Prevention of Strokes related to Atrial Fibrillation – Appendix 1

Case finding and Annual Review of patients with Atrial Fibrillation

NHS Hull CCG and PCNs

Colleagues

As you know funding has been agreed for the provision of opportunistic screening for AF for PCNs and CHCP. A second element of the funding has also been agreed to support practices in an annual review process optimising assessment and management, this is based on standards in the consensus statement of the European Society of Cardiology (ESC) 2020. This paper discusses the options for progressing these initiatives and provides some basis for PCN debate on how best to deliver optimal outcomes.

Case finding

The provision of devices to screen for AF is the beginning of a challenge for practices and community service providers, research shows that some areas have had great success and others have shown little impact. It is so important systems develop that manage to maintain enthusiasm and commitment, AF is not as common as some other Cardiac conditions, it will be necessary for example to check the pulse of around 50 0ver 65yr olds to find one in AF. Over time the screening process should become a part of routine care, practices may want to develop health checks and systems close to the waiting room for patients to interact with prior to seeing the health care worker, practice teams can experiment to see what is most efficient for them and PCNs can disseminate best practice.

Annual review

Hull PCNs will understand best how to deliver the annual review process to their patients . this paper summarises evidence and discusses the various elements of the annual review which are important, this is as you will see much more comprehensive than the QOF process.

The reasons for allocating funding to this are based on research over several years suggesting that a significant number of patients are not optimally managed , the GRASP AF study in 2017 suggesting that up to 40 % of patients on AF registers were not optimally managed , the current figure is likely to be considerably less now that DOACs are established as first line treatment for many , more recent studies suggest the figure is 5-10 % . assuming Hull AF registers approach 2000 patients in the coming years this could mean up to 200 patients not on optimal treatment . One in 20 patients not on adequate therapy will have an AF stroke each year. Given demographic changes over the coming 10 to 20 years, prevalence of AF is set to rise towards 4 % . This could increase AF stroke incidence to 150-200 per year , each stroke costing 100k over the ensuing 3 years (an annual bill of up to £20 million). This is why healthcare systems need to be ahead of the curve in identifying patients and optimising management.

A Comprehensive Annual Review

The elements of a comprehensive annual assessment are based on evidence in the ECS statement , accompanying this letter is a summary of the evidence that is relevant to Primary Care. There are a

number of ways in which this could be provided including appointment of part time Pharmacist/AHP/Specialist nurse to provide the service for all practices or a more localised solution designed by the PCNs.

The recommended elements of the annual review are summarised below with further information in the EHRA documents provided and attempt to address the common causes of suboptimal management.

Common factors in suboptimal management

Reluctance to prescribe DOAC to patients on Aspirin leading to the use of aspirin alone

Stopping of DOAC /Warfarin after fall (s)

Not restarting DOAC after treated GI or other bleeding episode

Inadequate overall rate control in AF leading to atrial remodelling and heart failure

Difficulty defining and managing Hypertension in AF

Reduction of DOAC doses after falls or in patients with mild/moderate renal impairment (reduced doses will increase stroke risk - see attached guidance notes).

Poor concordance and possible underlying cognitive decline

Warfarin patients with TTR less than 70%

This list is not meant in any way as a criticism of current care but simply a reflection of the evidence and of the complexity and level of detail required to ensure optimal management of AF patients. The detailed annual review is designed to address this and could be conducted by GP, Pharmacists and or Nurse /AHP with a special interest, a decision for the PCNs to work through.

Summary of the key elements in the annual review

Date of diagnosis

Pulse rate , BP , Hypertension and need for treatment

Medication Concordance based on computer records and patient history

Cognitive function and support network for medication compliance , mental health problems

Review of Renal and Hepatic function

Adequate DOAC dosage in relation to renal function

Symptoms and ERHA Symptom Score – (see attached guidance on symptom scoring) are symptoms controlled ,improving or getting worse.

Substrate assessment (has the patient had an echocardiogram -see notes later)

Warfarin patients Concordance and Time in Therapeutic Range >70% , frequency and stability of INR tests.

Presence of Anaemia

Previous AF burden on Holter monitor

Discussion of patient self monitoring (Kardia Mobile or Fibricheck Apps if relevant)

Assessment of Heart failure signs/symptom / need for NT Pro BNP test

Falls -history , nature , severity

It is anticipated this review will take 30 minutes and that there will be 1800-2000 reviews for Hull patients throughout the year. The logistics of this will require further discussion and agreement at PCN level but the funding allocated (60k) should cover the Human resource implications of around 0.6 WTE staff at a senior level.

Future challenges

European Cardiology Society use the curious concept of 'assessment of substrate' as part of initial and ongoing care. Substrate is a word designed to describe the form/function of the heart. This is a piece of the jigsaw that our local Primary healthcare system and annual review doesn't yet address. This word substrate refers to assessing the function of the heart and the impact of ongoing comorbidities and answers the questions – is this patient developing atrial enlargement or Heart failure? Do they require specialist review or intervention?

As an interim measure NT Pro BNP might provide some indication but the implication for new patients and those with changing symptoms is that an Echocardiogram should be part of initial assessment or reassessment for some patients .

Developments in community based investigations may address that issue in the future if optimal care is to be provided in a Primary care setting.

PCNs will need to arrive at a plan to deliver continued motivation for screening and case finding and to ensure skills and knowledge are in place to deliver a comprehensive annual review and ensure systems are optimal to address reducing stroke risk against a backdrop of rising prevalence.

Performance Monitoring and Indicators

Case finding

It is central to the success of Stroke prevention in this cohort that pulse checking using Alivecor or Watch BP devices is integrated into routine care for the over 65s and over 60s with comorbidities.

The PCN will need to consider and define what constitutes success

There is an established Algorithm for Primary care clinical systems which is used in some East Riding practices which interrogates the notes against three criteria as the records are opened

- Patient Age (over 60 or over 65 PCNs to discuss)

- No Pulse check within 6 months (important to code this or the alert will come up every time the notes are opened)

- A qualifying criteria in the CHADS VASC list (CHF Diabetes Hypertension etc)

If the three criteria are met there is a prompt to the health professional to check the pulse or if not appropriate at that time to arrange a pulse check. This may be something that the PCNs wish to consider

The recommendations above set out the standards for annual review. PCNs will need to agree a system for monitoring /reporting this to ensure that best use is made of the resources and to support the case for ongoing funding in terms of patient benefit and cost effectiveness.

The benefit of having specific AHP/Nurse and/or Pharmacist roles across all PCNs is that the data would be collated and provided by those appointed rather than being a task for each practice as well as developing specialised knowledge and skills , the Arrhythmia Alliance website provides some support for professionals with an interest in AF. Conversely staff from individual practices may have existing knowledge understanding and confidence of the patient.

There is an opportunity now for the PCNs to agree and plan for an optimal system of care to include collection on outcome data in time for patients returning to surgeries. As well as a reduction in illness for patients with AF there are significant cost savings a proportion of which the CCG can negotiate reinvesting in PCN service developments .

Dr Mark Hancocks on behalf of NHS Hull CCG

See attached summary of relevant European Cardiology Society evidence and guidance