Improving the detection and management of Atrial Fibrillation in Primary Care

Good Practice Guide
Improving the detection and management of Atrial Fibrillation in Primary Care

Good Practice Guide

Version number: 2

First published: 9th May 2014

Updated: 24th July 2014

Prepared by:

Sharon Adams    sharon.adams1@nhs.net
James Gillies   james.gillies1@nhs.net
Cecily Hollingworth  cecily.hollingworth@nhs.net

West Midlands Strategic Clinical Network and Senate
Contents

Contents .......................................................................................................................... 3
1 Introduction .................................................................................................................. 4
2 Improvement approaches ............................................................................................ 5
3 Case studies for improvement .................................................................................... 7
   3.1 Improve identification of patients with AF in primary care ................................. 7
      3.1.1 Pulse checks in flu clinics ............................................................................. 7
      3.1.2 Care homes – ‘can you feel it?’ .................................................................. 7
      3.1.3 Chronic disease clinics .............................................................................. 7
      3.1.4 Blood pressure machines ........................................................................... 8
   3.2 Improve detection of high risk AF patients ......................................................... 8
      3.2.1 GRASP-AF tool ............................................................................................ 8
   3.3 Improve management of high risk AF patients .................................................. 9
      3.3.1 INR clinics .................................................................................................. 9
      3.3.2 Performance data to drive improvement ..................................................... 9
      3.3.3 Use of NOACs over Warfarin .................................................................... 9
   3.4 Whole system approach to the management of AF ........................................... 10
      3.4.1 Using levers and initiatives to embed stroke prevention ............................ 10
      3.4.2 AFFinity: combining multiple approaches to improve AF detection and
management ................................................................................................................ 10
1 Introduction

This document has been written as part of the wider West Midlands Strategic Clinical Network project on improving the detection and management of Atrial Fibrillation in primary care. The aim of this document is to highlight different models that have helped address the challenge of improving the detection and management of AF in certain localities; these will hopefully provide a useful springboard for further discussions of the challenge for your specific population.

The case studies highlighted are from services within the West Midlands and beyond.

Sources are drawn from the Heart and Stroke Improvement work undertaken by NHS Improvement and specifically their case study report: Atrial Fibrillation in primary care: making an impact on stroke prevention. National priority project final summaries, October 2009.


There is also reference to Commissioning for Stroke Prevention in Primary Care – the role of Atrial Fibrillation (NHS Improvement, 2009)

http://www.nhsiq.nhs.uk/media/2335814/af_commissioning_guide.pdf

This report is not intended to provide full details on each of the case studies highlighted, but instead provides an overview of the approaches used and signposts the reader to further sources of information. This may be to the reports identified above or to other NHS colleagues.
## 2 Improvement approaches

<table>
<thead>
<tr>
<th>Challenge</th>
<th>Measure (QOF 2012/13)</th>
<th>Target(s)</th>
<th>Approaches</th>
</tr>
</thead>
</table>
| Using data to drive improvement | QOF AF1, AF5 and AF7 | 2% prevalence  
100% assessed using CHADS2  
85% of high risk patients on Oral Anticoagulant (OAC) | Generate reports using QOF data (possibly linking into HES data), to include:  
- Predicted AF prevalence based on the age profile of each practice  
- Monitor actual practice prevalence against predicted  
- Monitor % of high risk patients managed with OAC within each practice  
With the anticipated outcomes of  
- Reduction in number of patients diagnosed with AF stroke on hospital admission who have not been diagnosed previously as being at risk AF (SSNAP)  
- Reduction in the number of patients admitted with AF stroke on hospital admission who are not on anticoagulation therapy (SSNAP)  
2013/14 AF/stroke prevention reports could be developed by your CSU as an update to the 2012/13 CCG QOF reports produced by the SCN. |
| Improve identification of patients with AF in primary care | QOF AF1 | Use 2% or predict AF prevalence based on age profile of each practice | Pulse Checks as part of NHS Health Checks  
Opportunistic pulse testing for over 65’s  
- Pulse check and heart rhythm as added to GP templates as well as Practice Nurse visits and chronic disease clinics  
- In sessional Flu Clinics  
- Care homes (see ‘Can you feel it?’ case study below)  
- Community pharmacy/ pharmacist engagement  
- Use of blood pressure machine during routine consultations (see Erewash case study below) |
<table>
<thead>
<tr>
<th>Challenge</th>
<th>Measure (QOF 2012/13)</th>
<th>Target (s)</th>
<th>Approaches</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improve detection of high risk AF patients</td>
<td>QOF AF5</td>
<td>100%</td>
<td>Monitor % of patients on AF register at practice level that have been risk assessed using CHADS2. However, this will not be recorded via QOF in 2014/15</td>
</tr>
<tr>
<td>Case finding of high risk AF patients</td>
<td></td>
<td></td>
<td>- GRASP-AF or similar IT search facility that identifies patients with an AF diagnosis and automatically calculates CHADS2 and CHA2DS2-VASc score for each patient</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Commercial options <em>(pharmaceutical companies)</em></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- AF/INR nurse reviewing existing registers</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Community pharmacists reviewing existing registers</td>
</tr>
<tr>
<td>Improve management of high risk AF patients</td>
<td>QOF AF7</td>
<td>85%</td>
<td>Monitor % of high risk patients managed with OAC and query any patients not prescribed an OAC or any exception reporting. Can be done by INR/AF nurses/ community pharmacists</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Use of GRASP-AF risk stratification tool</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Education sessions for GP’s. <em>(Bleeding risk vs stroke risk on Warfarin, use of the new anticoagulation drugs)</em></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Education sessions for patients/ carers <em>(particularly useful for tackling numbers of patients declining warfarin)</em> Nurse led service helps as they are able to spend time on educating the patients so that an informed decision is made by the patient</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Processes to support the GP’s decision to use anticoagulants <em>(Stoke model)</em></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Access to ECG assessment</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- INR (Warfarin clinics) arrangements <em>(see Wolverhampton INR clinic case study)</em></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- APODI clinics</td>
</tr>
</tbody>
</table>
3 Case studies for improvement

3.1 Improve identification of patients with AF in primary care

3.1.1 Pulse checks in flu clinics

The most effective way to diagnose AF is through a simple pulse check and many surgeries now use their flu clinics as a way to target the over 65 population and carry out a pulse check while they attend the surgery for their flu vaccination. The checks can be carried out by practice nurses, health care assistants or a trained and competent receptionist. A protocol needs to be in place to ensure that those with an irregular heartbeat are followed up quickly and appropriately, and that clear and appropriate information is available to the patient.


The following link is to a research paper regarding opportunistic testing in Influenza clinics.


3.1.2 Care homes – ‘can you feel it?’

In 2009, Telford and Wrekin Primary Care Trust identified care homes with high ambulance and A & E attendances, many of which were due to falls. This population were targeted for detecting AF and reducing the number of falls (a known cause) through the following methods:

- A highly qualified district nurse, i.e. case manager, visited care homes during the week to monitor/observe residents, detect early signs/symptoms of illness and commence treatment, if required, or referred to their GP
- A RCN-accredited training programme was developed and provided to care workers with the aim of reducing ambulance call outs, reducing hospital admissions, empowering care home staff and developing a more proactive approach to the management of illness
- A train the trainer package and an e-learning package was developed

Karen George, Clinical Nurse Advisor, Shropshire Community Health NHS Trust Karen.george@shropcom.nhs.uk

3.1.3 Chronic disease clinics

Pulse checks can be carried out in chronic disease/long term condition annual checks or reviews. Existing templates can be amended so that codes for ‘pulse check carried out’ and the result can be recorded. It would also be good practice to ensure that a protocol exists for the next steps and that the fact that this process has started is recorded in the patient paper and/or electronic records.
3.1.4 Blood pressure machines

Erewash CCG in Derbyshire trialled a blood pressure machine in one of their practices between June 2012 and January 2013 as part of their wider AF Detection Programme and found additional diagnostic accuracy with a number of patients being identified with AF where fibrillation could not be detected with a pulse check.

NICE medical technologies guidance MTG13 recommended the WatchBP Home A machine in January 2013 for opportunistically detecting atrial fibrillation during the measurement of blood pressure by primary care professionals www.nice.org.uk/guidance/MTG13/chapter/1-recommendations.

Helen Rose, Head of Membership Development, NHS Erewash CCG helen.rose@erewashccg.nhs.uk

3.2 Improve detection of high risk AF patients

3.2.1 GRASP-AF tool

GRASP-AF is a free-to-download audit tool for use with all GP clinical systems in England and should be used as part of a systematic approach to the identification, diagnosis and optimal management of patients with AF to reduce their risk of stroke.

The GRASP-AF tool will apply a stroke risk stratification score to AF patients and identify those with AF at a high risk of stroke and not currently on oral anticoagulation therapy.

The tool works in the following ways:
- Identifies patients with atrial fibrillation
- Searches for co-morbidities and works out both a CHADS2 and CHA2DS2-VASc score
- Searches for current medication – warfarin, aspirin or newer (novel) anticoagulant (NOAC)
- Searches for recorded reason for NOT treating with warfarin
- Gives a simple alert for those at high risk and not on warfarin or newer oral anticoagulant

The tool does not assess contra-indications to Warfarin/ NOAC, the decision whether or not to start Warfarin/ NOAC remains a clinical one.

The output from the GRASP-AF tool can be viewed as an Excel spreadsheet as well as summary information that will show the number of patients at risk of stroke in the next twelve months if not optimally treated.

More information on the GRASP-AF can be found here:
3.3 Improve management of high risk AF patients

3.3.1 INR clinics

Wolverhampton GP practices were experiencing an 11 week wait for their patients to start warfarin in the INR clinics, which was being exacerbated by a steady increase in demand. A review of anticoagulation pathways by a cross-cutting group representing the CCG, GPs and secondary care led to a redesign of pathways and further clarity regarding the appropriate prescribing of OACs for AF patients.

Dr M.S. Kainth, GP, Primrose Lane Surgery via anjali.dave@nhs.net

3.3.2 Performance data to drive improvement

With more than 30% of medium/high risk AF patients in Bradford not on anticoagulation, Dr Matt Fay (GP) and Mr Greg Fell (Consultant in Public Health) worked with a team to develop two indicators to measure improvement in the management of AF. The first indicator aimed to ensure 70% of ‘high risk’ AF patient received anticoagulation and the second aimed for 80% of those patients achieving an INR in range. Data relating to the achievement of these indicators was extracted and published so that participating practices could see all other practice achievement. Ten evidence based strategies were used to encourage and incentivise achievement, including training for practitioners. This resulted in 714 additional patients on warfarin (31% relative improvement) within 18 months (65% of high risk patients) and 74% achieved an INR in range.

Mr Greg Fell, Consultant in Public Health, Bradford Metropolitan District Council greg.fell@bradford.gov.uk

3.3.3 Use of NOACs over Warfarin

In Somerset, Ian Evans, a Nurse Consultant, initiated a work programme with the CCG to improve the management of patients with AF, having worked in a rehabilitation unit and seen the impact of non-diagnosed or poorly managed AF. They ran a pilot with six practices where they used GRASP-AF to identify high risk patients and then ran a clinic to discuss AF and their treatment. Overall 30-40% of high risk patients were not on anticoagulants; now the vast majority are on NOACs. As part of this programme, Ian also ran education sessions for patients and clinicians.

Ian Evans, Consultant Nurse for Stroke, Somerset Partnership NHS Foundation Trust ian.evans@sompar.nhs.uk
3.4 Whole system approach to the management of AF

3.4.1 Using levers and initiatives to embed stroke prevention

In Dudley there has been a whole-system approach to addressing the challenge of AF and stroke prevention, initially through the development of an AF pathway and a local enhanced service in 2011, utilising GRASP-AF (outlined above). In response to an apparent decline in engagement and quality during 2012/13, incentive schemes were then developed with AF included in the practice-based pharmacy team work plans, a data quality LES developed and inclusion in the QOF QP indicators. Clinical leadership, GP education, the development of an anticoagulation steering group, weekly updates and constant reinforcement led to an increase in the AF register during 2013/14 with prevalence increasing by 5.21% (1.92% to 2.02%) and 130 patients commenced on an anticoagulant (33% on warfarin and 67% on a NOAC).

Joanne Gutteridge, Commissioning Manager Preventative Care, Dudley CCG
Joanne.Gutteridge@dudleyccg.nhs.uk

3.4.2 AFfinity: combining multiple approaches to improve AF detection and management

AFfinity was developed by the East Midlands Cardiovascular Network (EMCVN) to improve the treatment and outcomes for AF patients in the East Midlands, whilst at the same time saving the NHS valuable resources. Patients, GPs, commissioners, the voluntary sector and the pharmaceutical industry worked together to improve AF detection and increase warfarin uptake. There were some valuable lessons learned from this programme and some useful resources developed, including AF management guidelines, prescribing guidance and care pathways, all of which can be found at http://www.affinityprogramme.co.uk/the-affinity-programme/delivering-affinity