Correlations between symptoms and outcomes of physiological tests are shown in table 1. Age ($\beta=-0.007$, $p<0.001$), male gender ($\beta=0.073$, $p=0.035$), current mMRC dyspnoea score ($\beta=-0.107$, $p<0.001$) and pain ($\beta=-0.017$, $p=0.020$) were independent predictors of 4MGS (overall model fit $R^2=0.394$, $p<0.001$). Current mMRC dyspnoea score ($\beta=-1.274$, $p=0.019$) and use of facemask O_2 as maximal inpatient respiratory support ($\beta=2.188$, $p=0.012$) were independent predictors of 1STSreps ($R^2=0.309$, $p<0.001$). Variation in $SpO_2\%$ desaturation during the 1STS was not explained by the regression model ($R^2=0.078$, $p=0.082$). **Conclusion** Respiratory symptoms were not strong predictors of 4-metre gait speed and 1-minute sit-to-stand test performance. These data highlight the importance of face-to-face testing to objectively assess functional limitation in patients recovering from severe COVID pneumonia.

P137 THE IMPACT OF ETHNICITY ON THE LONG-TERM SEQUELAE OF COVID-19: FOLLOW-UP FROM THE FIRST AND SECOND WAVES IN NORTH LONDON

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Introduction Ethnicity has been reported as a possible risk factor for SARS-CoV-2 infection, with one meta-analysis suggesting individuals from Black, Asian and other minority ethnic (BAME) backgrounds are at increased risk of infection but not necessarily severe infection or death¹. However, there is little information on whether such individuals are more likely to develop prolonged symptoms after infection or 'Long COVID'.

Methods We established a follow-up clinic to review all individuals admitted to our Trust with COVID-19 and collected data on demographics, symptom burden and mental health outcomes at 8–10 weeks post discharge. We categorised our cohort into four main groups (White, Black, Asian and Other) based on self-reported ethnicity.

Results Between 27/2/20 and 17/2/21, our Trust admitted 2217 adults with COVID-19. Ethnicity data were available for 1806 individuals; 52.9% were White, 16.3% Asian, 12.5% Black and 18.3% from Other ethnic backgrounds. 342 patients died during admission; 63.2% were White, 9.4% Asian, 11.7% Black and 15.8% from Other ethnic backgrounds. More White adults died than expected ($p<0.001$).

Follow-up was completed on 1107 of 1464 (75.6%) adults discharged. 54.5% were White, 22.8% Asian, 11.7% Black and 11.0% from Other ethnic backgrounds. Table 1 summarises key demographic, admission and follow-up symptoms. Adults from White backgrounds were older and less likely to have diabetes ($p<0.001$), while Black adults were more likely to have higher BMI, hypertension and chronic kidney disease ($p<0.002$). There was no difference in admission National Early Warning Score (NEWS2), or number of adults requiring non-invasive respiratory support and intubation.

At follow up, there was no difference between ethnic groups in terms of burden of physical or mental health symptoms, breathlessness score and ability to return to work.

Abstract P137 Table 1 Demographics, admission severity and follow-up symptoms

Variable	White N = 603	Asian N = 252	Black N = 130	Other N = 122	p-value
Age	65 ± 16.5	59 ± 15.4	59 ± 13.9	59 ± 14.7	<0.001
Male (%)	372 (62)	148 (59)	72 (55)	81 (66)	0.28
Index of deprivation*	6 (3–7)	6 (4–8)	5 (3–7)	5 (3–7)	0.03
Body mass index	27.1 (23.5–30.5)	26.0 (23.7–29.2)	28.9 (25.9–34.7)	26.7 (25.1–30.9)	<0.001
Hypertension (%)	244/583 (42)	113/247 (46)	72/125 (58)	40/119 (34)	0.001
Cardiovascular disease (%)	133/415 (32)	45/166 (27)	15/86 (17)	16/73 (22)	0.02
Diabetes (%)	122/583 (21)	80/247 (32)	45/125 (36)	40/119 (34)	<0.001
Respiratory disease (%)	124/416 (30)	39/167 (23)	21/91 (23)	16/70 (23)	0.25
Chronic kidney disease (%)	61/583 (11)	29/247 (12)	27/125 (22)	9/119 (8)	0.002
Any mental health (%)	77/583 (13)	23/247 (9)	8/125 (6)	17/119 (14)	0.08
Smoking history (%)	250/587 (43)	43/244 (18)	44/127 (35)	44/118 (37)	<0.001
Clinical frailty score	3 (2–4)	2 (2–4)	3 (2–4)	3 (2–3)	0.11
NEWS2	4 (2–6)	4.5 (3–6)	5 (3–6)	5 (3–7)	0.3
Respiratory support	80/564 (14)	47/236 (20)	23/116 (20)	21/118 (18)	0.15
Follow-up symptoms					
MRC score*	2 (1–3)	2 (1–3)	2 (1–3)	2 (1–2)	0.61
Cough improved (%)	414/553 (75)	177/232 (76)	85/118 (72)	87/113 (77)	0.8
Fatigue improved (%)	451/552 (82)	193/228 (85)	109/122 (89)	88/115 (77)	0.05
Sleep improved (%)	342/536 (64)	155/228 (68)	76/117 (65)	68/112 (61)	0.57
Burden of symptoms*	1 (0–2)	1 (0–2)	1 (0–2)	1 (0–2)	0.78
Returned to work (%)	142/256 (56)	77/139 (55)	29/64 (45)	41/71 (58)	0.45
Felt back to normal (%)	256/439 (55)	112/186 (60)	62/103 (60)	43/78 (55)	0.87
Positive PHQ-2 (depression screening)	65/580 (11)	40/242 (17)	12/126 (10)	11/116 (10)	0.09
Positive TSQ (post-traumatic stress screening)	42/601 (7)	16/248 (7)	13/130 (10)	8/122 (7)	0.6

*Non-parametric data presented as median ± interquartile range, all other data presented as mean ± standard deviation.

Discussion Our data demonstrate that despite having more comorbidities associated with worse outcomes, adults from BAME backgrounds who are discharged from hospital following COVID-19 are no more likely to experience symptoms consistent with 'Long COVID'. However, given the increased risk of infection among BAME communities, we must ensure that reducing health inequalities remain central to the UK health agenda.

REFERENCE

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