provision is a known barrier, and the need for flexible models of CR has become more pronounced in the recent pandemic context. In a multicentre randomised controlled trial of the REACH-HF home-based self-management support programme for HFrEF demonstrated its clinical and cost-effectiveness. However, full understanding of its implementation is needed to inform scaled roll-out in a 'real world' NHS setting. The SCOT:REACH-HF study aimed to 1) compare outcome improvements with those identified in the RCT, 2) identify facilitators of and barriers to real-world implementation, and 3) estimate of the economic impact of implementation.

Methods We conducted a mixed-method implementation study of the delivery of REACH-HF in across NHS Scotland in 2021–22. Health professionals were trained to facilitate delivery of the 12-week programme to people with heart failure and a nominated 'caregiver' where applicable. Patient and caregiver outcomes assessed at baseline and four-month follow-up included the Minnesota Living with Heart Failure Questionnaire, EQ-5D-5L, Hospital Anxiety and Depression Scale, Health Literacy Questionnaire, and Caregiver Burden Questionnaire. Qualitative interviews were conducted with key health professionals and stakeholders, and analysis of broader contextual implementation data was also incorporated.

Results and Conclusions We recruited 136 people with HFrEF in six health board areas (NHS Ayrshire and Arran, Lanarkshire, Forth Valley, Highland, Orkney and Shetland) serving urban and rural populations. Of those, 124 completed baseline, 113 completed REACH-HF, and 99 completed 4-month follow-up. 47 participants brought caregivers into the study, with 29 of those completing the programme, and 20 completing follow-up. Semi-structured interviews were conducted with 11 trained REACH-HF facilitators, five supporting team members/managers, and four national stakeholders. We will report changes seen in patient and caregiver outcomes following participation in REACH-HF, present barriers and facilitators identified in the qualitative interviews, and discuss implications for the wider implementation and sustainability of the REACH-HF programme.

Conflict of Interest None

| 119 | WHAT ARE THE EFFECTS OF COVID-19 ON HEART FAILURE ADMISSION RATES AND MORTALITY? |

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Introduction Near the beginning of the COVID-19 pandemic, a reduction in ST elevation myocardial infarction (STEMI) presentation was reported. We hypothesise that this may lead to a substantial increase in heart failure (HF) admissions and an increase in HF mortality.

Methods Consecutive admissions with HF to Blackpool Victoria hospital were categorised into three groups: pre- COVID era (defined as 01/08/2019 to 31/01/2020), first COVID wave (01/02/2020 to 31/07/2021) and the third group is second COVID wave (01/08/2021 to 31/01/2021). Inpatient mortality was the primary end point. Patients were followed up for 60 days. Secondary end point was readmissions within 60 days.

Abstract 119 Table 1

Results There were 1178 consecutive episodes of admissions with heart failure (first diagnostic position) over 18 months. 140 inpatient deaths occurred (11.8% in-hospital mortality). Three-hundred and forty one consecutive episodes of HF admissions during the 6 months of the pre- COVID era were seen. A substantial increase in number of HF presentations was observed in the first wave (422 episodes). During the second wave, this remained high compared with the pre-COVID era- 415 episodes. In the pre-COVID era, 35/341(10%) died as inpatient. During the first wave, mortality remained 10% (41/422). However, there was statistically significant increase in mortality with the second wave, 64/415 died (15%) [p=0.036 comparing pre-COVID vs second wave; p=0.013 comparing the first and second wave]. In the pre-COVID era, 27% of patients were re-admitted within 60 days. By contrast 24% were admitted within 60 days during the first COVID wave and 19% during the second COVID wave (overall p=0.04). Post-hoc analysis showed there was significantly lower readmission between pre-COVID era and the 2nd wave. (p=0.015) [Table 1].

Conclusion The number of consecutive episodes of HF admissions has increased compared with the pre-COVID era. There were no changes in mortality between the pre-COVID era and the first wave however there was a statistically significant increase in mortality with the second wave.

Conflict of Interest None

| 120 | AUTOMATED DEVICE-HEART FAILURE AUDIT TOOLS IDENTIFY HIGH-RISK SUB-OPTIMALLY MANAGED HF PATIENTS |

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Introduction Chronic heart failure (HF) guidelines advocate that all patients with HF should undergo clinical assessment, at least 6-monthly for those who are stable, or more frequently if the clinical condition has changed. Despite this, many patients with less than optimally managed HF are not known to specialist HF services. Cardiac implantable electronic devices (CIEDs), often used in the treatment of HF can also be used to identify patients who are unstable or sub-optimally managed. The validated TriageHF algorithm in enabled CIEDs combines multi-parametric data (Table 1) to stratify patients as