matters" from patients' and caregivers' perspective are illustrated in Figure 1.

Regular follow up and access to primary care were cited most frequently by caregivers (53%) as a component of good healthcare system. Interestingly, for patients, being actively involved in their own care was considered the most important driver of quality healthcare (i.e., patient-centred care). Education about disease was also emphasised as an integral aspect by both patients and carers. Several caregivers regarded the use of age-appropriate technology as another important element of good healthcare for this group of patients. (Figure 2).

Conclusion Older patients with CHF and frailty have unique personal values and would like to be actively engaged in the management of their own health. Asking patients "what matters?" along with "what is the matter?" will provide clinicians insights into the patients' priorities and preferences, the integration of which is the hallmark of patient-centred care.

Conflict of Interest None

| 130 | THE TRAJECTORY OF NUTRITION STATUS AND ITS ASSOCIATION WITH CLINICAL OUTCOMES AND QUALITY OF LIFE IN PATIENTS WITH HEART FAILURE |

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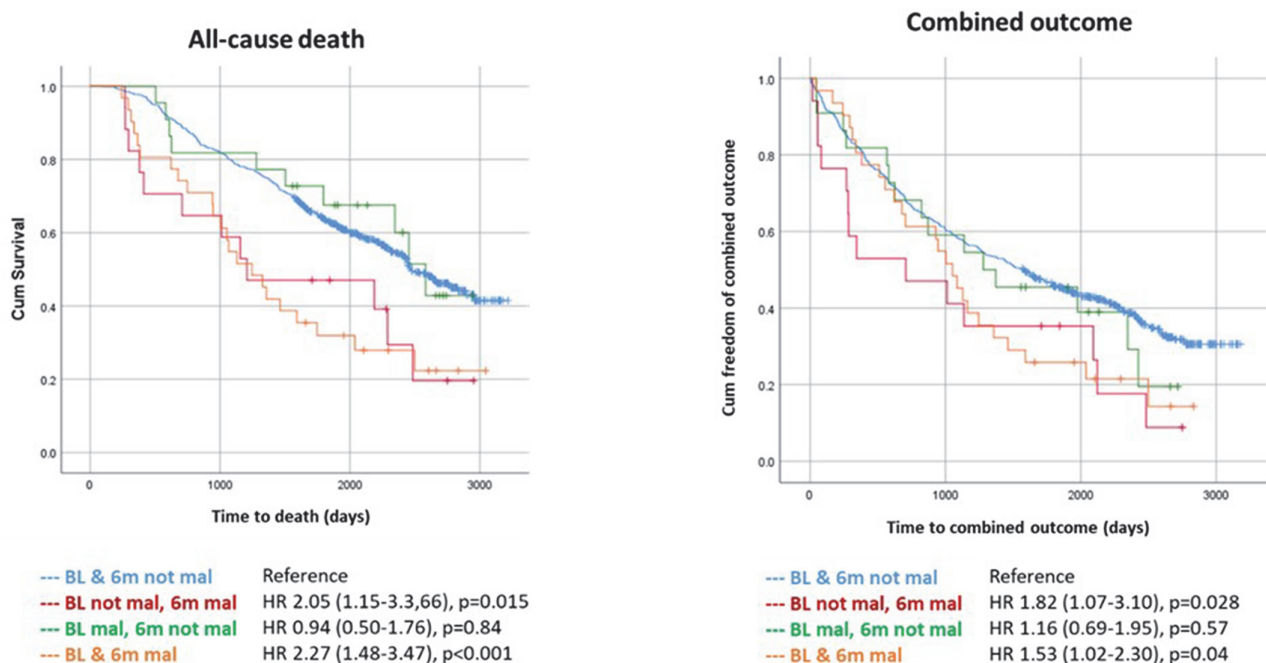
Background Malnutrition is common in patients with heart failure (HF) and is associated with adverse outcome. However, it is uncertain whether changes in nutrition status over time relate to clinical outcomes and quality of life (QoL) in patients with HF.

Objectives To evaluate the change in nutrition status between baseline visit and 6-month follow up and its impact on all-cause mortality, HF hospitalisation and QoL in patients with HF.

Methods This is a prospective longitudinal study of adults with HF from New Zealand. Patients were recruited either during a HF hospitalisation following stabilisation or from an outpatient setting within 6 months of an episode of decompensated HF. Malnutrition was determined using the geriatric nutritional risk index (GNRI) = [1.489 x albumin (g/L)] + [41.7 x current weight/ ideal weight]. Patients were malnourished if GNRI was ≤ 98. To evaluate the change in nutritional status, we stratified patients into 4 groups: Normal nutritional status at baseline & 6 month (A); normal at baseline, malnourished at 6 month (B); malnourished at baseline, normal at 6 month (C); malnourished at baseline and 6 month (D). The primary outcome was all-cause death. Secondary outcomes were death/ HF hospitalisation and QoL determined using the Minnesota living with HF questionnaire (MLHFQ).

Results 654 patients (72% male, median age 71 years, median NT-proBNP 1641 ng/L, 49% LVEF<40%) were enrolled. 53 (8%) patients were malnourished at baseline and 48 (7%) patients were malnourished at 6 months. Regarding change in

Figure 1: Kaplan Meier curve showing the relation between change in nutrition status and all-cause death and combined outcome.

--- BL & 6m not mal	Reference	
--- BL not mal, 6m mal	HR 2.05 (1.15-3,66), p=0.015	
--- BL mal, 6m not mal	HR 0.94 (0.50-1.76), p=0.84	
--- BL & 6m mal	HR 2.27 (1.48-3.47), p<0.001	

--- BL & 6m not mal	Reference	
--- BL not mal, 6m mal	HR 1.82 (1.07-3.10), p=0.028	
--- BL mal, 6m not mal	HR 1.16 (0.69-1.95), p=0.57	
--- BL & 6m mal	HR 1.53 (1.02-2.30), p=0.04	

Abstract 130 Figure 1 Kaplan Meier curve showing the relation between change in nutrition status and all-cause death and combined outcome

Figure 2: Change in nutritional status and change in QoL status determined by the MLHFQ (baseline vs 6 month).
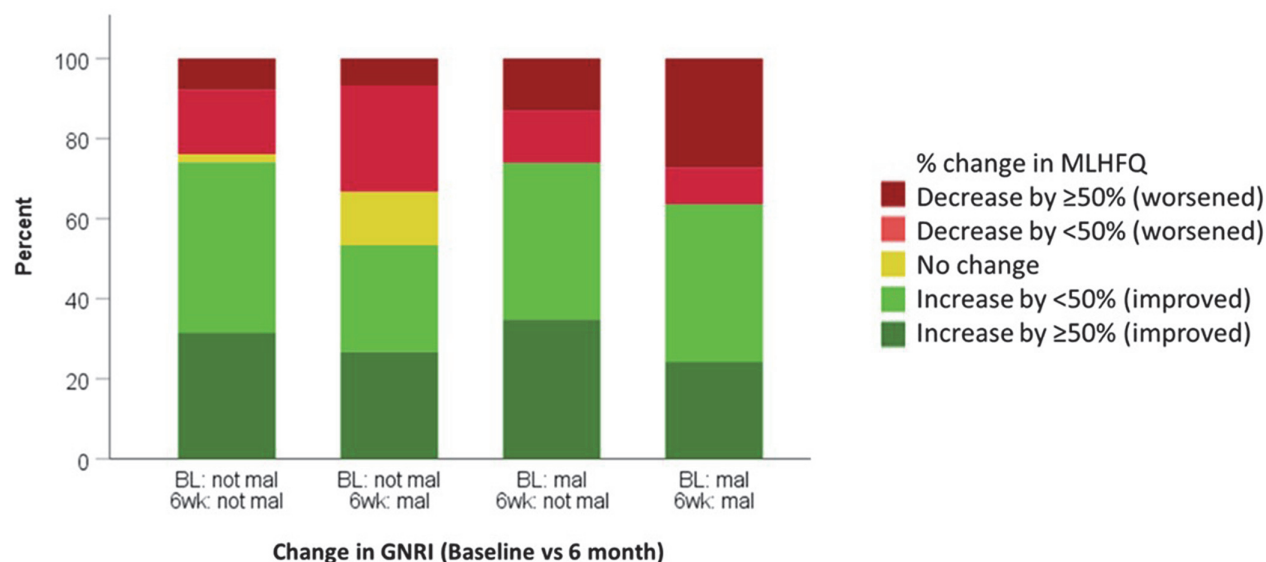
Abstract 130 Figure 2 Change in nutritional status and change in QoL status determined by the MLHFQ (baseline vs 6 month)

nutritional status at baseline & 6 months, 89% (N=584) were stratified into A, 3% (N=17) B, 3% (N=22) C and 5% (N=31) D. Amongst the 4 groups, patients in D were the oldest (median age 84 years), with worst HF (median NTproBNP 3628 ng/L).

During 4 years of follow up, 198 (30%) patients died and 419 (64%) patients had either a HF hospitalization or died. Compared to patients in A, those in B and D had a two-fold increased risk of death and combined outcome (Figure 1) with worse QoL (Figure 2).

A base model for predicting mortality at 1 year including age, NYHA class, log [NT-proBNP], ischaemic aetiology and systolic blood pressure had a C-statistic of 0.80. Addition of change in nutritional status at baseline and 6 months improved the performance of the base model in predicting mortality (C-stat = 0.83, p=0.01).

Conclusion Persistent malnutrition or subsequent development of malnutrition during follow up was associated with increased risk of mortality, HF hospitalisation as well as worse QoL in patients with HF. Future studies should evaluate the effectiveness of interventions targeting nutritional status in improving clinical outcomes in patients with HF.

Conflict of Interest none

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131   **RACIAL DIFFERENCES IN QUALITY OF CARE AND LONG-TERM OUTCOMES FOR PATIENTS ADMITTED WITH HEART FAILURE**

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Background Addressing racial differences in care delivery is one of the current challenges in the diagnosis and treatment of patients with Heart Failure (HF). Compared to Caucasians, patients from minority racial groups with HF and reduced Ejection Fraction (HFrEF) are less likely to receive evidence-based, medical, device or advanced therapies. However, there is a lack of contemporary, nationwide data on racial differences in in-hospital quality of care and long-term outcomes for patients with HFrEF. This analysis aims to investigate racial disparities in the quality of care and long-term outcomes of patients with HFrEF in the UK

Methods We used linked, routinely collected data from 3 large national UK registries (the National Heart Failure Audit, Hospital Episode Statistics, and the Office for National Statistics) from 2020 to 2022 to investigate care and outcomes for patients with HF. We compared clinical characteristics and long-term events of interest according to self-reported race. A multivariable Cox proportional hazard model was performed adjusting for age, sex, comorbidity profile and clinical characteristics at admission.

Results A total of 59,727 patients with HFrEF were analysed. At admission, white patients were generally older compared to other ethnicities (79 years [IQR 69;86] for white, 67 years [IQR 56;82] for black, 73 years [IQR 63;82] for Asians, 76 years [IQR 64;85] for mixed race and 73 years [IQR 60;83] for other races, p<0.001). Overall, approximately two-thirds of patients were men (64%, n=38,432), 78% (n=44,425) were admitted in NYHA class III or IV, and approximately half of the patients (49%, n=27,731) presented with moderate to severe peripheral oedema, without clinically meaningful differences between races. In-hospital care was similar between races, as were rates of guideline-recommended medications at discharge (70%, n=36,913 for renin-angiotensin-aldosterone