1.4 million people in England are estimated to have atrial fibrillation (AF) (2.5% of the total population).

There is significant variation between practices in the proportion of their patients with AF who remain undiagnosed.

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.

GRASP-AF is a free software tool that GP practices can use to help identify and improve the management of patients with AF.

Nationally 19% of eligible patients do not receive anticoagulation. This includes excepted patients, but some practices except far fewer than others.

AF Strokes in CCG
AF strokes in people with known AF in 2016/17:

| Eligible patients on AF register | 5,862 |
| Eligible patients anticoagulated | 7,330 |
| Difference                        | 1,468 |

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

Source: SSNAP 2017 (May not add to 100% due to rounding)

| Completely independent: | 28% |
| Slight disability, unable to carry out all usual activities, but able to look after own affairs without assistance: | 3% |
| Moderate disability, needing some assistance, but able to walk independently: | 21% |
| Moderately severe disability, unable to walk or care for self without assistance: | 17% |
| Severe disability, bedbound and needing constant nursing care and attention: | 10% |
| Dead: | 3% |

Case finding of AF in CCG
GRASP-AF is a free software tool that GP practices can use to help identify and improve the management of patients with AF.

| Number of GP surgeries | 51 |
| Number ever used GRASP-AF | 42 |
| Difference | 9 |

Undiagnosed AF in CCG
There is significant variation between practices in the proportion of their patients with AF who remain undiagnosed.

Number of AF patients anticoagulated in CCG
Nationally 19% of eligible patients do not receive anticoagulation. This includes excepted patients, but some practices except far fewer than others.

| Eligible patients on AF register | 4,932 |
| Eligible patients anticoagulated | 4,085 |
| Difference | 847 |
Why do we need to improve our case finding in atrial fibrillation (AF)?

1. The risk of stroke increases five-fold for people with AF.
2. AF strokes are often more severe with higher mortality and greater disability.
3. AF is a major risk factor for stroke and contributes to one in five strokes.
4. BUT - almost a quarter of people with AF are undiagnosed. They are therefore untreated and at a high risk of premature death and disability.

What do we need to know?

1. People with AF are at an increased risk of stroke irrespective of symptoms.
2. People with AF are at an increased risk of stroke even after treatment such as cardioversion or ablation.
3. All people with AF, paroxysmal AF and atrial flutter are at increased risk of stroke and should be assessed for anticoagulation.
4. For most people with AF the benefits of anticoagulation significantly outweigh the risks of bleeding.

What can CCGs do to find the missing high risk patients?

1. Compare recorded prevalence with the expected prevalence of AF for your practice.
2. Examine the level of variation in detection rates between practices.
3. Explore and share approaches being used by practices that are more successful in detecting AF.
4. Support practices to audit and improve case finding using local solutions as developed in Bradford for example, or off the shelf tools such as GRASP-AF.
5. Add pulse checking to local enhanced service specifications where appropriate.
6. Ensure all eligible patients receive the NHS Health Check which will systematically detect abnormal pulse rhythms as part of blood pressure measurement.
7. Ensure local practices have access to quality assured ECG interpretation.
8. Explore potential for community pharmacists to offer pulse checking with diagnostic technologies such as AliveCor.
9. Ensure appropriate training in pulse checking for health care assistants.
10. Contact your local AF Academic Health Science Network lead: https://tinyurl.com/ycenw7lq.

Glossary

QOF: Quality and Outcomes Framework
NCVIN: National Cardiovascular Intelligence Network
SSNAP: Sentinel Stroke National Audit Programme
GRASP-AF: Guidance on Risk Assessment and Stroke prevention for Atrial Fibrillation
DOAC: Direct Oral Anticoagulant
ECG: Electrocardiogram
CCG: Clinical Commissioning Group
Key Messages on Anticoagulation

Why do we need to improve our treatment of atrial fibrillation (AF)?

1. Anticoagulation substantially reduces the risk of stroke in people with AF.
2. BUT many people with AF on warfarin are undertreated and therefore at significant risk of stroke, with the average time in the therapeutic range being around 60% in major studies.
3. AND - only around half of stroke patients with known AF are on anticoagulation treatment at the time of their stroke.

What do we need to know?

1. Everyone with AF, paroxysmal AF and atrial flutter is at increased risk of stroke and should be offered risk assessment with CHA2DS2-VASc.
2. Everyone with AF who also has valvular heart disease should be offered anticoagulation - they do not need a formal risk score as the stroke risk is high.
3. Aspirin and other antiplatelet treatments should not be used for stroke prevention in AF - they are not effective in stroke prevention and increase the risk of bleeding particularly in older people.
4. Risk of falls does not justify withholding anticoagulation - benefits are likely to outweigh risks unless the person is falling on most days.
5. The HAS-BLED tool should not be used to exclude people from anticoagulation - rather it is a tool to identify risk factors than can be modified in order to mitigate the risk of bleeding.
6. For most people with AF the benefits of anticoagulation significantly outweigh the risks of bleeding.
7. Both warfarin and DOACs can be used for anticoagulation in non-valvular AF. Discuss choice of anticoagulants with the individual in order to improve adherence to treatment.

What can practices do to improve stroke risk reduction in AF?

1. Offer stroke risk assessment with CHA2DS2-VASc to all people with non-valvular AF.
2. Offer anticoagulation to adults where CHA2DS2-VASc risk score is 2 or above.
3. Use HAS-BLED to identify risk factors that can be modified in order to mitigate the risk of bleeding - e.g. alcohol, medication and high blood pressure.
4. Keep the quality of anticoagulation under close review by regularly checking that the individual time in Therapeutic Range (ITTR) of those on warfarin is greater than 65%. Adherence to both warfarin and DOACs should also be regularly checked.