UNIVERSITY OF LEEDS

ASPIRE
Action to Support Practices Implementing Research Evidence

Can your practice prevent more strokes in patients with atrial fibrillation?

1st report May 2015	2nd report July 2015	3rd report October 2015	4th report January 2016	5th report April 2016

Dear Practice Manager and colleagues

Many patients with atrial fibrillation (AF) are at increased risk of avoidable, life-changing strokes because they are not receiving appropriate treatment[1]. Practices across West Yorkshire are improving their management of atrial fibrillation, but more can be done. The ASPIRE team can offer support to improve outcomes for your practice population.

We know that anticoagulation carries risks and the fear of adverse events (e.g. bleeds) can prevent GPs from initiating anticoagulation. You may have experienced organisational and logistical barriers to providing appropriate anticoagulation therapy, e.g. lack of clear pathways of care, or patients who don't wish to attend hospital.

All GPs will at some point have clinical responsibility for a patient receiving anticoagulation therapy, either in initiating or monitoring treatment. We have provided some guidance (page 4 of this report) to support you in managing AF more effectively. Practical tools provided through ASPIRE are still available to you until the end of March, including SystmOne searches, and pharmacist support to help you identify relevant patients and review their care.

Please share and discuss your practice data with your team. We will also send you ten copies of this report. If you require more copies of this or previous reports, or have any other queries about ASPIRE, please contact Dr Tom Willis (**aspire@leeds.ac.uk**; 0113 343 6731).

Yours sincerely

Dr Robbie Foy
General Practitioner & Professor of Primary Care on behalf of the ASPIRE team

"AF increases the thrombotic environment in the atria and the risk of thrombus formation is considerable[2]. This risk can only be reduced by oral anticoagulation. Five of the six NICE Quality Standards for AF published in July 2015[3] relate to this issue, stressing:

- **The need for risk assessment**
- **The risks of taking aspirin outweigh any benefits of taking it as monotherapy for stroke prevention in AF**
- **The need for the use of a high quality anticoagulant, based on patient preference and personal characteristics."**

Dr Matt Fay
GP Bradford and Trustee, AF Association

"If no contraindication to anticoagulants, doing nothing is not an option."

Dr Duncan Petty
Practice Pharmacist, Bradford

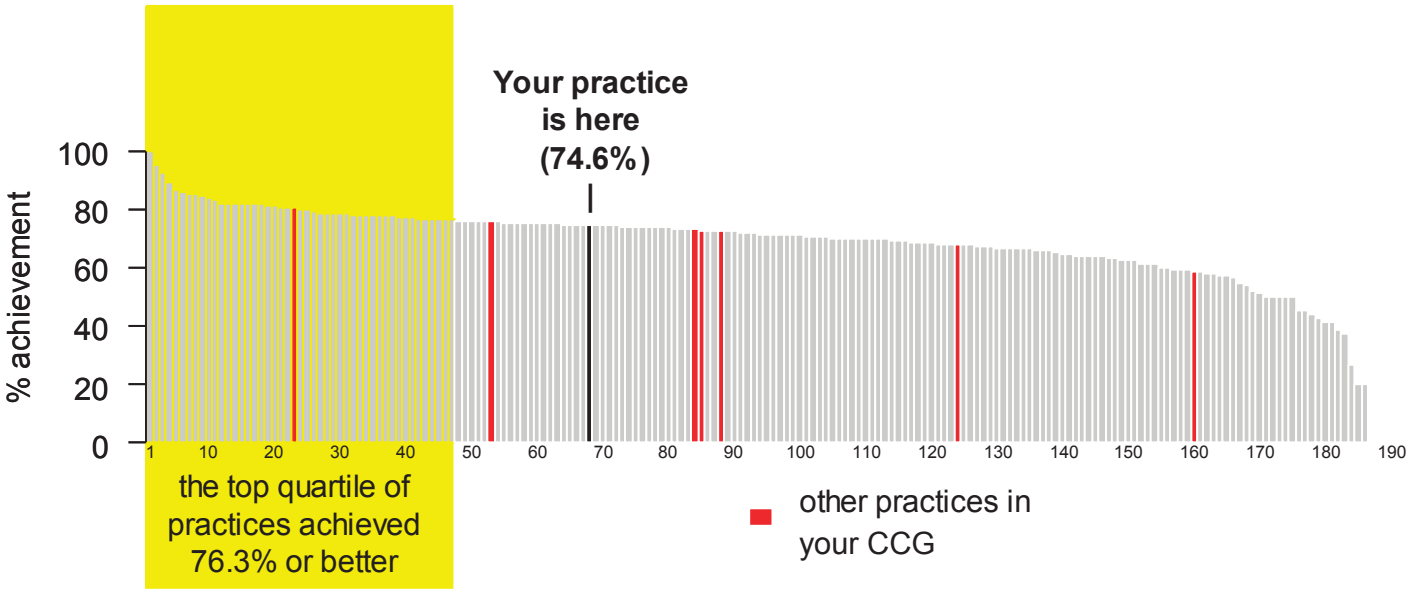
For more information on ASPIRE, please see **http://medhealth.leeds.ac.uk/aspire**

NHS National Institute for Health Research

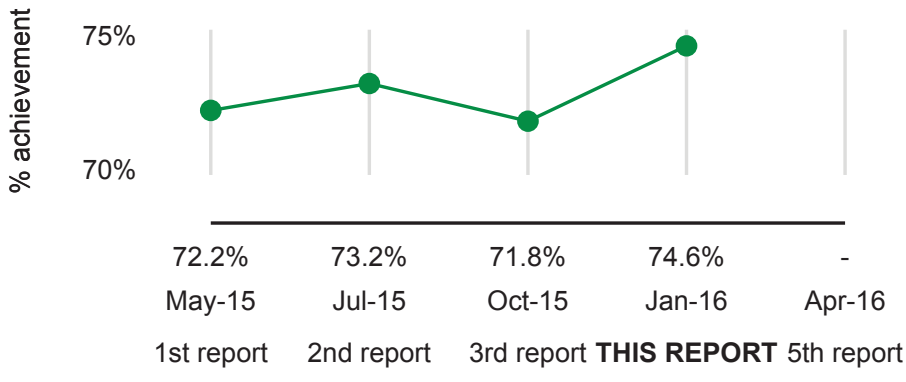
How well is your practice doing?

Current achievement in participating practices across West Yorkshire

- Your practice (black bar) and % achievement (74.6%)
- Achievement throughout West Yorkshire overall (range 0 to 100%)
- The top quartile of practices within West Yorkshire (yellow box – achieving 76.3% or above)
- Other practices within your CCG (red bars, n=7)



What has changed?



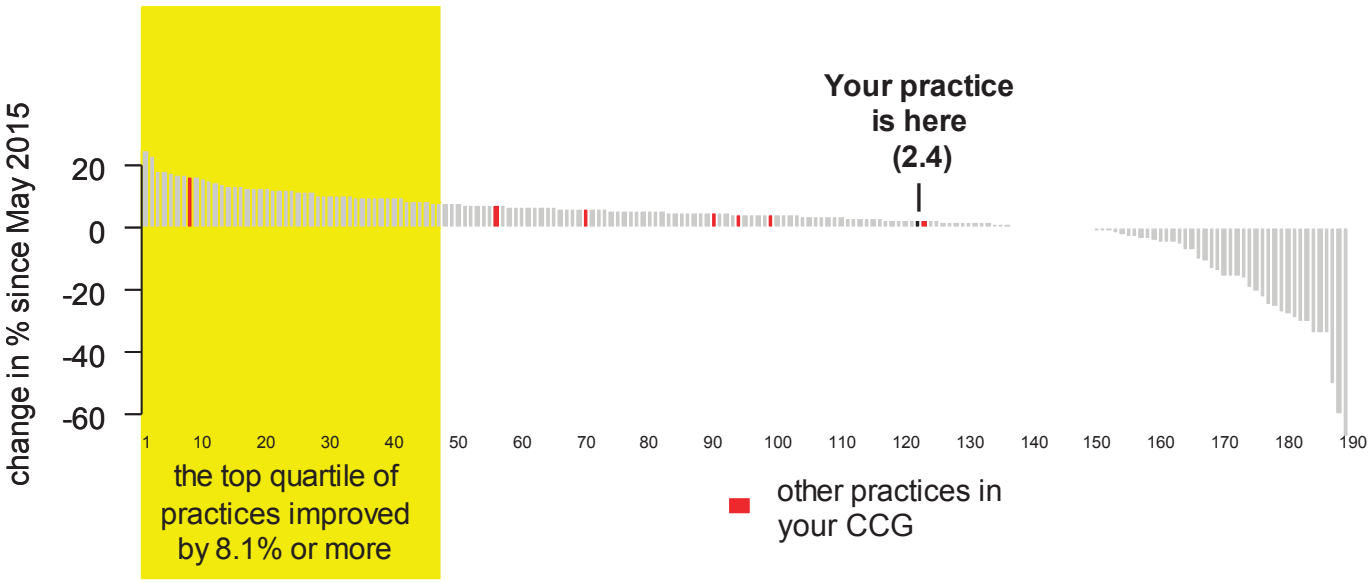
Your achievement rose by

2.4%

since May 2015.
Now, 197 out of 264 patients are in line with evidence-based targets whilst 67 could benefit from further action.

Congratulations! Please share these data with your colleagues. Your team are reducing the risk of stroke for your patients with AF. Can you identify what has had the most impact? Please review your action plan to ensure this improvement continues.

What have other West Yorkshire practices achieved in nine months?



Where can we take action?

Indicators (for patients with atrial fibrillation)	Proportion of patients (%)	Your Progress: Change in proportion since May 2015	Data for Action Plan: Number of patients	Data for Action Plan: Number of patients to be reviewed	Data for Action Plan: Proportion of patients to be reviewed (%)
AF register + male + CHA2DS2-VASc score = 1 + receiving anticoagulation	**56.5**	**+27.1**	**13/23**	**10**	**43.5**
AF register + male + CHA2DS2-VASc score = 1 + receiving anticoagulation OR contraindication for anticoagulation	**60.9**	**+25.6**	**14/23**	**9**	**39.1**
AF register + CHA2DS2-VASc score = 2 or higher + receiving anticoagulation	**76.3**	**+0.9**	**184/241**	**57**	**23.7**
AF register + CHA2DS2-VASc score = 2 or higher + receiving anticoagulation OR contraindication for anticoagulation	**79.7**	**-2.9**	**192/241**	**49**	**20.3**
Combined indicator	**74.6**	**+2.4**	**197/264**	**67**	**25.4**

Action planning & achieving change

The following questions might help your team to think about how you could work to improve practice performance:

What are we struggling with at our practice?

- Which indicator(s) or subgroup(s) of patients are we concerned about? Where should we start?

Who is this a problem for?

- Which members of our team can identify patients or review their management?

What have we or others done before, for this or similar problems?

- How can we maximise what we do well in this and other areas?

What do we need to do to move forward?

- Who in our team can run and review the ASPIRE SystmOne searches to identify eligible patients?
- Have we arranged our ASPIRE outreach meeting?
- How can we use two days of pharmacist support?

What have other practices done?

Our pharmacist support has been used to assist with the identification of at-risk patients as well as those who had anticoagulation stopped following a fall. Here, the lead GP considered the options: leave patients at greater risk of a stroke, or re-start anticoagulation with risk of a bleed?

A patient would have to fall ~300 times in one year for the risk of a bleed to outweigh the risk of a stroke with no treatment[4]. Patients were invited to appointments where the pharmacist could discuss the options and conduct all appropriate checks (e.g. absolute and relative contraindications, bloods). In many cases, the recommendation was made to refer for anticoagulation.

Anticoagulation does not cause bleeds, but it can make existing bleeds worse. Bleeds and adverse events are obvious, acute and significant and can put GPs off. However, it is worth remembering that clinicians do not see the many strokes that they have prevented by treating patients with anticoagulation.

Frequently Asked Questions

Since earlier reports, you have raised some questions about the data and/or ASPIRE in general:

Will ASPIRE help our QOF performance?

The prevention of stroke in patients with AF is a clinical area featured in QOF. Achievement of the indicators in this report is likely to benefit performance on QOF indicator AF007.

We hope that our intervention will help QOF achievement, but the plain truth is that we won't know until we have analysed our results.

We are simply too busy – what can you do to help?

We can offer up to two days of pharmacist support to identify your patients and review their risk – please contact **aspire.admin@nhs.net** to arrange this. We offer our resources free of charge to practices. We also offer a modest 'Service Support Cost' sum for research activity. We have recently provided information on how ASPIRE can help to provide evidence for a CQC submission. Please contact us if you did not receive this.

References

1. National Institute for Health and Care Excellence. *Atrial fibrillation: the management of atrial fibrillation*. 2014; Available from: **https://www.nice.org.uk/guidance/cg180**.
2. Watson, T., E. Shantsila, and G.Y. Lip, *Mechanisms of thrombogenesis in atrial fibrillation: Virchow's triad revisited*. Lancet, 2009. 373(9658): p. 155-66.
3. National Institute for Health and Clinical Excellence. *Atrial fibrillation - NICE quality standard (QS93)*. 2015; Available from: **https://www.nice.org.uk/guidance/qs93**.
4. Man-Son-Hing M, Nichol G, Lau A, Laupacis A. *Choosing antithrombotic therapy for elderly patients with atrial fibrillation who are at risk for falls*. Arch Intern Med. 1999;159:677–685.