

18 **ONE PAGE USER FRIENDLY PROFORMA DELIVERS  
DRAMATIC IMPROVEMENTS IN HEART FAILURE  
MANAGEMENT IN A BUSY DISTRICT GENERAL  
HOSPITAL**

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10.1136/heartjnl-2016-309890.18

**Background** Heart failure affects almost one million people in the UK with survival rates comparable to or worse than many cancers. Recent publications of the NICOR National Heart Failure Audit have focused attention on the need for improvement. This challenge is particularly acute in busy district general hospitals in London such as Whipps Cross University Hospital.

**Objective** We aimed to investigate if the implementation of a simple one-page user friendly Whipps Cross Heart Failure Improvement Proforma- the 'WHIP form' in all medical wards could help improve the management of patients admitted with heart failure against standard quality measures.

**Methods** The 'WHIP form' was introduced and implemented in all medical wards supported with a one-day educational seminar and a new dedicated heart failure email service.

**Results** Between June to September 2015, 106 patients with a primary admission diagnosis of heart failure were enrolled and managed using the 'WHIP form'. Inpatient mortality remained stable at 11.3% with an average hospital stay of 13.5 days. The 30-day readmission rate halved from 14% to 7%. Patients with documented left ventricular systolic dysfunction on Echocardiogram had significant improvements in the prescription of prognostic medication on discharge: ACEi/ARBs prescription increased from 78% from 88% [10% improvement]. B-Blockers prescription increased from 68% to 95% [27% improvement].

**Conclusion** The initiation of an "easy to use" one page heart failure management proforma led to a dramatic reduction in 30-day readmission rates and significant increase in the prescription of prognostically important ACE inhibitors and B-blockers. If the reductions in 30-day readmissions are sustained, we estimate that our cost neutral intervention could translate to yearly savings of nearly £80K for Whipps Cross University Hospital alone.

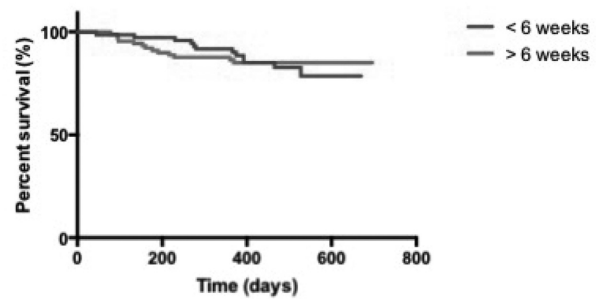
19 **TIME FROM SYMPTOMS ONSET TO DIAGNOSIS AND  
OPTIMUM THERAPY; DOES IT RELATE TO OUTCOME IN  
HEART FAILURE PATIENTS?**

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10.1136/heartjnl-2016-309890.19

**Introduction** Current National Institute of Health and Care Excellence (NICE) guideline recommendations on diagnosing heart failure (HF) in primary care include the measurement of serum natriuretic peptide concentrations (NP). NP concentrations are raised in HF related to severity. In addition to advising a referral above an 'intermediate' level (to be seen within 6 weeks), the guidelines suggest that patients with 'high' levels should be seen more urgently (within 2 weeks). This prospective service evaluation aimed to provide evidence to support this challenging requirement by exploring the impact of time

**Survival analysis of raised BNP: < 6 weeks and > 6 weeks**



**Abstract 19 Figure 1** Kaplan Meier curve showing no significant difference in mortality for patients with raised BNP seen within and after 6 weeks ( $p = 0.49$ )

from symptoms onset to diagnosis and optimum treatment on subsequent long-term mortality in patients with HF due to left ventricular systolic dysfunction (LVSD).

**Methods** We recorded date of symptom onset, referral, diagnosis and subsequent mortality in 206 patients newly diagnosed with HF due to LVSD seen in clinic following a NP test over twelve months from May 2012. The primary investigator (AW) was blinded to the NP result. Patients were initially divided into groups 'high' and 'intermediate' and then by whether they were seen within NICE-stipulated timeframes ( $n = 71$ ) or not ( $n = 109$ ). Due to a limited number of events, outcomes have been pooled using the 6 weeks cut-off. All-cause mortality was plotted on Kaplan-Meier curves and logistic regression was used to determine whether times between points on the pathway and being seen within 6 weeks featured in models including other known predictors of mortality.

**Results** After a mean follow-up time of 411 days (range (219–255 days)) 24 patients with a raised NP result had died (15%). Mean clinic visit time from the date of the blood test was 60 days (range (57–63 days)). Kaplan-Meier curves indicated no difference in mortality for patients seen within 6 weeks according to NP levels and those seen later than 6 weeks ( $p = 0.49$ ).

**Conclusion** In patients presenting to their primary care physician with symptoms possibly due to heart failure, subsequently confirmed to have LVSD, there is no difference in outcomes if they are seen within 6 weeks or not. The guideline that patients with symptoms possibly due to HF and a raised NP level should be seen within 6 weeks, has the potential to lead to great pressure on all outpatient cardiology services yet seems to have no impact on mortality. Whether hospitalisation is avoided by urgent referral remains to be assessed.

20 **FACTORS WHICH IMPACT ON MORTALITY AND  
READMISSION IN PATIENTS WITH HEART FAILURE:  
REAL WORLD LONGITUDINAL DATA**

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10.1136/heartjnl-2016-309890.20

**Background** Heart failure remains challenging to manage and treat globally. Much of the data on its prognosis stems from clinical trials, where cohorts are often younger and less sick than the groups of patients usually treated in hospitals and