their mobile device, coached by a Physiologist who is able to see the patient via their mobile phone camera and view spirometry flow loops in real time, downloading results ready for the subsequent clinic. Review of spirometry available for clinics in May 2021 was then performed and the number and quality of reports available compared.

Results Spirometry reports were available for 35 out of 70 appointments for patients with Spirobank® devices in January 2021, of which 26/70 (37%) were ATS grade A or B. In May 2021, 50 patients with devices had clinic appointments: 9 provided reports independently (7 grade A or B), 37 were coached by a physiologist (31 A or B), and 4 did not attend or declined a coaching session.

Conclusion Without coaching, only 37% patients with a Spirobank® device provided ATS grade A or B spirometry for virtual CF clinics; this increased to 76% with the introduction of pre-clinic online Respiratory Physiologist coaching sessions.

We plan to review how the number and quality of reports provided with and without coaching changes as patient experience in the use of home spirometers increases.

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P107 CREATING A NEW ROLE ON RESUSCITATION TEAMS RESPONSIBLE FOR PPE AND TEAM SAFETY SIGNIFICANTLY IMPROVES THE SAFETY OF RESUSCITATION TEAMS WORKING IN THE PANDEMIC: A SINGLE CENTRE STUDY

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Introduction and Objectives Due to the COVID pandemic, aerosol generating procedures at resuscitation calls have created new risks for resuscitation teams. In our centre we identified that during resuscitation calls, PPE guidelines were often not being followed due to the focus of all the resuscitation team members being primarily on managing unwell patients rather than personal safety. This study aimed to assess whether the introduction of a new role in the resuscitation team with responsibility of ensuring full PPE protection for all team members, a 'PPE lead', could improve the safety of resuscitation teams.

Methods In December 2020, at the start of the 'second COVID wave' we created a new role on every resuscitation team, a PPE lead, whose responsibility was to ensure that all other team members received correct PPE provision and were using this correctly during resuscitation calls.

The effectiveness of this change was measured by asking resuscitation staff to complete a questionnaire. Standard statistical analysis was undertaken.

Results 32 questionnaires were given to resuscitation team members with 100% returned. 28 (87.5%) respondents agreed or strongly agreed that the introduction of a PPE lead in the resuscitation team helped to improve adherence to PPE guidelines at arrest calls, compared to 4 (12.5%) respondents who remained neutral ($p < 0.001$). 27 (84.4%) respondents agreed or strongly agreed that the introduction of a PPE lead improved personal safety, compared to 5 respondents (15.6%) who remained neutral ($p < 0.001$).

Conclusion Effectively protecting healthcare staff from exposure to COVID remains paramount, especially with concerns regarding new variants which are more transmissible. This study has shown that listening to the concerns of staff can lead to innovative improvements. To our knowledge this is the first study that has introduced within the resuscitation team a PPE lead.

This study has established that a PPE lead helps improve adherence to PPE guidelines, and helps healthcare staff feel safer. Our study helps evidence the need to introduce a PPE lead on resuscitation teams on a national level.

P108 ANNUAL PHYSIOTHERAPY REVIEWS IN A SPECIALIST RESPIRATORY CLINIC FOR BRONCHIECTASIS: THE IMPACT OF COVID-19 ON AN ALREADY STRAINED WORKFORCE

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Introduction The British Thoracic Society Guidelines (2019) require individuals with bronchiectasis in secondary care clinics are seen annually by a respiratory physiotherapist.

The NHS Long Term Plan (2019) emphasises respiratory as a priority area and acknowledges an increase in workforce is needed. COVID-19 has had a drastic impact upon healthcare provision, with a reduction in access to care for many patients with chronic respiratory diseases (Chudasama, et al., 2020).

Objectives To analyse the impact of COVID-19 on the number of bronchiectasis patients receiving an annual physiotherapy review within a specialist respiratory clinic.

Methods Patient databases were analysed and coded to identify the number of patients active in the clinic between 31/03/2019–2020, and 01/04/2020–2021, and the percentage of whom received a physiotherapy review during the respective periods. These dates were selected taking into account COVID-19 government directives and resultant clinic operating restrictions. Virtual consultations were included.

Results The percentage of bronchiectasis patients who received a physiotherapy review declined by 25.7% during COVID-19. See table 1 for results.

Conclusion The respiratory workforce has been central in the acute response to COVID-19, whilst reduced provision of pulmonary rehabilitation and specialist respiratory clinics has led to a significant reduction in access to care for patients with chronic respiratory conditions reliant on highly specialised management. It is anticipated that the consequences on chronic disease burden will continue to unfold long after the pandemic has been controlled.

This research identifies a significant unmet need of physiotherapy within a specialist respiratory service, exacerbated by COVID-19. A wider exploration into respiratory workforce

Abstract P108 Table 1 Delivery of annual physiotherapy reviews before and during COVID-19

Year	Patients for review	Patients reviewed	% patients reviewed
31/03/2019–2020	392	226	57.7
01/04/2020–2021	408	130	31.9

nationally will help to further understand the increased need in a COVID-19 world.

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P109

INFECTION CONTROL POLICIES DURING THE COVID-19 PANDEMIC WERE EFFECTIVE IN LIMITING MORBIDITY AND MORTALITY ASSOCIATED WITH NOSOCOMIAL VIRAL TRANSMISSION AT A LARGE NHS RESPIRATORY DEPARTMENT

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Introduction Prevention of nosocomial transmission was a priority for NHS hospital teams during the SARS-COV-2 pandemic. However, infection control policies were developed in the face of uncertainty about duration of infectivity, routes of transmission, and safety of shared admission spaces. We retrospectively reviewed all hospital admissions to the University Hospitals of Leicester (UHL) respiratory department, which managed more than 30% of UHL patients with a diagnosis of COVID-19 between March 2020 and March 2021 to determine the proportion of cases with laboratory evidence of healthcare associated infection (HCAI) and mortality within 28 days of PCR conversion

Methods This was a retrospective cohort study performed using a bespoke database collating COVID-19 throat swab (TS) PCR results for UHL (COVTRACK). Nosocomial transmission was identified by demonstrating PCR conversions during admission and categorized into definite (conversion time > 14 days) or probable (conversion time 8–14 days). In depth records based analysis was undertaken for patients admitted to respiratory medicine (RM) and deceased within 28 days after conversion.

Results Out of 10485 patients admitted to the Respiratory Department at UHL, 2054 (19.6%) were COVID-19 spell positive, including 57 with probable (41) or definite HCAI (16). 23 patients (7 with definite HCAI) died within 28 days of PCR conversion (0.22%, of total admitted, 1.1% of COVID19 positive), with 21 (91%) deaths in the 2nd wave. Compared with non-COVID admissions not acquiring nosocomial infection, HCAI was significantly associated with older age (mean difference (95%CI) 11.5 (7.5–15.5) years), length of stay (median LOS 18 Vs 1 day) and multiple ward occupancy (median 3 vs 1 ward); all analyses $p < 0.001$.

Discussion Our analysis suggests HCAI with SARS-COV-2 contributed a very small fraction of COVID-19 related morbidity and mortality at our department and in the majority the trajectory of care was not changed. Despite the high numbers of highly infectious cases during the 1st and 2nd wave, we successfully implemented a suite of infection control measures that effectively mitigated risk. High throughput in admission areas, multiple ward moves, and prolonged hospital stay were significant risk factors associated with HCAI.

P110

ASSESSING COVID VACCINE RELATED SIDE-EFFECTS PROFILE AND SUBSEQUENT STAFF SICKNESS BURDEN IN HEALTHCARE WORKERS

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Introduction The COVID19 national immunisation campaign is well underway across the United Kingdom. A large study reported, side-effects from COVID vaccines are moderately frequent, commonly mild and short-lived in a community setting.¹

Objectives To examine the side-effects and staff sickness profile from COVID vaccination in healthcare workers and whether the second COVID vaccine dose (VAX2) led to worsening side-effects or sickness burden, compared to the first dose (VAX1).

Methods Self-reported questionnaire survey to 1500 consecutive healthcare workers (working for 1 NHS Trust) receiving VAX2 at a single central vaccination site from 29/03/2021 to 23/04/2021. VAX1 data was collected at the appointment and VAX2 data asked to be returned via internal mail 7 days later. Responders were asked to grade symptoms (asymptomatic, mild, moderate or severe) & step scores of 0, 1, 2 & 3 allocated correspondingly to estimate side-effect severity changes following VAX2. Data for baseline demographics & sickness burden collected.

Results The response rate for VAX1 was 81% (1213) & VAX2 was 31% (464). Matched data was available for 30% (444). There was 81% female preponderance. Median age was 51 (Range 19–74, IQR 18). Most commonly reported side-effect was injection site pain (83%) followed by fatigue (46%), muscle pain (45%), headache (41%), injection site swelling (32%), injection site redness (27%), joint pain (26%), chills (21%) & fever (17%). The frequency of side-effects was similar with no significant severity change after VAX2. Mean duration of side-effects was alike (2.2 days). 3.6% and 5.6% of responders took time (mean) off work for 3.6 and 1.4 days following VAX1 & VAX2 respectively.

Conclusions Our study demonstrated healthcare workers had moderately frequent side-effects, with no significant exacerbation after VAX2. The side-effects burden was short-lived with minimal impact on workforce during resource constrained times, which suggests future booster doses in healthcare workers should remain safe and can be pursued.

Abstract P110 Figure 1