

## **Atrial Fibrillation in Primary Care Surrey Heart and Stroke Network, 13 GP practices in Woking and West Byfleet, Surrey PCT**

### **Duration of project**

January 2008 - October 2008

### **Scope of project**

To improve detection and treatment of atrial fibrillation in a sample of practices in Woking and West Byfleet in order to make best practice recommendations for rollout across Surrey.

### **Baseline position**

Thirteen practices with a combined population of 107,304. Of these patients, 1,346 were already registered by March 2007 as having AF, giving a prevalence of 1.25%.

### **What we did**

- A clinical lead was appointed for the project
- A project steering group that included a GPSI cardiology, PCT commissioning lead, consultant cardiologist, pharmacist and IT lead was established
- Thirteen out of 15 practices across three practice based commissioning groups were recruited.

There were three stages to practice involvement in the project:

- Attendance at a lunchtime session practice update to be led by consultant cardiologist, covering primary care management of AF
- Opportunistic screening to detect people with atrial fibrillation twinned with piloting the use of a hand-held ECG machine
- Review of patients already diagnosed with AF to improve rates of anticoagulation (stroke prevention).

Patient satisfaction was sought on information that they receive about AF through a targeted questionnaire and a focus group.

### **Opportunistic screening**

Practices were given a care pathway to follow for three months requiring patients aged over 64 years who were not on the AF register to have their pulse taken when presenting for an appointment at the practice. A basic care pathway with READ codes was given to all GPs in the pilot practices, along with various reminder posters and flyers for both clinicians and patients.

In addition, practices were given a hand-held ECG monitoring device called the Omron Heart Scan and corresponding software.

### **Review of patients**

Practices were asked to use MIQUEST (GRASPAF) search and spreadsheet being developed by West Yorkshire Cardiovascular Network with PRIMIS+ to identify AF patients, risk stratify for stroke using CHADS2 and review for prescribing warfarin as part of an incentivised scheme.

### **Key challenges**

- Maintaining momentum in wide range of Practices
- Getting information back from practices.

### **What went well**

Most were happy to do the opportunistic screening without payment and continue to take pulses now opportunistically, although not routinely recorded.

### **Key learning from work**

- The MIQUEST search identified patients who had AF in the past but no longer did, generating unneeded patient reviews
- CHADS2 was welcomed by the majority of practices as an easily administered stroke risk decision making tool
- There is a wide variety of practice with respect to who to prescribe warfarin to for AF.

### **Outcomes**

#### **Practice updates**

34 clinicians, mostly GPs, attended two sessions. Overall evaluation was excellent; GPs really welcomed local educational updates of such a high quality and indicated a preference for such updates in the future. However, it was difficult to arrange mutually convenient dates and times in outer Working, the largest area with most of the pilot practices.

#### **Opportunistic screening**

Three practices out of a potential 13 returned information on numbers of people newly diagnosed with AF following opportunistic pulse palpation.

407 patients out of 3,000 patients over the age of 65 years, who attended the three practices over the three month period were READ coded for pulse palpation (13.6%). 11.5% of these 407 patients had an irregular pulse (47)

- 18 went on to be diagnosed with atrial fibrillation (4.4% of those READ coded for pulse palpation).

There was a wide variance in use and acceptability of the Omron Heart Scan. The majority of practices did not find it useful.

There were issues with downloading the

software that allowed clinicians to view the ECG trace in greater magnification and a single-trace ECG was not clinically acceptable for most GPs when investigating possible AF. One GP who found it very useful was one with a special interest in cardiology.

#### **Review of patients**

- 56% of all AF patients had a CHADS2 score of two or more i.e. were high risk for stroke
- 41% (378) of these 'high risk for stroke' patients were not being prescribed warfarin; aspirin was the most common antithrombotic alternative with a small number being prescribed clopidogrel
- Nine out of the 13 practices that were sent reports that highlighted these patients carried out patient reviews. The remaining four did not return audit forms
- 178 (71%) patients in these nine practices had their notes reviewed to see if they could be safely switched to warfarin
- 41 patients attended for medication review (the remainder was ruled out as being unsuitable for warfarin following a review of their notes)
- Eight patients were switched to warfarin amounting to 2% of the total number of patients in these nine practices who were highlighted as being at high risk of stroke. The overall conversion rate to warfarin is very low, certainly in comparison to Leeds where the same exercise was carried out but patients' notes were initially reviewed by arrhythmia nurse specialist with 50% being tagged as 'appropriate for warfarin'. The main reason given for patients not being switched to warfarin was 'not suitable'.

AF guidelines were circulated to all practices in Surrey in June 2008. This includes a care pathway.

A service specification is being written for atrial fibrillation.

All practices are to be sent very clear information about warfarin and stroke; practice-based pharmacists have agreed to talk to all practices about GRASP-AF and CHADS2, the aim being to review all patients in Surrey to see if more could be converted from aspirin to warfarin to prevent stroke. Acute trust cardiology departments are to write to GPs whenever they refer patients for AF investigation/management asking them to CHADS2 score where appropriate.

#### **Challenges for sustainability**

If we utilise practice-based pharmacists to continue 'spreading the word' about AF, ensuring that it is in their work plan, it could be sustained quite well.

They are already planning to review beta blockers which will include some AF patients as well as hand delivering the AF and warfarin flyer that we are currently developing. The best way to make sustainable changes though is via contracts i.e. QOF. Including CHADS2 scoring in QOF for AF patients would make a big impact in awareness.

#### **Costs incurred**

##### **Summary**

- To trial use in primary care to see if they reduce need for 12-lead ECGs £5,872.06
- To trial use in community to see if they improve detection of AF £2,998.00
- To encourage practitioners to follow NICE guidance when managing AF £165.00
- To attract clinicians to education session with Vince Paul £56.68
- To carry out a focus group with AF patients to better understand their experiences of having AF £171.66
- To encourage review of patients from MIQUEST search £1,139.00
- Feedback from practices - cancelled due to lack of interest £235.00
- Arrhythmia and SCD masterclass £1330.00. NB. Full budget is available through the NHS Improvement System.

#### **Patient, carer and staff involvement**

##### **Patient satisfaction**

Two of the pilot practices posted out a questionnaire to all the patients on their AF registers:

- Information about AF was not routinely given out to these patients. Most reported that they 'felt alone' at the time of diagnosis and had no one to ask questions
- Most were aware of the stroke risk concomitant with having AF, but the majority were much more concerned with controlling their AF symptoms e.g. palpitations
- They were not really sure what meaningful actions they could take to reduce their risk of stroke
- There were lots of questions about medication, surgical interventions, cardioversion, symptoms.

It really felt as though there is a large unmet need in this patient group

- Developing a support group for people with AF was popular at the focus group session itself. All reported how good it was to talk to other people with the same condition and to swap tips and advice. Linking AF patients with existing cardiac support groups at the time of diagnosis would be the most efficient way of ensuring such patients received peer support.

### **Resources and tools developed to support the changes**

Available for sharing through the NHS Improvement website ([www.improvement.nhs.uk/afprojectssummaries](http://www.improvement.nhs.uk/afprojectssummaries)):

- Project budget
- Poster to remind clinicians to take pulse
- West Surrey AF in primary care final report
- Final protocol for AF in primary care project
- Project budget.

### **Future plans**

None at present

### **Sites outside of the network where the approach has been adopted by others**

Contacted by networks in Kent and Sussex for details of the project and shared project protocols and other resources.

### **Contact details**

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Clinical lead:

Dr. Vince Paul provided initial support.

[Atrial fibrillation in primary care: making an impact on stroke prevention 31](#)

[www.improvement.nhs.uk](http://www.improvement.nhs.uk)