Atrial Fibrillation (stroke prevention) Commissioning Toolkit Final

Full implementation of this toolkit would prevent at least 600 strokes each year in Greater Manchester, Lancashire and South Cumbria. This toolkit will support commissioners, including CCGs and local authorities, to provide services that improve the identification, diagnosis, risk stratification and management of patients with AF to reduce the risk of stroke.

> The commissioning of anticoagulant services sits within the wider commissioning strategy for CVD and stroke prevention. **Commissioners should** work with Strategic Clinical Networks, Academic Health Science Networks and Public Health England for cardiovascular disease to develop an effective and integrated local pathway for anticoagulation therapy that takes into account NICE recommendations for the novel oral anticoagulants, patient safety, patient experience, and timely access to assessment and treatment (NICE Commissioning Guide 2013).

Description of Toolkit:

This toolkit will provide commissioners with the tools required in order to commission an effective service for the prevention of stroke in people with atrial fibrillation (AF) and have been produced with patient and public input. These tools can be accessed through a series of hyperlinks throughout the document or via the GMLSC SCN website. An effective service improves quality outcomes for patients with AF and reduces health and social care costs by reducing patient's risk of stroke through service improvements.

Elements to be considered when commissioning services related to stroke prevention in **AF** can be found in the following index:

Contents

Each will be discussed in more detail in the following text or via the numerous hyperlinks throughout the document.

- *Summary of key points and recommendations*
- *Contents of interest to stakeholders*
- List of *references*
- The *route map* for Change & the European Atlas for the Prevention of AF-related Strokes

Related Standards and Guidance

Framework	Outcome domains and improvement areas
NHS Outcomes Framework 2014-15	- Domain 1: Preventing people from dying prematurely - Domain 2: Enhancing quality of life for people with long-term conditions - Domain 3: Helping people to recover from episodes of ill-health or following injury - Domain 4: Ensuring that people have a positive experience of care - Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm
Public health outcomes framework for England 2013– 16	- Domain 4: Healthcare, public health and preventing premature mortality
Adult social care outcomes framework 2014-15	- Domain 2: Delaying and reducing the needs for care and support - Domain 3: Ensuring that people have a positive experience of care and support
CCG outcomes indicator set 2014-15	- Domain 1: Under 75 mortality from cardiovascular disease - Domain 2: Ensuring people feel supported to manage their condition - Domain 3: Emergency admissions for acute conditions and re-admissions within 30 days of discharge from hospital - Domain 4: Patient experience of GP out-of-hours services and patient experience of hospital care - Domain 5: Patient safety incidents reported
Quality and outcomes framework (QOF) 2015-16	- The contractor establishes and maintains a register of patients with atrial fibrillation - The percentage of patients with atrial fibrillation in whom stroke risk has been assessed using the CHA_2DS_2-VASc score risk stratification scoring system in the preceding 12 months (excluding those patients with a previous $CHADS_2$ or CHA_2DS_2-VASc score of 2 or more) - In those patients with atrial fibrillation with a record of a CHA_2DS_2-VASc score of 2 or more, the percentage of patients who are currently treated with anticoagulation drug therapy
NHS Five Year Forward View	- Strengthen primary care so it is the foundation for personalised NHS care - Building the capacity and capability within primary care to support the prevention agenda and provide proactive care for people with long term conditions, especially those with complex care needs. - Demonstrating different ways of organising and delivering care, particularly when harnessed to investment in technology innovations. This will support the wider new care models work.
NICE Quality Standard	- NICE Quality Standard QS93 Atrial fibrillation: treatment and management - Quality Statements 1-6.

Case for Change

Atrial Fibrillation (AF) is the most common heart arrhythmia in the UK which affects at least 1.8% of the population, rising to >6% in people over the age of 65years[1]. The lifetime risk of developing AF is 1 in 4 and the risk doubles for every decade after 55.

On account of our ageing population and increased prevalence of risk factors associated with AF, the number of people with AF is expected to at least double in the next 50 years[2]. In addition hospital admissions for AF have risen by 60% over the last 20 years.

AF causes stagnation of blood within the heart and this can lead to blood clots, strokes and an increased risk of dementia. If AF is detected, the risk of stroke can be dramatically reduced by around two thirds with anticoagulant drugs and further reductions may be achieved with effective modification of other risk factors.

People with AF are five times more likely to have a stroke than people unaffected by the condition and AF-related strokes account for about 14% of all strokes[3]

Strokes suffered by people with AF tend to be more serious in terms of morbidity and mortality than those experienced by people without AF[4].

Although men have a 1.5 times greater risk of developing AF than women, AF-related strokes in women are more devastating than AF-related strokes in men[5].

In addition to the human burden of AF related stroke – greater disability and personal suffering, AF-related stroke is also a financial strain, costing the NHS on average £11,900 per stroke in the first year alone.

Addressing stroke prevention and appropriate management of atrial fibrillation is a strategic fit with regards to the Health and Wellbeing Board strategic priorities and the Strategic Clinical Network supports the need to switch to focusing on prevention of strokes.

> **Make Every Contact Count**
>
> All health care professionals, across health and social care, can contribute to opportunistic and targeted screening for AF

> **Recommendation 1**
>
> Easily accessible lifestyle support services should be commissioned to enable patients with AF to reduce their risk of stroke

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Local data

There is a considerable data available to support local commissioners.

A summary of local expected prevalence compared to actual prevalence by *individual CCG and Practice* in Greater Manchester, Lancashire and Cumbria has been compiled with data taken from the *Cardiovascular National Intelligence data packs* that have recently been published.

Other sources of data include the Sentinel Stroke National Audit Programme (SSNAP). The recent *SSNAP annual report 2014-2015* and quarterly *data* reports are available on a three monthly basis.

> **Recommendation 2**
>
> Commissioners and practices should check whether the prevalence of recorded AF is lower than expected - based on the characteristics of their population

> **Check Your Atrial Fibrillation Prevalence**
>
> You can monitor this at a CCG level or at practice level through the use of tools such as the GRASP AF Case Finder Tool. These tools enable all patients to be entered onto the AF register

AF infographics are able to demonstrate a *visual summary* of local data and the Greater Manchester Academic Health Science Network (GM AHSN) have produced local dashboards for Greater Manchester to support CCGs in a variety of self-improvement areas including AF. The Stroke Association has also recently distributed AF data packs that have been developed in conjunction with PHE, RCGPs and RCP.

Cost analysis

AF accounts for at least 0.4% of healthcare expenditure in the UK. In 2008 it was reported that, the total costs for treating the 12,500 AF related strokes in England is £148 million in the first year and the direct costs of managing AF was £429 million.

The cost of a stroke in terms of healthcare alone in the first year is estimated to be around £11,900 per stroke. This does not take into account the additional economic costs of a stroke, which from a societal perspective amount to £9 billion a year[6]. This considers the weekly costs of a stay in a residential care home of £523, in addition to informal care costs, productivity losses and benefit payments.

If the assumptions around future usage of stroke prevention treatments are recognised, it is estimated that this will equate to a 30% reduction in the number of AF-related strokes which will reduce the costs of stroke treatment by £224,000 per 100,000 population.

Further information can be found in the *NICE costing report: atrial fibrillation*
The *NICE local costing template* enables organisations to estimate the impact locally.

Please find further information on *costings and benefits*, an example of the *Blackpool LES cost analysis* and an example of a condensed *business case for optimising AF prevalence*. The AF Association have provided Strategy in relation to AF. NHS IQ have developed an *economic analysis* based on GRASP AF.

Identification of AF/Case finding

NICE CG180 (2014) recommends manual pulse palpation to assess for the presence of an irregular pulse that may indicate underlying AF in people presenting with certain criteria. The SAFE Study reviewed whether AF screening is beneficial. Further information on *identification and case finding* is attached for information.

Recommendation 3 Commissioners should ensure that health professionals check for pulse rhythm annually in all patients aged over 65 years and in younger patients with diagnosed cardiovascular disease, hypertension, diabetes and other related risk factors	**Recommendation 4** Commissioners should identify other opportunities for health and social care staff to perform manual pulse checks on individuals 65years and over e.g.in community settings and in care homes	**Recommendation 5** Commissioners should ensure that a manual pulse check is performed as part of the NHS Health Check when using automated BP machines. They should add manual pulse check to their local NHS Health Check service specification

Diagnosis and monitoring of AF

Commissioners should ensure that all practices within their locality enter confirmed diagnosis of AF patients onto an AF register with the appropriate READ code e.g. READ code (G573%) in order to comply with QOF ID AF001.

This will ensure that when a *diagnosis of AF* is confirmed the patient then receives the appropriate follow up and *review o*f their condition. East Midlands Strategic Clinical Network working in collaboration with Nene CCG have developed an electronic GP AF Clinical Audit template for *SystmOne and EMIS Web* please see attached for how to access.

There are an array of *technologies* available to support the detection and monitoring of AF as well as a variety of different *audit tools* to support primary care in both identifying and managing AF. The AF Association have developed a *Guidance on the utilisation of GRASP* tool that includes commissioner and primary care recommendations.

NHS Improving Quality have developed a range of user guides to support the use of AF Case Finder and GRASP AF audit tool these are:

- *Understanding the AF case finder headings and scores - all systems* (NHS IQ Guides)
- *Using and understanding the AF case finder results – all systems*
- *Using and understanding the GRASP AF tool results*
- *Using the GRASP AF results to aid with the QOF*

Further guidance in the form of crib sheets/user guides for the use of GRASP AF and AF Case finder can be found below:

- *Understanding GRASP AF*
- *Why use GRASP*
- *Understanding AF Case finder*
- *Warfarin Patient Safety Audit*

Use GRASP-AF

This tool is free to download from PRIMIS which will allow CCGs and practices to implement an effective stroke prevention programme. This should include training and education for primary care teams

Recommendation 6

Commissioners should ensure that technology and expertise to support the prompt diagnosis and management of AF is readily available

Utilise Technology

There are an increasing number of devices that support the detection and monitoring of AF – see medical device framework for commissioning options

Anticoagulation: Commissioning anticoagulation services which includes NOAC's, Self-monitoring and Self-management

There are a variety of commissioning guides for anticoagulation services:

- *NICE commissioning guide for anticoagulation services* and *NICE Consensus guide* for implementation of NOAC's
- *Rising to the challenge - Delivering QIPP by preventing AF-related stroke*
- Commissioning effective anti-coagulation service for the future: *Resource pack for Commissioners*
- *Summary of above*

Safety and Quality – Key Points

There should be robust monitoring of OAC provision and its safety	Service users and carers are actively involved in any discussions that have an impact on the initiation, monitoring and review of OAC therapy	Ensure that health care profe*ssionals (*HCPs) who initiate, monitor and/or review OAC therapy have the training, skills and competencies to meet the requirement of the role

Supporting information: *Safety and Quality*

*Summary of the elements***:** to consider when commissioning an anticoagulation service; including information to be inserted into a contract.

Oral Anticoagulation (OAC)

It is a statutory obligation for commissioners to make funding available within three months for drugs that have been recommended by a NICE technology appraisal

Adults with atrial fibrillation are not prescribed aspirin as monotherapy for stroke prevention.
Healthcare professionals should be aware that adults with atrial fibrillation may need to take aspirin for other indications. (Quality statement 2 NICE)

The NICE consensus document advocates that primary care should identify local 'champions' to take the lead in anticoagulation for AF

The above recommendations were stipulated in a recent *NICE Implementation Collaborative Consensus* document which advised on the review and development of local policies for the use of anti-thrombotic therapies in AF. A recent *NICE Good Practice Guidance* on developing and updating local formularies endorses that drugs with a positive NICE Technology Appraisal should automatically be included in local formularies and should not duplicate NICE assessments or challenge an appraisal recommendation. Lancashire Medicines Management Group (LMMG) have released a *Consensus Statement* and *Anticoagulation Decision Support Tool* based on NICE CG 180 which should be automatically included within the local formulary. LMMG, have also produced NOAC prescribing guidance 2013. GM Medicine Management Group has also produced prescriber decision support guidance for NOACs.

Self-Monitoring and Self-Management of Warfarin

Near patient or point-of-care testing devices have made it possible for people on long-term oral anticoagulation to monitor their blood clotting time measured as the international normalized ratio (INR) in the home setting. Although it is called self-management/monitoring, the testing and adjustment of the dose can be done by a carer as well as the patient.

Self-monitoring or self-management can improve the quality of oral anticoagulant therapy, leading to fewer thromboembolic events and lower mortality, without a reduction in the number of major bleeds. Self-monitoring and self-management are not feasible for all patients, which will require the identification and education of suitable patients.[7]

Self-Monitoring: refers to the user performing the INR test themselves and then contacting their local healthcare professional/anticoagulation service with the reading for advice on any change to the dosage of the anticoagulant that may be needed.

Self-Management: refers to the user performing the INR test themselves and then self-adjusting the dosage of their anticoagulant medication by following an agreed care protocol. Self-management becomes cheaper than a NOAC over time as most of the cost is the non-recurrent cost of the machine and the cost is even less if the machine is recycled from a previous patient. Supporting information can be found in:

- *Is self-monitoring an effective option for people receiving long-term vitamin K antagonist therapy? A systematic review and economic evaluation (June 2015)*
- *A report by the Anticoagulation Self-Monitoring Alliance (July 2014)*
- *Risk Reduction in Atrial Fibrillation Flow chart* and *supporting guidance*
- *Atrial fibrillation and heart valve disease: self-monitoring coagulation status using point-of-care coagulometers*
- *Maintaining high-quality anticoagulation and the use of self-monitoring*
- *Clinical Governance Resource Pack: Self- monitoring for patients on long term warfarin NCAT, 2013*

Recommendation 7

Commissioners should ensure that all patients are given the opportunity to choose self – management or self-monitoring

Ensure safe anticoagulation

When commissioning anticoagulation services ensure patient safety through adequate monitoring and reporting of time within therapeutic range. Anticoagulation clinics should ensure perioperative bridging of anticoagulation in patients with AF should be routine practice

Recommendation 8

Commissioners should recognise that there are various professionals who could provide a service for undertaking AF reviews e.g. GP's, Practice Pharmacists, nurse practitioners, practice nurses, private providers

Management of Transient Ischaemic Attack (TIA) in AF Patients

TIA services:
Patients who have had a TIA and are also in atrial fibrillation should be anticoagulated with an agent that has rapid onset (NOAC) in the TIA clinic once intracranial bleeding has been excluded and if there are no other contraindications[8].

Recommendation 9

Commissioners need to be aware that: all high risk TIA patients who have AF need to be immediately anti-coagulated after ruling out intracranial haemorrhage

Recommendation 10

Commissioners should ensure that there are local protocols and pathways for the timely assessment of TIA patients and that access to brain imaging complies with national guidance

Education and Training

In order to ensure that the recommendations within this toolkit are achievable, education and training for Primary Care professionals needs to underpin all identified areas of improvement. CCGs may wish to facilitate these themselves locally in the form of protected learning time or alternatively direct GP practices to training courses either online or with accredited training establishments.
Training and education opportunities are listed in the attached table.

Recommendation 11

Commissioners should support education for primary care professionals on AF and stroke risk in order for them to manage and educate patients effectively

Recommendation 12

Commissioners should ensure that plans are in place to train or update all frontline staff across health and social care in the use of the FAST tool in recognising the symptoms of stroke or TIA

Recommendation 13

Commissioners should ensure that training is available for all HCP in stroke prevention in particular with regard to the detection and management of hypertension and AF

Raising Patients, Carers and Public awareness

As stated in the case for change; due to our ageing population and increased prevalence of risk factors associated with AF, the number of people with AF is expected to at least double in the next 50 years. Commissioners should have a strategy of how they are going to pro-actively manage raising awareness of AF and associated risk factors to patients, carers, public and health and social care professionals. The North West Coastal AHSN have produced a case study on their AF campaign run in Lancashire and Cheshire and Mersey. More patient information on AF can be found on websites such as *AF Association*, *British Heart Foundation* (BHF) and *NHS Choices.*

The patient representatives, who have contributed to this toolkit, have developed a *patient information sheet* for patients and carers on the initial diagnosis of AF, stating "*it was the one thing missing from all their AF experiences that would have made a difference*". This information sheet explains in simple terms, what AF is and what the treatment options are, including management. Commissioners should ensure this information is included in any future patient awareness raising initiatives or patient publications. All GP's should be encouraged to disseminate the information to improve the patient's experience and promote self-management.

Recommendation 14

Commissioners should consider strategies to raise public awareness of AF and stroke risk as part of either a local or national campaign

Raise Public Awareness

Raise public and professional awareness of AF related stroke, to ensure that people recognise the importance of early diagnosis and preventative treatment

Best practice examples:

- *Summary of approaches to setting up services*
- *Summary of Best Practice Examples, Additional Resources, Case Studies, Service Specifications*
- *Report on Stroke Prevention in AF project 2015/16*

There are a number of guides that have been incorporated throughout the document that can be found via the above best practice examples links and on the GMLSC SCN website under additional resources.

If the above guidance is implemented the effects on the quality of patient care will be:

Safety
- Improved detection of AF through opportunistic and systematic pulse palpation
- Improved quality outcomes for patients with AF through optimal therapy to reduce the risk of stroke

Effectiveness
- Cost effective treatment for AF, reduced risk of stroke and avoidance of significant health and social care costs per stroke due to AF
- Improved productivity through a reduction in referrals and bed days saved

Patient Experience
- Prevention of avoidable mortality and morbidity; the prognosis of patients who suffer a stroke as a result of AF is particularly poor

Summary of Evidence: All the interventions described in this document:

- have been successfully implemented
- have been successfully replicated
- are linked to standards or guidance
- are supported by one or more national organisations
- have robust evaluation evidence
- have peer reviewed journal evidence