understand its impact on HF patients and subsequently the changes that can be implemented to improve quality of care for weekend admissions.

Methods A retrospective study of consecutive admissions with HF as first diagnostic position in Blackpool Victoria Hospital from 1st August 2019 to 31st January 2021, with admission time and date recorded. Normal working hours is defined as 9am to 5pm during weekdays except UK Bank holidays. The primary endpoint was index episode mortality. Secondary endpoints were readmission within 60 days and the composite endpoint of death and readmission within 60 days of admission.

Results: 609 patients were admitted with HF. 426 of these patients were admitted on a weekday, whilst 183 were admitted on the weekend or bank holiday. There was no significant difference in baseline characteristics between the 2 cohorts [Table 1]. Thirty-eight patients (8.9%) admitted during the weekday died. By contrast, 9 of 183 (4.9%) patients admitted during the weekend or bank holiday died [p=0.099]. Significantly higher proportion of weekday admitted patients experienced the composite endpoint of death and readmission within 60 days of admission (38% vs 27%, p=0.014). Death within 60 days after admission was also significantly higher for weekday admissions [79 patients (19%) vs 21 patients (11%) (p=0.031)]. Readmission within 60 days was also significantly higher after weekday admission [108 (25%) vs 32 (17%)], p=0.037]. There is no significant difference between the 2 cohorts in appropriate use of disease modifying drugs. There is no difference in the number of echocardiogram performed within 48 hours of admission (weekday admission: n=150, 35%; weekend/bank holiday: n=65, 36%; p>0.99). If the echocardiogram was not completed within 48 hours, the median number of days it took for patients admitted on both the weekday and the weekend to get the echocardiogram was 4 days [weekday admission: 4 days, interquartile range (IQR) 4–6 days; weekend admission: 4 days, IQR 3–5 days], p=0.039].

Conclusion Survival and readmission outcomes were surprisingly better in patients who were admitted over the weekend or bank holiday vs weekday. Future multicentre studies are merited to better understand the weekend effect and its impact on the care of HF patients.

Conflict of Interest None

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Background Frailty is common in patients with chronic heart failure (CHF). Frail patients are at high risk of death which might be attributable to the presence of multiple comorbidities. The impact of comorbidities on clinical outcomes in frail patients with CHF is not well described.

Aim To study the burden and patterns of comorbidities in frail vs non-frail patients with CHF and their impact on mortality.

Methods We studied consecutive patients attending a routine follow-up visit to a HF clinic. Frailty was assessed using the Clinical Frailty Scale (CFS); those with CFS≥5 were classified as frail. Patients were classified into 6 comorbidity groups including: metabolic (obesity, diabetes); respiratory; renal; cancer; neuropsychiatric (depression, dementia); and degenerative (falls, arthritis, fragility fractures). We investigated the relation between frailty, comorbidity groups and all-cause mortality in patients with CHF.
Amongst 467 patients with CHF [67% male, median (IQR) age 76 (69–82) years, NTproBNP 1156 (469–2463) ng/L], 291 patients had HF with reduced ejection fraction (HFrEF, LVEF <40%), and 176 had HF with preserved ejection fraction (HFpEF, LVEF/C2140%). Frailty was more common in HFpEF vs HFrEF (51 vs 40%). 64% of patients had ≥5 comorbidities (36% 5–6, 21% 7–9 and 7% >9 comorbidities). Frail patients were more likely to have multiple comorbidities than non-frail patients (85% vs 48% with ≥5 comorbidities, p<0.001). The number of comorbidities increased with worsening frailty severity (Figure 1). Those with HFpEF were more likely to have neuropsychiatric, metabolic and degenerative comorbidities, whereas those with HFrEF were more likely to suffer from cancer.

During a median follow up of 554 days, 82 (18%) patients died. Increasing number of comorbidities was associated with increasing mortality. Patients who were frail with ≥5 comorbidities had a 6-fold increased risk of mortality compared to those who were neither frail nor had multiple comorbidities (figure 2). In a model adjusted for age, sex, logNTproBNP and NYHA class, amongst comorbidity groups, the presence of renal and neuropsychiatric comorbidities were independent predictors of higher mortality.

Frail patients with CHF have a high comorbidity burden. The co-existence of frailty and multiple comorbidities predisposes to higher risk of mortality. Future studies should investigate whether treatment focusing on comorbidities improve outcomes.

**Conclusion**

Frail patients with CHF have a high comorbidity burden. The co-existence of frailty and multiple comorbidities predisposes to higher risk of mortality. Future studies should investigate whether treatment focusing on comorbidities improve outcomes.

**Conflict of Interest**

none

**Introduction**

Left ventricular thrombus (LVT) is a frequent complication of left ventricular systolic dysfunction(1). Incidence following acute myocardial infarction is estimated at 13–20% and up to 15% in non-ischaemic cardiomyopathy(2, 3). Once diagnosed, guidelines recommend anticoagulation with vitamin K antagonists (VKA) to reduce the risk of stroke and systemic embolic events (Class IIa, Level of evidence C)(4). However, these recommendations are not predicated on randomised control trial (RCT) evidence but represent a consensus view based on observational data published 30 years ago(5). There have been no RCTs comparing anticoagulation therapy versus no anticoagulation. Additionally, off-label use of direct oral anticoagulants (DOACs) for LVT has steadily increased. Several fundamental questions remain unanswered; does anticoagulation reduce embolic events, how long should treatment be continued, which agent should be used and how should the diagnosis be established.

**Methods**

This population-based, cross-sectional study utilised an electronic survey using the online platform Google Forms. Questions were designed to establish how many cardiologists believe that anticoagulation is mandatory despite the lack of evidence, how often cardiac magnetic resonance imaging (CMR) is used and how frequently DOACs are prescribed. The survey was distributed via email to members of the British Society for Heart Failure, as well as to hospital email groups in multiple large centres. Completion of the survey was voluntary with no remuneration for participating. The study was exempt from formal research and ethics committee approval as no individually identifiable data was collected.

**Results**

In total 74 responses were received over a six-week period. 81% of respondents reported having routine access to CMR on site. When asked what proportion of LVT found on echo would be verified on CMR, 51% stated <50%, 20% 50–75% and 29% >75%. Regarding frequency of cases seen annually, 41% reported seeing <20 cases and 8% >60 cases. For treatment, 66% preferred VKA whilst 30% used a