Report to: **SINGLE COMMISSIONING BOARD**

Date: 26 September 2017

Officer of Single Commissioning Board Jessica Williams – Interim Director of Commissioning

Subject: **ATRIAL FIBRILLATION IN PRIMARY CARE**

Report Summary:

Atrial Fibrillation is a common heart condition which causes an irregular and often abnormally fast heart rate. It can increase the risk of a blood clot forming inside the heart. If the clot travels to the brain, it can lead to a stroke. Atrial Fibrillation increases stroke risk by around four to five times.

Single Commission officers and clinical leads are members of the Tameside and Glossop Heart Disease Programme Board. This group is led by Tameside and Glossop Integrated Care Foundation Trust, and reports via the Trust's governance through the Director of Operations.

The Heart Disease Programme Board identified Atrial Fibrillation as a priority area for their 2016-17 programme of work. As a result, a pathway for Atrial Fibrillation management was developed and approved via the Professional Reference Group and Single Commissioning Board in January 2017.

The Single Commission members of the Heart Disease Programme Board have been tasked with taking forward further work to address the identification and management of patients with Atrial Fibrillation in primary care. The proposal for doing this is outlined in this report. The purpose of the report is to provide an update on action taken to date and a summary of the proposed activities for 2017-18, with a view to seeking Single Commissioning Board support for the project.

Recommendations: That the Single Commissioning Board supports the project outlined in this report and proceeds as described.

Financial Implications:

(Authorised by the statutory Section 151 Officer & Chief Finance Officer)

Budget Allocation (if Investment Decision)	No funding in ICF, but external funding available to implement.
CCG or TMBC Budget Allocation	CCG
Integrated Commissioning Fund Section – S75, Aligned, In-Collaboration	S75
Decision Body – SCB, Executive Cabinet, CCG Governing Body	SCB
Value For Money Implications – e.g. Savings Deliverable, Expenditure Avoidance, Benchmark Comparisons	Full determination of the value for money requires more information. But if scheme is funded externally and this ultimately results in reduced number of strokes VFM should be good, even if GP prescribing costs do increase.

	Additional Comments Finance Task and Finish group support this proposal, which links well with the strategic objectives of care together. It does not require up front funding from the Clinical Commissioning Group, and it has the potential to reduce the number of strokes. As referenced in section 5.5 of the document, the ownership of the equipment will be confirmed before distribution, and it is recommended that the practices are the owners of the equipment. There is no additional funding for the replacement, maintenance or calibration of the equipment and this will be confirmed with the practices prior to distribution.
Legal Implications: **(Authorised by the Borough Solicitor)**	The proposals if agreed and as set out in this report should be effectively monitored to ensure compliance with targets in achieving improved outcomes and reducing the costs to the system. Members must by law have regard to the Equality Impact Assessment attached to this report before making their decision.
How do proposals align with Health & Wellbeing Strategy?	The proposals align with the living and ageing well elements of the Health and Wellbeing Strategy.
How do proposals align with Locality Plan?	The proposals align with the Locality Plan through the delivery of improved early identification and management of conditions which will reduce the incidence and long term impact of stroke and long term health conditions.
How do proposals align with the Commissioning Strategy?	The Care Together programme is focused on the transformation of the health and social care economy to improve healthy life expectancy, reduce health inequalities and deliver financial sustainability. The improved identification and management of AF and therefore the associated improvement in quality of life and reduction in the incidence of strokes aligns with the locality Commissioning Strategy.
Recommendations / views of the Professional Reference Group:	The Professional Reference Group supported the proposal, with the recommendation that the training element of the project focuses on the practical delivery of the project's aims and objectives, and not on the theory of the management of Atrial Fibrillation and the improved outcomes this can deliver. The financial comments were also reiterated, with assurance sought and given that the ownership of the equipment would be with the Practices, and therefore no financial consequences for the Clinical Commissioning Group / Single Commission relating to capital assets.
Public and Patient Implications:	The proposal has been developed with input from Patient Neighbourhood group representatives. We will continue to ensure engagement with / involvement of patients and the public in this project. We have included patient / user feedback and satisfaction reporting in the project objectives.

Quality Implications:	Quality Impact Assessment attached.
How do the proposals help to reduce health inequalities?	The incidence of Atrial Fibrillation increases with age. By identifying Atrial Fibrillation early, and by supporting and managing people appropriately, it will ultimately reduce the number of people who would go on to have a stroke
What are the Equality and Diversity implications?	Equality Impact Assessment attached.
What are the safeguarding implications?	The process outlined in this paper focuses on the delivery of care by the Tameside and Glossop member practices, therefore is covered by the existing safeguarding arrangements in place with General Practice. There is no expectation that this project will involve any safeguarding implications.
What are the Information Governance implications? Has a privacy impact assessment been conducted?	This proposal is to be presented to the Information Governance Strategy Group to ensure all elements of IG have been identified and addressed, and the necessary assurance provided, particularly in relation to the practice review process.
Risk Management:	The project will ensure any potential risks are identified and monitored / reviewed, via the Clinical Commissioning Group risk management processes, and reporting to the Clinical Commissioning Group and / or Heart Disease Programme Board as appropriate.
Access to Information :	The background papers relating to this report can be inspected by contacting Alison Lewin, Deputy Director of Transformation  Telephone: 07979 713019  e-mail: alison.lewin@nhs.net

1 BACKGROUND AND INTRODUCTION

1.1 Atrial Fibrillation is a common heart condition which causes an irregular and often abnormally fast heart rate. It can increase the risk of a blood clot forming inside the heart. If the clot travels to the brain, it can lead to a stroke. Atrial Fibrillation increases stroke risk by around four to five times.

1.2 Single Commission officers and clinical leads are members of the Tameside and Glossop Heart Disease Programme Board. This group is led by Tameside and Glossop Integrated Care Foundation Trust, and reports via the Trust's governance through the Director of Operations.

1.3 The Heart Disease Programme Board identified Atrial Fibrillation as a priority area for their 2016-17 programme of work. As a result, a pathway for Atrial Fibrillation management was developed and approved via the Professional Reference Group and Single Commissioning Board in January 2017.

1.4 The NHS Right Care pathway for circulation has identified Atrial Fibrillation prevalence as an area where Tameside and Glossop are outliers in relation to the 10 comparator Clinical Commissioning Groups (see section 3 below) and where there are opportunities for improvement from a an outcome and financial perspective.

1.5 The Single Commission members of the Heart Disease Programme Board have been tasked with taking forward further work to address the identification and management of patients with Atrial Fibrillation. The proposal for doing this is outlined in this report. The purpose of the report is to provide an update on action taken to date and a summary of the proposed activities for 2017-18, with a view to seeking Single Commissioning Board support for the project.

2 WHAT IS ATRIAL FIBRILLATION[1]

2.1 Atrial Fibrillation is a common heart condition which causes an irregular and often abnormally fast heart rate. It can increase the risk of a blood clot forming inside the heart. If the clot travels to the brain, it can lead to a stroke. Atrial Fibrillation increases stroke risk by around four to five times. However, with appropriate treatment the risk of stroke can be substantially reduced. Anti-coagulant (blood thinning) drugs like warfarin and a newer class of drugs called NOACS are the most effective treatments to reduce the risk of stroke in people with Atrial Fibrillation.

2.2 Sometimes Atrial Fibrillation does not cause any symptoms and a person with it is completely unaware that their heart rate is not regular

2.3 The cause is not fully understood but it tends to occur in certain groups of people and may be triggered by smoking, drinking alcohol, and is more common as people get older. It is the most common form of heart rhythm disturbance.

2.4 Atrial Fibrillation can affect adults of any age, but it becomes more common as you get older. It affects about 7 in 100 people aged over 65, and more men than women have it. Atrial fibrillation is more likely to occur in people with other conditions, such as high blood pressure (hypertension). It can be treated, with the most effective method to reduce using medication.

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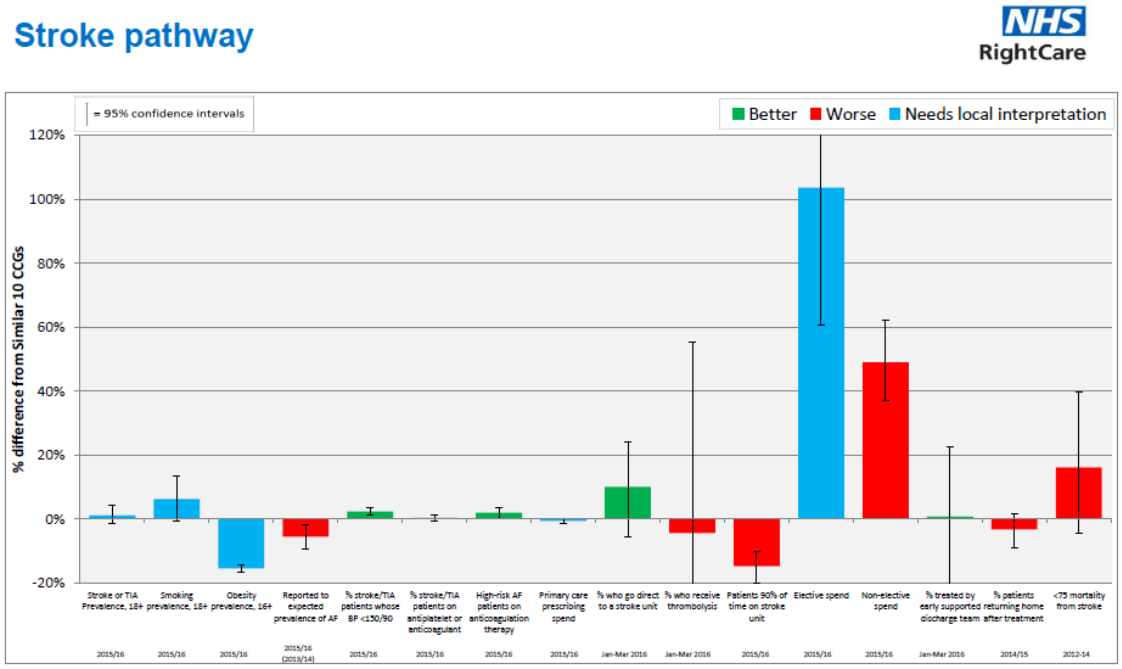
[1] http://www.nhs.uk/conditions/Atrial-fibrillation/Pages/Introduction.aspx
https://www.bhf.org.uk/heart-health/conditions/atrial-fibrillation

2.5 Although Atrial Fibrillation can greatly increase the risk of stroke, there are other lifestyle factors that can contribute to a stroke. These include smoking, high cholesterol, high blood pressure, physical inactivity, obesity and diabetes

3 THE CASE FOR CHANGE: TAMESIDE AND GLOSSOP STROKE AND ATRIAL FIBRILLATION DATA

3.1 This section outlines a sample of data sources which indicate why the identification and management of Atrial Fibrillation in primary care is an issue in Tameside and Glossop, and one which needs to be addressed.

3.2 The NHS Right Care data and Stroke pathway shows that Tameside and Glossop are an outlier, when compared with the 10 'comparator Clinical Commissioning Groups', for the reported to expected level of Atrial Fibrillation.



3.3 The General Practice Quality Outcome Framework includes data on the incidence, prevalence and management of AF in primary care. The 2015-16 report indicates that there were 4014 patients on an AF register[2] in Tameside and Glossop, with an average Tameside and Glossop prevalence of 1.52%. 12 Tameside and Glossop practices had a reduction in numbers of patients on AF registers in 2015/16 compared to the previous year (2014-15). According to the 2015-16 Quality Outcome Framework data, there is significant variation in the prevalence in Tameside and Glossop Practices, with prevalence ranging from 0.38% to 2.53%.

3.4 There were two Atrial Fibrillation Quality Outcome Framework indicators in 2015/16:

AF006 - The *percentage of patients with atrial fibrillation in whom stroke risk has been assessed using the CHA2DS2-VASc score risk stratification scoring system in the preceding 12 months (excluding those patients with a previous CHADS2 or CHA2DS2-VASc score of 2 or more).*

All practices achieved maximum points, however, 53 patients were exception coded; and 82 patients did not receive treatment for this indicator. Exceptions per practice ranged from 10 patients in one practice and 0 exceptions in other practices.

[2] http://www.content.digital.nhs.uk/catalogue/PUB22266/qof-1516-prev-ach-exc-cv-prac-v2.xlsx

AF007 - In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy

All practices achieved maximum points, however, 228 were exception coded and 177 were either not treated or exception coded. Exceptions per practice ranged from 25 patients in one practice to 0 exceptions in other practices.

Practice achievement of Quality Outcome Framework indicators is measured according to the percentage of relevant patients who are treated in a certain way, or who have certain outcomes resulting from care provided by the practice. The Quality Outcome Framework includes the concept of 'exception reporting' to ensure that practices are not penalised where, for example, patients do not attend for review, or where a medication cannot be prescribed due to a contraindication or side-effect. Patient exception reporting applies to those indicators in the clinical domain of the Quality Outcome Framework where level of achievement is determined by the percentage of patients receiving the designated level of care.

3.5 With the Practices' agreement the Clinical Commissioning Group are carrying out remote access reviews of current figures relating to Practices' Atrial Fibrillation data to ensure an up to date baseline is available at the start of the project.

3.6 The Sentinel Stroke National Audit Programme is the single source of stroke data in England, Wales and Northern Ireland. The clinical audit collects a minimum dataset for stroke patients in England, Wales and Northern Ireland in every acute hospital, and follows the pathway through recovery, rehabilitation, and outcomes at the point of 6 month assessment. Data is reported at a provider and commissioner level. Data for the registered population of Tameside and Glossop on the incidence of strokes is as follows:

	2013-14	2014-15	2015-16	2016-17
Number of strokes	379	361	402	340
Gender				
Female	206	160	186	160
Male	173	201	216	180
Age				
<60	61	64	73	47
60-69	70	50	77	70
70-79	107	112	109	106
80-89	109	111	106	93
90+	32	24	37	24

3.7 The Sentinel Stroke National Audit Programme data reports the number of stroke patients recorded as having Atrial Fibrillation before their stroke, and details of how the Atrial Fibrillation was being managed.

AF before stroke	2013-14	2014-15	2015-16	2016-17
Number	56	59	52	46
% of total stroke patients	14.8	16.3	12.9	13.5
If AF before stroke, on antiplatelet medication:				
Yes	21	27	17	7
No	35	32	35	39
If AF before stroke, on anticoagulant medication:				
Yes	18	19	25	21
No	38	40	27	25
If AF before stroke, on anticoagulant and/or antiplatelet medication:				
Both anticoagulant and antiplatelet medication	3	2	4	0
Anticoagulant medication only	15	17	21	21
Antiplatelet medication only	18	25	13	7
Neither medication	20	15	14	18

3.8 This data describes a situation where only 14.3% of the people who had a stroke in the years 2013-17 had previously identified and recorded Atrial Fibrillation. And of these, the management of the Atrial Fibrillation varied, with 31% of those identified with Atrial Fibrillation receiving no medication for the management of their Atrial Fibrillation.

4 PROGRESS TO DATE

4.1 A pathway was developed using national guidelines (e.g. NICE 2014), other North West pathways (e.g. Cheshire and Merseyside SCN, 2015) and input from GPs and Cardiologists. This was presented to the Single Commissioning Board in January 2017 and approved for use in Tameside and Glossop.

4.2 The pathway focuses on Primary Care and how GP practices can:

- Identify Atrial Fibrillation, including regular pulse checks in flu clinics, and reviewing practice data (such as by using GRASP-AF);
- Treat Atrial Fibrillation by changing the heart rate and prescribing anticoagulation if required;
- Manage people with Atrial Fibrillation in Primary Care by booking in annual reviews and reviewing medication;
- Providing clear details of when to refer to Secondary Care, when to use Cardiology Advice and Guidance and a reminder that ECGs are offered in the community.

4.3 The Heart Disease Programme Board has now asked that this work is taken further, with increased support provided to the primary care identification and management of Atrial Fibrillation.

4.4 A parallel piece of work is being led by the Integrated Care Foundation Trust to look at the identification of Atrial Fibrillation in the hospital setting, with discussions including the potential for an arrhythmia nurse supporting urgent care and elective care pathways and services.

5 THE PROPOSED PROJECT

5.1 The aim of this project is to reduce the number of Atrial Fibrillation related strokes in the population of Tameside and Glossop through the effective identification and management of patients with Atrial Fibrillation. The objectives to support this aim are:

- To increase the prevalence and number of people with Atrial Fibrillation identified and recorded on primary care systems;

- To improve the Time in Therapeutic Range for people with Atrial Fibrillation;
- To improve the management of the 'known not treated' patients with Atrial Fibrillation;
- To improve the competence and confidence of the current & future primary care workforce to help deliver improved levels of care around management and treatment of Atrial Fibrillation;
- To help support provision of and use of devices to improve levels of detection amongst identified patient cohorts;
- To improve the coding and record management in primary care of patients with Atrial Fibrillation.

5.2 The project team will ensure patient and staff satisfaction are monitored throughout the project and in the ongoing delivery of support to people with Atrial Fibrillation.

5.3 The Single Commission has been working closely with the Greater Manchester Academic Health Science Network on an approach to the identification and management of Atrial Fibrillation. The Greater Manchester Academic Health Science Network is one of 15 Academic Health Science Networks across England, established to spread innovation, improve health and generate economic growth. The Greater Manchester Academic Health Science Network brings together 33 members comprising NHS providers, commissioners and universities across Greater Manchester, East Lancashire Trust and East Cheshire. The Network is seeing the project with Tameside and Glossop as their 'flagship' Atrial Fibrillation project, and one in which they are investing significantly in terms of financial resource and manpower.

5.4 The proposed project is being funded by the Academic Health Science Network and the project will require input from the 39 Tameside and Glossop member practices, led by the Single Commission, supported by the Network. Any additional funding required is being provided by the Academic Health Science Network. Tameside and Glossop is the only locality in Greater Manchester receiving funding for an Atrial Fibrillation project, and is being seen by the Network as a test site for their work, which links into the Greater Manchester Health and Social Care Partnership.

5.5 There are 3 elements to the project:

Reviews – Academic Health Science Network to fully fund the cost of pharmacy led clinical reviews in ALL Tameside and Glossop practices. This will involve the use of the GRASP AF tool in all practices, and will provide the practices with a validated list of all Atrial Fibrillation patients and an action plan as to how to improve their prevalence and management. The intention is to complete these reviews by the end of the calendar year (2017). This approach has been successfully piloted at Lockside Medical Centre (Stalybridge). The aims and objectives of the reviews are:

To improve patient outcomes in conditions associated with anticoagulant use, such as stroke prevention and Atrial Fibrillation and treatment and prevention of Venous Thromboembolism. In summary:

- Counselling, support and education to patients for whom the decision has been made by the patients' GP, or other designated NHS prescribing authority, to transition patient(s) to a Noval Oral Anticoagulant.

- The prescribing of Novel Oral Anticoagulants is appropriate of patients on the basis of approved indications, patient suitability and avoiding the interruption of therapeutic anticoagulation during the transition.

- The facilitation of transition or initiation of novel oral anticoagulation therapy under the authorisation and specification of patients' GP, or NHS prescribing authority, as required to optimise safe and effective treatment.

By informing patients of treatment aims and options, a pharmacist led consultation involving patient assessment, enables NHS clinician(s) to implement safe and effective anticoagulation treatment interventions whilst ensuring informed patient consent and adherence to treatment.

Equipment – to improve levels of detection amongst identified patient cohorts the Academic Health Science Network have agreed to fund 96 devices for use in Tameside and Glossop. These devices will enable staff in practices to carry out 'near patient testing' of heart rhythms and detect the presence of Atrial Fibrillation. The proposed device is the AlivCor Kardia Mobile[3] device, which has been approved by the Academic Health Science Network as appropriate for use in this project. The project team will ensure that all appropriate assurance is provided by the Academic Health Science Network prior to release of equipment to our practices, and that any issues relating to ownership and maintenance (including calibration) are confirmed. The proposal is that the majority of the devices are used in General Practice, but the project team will also work with the Be Well service and Live Active to identify opportunities where these services can engage with the project.

GP Education – the Academic Health Science Network and the Single Commission (clinical lead) will design and deliver an interactive education session for the member practices in October 2017 which will outline the approach to the identification and management of Atrial Fibrillation outlined in this paper, and will reiterate the use of the pathway approved by Single Commissioning Board in January 2017. At this session, pending Single Commissioning Board approval of this report, practices will receive their 'Kardia Mobile' devices. The education session will include training on the use of this equipment. Ongoing support will be provided via the Academic Health Science Network as required.

5.6 The Integrated Care Foundation Trust, as leaders of the Heart Disease Programme Board, are aware of this project and this progress will be reported through the Heart Disease Programme Board and Integrated Care Foundation Trust governance as well as through the internal Clinical Commissioning Group governance. In addition, the Integrated Care Foundation Trust Clinical Directors are involved through the Neighbourhoods, particularly in the case of the Hyde Neighbourhood, where the use of the mobile equipment is being piloted.

5.7 The benefits of the Single Commission leading this project, as part of the work of the Heart Disease Programme Board, are that we can ensure it is aligned with the ongoing development of the primary care quality agenda, and the role of General Practice in the delivery of integrated care in Tameside and Glossop. And we can align this with the devolved contractual responsibilities held by the Clinical Commissioning Group. It also ensures the project is aligned with the primary care prescribing Quality, Innovation, Productivity and Prevention plans and budget management.

6 PROJECT MANAGEMENT AND TIMESCALES

6.1 Project management is being provided by the Single Commission Commissioning Directorate. Membership of the project team includes representation from the Integrated Care Foundation Trust, and officers from the 'long term conditions' and primary care commissioning teams. Reporting on the project is via the Heart Disease Programme Board. Updates will also be provided to the Single Commissioning Board as required.

6.2 The monitoring of the project will be supported by the Academic Health Science Network to ensure we can report progress and delivery of the project aim and objectives.

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[3] https://www.alivecor.com/?gclid=EAIaIQobChMIvOOtrNLe1QIVR7XtCh1xfg6_EAAYASAAEgJh2_D_BwE

6.3 Baseline data will be collected, with monthly updates collated to indicate the impact of the project. This will include monitoring the number of patients with recorded Atrial Fibrillation, the prevalence, the number of 'known but not treated patients' (which should decrease), and the 'Time in Therapeutic Range'. Thus enabling the project to monitor and report on the delivery of the aims outlined in section 5.1 of this report. The Academic Health Science Network will support the design and population of a dashboard which will be presented to the Heart Disease Programme Board and Professional Reference Group following completion of the project.

6.4 Clinical Leadership – the Clinical Leadership for the project will be provided by Dr Tom Jones. Dr Jones is a partner at Lockside Medical Centre in Stalybridge, and is the Clinical Commissioning Group Clinical Lead for Long Term Conditions, supporting Dr Alison Lea (Governing Body GP Member). He will provide medical/clinical input to the project, and will do so from the perspective of having carried out the reviews proposed in this paper in his own practice as part of the testing and development of the proposals.

6.5 Medicines Management – the Head of Medicines Management for the Single Commission is a member of the project team. He will provide expert advice and assurance to the project team that the project (particularly the practice review process) is in line with local medicines management guidelines, is included within / aligned with the local prescribing budget management and Quality, Innovation, Productivity and Prevention plans (therefore not placing additional pressure on existing plans and prescribing budgets), and is delivered by appropriately qualified staff from a pharmacy perspective. The involvement of the medicines management team also enables the project to work with the Clinical Commissioning Group and Integrated Care Foundation Trust medicines management teams, and potentially the Neighbourhood Pharmacists as they come into post. This will facilitate the sustainability of the project.

6.6 The project members are working with the Academic Health Science Network to explore opportunities, and potentially additional funding, for the digital monitoring of patient compliance / concordance with treatment provided for identified Atrial Fibrillation.

7 RECOMMENDATION

7.1 As outlined in the front cover of this paper.