

further management. CAFs are rare and could be asymptomatic. However, those with significant shunts, symptoms or complications will need surgical or percutaneous closure.

Conflict of Interest Nil

Allied Health Professionals/Nursing/Health Scientists

75 EXPERIENCE AND OUTCOME FROM A LONDON NHS TRUST HEART FAILURE VIRTUAL WARD

¹Emil Elias, ¹Trish Winn, ¹Eddison Paz, ¹Audrey Alimo, ²Chris Malone, ¹Shrawan Sharma, ¹Piers Milner, ¹Jaymin Shah. ¹London North West University Healthcare NHS Trust; ²LUSCII Healthtech, Amsterdam, Netherlands

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Introduction Virtual ward is a safe and efficient alternative to NHS bedded care that is enabled by technology and includes admission avoidance and early supported discharge. We introduced a digitally enabled nurse-led heart failure virtual ward (HFVW) in our London NHS trust in July 2021 to support early discharge, prevent avoidable admissions and enhance post-discharge care. We present a short analysis of our cohort alongside some outcomes and challenges.

Methods and Results A retrospective analysis of consecutive patients (n=1041) admitted with presumed diagnosis of heart failure was conducted from 16/11/21 to 01/09/22. Patients with a confirmed diagnosis of heart failure (symptoms/signs, abnormal BNP, and an abnormal echocardiogram – 542 (52.1%)) were considered eligible for the HFVW. The heart failure nursing (HFN) team was responsible for the identification, recruitment, and optimisation of therapies. Daily HFN review of patient symptoms and observations were undertaken through a dedicated smart device app (LUSCII Healthtech, Netherlands). 102/542 patients (18.8%, mean age 61.7 ± 14.3 years, 73 (71.6%) males, 39 (38.2%) with 3 or more co-morbidity, 93 (91.2%) heart failure with reduced ejection fraction (HFrEF)) were recruited to the HFVW. Of those not recruited, 174 (32.1%) patients had no access to a smart device or were unable to use one. 152 (28.0%) were too frail or with a language barrier. 12 (2.2%) declined recruitment. The mean time to recruit a patient was 22.2 ± 7.1 minutes. The mean duration on the HFVW was 11.7 ± 6.2 weeks. All patients had weekly medical optimisation reviews. 21/93 (22.6%) of the patients with HFrEF at recruitment were on 4 pillars prognostic therapy, on discharge, this improved to 48 (51.6%, p < 0.001). 5 (4.9%) withdrew consent after recruitment. 3 (2.3%) deaths were documented whilst on the HFVW. One died with sudden cardiac death from VF despite CRTD device therapies. A second died of ruptured aortic aneurysm. The third due to flash pulmonary oedema. There have been 3 (2.9%) readmissions due to heart failure decompensation. For the 102 patients recruited to the HFVW an analysis of traditional hospital resource utilisation demonstrates a reduction in in-patient bed days (mean reduction of 7.7 days, 95% CI 5.3, 10.0; p < 0.001) and a reduction in ED attendances (mean

reduction 1.3, 95% CI 1.0, 1.7, p < 0.001) in 6 months prior to recruitment to the HFVW compared to after.

Conclusion HFVW provides an exciting opportunity to successfully optimise heart failure patients in the community. Our

findings indicate a reduction in traditional resource utilisation with better patient outcomes; however, a significant number of patients still cannot be supported through this innovative model. We concluded that digital poverty and digital exclusion remains a significant barrier in providing equitable care and in achieving the full potential of this model of care.

Conflict of Interest None

76 THE IMPACT OF A NOVEL ADVANCED CLINICAL PRACTITIONER (ACP) - PHYSICIAN HYBRID CLINIC MODEL ON SPECIALIST CARDIOLOGY OUTPATIENT CLINIC SERVICES WITHIN A BUSY TERTIARY CARDIAC CENTRE AND HOW IT COMPARES TO THE TRADITIONAL PHYSICIAN-LED MODEL

¹Aleksandar Dimitrov, ¹Shouvik Haldar, ²Vasileios Panoulas, ¹Radoslaw Pracon, ¹Athanasios Moulis. ¹Royal Brompton and Harefield Hospitals, part of Guy's and St Thomas' NHS Foundation Trust, London; ²RBHT

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Introduction Advanced Clinical Practice (ACP) is an established structured university training programme available to registered non-medical healthcare professionals preparing them to safely manage clinical patient care incorporating complex clinical decisions and high degree of autonomy.

Aim To assess the service impact, safety and efficiency of a clinical cardiology pharmacist with ACP training providing a sustainable, holistic and independent clinical care to non-pre-defined cohort of patient within a consultant-led cardiology clinic environment.

Methods A pharmacist-prescriber undertaking ACP course within a tertiary cardiac centre autonomously reviewed randomly selected patients, face-to-face or virtually, in two consultant-led outpatient cardiology clinics, interventional and heart rhythm clinic, twice weekly over 12-month period. Clinical examination, diagnostic skills and IRMER training were completed prior to commencing. Data was collected from each clinic capturing number of patients reviewed, time spent per patient and consultation outcomes. Clinical decisions made for every patient were timely discussed with the relevant consultant to assess the safety of this service concept.

Results A total of 358 patients were reviewed: 217 (60.6%) in the heart rhythm and 141 (39.4%) in the interventional cardiology clinic, 86 (24%) were newly referred, 196 (54.7%) were routine follow-up patients and 76 (21.3%) were booked for their first post-intervention cardiology outpatient review.

Mean number of patients reviewed per clinic was 6.03 (+/- 1.63) with 17.7 (+/- 2.4) minutes spent per patient. Outcome data revealed 227 (63.4%) had further diagnostic tests organised, 127 (35.5%) had their medications optimised, 63 (17.6%) were discharged, 44 (12.3%) patients were referred to a different specialist and 38 (10.6%) were referred for elective cardiac intervention e.g. coronary angiography, DCCV, or catheter ablation. No patients were admitted to hospital directly from clinic. 16 patients (4.5%) had their plan changed following consultant oversight safety discussion.

Over the 12-month period ACP total discharge rate was 14.3% compared to 14.7% (p=0.88) by consultant, in the heart rhythm clinic and 22.7% compared to 50% (p<0.01) by consultant and 27.9% (p=0.32) by other senior cardiology specialist physicians, in the interventional cardiology clinic. Average clinic capacity increased by 26% (p<0.01) and 8.7% (p<0.01) respectively compared to the preceding year.