

adverse events during the follow up period. Average patient travel time and distance for follow up was reduced. Hospital transport was not required for any patient. The feedback from patients was positive and based around ease of travel, length of travel and stay, and flexibility to attend.

**Conclusions and Implications** This pilot study demonstrates the feasibility and benefits of remote pacemaker monitoring from a community location. This model could be replicated in the future by other Trusts.

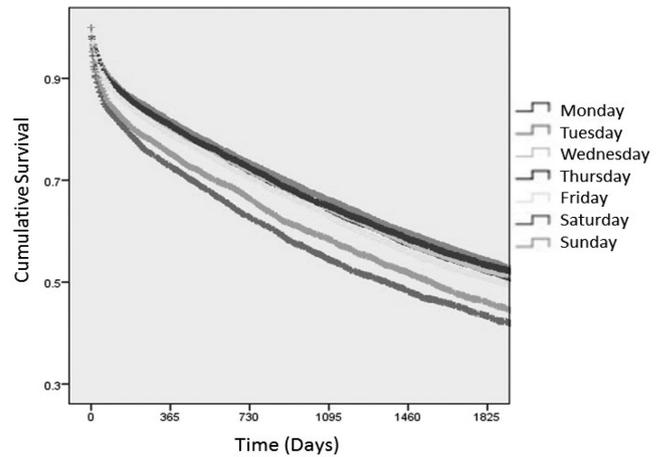
**60 PATIENTS ADMITTED TO HOSPITAL WITH A DIAGNOSIS OF ATRIAL FIBRILLATION OUTSIDE OF STANDARD WEEKDAY WORKING HOURS AND AT WEEKENDS HAVE WORSE MORTALITY AND POORER SURVIVAL**

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**Introduction** Atrial fibrillation (AF) is the most common cardiac arrhythmia and is associated with serious sequelae such as stroke and a significant mortality rate. Timely and optimal treatment of this condition can minimise these complications. There is evidence that patients with a range of conditions admitted out-of-hours (during evenings and weekends) have worse mortality compared to patient admitted during standard working hours. Mortality rates of AF patients admitted out of hours in the UK have not been previously been studied. We therefore aimed to study the impact of day and time of admission on short and long-term mortality in patients with AF.

**Methods** Anonymous data was collected from all patients with a diagnosis of AF admitted to several NHS hospitals in the



Abstract 60 Figure 1

North of England from 1<sup>st</sup> January 2000 to 31<sup>st</sup> March 2013 using the ACALM study protocol. The primary outcome of the study was “in and out of hospital mortality” within 30 days, 1 year, 5 years after the index admission.

**Results** 929,552 patients were admitted, of which 42,687 (4.6%) patients had AF. 18,732 (43.9%) of these were admitted during normal working hours (0900–1700; Monday–Friday) and 23,955 (56.1%) were admitted out of hours. Unadjusted crude mortality rates of patients admitted out of hours (539/1000) were higher than those admitted during normal working hours (489/1000). Unadjusted crude death rates of patients admitted on Saturday (588/1000) and Sunday (548/1000) were significantly higher than other days of the week (Figure 1). Cox regression analyses accounting for variations in age, gender, ethnic group and the ten most common causes of death in the UK (Listed in Table) showed that out of hours admission with AF conferred significantly worse

Abstract 60 Table 1 Demographics and comorbidities of atrial fibrillation patients

	All patients	Admitted during normal hours(0900–1700 Monday to Friday)	Admitted outside of normal working hours
Age, years ± S. D	74.2 ± 12.5	73.8 ± 12.0	74.5 ± 12.9
Male	21 891 (51.3%)	9 881 (52.7%)	12 010 (50.1%)
Female	20 796 (48.7%)	8 851 (47.3%)	11 054 (49.9%)
Ethnicity	38 052 (89.1%)	16 900 (90.2%)	21 152 (88.3%)
Caucasian	735 (1.7%)	280 (1.5%)	455 (1.9%)
South Asian	283 (0.7%)	118 (0.6%)	165 (0.7%)
Afro Caribbean	107 (0.3%)	44 (0.5%)	63 (0.3%)
Oriental	51 (0.1%)	21 (0.1%)	30 (0.1%)
Mixed	3 459 (7.2%)	1369 (7.1%)	2090 (8.7%)
Other			
IHD	13 900 (32.6%)	6 214 (33.1%)	7 686 (32.1%)
Heart Failure	10 992 (25.8%)	4 599 (24.6%)	6 393 (26.7%)
Lung Cancer	926 (2.2%)	431 (2.3%)	495 (2.1%)
Breast Cancer	810 (1.9%)	356 (1.9%)	454 (1.9%)
Colon Cancer	340 (0.8%)	170 (0.9%)	170 (0.7%)
COPD	6 379 (14.9%)	2 741 (14.6%)	3 638 (15.2%)
Pneumonia	5 414 (12.7%)	2 101 (11.2%)	3 313 (13.8%)
CVD	5 007 (11.7%)	1 934 (10.3%)	3 073 (12.8%)
CKD	4 062 (9.5%)	1 721 (9.2%)	2 341 (9.8%)
Dementia	3 570 (8.4%)	1 309 (7.0%)	2 261 (9.4%)

IHD= Ischaemic heart disease; COPD= Chronic Obstructive Pulmonary Disease; CKD= Chronic Kidney Disease; CVD= Cerebrovascular Disease

mortality (OR 1.12 (95%CI 1.09–1.15) compared to admission during normal working hours.

**Conclusions** This study suggests a higher risk of death for patients with a diagnoses of Atrial Fibrillation admitted outside of normal hours and weekends compared with standard weekday normal working hours. The impact of our findings on service provision and healthcare delivery should to be widely debated.

## 61 ANTICOAGULATION FOR ATRIAL FIBILLATION IN THE ELDERLY

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**Introduction** The incidence of atrial fibrillation (AF) increases with age and carries with it a 5 fold increased risk of having a stroke. The most effective prevention is anticoagulation yet elderly people are often viewed of as high risk and are not started on therapy. The first cycle of this audit included 166 current inpatients of the Care of the Elderly Department (COTE) in Gartnavel General hospital (GGH) aged 65 and over. Over one third (36%) of admissions had AF however only 33% of these were on anticoagulation. 11/40 (28%) of those with AF had no decision about anticoagulation recorded. All patients had a CHADSVASC score of 2 or greater so should have been considered for anticoagulation. Novel anticoagulation (NOACs) are now available as first line treatment of non-valvular atrial fibrillation accounting for 50% of those anticoagulated with the remaining 50% on Warfarin.

**Intervention** The audit findings were presented to the GGH COTE department and included the current guidelines for AF and use of NOACs. A copy of the presentation was also sent to all departmental staff via email. Information is now included in the junior doctor departmental handbook given at induction, and a section in the admission document regarding Atrial Fibrillation must be completed for each patient.

**Results** A regular audit of the COTE department in the form of Plan Do Study Act (PDSA) cycles was implemented to monitor the effectiveness. In March 2015 the first cycle after initial intervention, 60% of those with AF were receiving anticoagulation, however during April (junior doctor changeover) this fell to 23%. Further education was implemented and 50% of patients were on anticoagulation in May. There was also increasing compliance with filling in the admissions box regarding AF, rising from 39% at baseline to 71% in May.

**Discussion** All new admissions to COTE departments should be assessed for atrial fibrillation and considered for anticoagulation including use of NOACs as an alternative to warfarin. Having a section regarding AF in the admissions booklet is a useful prompt for discussion of anticoagulation.

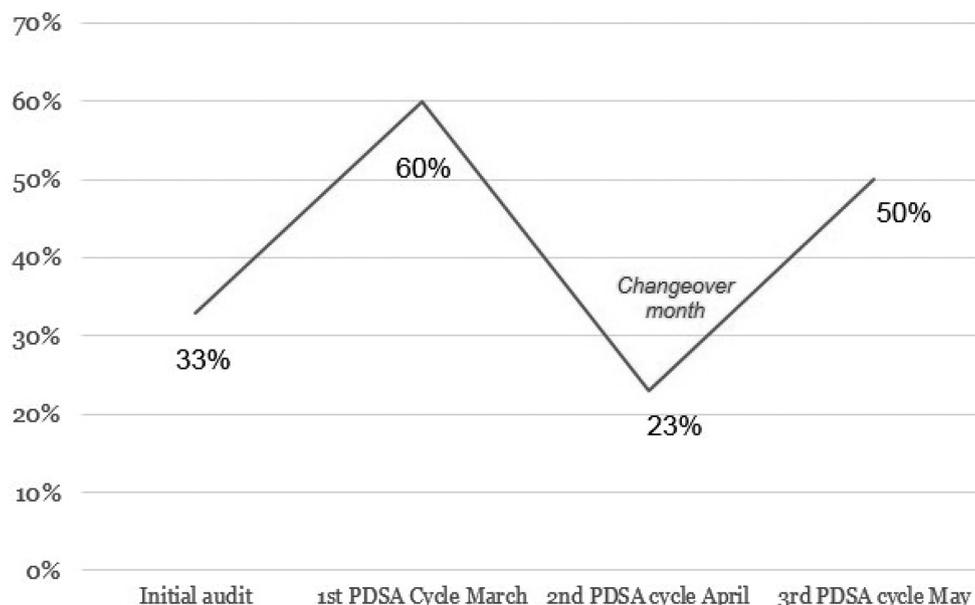
## 62 LEFT ATRIAL APPENDAGE OCCLUSION FOR STROKE PREVENTION IN ATRIAL FIBRILLATION: CONTEMPORARY EXPERIENCE FROM A COMMISSIONING THROUGH EVALUATION SITE

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**Background** Since October 2014, NHS England has approved funding for left atrial appendage occlusion (LAAO) for stroke prevention in patients with atrial fibrillation in 10 UK sites as part of Commissioning through Evaluation (CtE) process. There are no data available on contemporary LAAO practice in the CtE era.

**Methods** In July 2014, we instituted several processes to ensure compliance with stringent CtE requirements. These included creation of a multidisciplinary team (MDT) that included stroke physicians and non-invasive cardiologists with interest in cardiac imaging, agreement on objective inclusion



Abstract 61 Figure 1