Partners in improving local health

North of England Commissioning Support

Atrial fibrillation: the management of atrial fibrillation

NICE guidelines [CG180] Published date: June 2014

Purpose

This paper is designed to give an executive summary of the key points in relation to medicines optimisation arising from NICE CG 180.

It highlights some issues CCGs may wish to consider in terms of implementation of the guidance.

Summary

Implementing the clinical guideline is expected to reduce the incidence of stroke for people with atrial fibrillation to 69% of the current level. This translates to a relative risk reduction of 31% and a **reduction in stroke incidence from 59 to 41 per 100,000 population per annum**.

There are significant resource implications arising from the recommendations and it has been assumed that the majority of change in practice will occur in the first year following publication of the guideline. The net cost impact estimate is £88,530 per 100,000 population derived from:

- Increased prescribing costs per 100,000 per annum = + £308,370
- Reduction in adverse event costs per 100,000 per annum = - £ 219, 840

This estimate relates to direct costs to the NHS. They do not include consequences for the individual, the private sector or the not-for-profit sector. Non-recurrent costs will need to be determined locally.

The calculations are based on AF prevalence of 1.6% of the population. Local baselines will need checked to validate these costing assumptions and are available from a variety of sources including RAIDr. (Appendix 1)

The main changes in recommendations that will impact on costs are:

1. **Do not offer aspirin monotherapy solely for stroke prevention to people with atrial fibrillation.**

Current and future national treatment ratios for medication are modelled by NICE as:

Treatment	Current usage	Future usage	Change in practice
Warfarin	34.32%	46.74%	+12.42%
Aspirin	22.49%	2.50%	-19.99%
Dabigatran	4.73%	11.65%	+6.92%
Rivaroxaban	4.73%	11.65%	+6.92%
Apixaban	4.73%	11.65%	+6.92%
No treatment	28.99%	15.79%	-13.2%

2. Use the **CHA2DS2-VASc** stroke risk score to assess stroke risk

The previous guideline recommended using CHADS2 to assess stroke risk .This change will increase the percentage of people who would be offered anticoagulation treatment, from 57.81% to 84.21%.

3. **Refer people promptly at any stage if treatment fails to control the symptoms of atrial fibrillation and referral for more specialised management is needed.**

Commissioning considerations

- Implementing the clinical guideline is expected to result in fewer strokes in people with atrial fibrillation but commissioners will need to decide how to manage the increased cost pressure in prescribing. Clinical commissioning groups and acute hospitals should work together to ensure effective use of resources.
- Existing anticoagulation services will need to be reviewed to ensure that there is sufficient capacity for newly diagnosed people with atrial fibrillation and people changing treatment.
- Key groups in whom newer oral anticoagulation drugs (NOACs) should especially be considered include :
    - Those who cannot take vitamin K antagonists
    - Those who cannot be stabilised on vitamin K antagonists with poor time in therapeutic range(e.g.<65% despite adequate adherence)
    - Those taking aspirin for stroke prevention
- All NOACs are approved for use by NICE .Rebate schemes exist for dabigatran and rivaroxaban. This should be considered in the local decision making process.
- NHS England monitors uptake of NOACs on the Medicines Optimisation Dashboard.

Practice resource Implications

- A patient decision aid has been published alongside the guidance to aid clinicians and patients when discussing potential treatment options .This is 36 pages long and will be time intensive. The Health Foundation's MAGIC programme, focussing on shared decision making, is also undertaking work in this area and NECS are working with them to explore the opportunities this may present.
- There is no need for routine coagulation monitoring with NOACs and concern has been expressed about patient adherence. The full benefits of the newer agents will only be realised if compliance is as in trials and health care professionals should ensure that patients understand why they are taking an anticoagulant and the expected benefits. Renal function monitoring is required at least annually and compliance checks should be considered as part of the medication review process.
- For people taking an anticoagulant and those diagnosed with AF but not taking an anticoagulant, an annual review of stroke and bleeding risks is essential.
- Two-thirds of people admitted to a hospital with a stroke caused by AF are not taking recommended anticoagulants. Effective detection of atrial fibrillation is needed. RAIDR can be used to produce(Appendix):
    - The number of atrial fibrillation patients not currently treated
    - The number of strokes per year that would be seen in this untreated population
    - The number of patients who may have atrial fibrillation but do not have a diagnosis

- Practice systems need updating to the new risk assessment tools (CHA2DS2**-VASc** for stroke risk and HAS-BLED for bleeding risk). Training will need to be undertaken to familiarise practitioners with these.

Appendix - Using the RAIDR AF risk stratification tab

This guide will show you how to produce a list of patients using specific criteria selected by you and how to use the AF case finder to identify patients with likely AF but who have no Read coded diagnosis of AF.

Open the Primary Care dashboard from the RAIDR website.
Once loaded select the white 'AF tab'.
You must first select which risk score to use – CHA2DS2-VASC or CHADS2.
This will highlight how each risk score is calculated, and there are links to AF pathways and guidance.

The first screen will show a summary for your practice. The bar charts show:

1. The AF rate per 1000 patients in your practice by age group; and
2. The % patients in your practice with different risk factors e.g. hypertension

In addition you will be able to see:

1. The number AF patients not currently being treated
2. The number of strokes per year that would be seen in this untreated population; and
3. The number of patients who have Read coded factors indicating that they may have AF but do not have an AF diagnosis.

Produce a list of AF patients:
To produce a list of your AF patients click the orange 'Produce Patient list' button.
There are a number of blue selection buttons on the right side of the screen which allow you to filter the patient list for specific criteria.
Click once on a button to make the selection – the button will change to red.

This list can be exported to Excel by clicking the button.
To view records for a patient in more detail, click onto their NHS Number:
□□To go back to the full list of patients click the 'Clear NHS Number selection' button.
□□To go back to the main AF screen select the orange 'close sheet' button.

AF Case Finder:

To investigate the number of undiagnosed patients with possible or probable AF – select the orange 'launch AF case finder' button. (As these patients are undiagnosed they will not have a risk score.)
On the 'AF case finder' tab you will see the corresponding list of patients for your practice; these are patients who have a factor, or factors, which indicate that they are likely to have AF but do not have a READ coded AF diagnosis.
You can filter this table by selecting a contributing factor e.g. SVT/ Flutter in the blue bar chart top right. To clear this selection, click the 'clear' button.
You can also select an NHS Number to view related records for a patient. To clear this, select the blue 'clear NHS selection' button

References with hyperlinks:

1. NICE guidelines [CG180] Atrial fibrillation: the management of atrial fibrillation. Published date: June 2014
NICE CG 180
Costing template
Costing report: http://www.nice.org.uk/guidance/cg180/resources/cg180-atrial-fibrillation-update-costing-report2

2. NICE Implementation Concensus
http://www.nice.org.uk/guidance/cg180/resources/cg180-atrial-fibrillation-nic-consensus-statement-on-the-use-of-noacs2

3. The Health Foundation Person Centred Care Resource Centre. The Magic programme
Brief Decision Aids | Person-Centred Care Resource Centre