

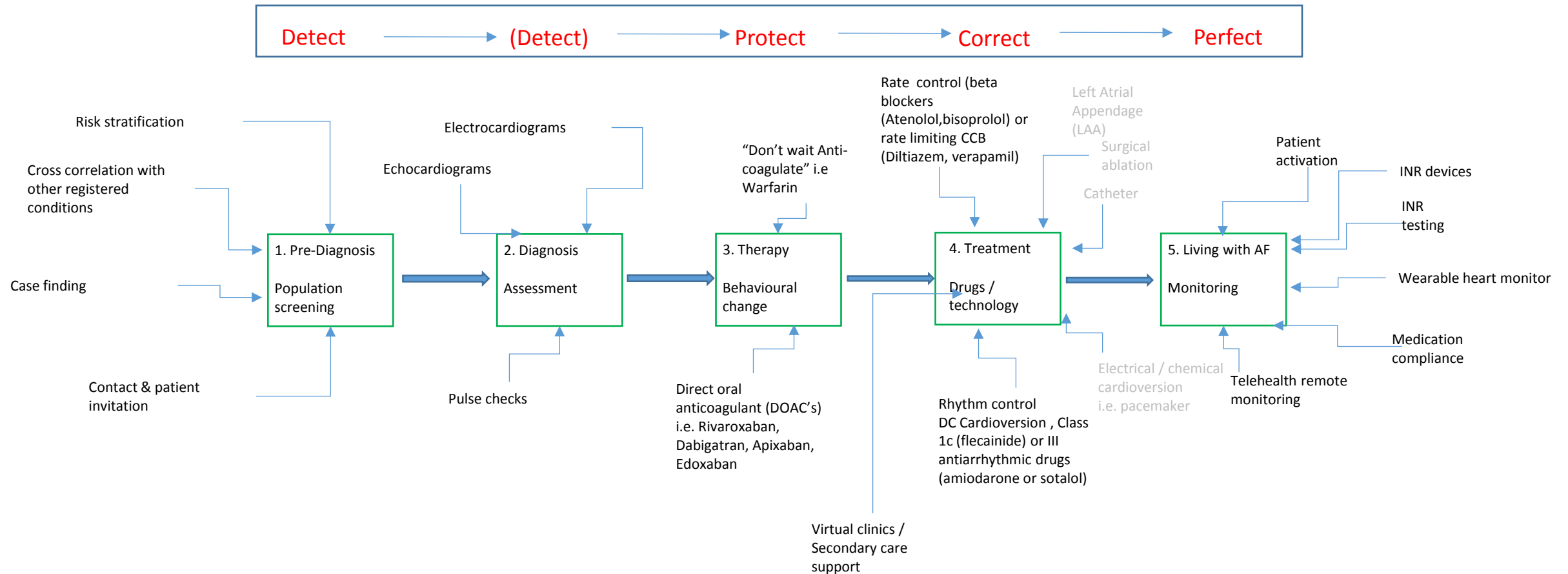
Pan London AF Improvement Programme

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On behalf of Pan London Primary Care AF Improvement Programme

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A simplified view of the AF Pathway



Why? - London picture

AF Strokes in CCG

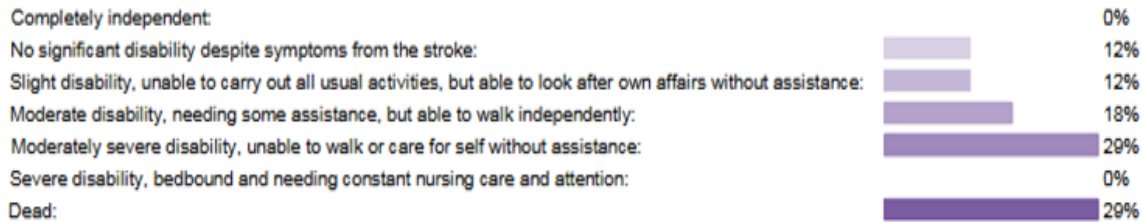
Source: SSNAP 2014

AF is a major risk factor for stroke and a contributing factor to one in five strokes. Treatment with an oral anticoagulant medication (e.g. warfarin) reduces the risk of stroke in someone with AF by two thirds.



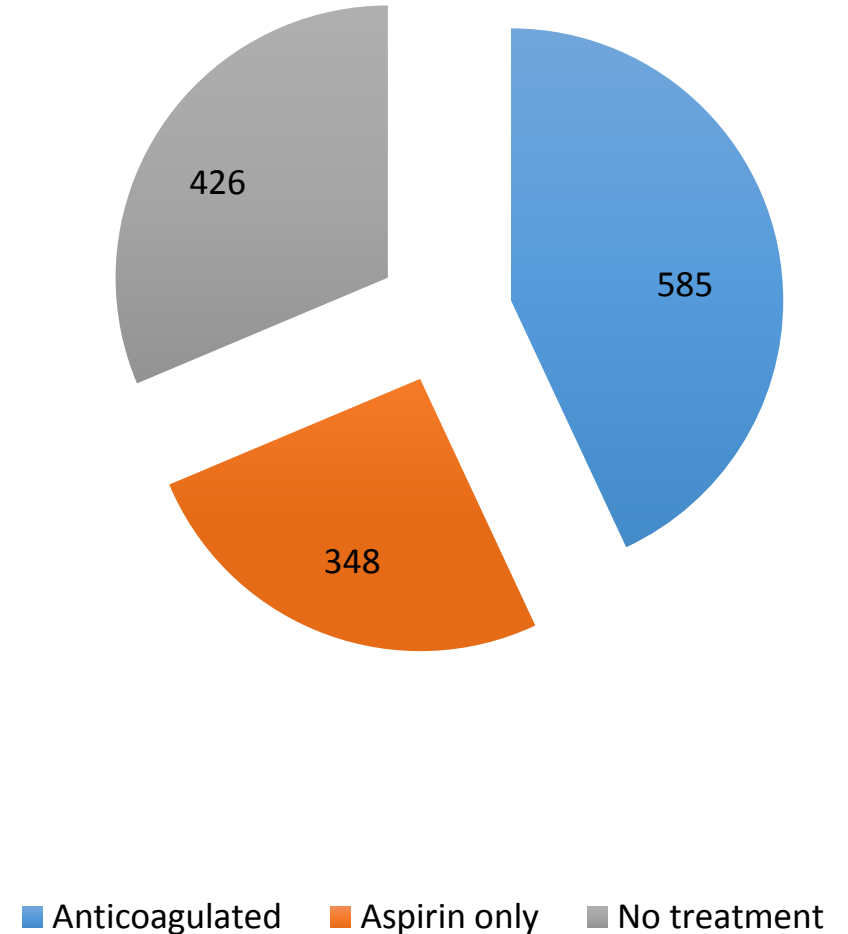
AF Strokes: Outcome after discharge in people NOT anticoagulated before their stroke in CCG

Source: SSNAP 2014



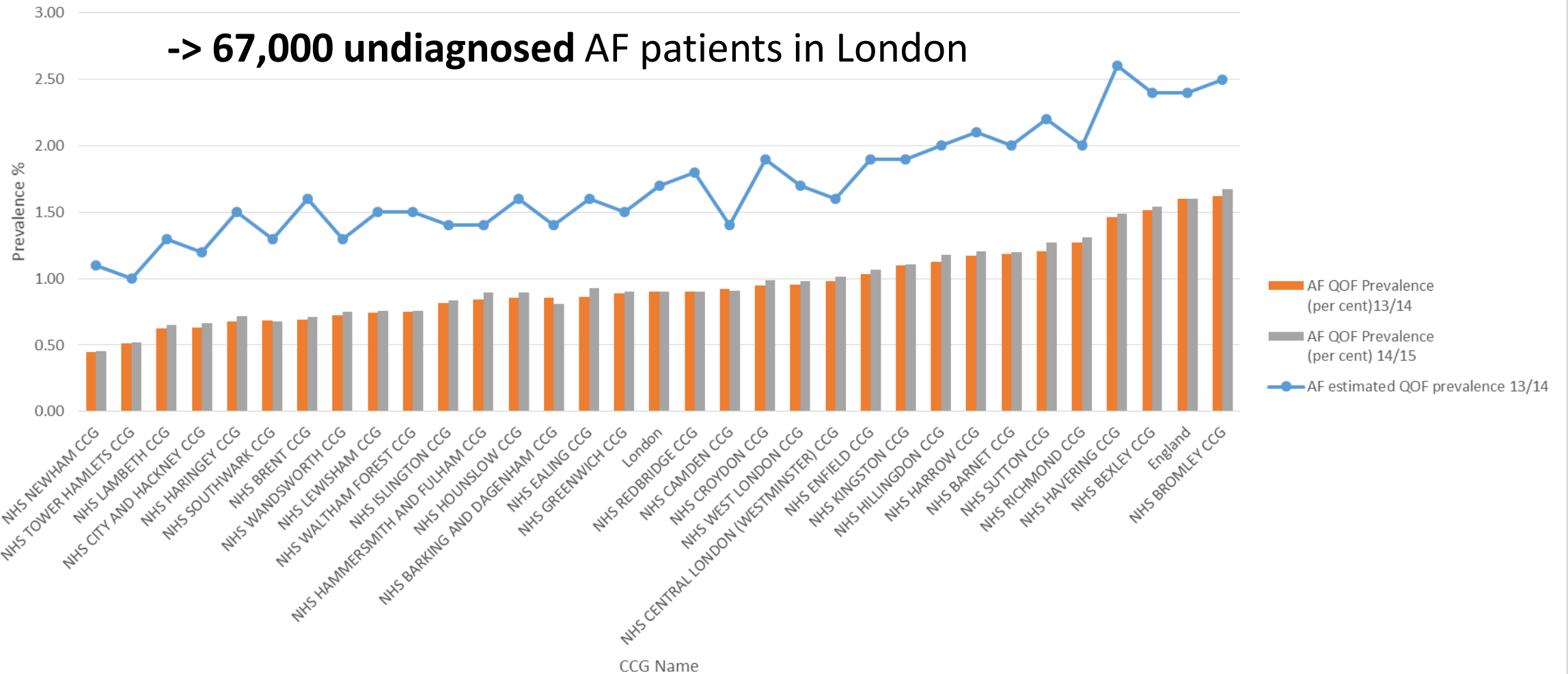
Source: Stroke association: <https://www.stroke.org.uk/professionals/af-page/af-page-%E2%80%93ccgs-d>

SSNAP 2014/15: Strokes and known AF



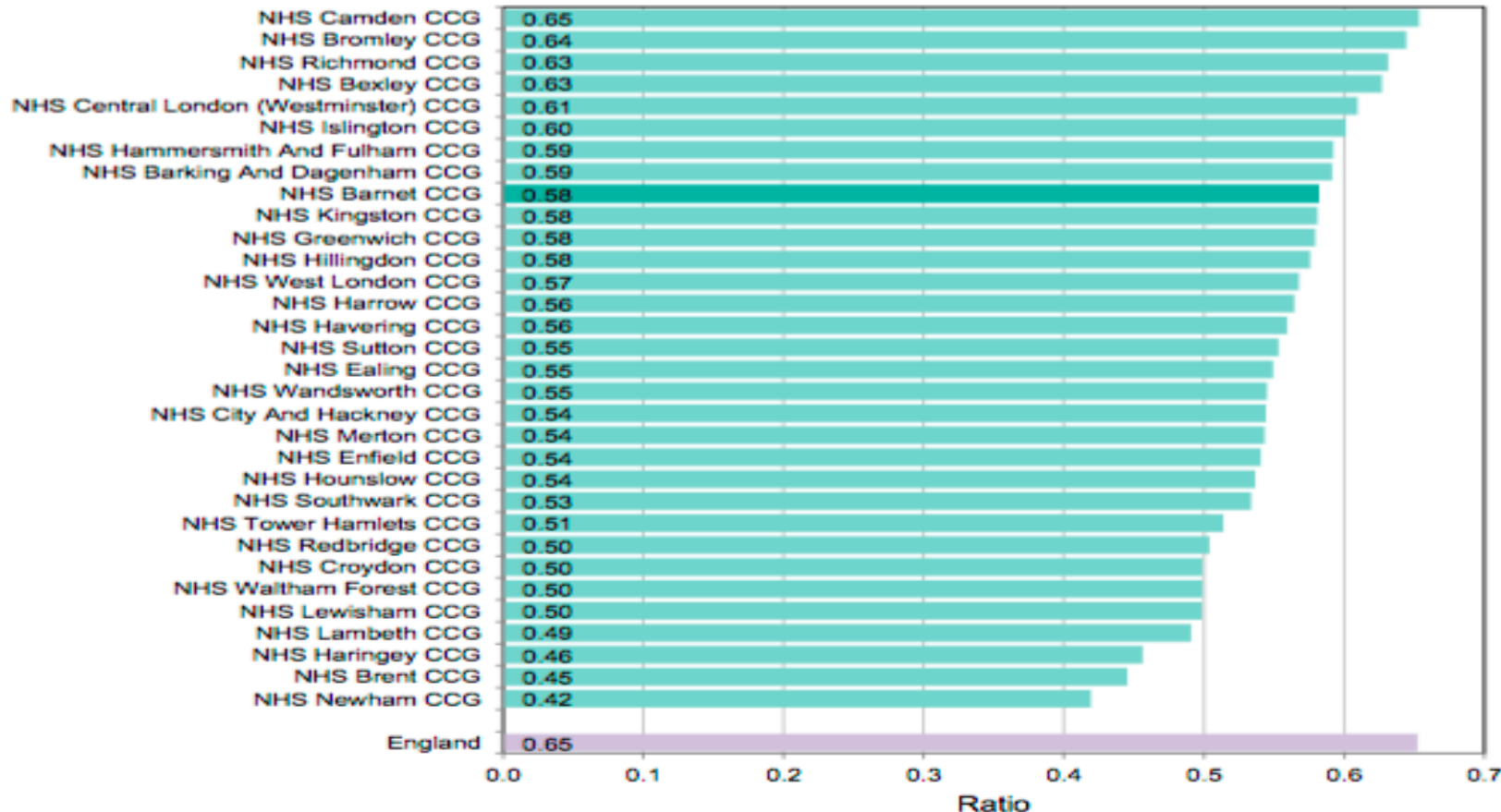
London AF QOF estimated and actual prevalence

-> 67,000 undiagnosed AF patients in London



Atrial fibrillation observed prevalence compared to expected prevalence by CCG

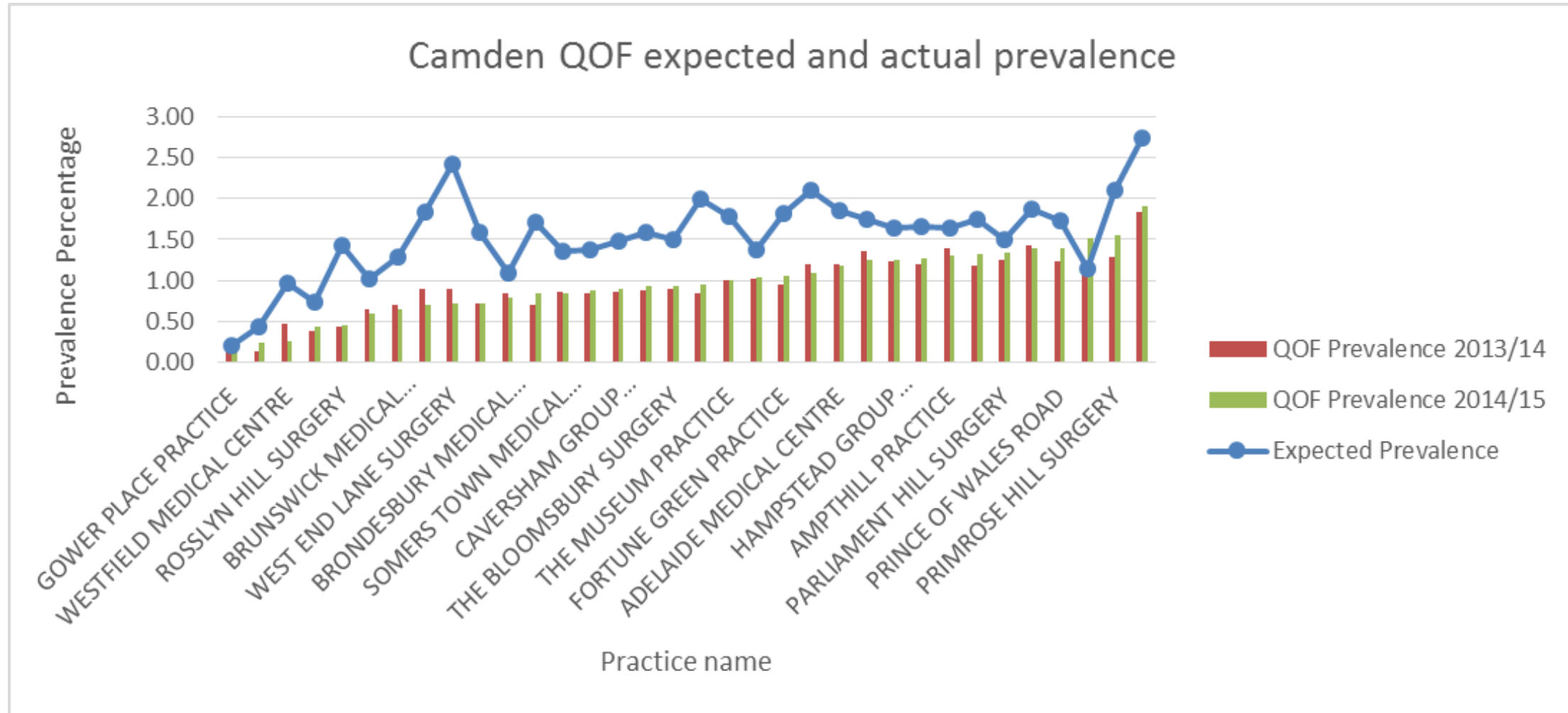
Comparison with CCGs in the SCN



- 0.58 ratio of observed to expected atrial fibrillation prevalence in NHS Barnet CCG compared to 0.65 in England.
- This suggests that 58% of people with atrial fibrillation have been diagnosed.

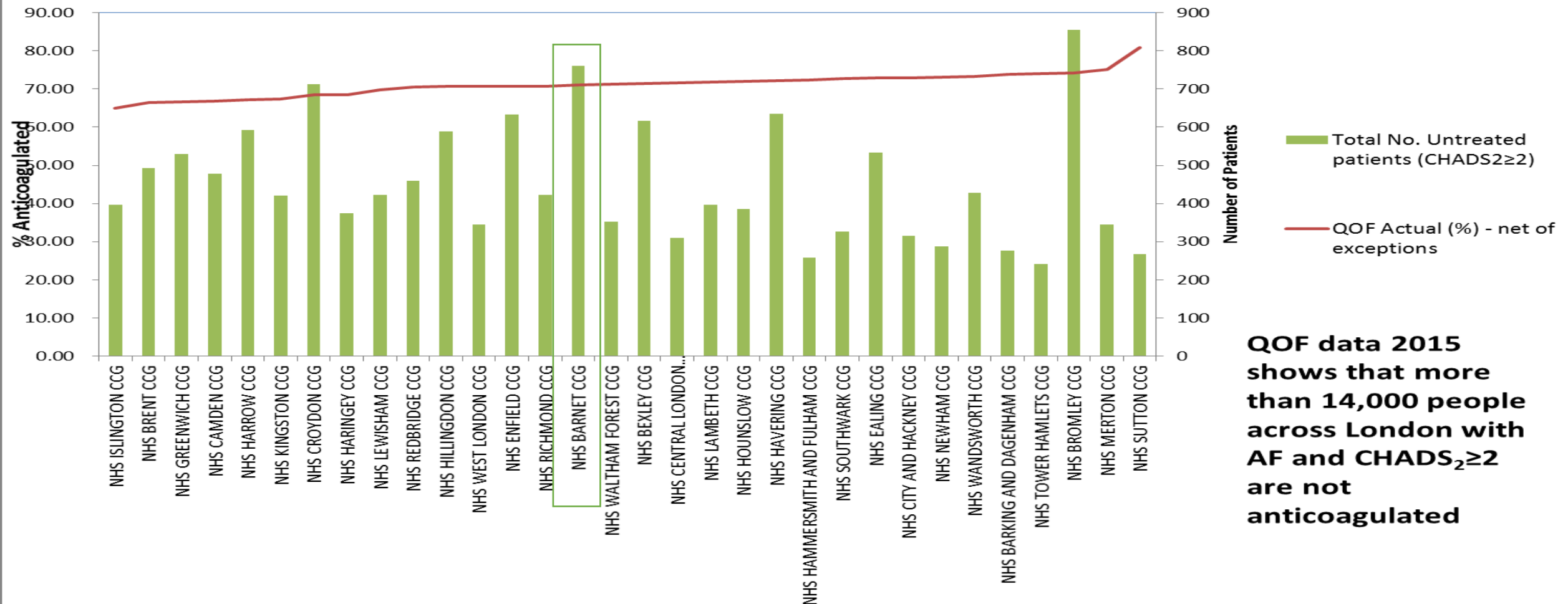
Note: This slide compares the prevalence of atrial fibrillation recorded in QOF in 2013/14 to the estimated prevalence of atrial fibrillation, taken from National Cardiovascular Intelligence Network estimates produced in 2015. The estimates were developed by applying age-sex specific prevalence rates as reported by Norberg et al (2013) to GP population estimates from the Health and Social Care Information Centre. Estimates reported are adjusted for age and sex of the local population.

Prevalence data for practices in the CCG

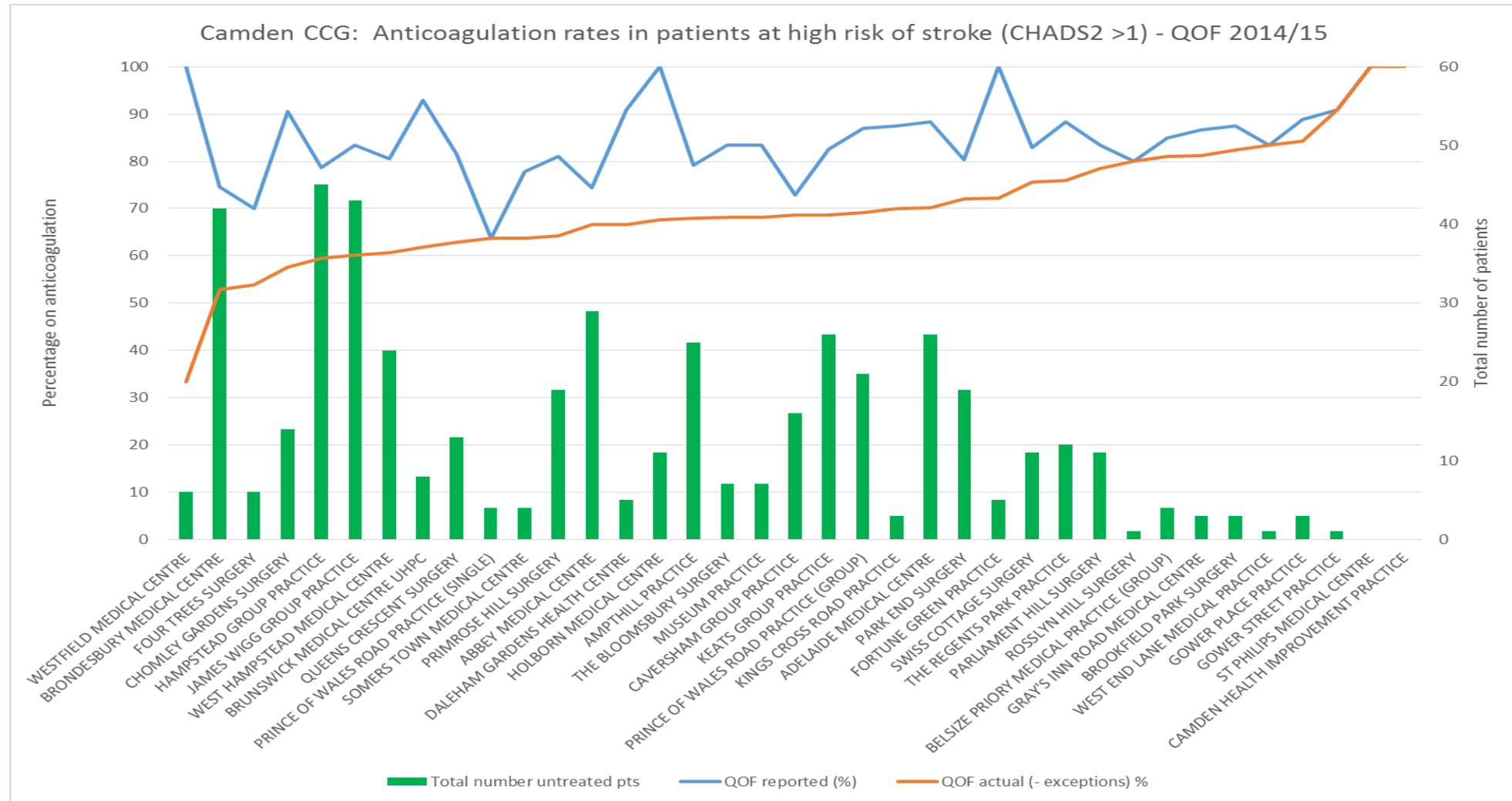


Barnet – 760

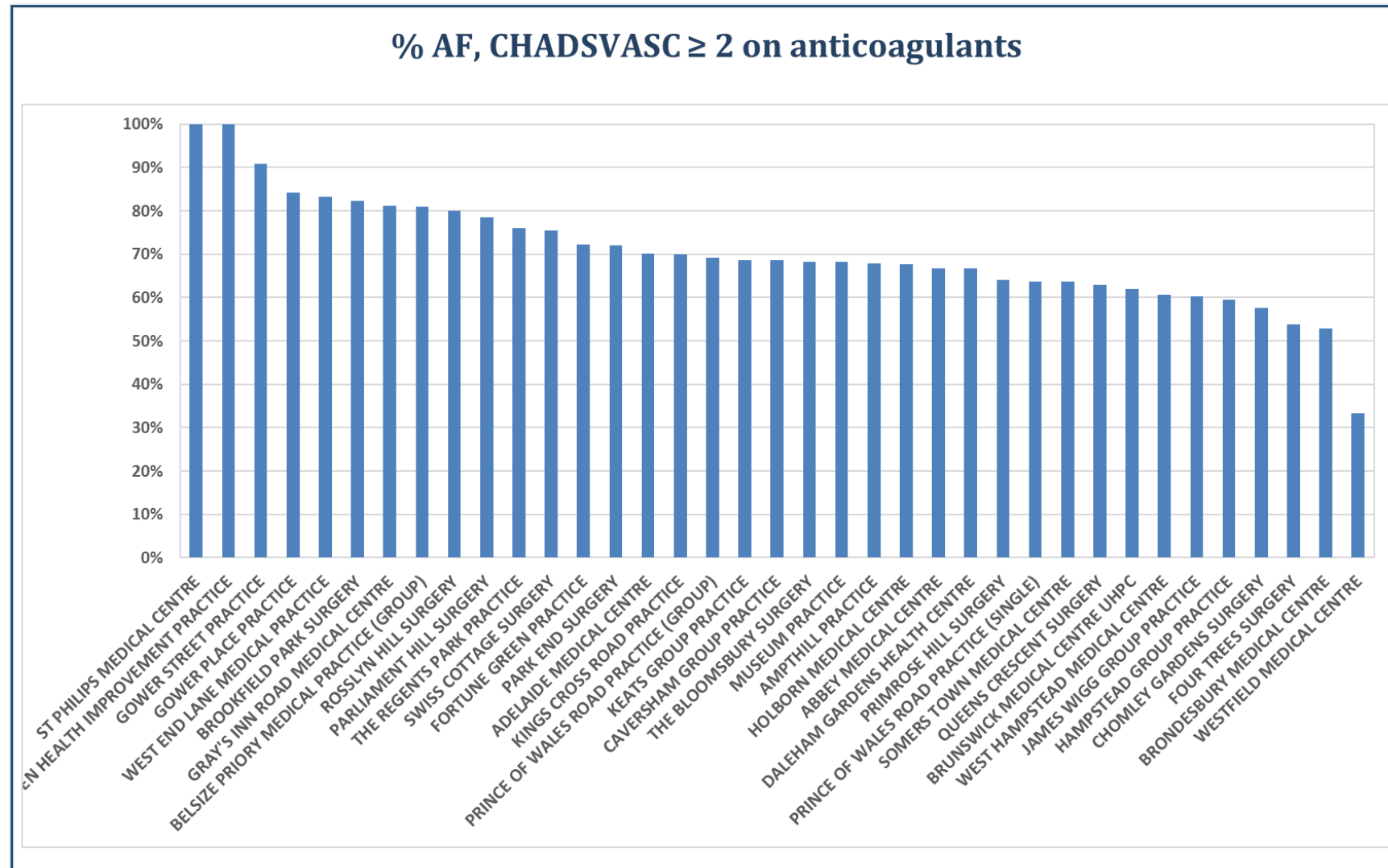
% Rates of anticoagulation in high risk AF patients (CHADS₂≥2) and number of untreated high risk patients by CCG (QOF 2015)



Anticoagulation rates – untreated patients

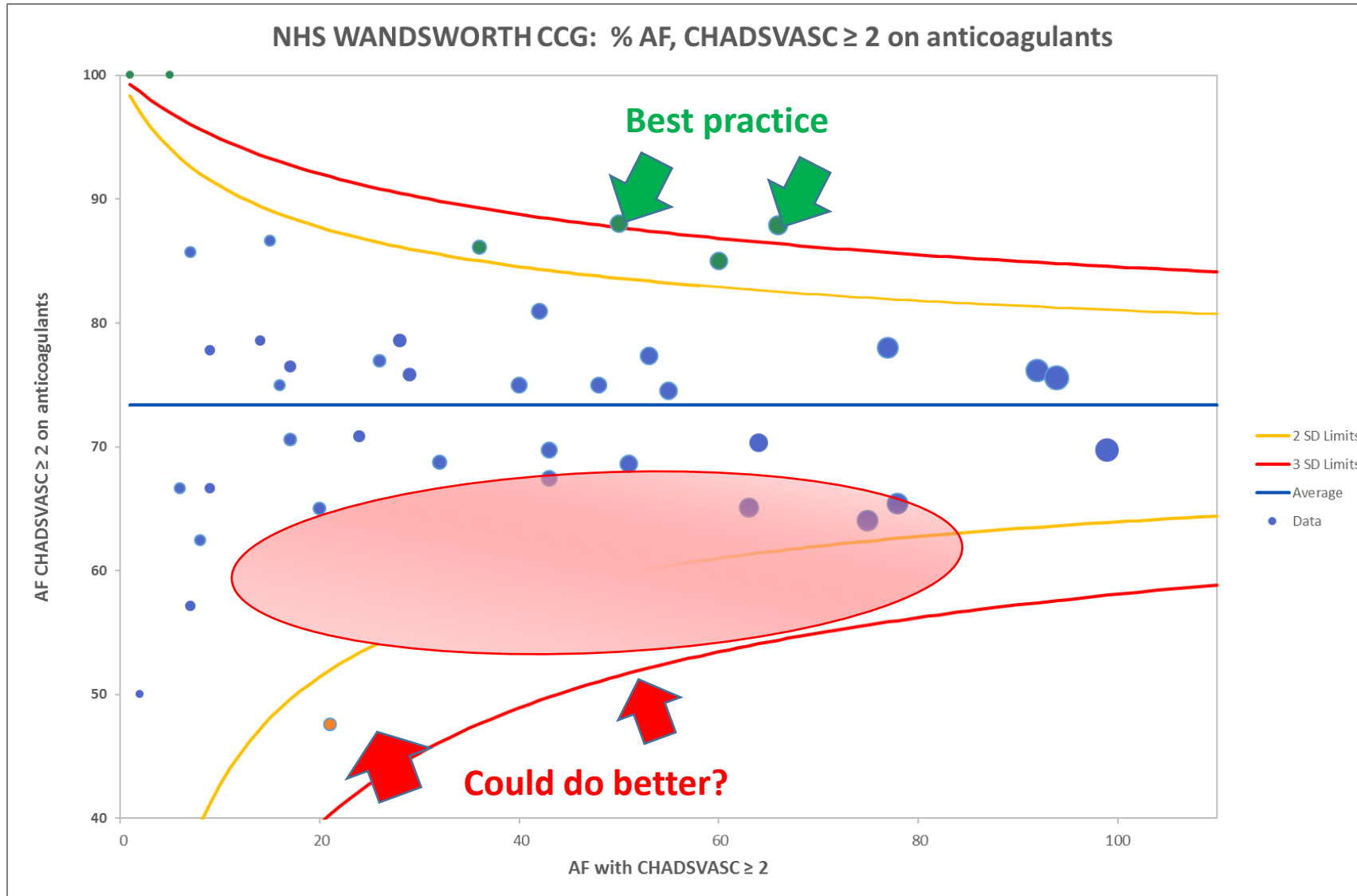


Variation in anticoagulation rates for practices in the CCG



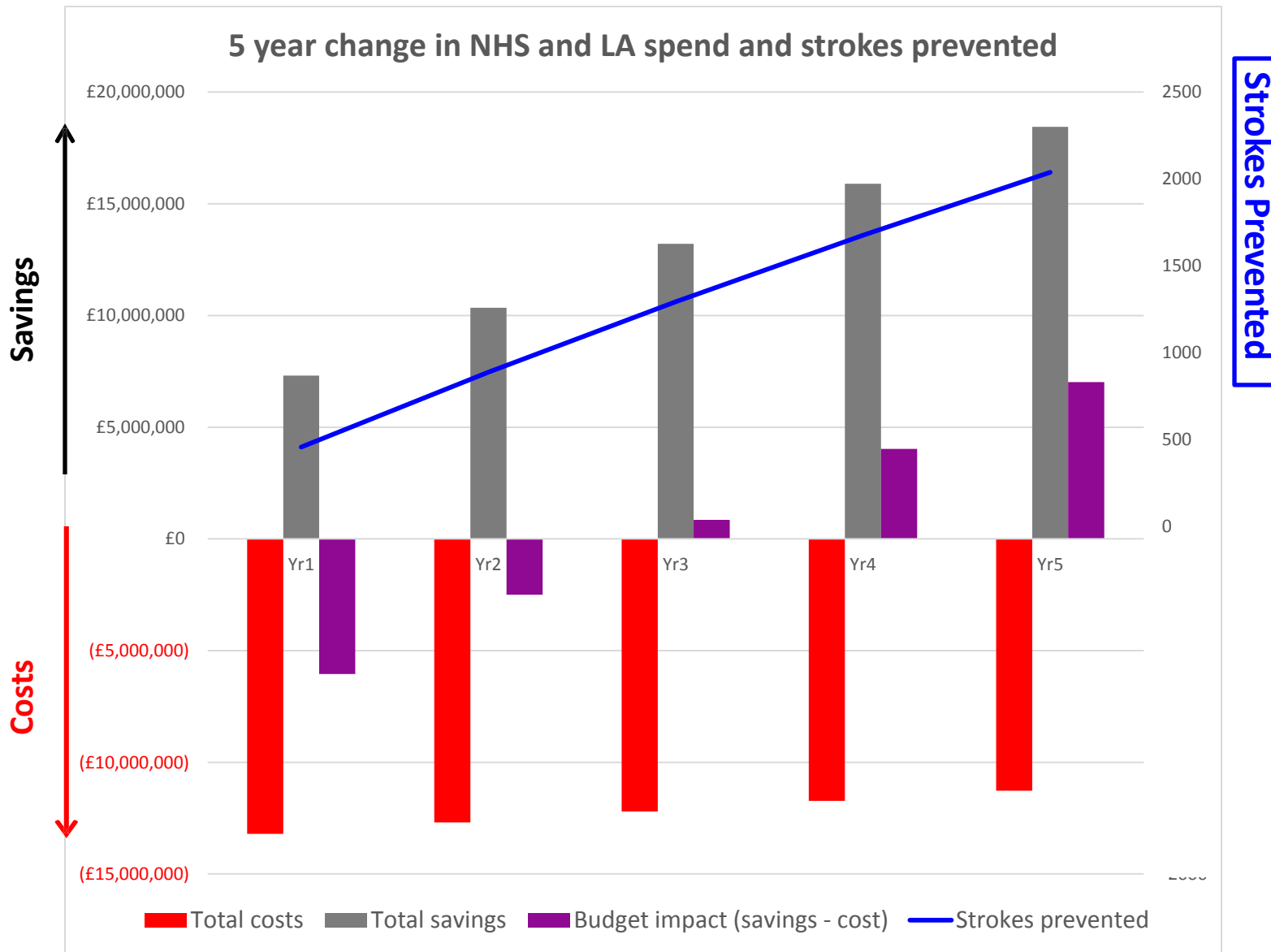
Source: QOF 14-15
AF 004 no exceptions
QOF Actual

Anticoagulation rates



Source: QOF 14-15
AF 004 no exceptions

Health and budget impact modelling – London



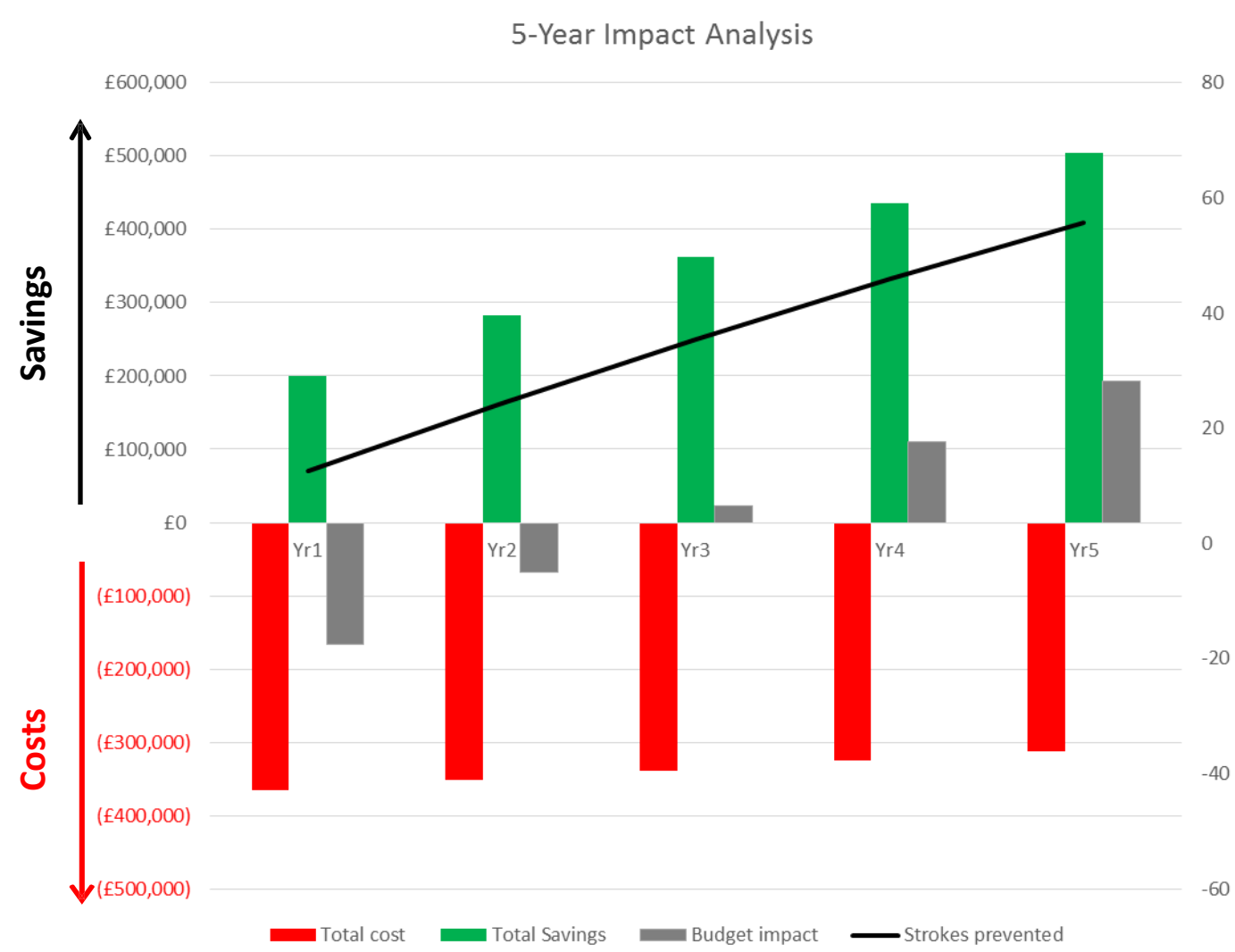
Benefits

- Prevent over **2000 strokes** over 5 years
- ~ **400 - 500 lives saved** over 5 years
- Net savings seen at year 3, and accumulative net savings to health economy of ~ **£3.5 million** over 5 years.

Modelling assumptions

- Based on the NICE AF costing tool (2014) with the same modelling assumptions
- 84.21% of AF population have CHADSVASC ≥ 2
- Baseline demographic data from QOF 2014/15
- Current and future treatment estimates from NICE AF costing report 2014
- 3 NOACS (not edoxaban) used in equal proportion
- Cost of stroke £12,228 (NICE); major bleed cost £1,173 (NICE)
- Cost of long-term nursing care £6,880 **does not include all social care costs**
- Drug costs from MIMS 2015
- Does not include other economic benefits
- Does not include increase in AF incidence year-on-year
- Does not include additional patients identified through screening

Health and budget impact modelling – CCG



Strokes Prevented

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Measurable Outcomes

AGREED AF QUALITY STANDARDS

- Proportion of patients with a CHA₂DS₂VASc score ≥ 2 on anticoagulation treatment: **aim > 80% (no exceptions)**
- Proportion of patients with a CHA₂DS₂VASc score ≥ 2 on anti-platelet treatment: **aim < 10% (no exceptions)**
- Proportion of patients taking warfarin with a TTR < 65% who have their anticoagulation quality reassessed at least once every six months – **aim = 100%**
- Proportion of patients over 65 who have a pulse check (manual or other technology) over 5 years – **aim > 90%**

SYSTEM LEVEL IMPACT MEASUREMENT

- Numbers of patients who **died as a consequence of a stroke**
- Number of **AF-related stroke** episodes

Communities of Practice – why?

- New knowledge being generated through the experience of people working to improve care for people with AF
 - Much of this knowledge goes untapped
 - Leads for this work often feel isolated,
- Access to colleagues across boundaries of institutions and professions in London
 - Supporting people with a passion for improving practice (in AF)
- Building relationships between peers,
 - Share learning from (and with) one another

Communities of Practice – benefits?

- collective experience and intelligence of the community, turning *‘promising practice’* into *‘shared best practice’*.
- sustainable improvement
- encouraging us to reflect on our own practice in light of the practice of colleagues.
- consider approaches that may work, and identify what will not work, in improving the care of patients living with AF across London.

Communities of Practice - experience

- On each theme
 - Detect, Protect and Perfect
- Tailored to individual CCGs
 - Croydon - re-commission anticoagulation service
 - Barnet – primary care initiation
 - Bromley – implementing early detection
- Support around Quality Improvements
- Separate vs. altogether and themed breakouts

Communities of Practice - toolkits

Self-monitoring and management

	Steps	Activities	Materials
1	Prepare	Secure resources Build project team Establish project governance Collect baseline	Business case, engage AFA A-A clinical lead, project manager, patient representative Accountability, reporting, risk/ issue management, project plan Numbers of patients self monitoring and self managing; waiting time for follow up; TTR
2	Assess	Engage stakeholders Learn from models of good practice Assess staff readiness for change Review pathway for ongoing monitoring / management	Compelling case for change', primary care staff (GPs, Pharmacists), Haematologists, Cardiologists, AC service managers Case studies of successful models and governance; review different technologies and service providers Identify workforce and determine knowledge/ skills - gap analysis, competency framework skills audit AF pathway, capacity planning,
3	Plan	Set realistic aims and quality standards Create enablers for sustained behaviour change Train core staff Prepare resources for providers	Review to case studies, agree eligibility criteria, agree governance arrangements Service Specification, incentives, digital infrastructure Training providers, protocols, competency framework, Guidelines, referral forms, patient information, equipment
4	Implement & evaluate	Continue to support providers Monitor patient numbers and patient flows Seek public and provider feedback Refine resources/ support real time	Service visits, review of patient numbers, reviewed clinical governance Service audit: waiting times, TTR, quality standards Set up audits: numbers trained. Audit of patients experience and choice Adapt model eg training provider, eligibility, protocols etc in response to feedback