knowledge	Change in training	Change in adherence	Reason(s) for change in adherence
2	No change	No change		Fear of contracting COVID-19
22	Decreased	Decreased		Worsening of symptoms during COVID-19
30	No change	No change		Fear of contracting COVID-19; Worsening of symptoms during COVID-19
38	No change	No change	Increased	Motivation from awareness of COPD as a COVID-19 risk factor
49	Increased	No change		Perception of high therapeutic benefit from new prescription during COVID-19; Motivation from awareness of COPD as a COVID-19 risk factor
17	Decreased	Decreased		Social isolation/depression and neglectful of COPD treatment during COVID-19
23	No change	No change	Decreased	Improvement in symptoms during COVID-19
28	No change	Decreased		Social isolation/depression and neglectful of COPD treatment during COVID-19

Methods A 60-item questionnaire, devised through an iterative process, formed the basis of ~45-minute one-to-one semi-structured telephone interviews with COPD patients. Objective medical data were obtained from electronic records.

Results Of 54 participants (females, 48%; age, 68.8±8.14 years), although 88.9% perceived to possess sufficient knowledge regarding their inhalers, only 55.6% recounted correct therapeutic indications, while 16.7% reported inclusion of an inhaler or nebuliser in their current exacerbation 'action plan'. Device training was primarily delivered non-routinely (41.7%), through face-to-face demonstrations (70.1%) pre-pandemic. However, inhaler technique reviews reduced by over two-thirds (71.4%) in the comparable pandemic period, with virtual face-to-face demonstrations constituting only 42.9% of reviews. A third (33.3%) affirmed a desire for more frequent reviews. Among participants' n=137 prescribed inhalation devices, the pressurised metered-dose inhaler (pMDI), nebuliser, and unit-dose dry powder inhaler (DPI) displayed lower usability scores. 59.3% of participants encountered multiple problems with critical steps of pMDI and DPI technique, and reiterated need for specific inhalation device features. Nevertheless, most participants reported no change in knowledge (85.2%), training (92.6%), and adherence (85.2%) regarding inhalation therapies. Adherence increased by 3.7% and reasons attributed to this change included COVID-19-induced fear, motivation, and altered symptom control likely due to 'shielding' measures.

Conclusions Disparities between patients' perceived and actual knowledge, deficiencies in training delivered, and potential for more appropriate inhalation device selection exist. COVID-19 induces bidirectional change in adherence; the impacts of 'shielding' and disruption to routine care may limit positive change. Although a larger study is required to confirm statistical significance, these findings warrant improved patient education provision.

P100 IMPACT OF THE COVID-19 PANDEMIC ON HEALTH SERVICES UTILISATION IN A LUNG CANCER SCREENING COHORT

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Background The COVID-19 pandemic has caused significant disruption to healthcare services. Participants in lung cancer screening programmes are at elevated risk of lung cancer, have high rates of comorbidities, and therefore may be adversely affected by delayed or cancelled appointments. Analysis of lung health check data collected within the SUMMIT study allow us to quantify the impact on this population.

Methods The SUMMIT study aims to assess the implementation of low-dose CT (LDCT) for lung cancer screening in a high-risk population and to validate a multi-cancer early detection blood test (NCT03934866). Enrolled participants attend three annual lung health checks. Participants attending their second (Year 1) lung health check were asked about the impact COVID-19 had on their health service utilisation the preceding year.