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Atrial Fibrillation and NHS Health Checks

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Flu LES

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- Pulse check was ‘added’ to flu LES in September ’08-March ‘09
- We met with some challenges initially
  - Read Codes
  - Unclear Referral Pathway
  - Lack of training re: pulse checks, in particular for practice nurses

GP Feedback re: Flu LES

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-St John’s Wood practice -successfully managed to incorporate pulse checks into their flu appointments (with 82% over 65 seasonal flu coverage in 2009/10)

-operated 5 minute appointment slot system spread throughout the week

-Saturday morning surgeries purely for flu (not as popular with the over 65s!)

GP Feedback cont.

-5 minute appointments allowed for

-consent

-administration of flue vaccine (+swine flu and pnuemovax if required and wanted)

-checking of pulse over one minute

GP Feedback cont.

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-Issues

1)Ad hoc arrangement as to whether patients sent for ECG or 24 hour tape – most initially sent for ECG

2)Lack of clear pro-forma/pathway for what to do if irregular pulse detected

3)Uncertainty about which investigations were required; eg: bloods and who would follow up ?GP/Cardiologist

Response to GP Feedback

-Development of clear clinical algorithms for clinicians to follow

-Community Cardiac Team Support
(provided by Imperial College Healthcare NHS Trust)
- -Due to start in May 2010
- -2 central community cardiology service hubs
  - -Maida Vale
  - -South Westminster Centre

Community Cardiac Team

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4 cardiac care pathways identified as appropriate for the community

1)Arrhythmia and specifically atrial fibrillation

(arrhythmia nurses)

2)Complex or uncontrolled hypertension

(hypertension cardiac risk nurse)

3)Heart failure

(heart failure nurse)

4)Stable sub-optimally controlled angina

(chest pain nurse)

AIM: Shift 90% of cardiac outpatient activity to the community cardiac team

Community Cardiac Team

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-Investigations able to be performed by community cardiac team

-Phlebotomy, including brain natriuretic peptide assays

-ECG

-ECHOcardiography

-24-hour ECG

-24 hour blood pressure monitoring

-Lung function tests for use in joint breathlessness clinics

-Links to secondary care for patients requiring more complex investigations

NHS Health Check

-Decision made to incorporate pulse check into the NHS Health Check, for all 40 to 74 year olds in Westminster

-Health Checks currently carried out via CVD LES; targets those who are high risk and does not currently include pulse check

-New CVD LES (incorporating pulse check) due to launch in April 2010

(-Additionally, pulse check will be re-incorporated into flu-LES for winter 2010/11)

Rationale for inclusion of pulse check in NHS Health Check

-**Objective**: increase AF detection in community and thus reduce risk of strokes
-Current **Westminster prevalence** of AF is 0.7% (national prevalence is 1.2%)
-Epidemiological studies suggest AF causes 15-20% of all thrombo-embolic strokes
-Strong evidence associating AF with worst strokes (morbidity and mortality)
-NICE estimate approximately 40% patients in whom warfarin is indicated are not receiving it – approx. 166 000 patients nationally
-NICE also found a minority of AF patients at high risk of stroke NOT on warfarin had contraindications
-Likely that DoH guidance will change to incorporate pulse check in the next year or two

Proposed Methodology for pulse check…

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1) Manual pulse check on attending GP practice (practice nurses)
2) Activity recorded on IT system
3) Any concerns about nature of pulse – checked by clinical lead (designated GP in surgery that day)
4) Patients with irregular pulse sent to community cardiac team for ECG and interpretation of ECG as well as other initial investigations (ie-bloods)
5) Positive diagnoses reported and then validated by clinical lead. GP to manage confirmed cases of AF in accordance with NICE guidelines

Pulse Check/AF Protocol for NHS Health Check

Refer to handout

CHADS-2 Score

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CHADS2 Score

Congestive Heart Failure (1 point)

Relative risk of stroke or TIA: 1.4

Hypertension (1 point)

Relative risk of stroke or TIA: 1.6

Age over 75 years (1 point)

Relative risk of stroke or TIA: 1.4

Diabetes Mellitus (1 point)

Relative risk of stroke or TIA: 1.7

Stroke or TIA history (2 points)

Or Mitral Stenosis or prosthetic heart valve (which carry similar risk) also

Indicate warfarin

Relative risk of stroke or TIA: 2.5

CHADS-2 Score

Interpretation

CHADS score >2 (CVA risk >5% per year):

Warfarin with goal INR 2.0 to 3.0

CHADS score 1-2 (CVA risk >4% per year):

Warfarin or Aspirin

CHADS score 0: Aspirin 75 to 300mg/day

Actual Contraindications to Prescribing Warfarin

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-Pregnancy

-Hypersensitivity to warfarin

-Within 3 days of surgery

-Bacterial endocarditis

-Severe renal or hepatic disease

-Actual or potential haemorrhagic conditions –eg:

- -haemophilia/other haemorrhagic conditions (thrombocytopenia)
- -uncontrolled hypertension
- -gastro-intestinal ulceration
- -threatened abortion

Barriers to Warfarin Prescribing

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- -Difficulty assessing risk of stroke in pts with AF (poor knowledge/use of tools such as CHADS2)
- -Difficulties attaining therapeutic dose of warfarin – need for regular monitoring and dose titration (particularly when new drugs initiated, impact of vitamin K rich foods)
- -Fears about side effects of warfarin – eg: risk of bleeding
- -Patients being ‘at risk’ of falls
- -Patient factors -Qualitative research with physicians reports patient aversion to using warfarin due to negative connotations

Barriers to Warfarin Prescribing

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Specific Challenges

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1) **TRAINING** practice nurses to take and interpret the pulse

2) **CLEAR MANAGEMENT/REFERRAL PATHWAY** – see attached

3) **GP EDUCATION** – addressing barriers to warfarin prescription

4) **EMIS/VISION ALERTS** re: CHADS2 score and development of a process for reviewing CHADS2 scores as patients' medical status or age changes

Broader Challenges

- Getting up and running
- Reaching the right population
- Treatment/management -?dabigatran

Any Questions?!

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