patients on SGLT2 inhibitor. Average HbA1c, T2DM patients = 62.7 mmol/mol. HFrEF medication 3 classes: Beta Blockers/Angiotensin-converting-enzyme inhibitors, Angiotensin II Receptor Blockers or Sacubitril Valsartan/ Mineralocorticoid receptor antagonists. No therapy, 2 (0.62%), Monotherapy: 22 (6.85%), Dual-therapy 156 (48.60%), Triple-therapy 141 (43.93%).

Conclusion Applying DAPA HF inclusion criteria, 292 (90.97%) should be considered for introduction of SGLT2 inhibitors. Renal function isn't a significant barrier to SGLT2 inhibitor introduction. SGLT2 inhibitors aren't widely prescribed in patients with T2DM and HFrEF. Following recent NICE approval, there is scope for local and regional guidelines, directed at primary and secondary care for the prescribing of SGLT2 inhibitors in a HFrEF population.

Conflict of Interest Nil

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NHS TEST BED PROJECT: MONITORING OF HEART FAILURE PATIENTS IN THE COVID-19 PANDEMIC

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Introduction Heart failure carries a high morbidity and mortality but increasing numbers of patients are diagnosed with heart failure, with prevalence currently estimated as 26 million worldwide.¹ This better recognition of the syndrome is also compounded by the increased number of readmissions for heart failure, which carries an increased mortality risk for heart failure patients.² We evaluated: the use of NHS digital model for ambulation of heart failure patients called the NHS Test Bed project and the use of digital cardiology to follow up patients to detect early signs of deterioration, and hence prevent readmission. Its importance is recognised increasingly in the global COVID-19 pandemic to help free up inpatient beds.

Methods We initially evaluated the time involved in providing an ambulatory heart failure service compared to an inpatient admission for decompensation of heart failure. The NHS Test Bed project is a method of providing access to ambulatory services for heart failure patients and we evaluated the impact of this on admissions, focusing on Emergency Department presentations and emergency inpatient admissions.

Results We have demonstrated that an ambulatory heart failure service leads to a reduction in time caring for each patient by 4 hours and 6 minutes compared to an inpatient admission (tables 1 & 2). Our NHS Test Bed study was conducted over a two-year timeframe (inclusive of the introduction of the Combined Application System Innovation (CASI) tool to access ambulatory care services in April 2019) shows a promising linear trend with a step-by-step reduction in Emergency Department presentations for heart failure patients every month (figure 1). However, this was not statistically significant as a greater reduction was seen in the control group who did not have access to this service. The largest study of 1600 heart failure patients used telephone-based heart failure monitoring.³ This showed no reduction in mortality or hospitalisations attributed to this monitoring strategy, but this was attributed to poor adherence with only 55% of patients taking part by the six-month timepoint. The deficit in our study and others

Abstract 146 Figure 1 Representation of the NHS Test Bed data showing the effects of registering for the Combined Application System Innovation tool to access ambulatory care services (red) versus not

Abstract 146 Figure 2 Representation of the NHS Test Bed data showing the effects of registering for the Combined Application System Innovation tool to access ambulatory care services (red) versus not registering (blue) on the number of emergency hospital admissions for every 1,000 patients. Lines represent the Poisson regression model fit for the 2 cohorts

Abstract 146 Table 1 Journey of a patient admitted to hospital for heart failure decompensation in terms of hours of staff time spent looking after them

One off events	
Booked in	5 minutes
See in in A+E + BLOODS	20 minutes
Chest x-ray + porters	25 minutes
STAT furosemide	10 minutes
Transfer to AAU	15 minutes
Clerking by medical team and drugs written up, post take	1 hour
Pharmacy medicine reconciliation	20 minutes
Referral to cardio	15 minutes
Seen by cardio	30 minutes
Seen by heart failure team	30 minutes
Discharge summary	15 minutes
	4 hrs 10 minutes
Daily events	
Furosemide infusion	15 minutes/day
Daily ward rounds	10 minutes/day
Daily bloods	5 minutes/day
Weights and fluid restricting	10 minutes/day
Obs 4 hourly	12 minutes/day
	52 minutes x 3 = 156
	Multiplied by 3 as average patient stays for 3 days as per data since January 2019
Total time	6 hrs 46 minutes

Abstract 146 Table 2 Journey of a patient seen in Ambulatory Care in terms of hours of staff time spent looking after them

Each visit	
Booked in	5 minutes
Seen by Doctor and bloods taken	20 minutes
Furosemide infusion	2 hours
Discharge summary	15 minutes
Total time	2 hours 40 minutes

in demonstrating a real-world benefit could be attributed to small numbers of patients and short timeframes to evaluate impact.

The results also help convey an important safety aspect of using the CASI tool showing a 1.9-fold (95% CI: 1.25 - 2.89; p-value=0.007) increase in the number of emergency admissions for heart failure compared to prior to induction of CASI in the registered users (figure 2). This demonstrates an important triage system embedded in the NHS test bed work in being able to not just send patients to ambulatory care but also filter out patients that need more urgent review.

Conclusion It is important to appreciate the importance of an ambulatory heart failure service in freeing up NHS beds. Evaluating the NHS Test Bed project over a longer timeframe with large numbers of patients to reach statistical significance will be of vital importance to prepare for the future surges of the COVID-19 pandemic.

Conflict of Interest None

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DAILY WEIGHT AND FLUID BALANCE ASSESSMENT IN PATIENTS ADMITTED WITH ACUTE HEART FAILURE

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Introduction Associated with high morbidity and mortality, congestive heart failure (CHF) is a common consequence of numerous cardiac diseases. Close monitoring of fluid balance and daily weights in patients admitted with acute heart failure (AHF) plays a crucial role in its management and allows the therapeutic efficacy of diuretic therapy to be maximized. It's recommended by ESC guidelines that patients hospitalized due to acute heart failure should be weighed daily and have an accurate fluid balance chart completed.

Purpose To collect information on the demographic of the patients admitted, type of heart failure and underlying cause. To measure the compliance for daily weight and fluid balance assessment in patients admitted with AHF and receiving IV diuretic therapy.

Method Retrospective analysis of data on 94 patients who were admitted over 6 months period to the cardiology ward of a district general hospital with AHF and requiring intravenous diuretic therapy.

Results Average age for admissions was 76.5 year old (54% male, 46% female), and average length of admission was 4.9 days. Table 1 shows the number of patients of Heart failure with reduced ejection fraction (HFrEF) or Heart failure with

Abstract 147 Figure 1 Completion of fluid balance charts (N = 69)

Abstract 147 Figure 2

Abstract 147 Table 1

	HFrEF or HFmrEF	HFpEF
Ischaemic heart disease	17 (29%)	5 (6%)
Atrial fibrillation	8 (9%)	11 (13%)
Other arrhythmia	0	1 (1%)
Aortic valve disease	5 (6%)	5 (6%)
Mitral valve disease	2 (2%)	1 (1%)
Mixed valve disease	2 (2%)	1 (1%)
Dilated cardiomyopathy	10 (11%)	0
Hypertrophic obstructive Cardiomyopathy	0	1 (1%)
Non-compaction cardiomyopathy	1 (1%)	0
No clear cause	13 (15%)	11 (13%)
Total	58 (67%)	29 (33%)