Westcliffe Medical Practice
Shipley

Westcliffe Cardiology Service

Westcliffe Cardiology Service Perspective
Atrial Fibrillation in Bradford Airedale tPCT.

With the advent of the NICE guidance for the management of Atrial Fibrillation (AF) being released in June 2006 we now a clear guide on how we should manage this clinical situation.

Atrial Fibrillation (AF) is the commonest sustained cardiac arrhythmia with a prevalence of around 1 in 20 of the over 65s in the UK and is more prevalent towards the older end of the age spectrum. The number of patients with AF roughly doubles with each advancing decade of age peaking at around 8-9% of 80-90 year olds. AF is also associated with an increased risk of stroke which itself is a major cause of debilitation.

We feel that, as a condition atrial fibrillation lends itself to a simple pathway for both its clinical management and its adoption in the Practice Based Commissioning framework in which the NHS is currently operating. This pathway can clearly streamline the patient pathway from the General practitioners initial consultation to appropriate intervention if all providers work in cooperation.

The addition of Atrial Fibrillation to the Quality and Outcomes Framework has assisted in raising the profile of this common dysrhythmia however it does suffer from some over simplification of the condition. We feel that this can be addressed with developing enhanced practice in the management of atrial fibrillation and paroxysmal atrial fibrillation.

The services already established around the city are working with variable success but all the components required for integrated care are either in place or in development. The appropriate intervention to reduce the mortality and morbidity of atrial fibrillation just requires a clear pathway of care with demarcation of services provided. This will require close working of the general practice team, enhanced practice in electrocardiogram (ECG) interpretation, intermediate cardiology and anticoagulation services, the Arrhythmia Care Coordinator and Cardioversion services of secondary care service.

The Role of the tPCT and Support Groups.

Atrial Fibrillation is the commonest dysrhythmia in the community and brings a significant risk to the individual due to the increased risk of stroke illness. However despite its significance, simplicity to screen and presence of effective interventions awareness of the problem in the community is poor.
We feel that the tPCT can improve the health of our community by increasing awareness of AF in the population; Encouraging people to attend for health checks to ensure that this condition has not developed asymptptomatically.

We feel that screening of the over 65 population should be encouraged with a local incentive scheme. Screening of atrial fibrillation has been shown to be simple and effective, practitioners need just to take a pulse and determine the rhythm, and a hypertensive assessment could be performed at the same time.

**The Role of the General Practitioner.**

General Practice is well positioned to opportunistically determine if a patient has started to suffer from atrial fibrillation. The person may have presented for:

- Problems unrelated to a cardiac condition. By simply taking the pulse during a consultation for another issue can determining whether the pulse is regular or erratic. If erratic then further investigation is warranted.
- The person may have presented with mild symptoms of palpitations or breathlessness of either acute or chronic duration. In this setting the simple cardiovascular exam is an essential part of assessment. This could lead to various outcomes the most significant being:
  - The person is found to have an erratic pulse but is otherwise clinically stable. Prompt assessment with an electrocardiograph is essential to clarify the diagnosis. This should be assessed by those appropriately trained in its interpretation to confirm the diagnosis.
  - The person may be found to be currently in sinus rhythm. In this setting, if frequent episodes (paroxysms) of atrial fibrillation are the suspected diagnosis then ambulatory rhythm monitoring should be undertaken.
- The person may have presented in an acutely unstable state and further urgent assessment should be arranged. This probably will require acute admission to hospital, or dependent on the practitioners experience base may require only taking further urgent advice.
- The person may have presented with acute chest pain and is found to be in atrial fibrillation. **These people require urgent admission if a myocardial infarction is suspected. An electrocardiogram should not be performed prior to urgent admission.**

In a stable patient who is found to be, or suspected of episodically being, in atrial fibrillation simple investigation to explore possibly aetiologies should be arranged. These must include:

- 12 Lead ECG
- FBC
- Electrolytes
- Liver function and Gamma GT
- Thyroid Function

If no clear metabolic issue can be found to establish a cause of the dysrhythmia then it must be assumed to be cardiac in nature. At this point the most important consideration in the stable patient is that of thromboembolic risk assessment. This can be undertaken by the practitioner but we feel that only an appropriate tool should be used.

Once a patient is thought to be in chronic atrial fibrillation they should undergo annual review to ensure that their thromboembolic risk has been reassessed and appropriate
changes made to their prescription as needed. This should also be taken as an opportunity to reassess the blood pressure and interventions taken as appropriate.

**The Role of Enhanced General Practice**

Practices may choose to enhance their role within the management of atrial fibrillation through:

- Electrocardiograph interpretation; recent studies published in the British Medical Journal state that general practitioners are not affective at determining atrial fibrillation on an ECG. To these ends we feel that interpretation of ECG should be regarded as an enhanced function of primary care, with cost per case payment following further training of practitioners in the skills they require. Periodic assessment of practice with ‘test’ ECG should be undertaken to ensure that standards are being maintained. Centres of excellence should also be established either with further training or intermediate (GPwSI) cardiology services where ECG’s with a queried significance or diagnosis can be referred for more detailed assessment. The Westcliffe Cardiology Service already has established this function with a reduced tariff available through choose and book.

- Anticoagulation provider templates are already underway within the tPCT commissioning and governance structures. These are essential within the locality to ensure that patients have prompt and appropriate access to anticoagulation. It is imperative that some of these services can initiate therapy to speed the pathway from presentation to Cardioversion. These services must have short waits for initiation if they are to be of value to patients with recent onset atrial fibrillation.

**Intermediate Cardiology Services**

Bradford and Airedale tPCT has the most comprehensive intermediate cardiology service being provided through the provider limb of the tPCT or from general practice. These services should assist in the management of dysrhythmic problems as a whole but can have a specific role in atrial fibrillation.

We feel the role can be seen in several ways:

- To assist other practices in the interpretation of electrocardiographs as needed by the practices enhanced status
- Receive referrals directly from other practices who feel unskilled in the management of atrial fibrillation to ensure good evidence based practice is brought to the patient in a convenient and local manner
- To assist in the diagnosis and management of patients presenting with possible Paroxysmal Atrial Fibrillation. Most of the locality services have a hub and spoke model of ambulatory rhythm monitors in operation. The service at Westcliffe Medical Practice has well established links to both Bradford Hospitals and the Yorkshire Heart Centre to ensure patients have a wide array of treatment options available.
- To assist in the decision of Rate over Rhythm management and if the later to ensure rapid referral to locality anticoagulation services and referral to DC Cardioversion to obtain optimum treatment intervals for effective intervention
- Arrange locality echocardiography in individuals where questions regarding the suitability of anticoagulation or possibility of successful Cardioversion are in question.
• Receive patient back from secondary care cardioversion services to monitor progress and reassess medication strategies dependant on the success of cardioversion.

**Role of the Arrhythmia Care Coordinator**

We feel that the Arrhythmia Care Coordinator should have a clear role within the management of Atrial Fibrillation as well as other dysrhythmias, syncope and support and coordination in families who have suffered the trauma of a probable sudden arrhythmic death.

We feel that this role would be enhanced in our area by requesting adoption of the Arrhythmia Care Coordinator by the British Heart Foundation, who have previously offered to do so. This adoption would enable clearer educational support and also support from their peers who are developing services around the country.

We feel the role within the remit of atrial fibrillation is:

• Education of patients suffering from chronic atrial fibrillation. This should be enhanced by a local support group with affiliation to the Atrial Fibrillation Association. This support would empower patients with an understanding of their condition and therapeutic options available to them. We would see this work mainly being performed through a group activity rather than individual patient work, although that may also be appropriate on occasion.

• Education and support of General Practice, coordinating how they may screen their population and assess thromboembolic risk. As stated above this is a function of general practice and the Arrhythmia Care Coordinator should assist but not perform this work.

• Education and support of patients referred to cardioversion services. They should also take a coordination role to ensure that patients are appropriately and promptly anticoagulated and be their advocate within the system to ensure their smooth passage. They should liaise with the cardioversion service to ensure a seamless journey. They should ensure follow up within their own service or intermediate cardiology services as appropriate to ensure support is given following the procedure.

• Support for patients with chronic symptomatic atrial fibrillation. This again can be performed through group work, one to one work or referral to cardiac psychological services already established in the area.

We feel the role would be best supported if the Arrhythmia Care Coordinator is adopted by the BHF but also establishes strong links to one of the intermediate cardiology services to ensure local support and rapid access to clinical support.

**Role of Secondary Care Services**

We feel that the role our colleagues in secondary care is pressurised by the volume of work in atrial fibrillation and a lack of clear demarcation within the specialties. We feel through discussion with primary care we should assist in clarifying roles.

Much of this could be assisted by the adoption of principles already outlined. We feel the majority of work in atrial fibrillation should be carried out and supported in primary care.

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Mrs Tear
There are situations where the cardiology services of secondary care are imperative and we should work together to develop pathways to ensure a seamless and appropriate journey for the patient.

Areas that need to be clarified include:

- Patients who are acutely unwell with atrial fibrillation require acute admission through the appropriate medical assessment unit determined by age. At this point a clear pathway of investigation should be established to clarify the aetiology of the atrial fibrillation and rapid access to cardioversion should be facilitated if appropriate.
- We should work with our colleagues in Secondary Care to implement the NICE recommendations for Rhythm (over rate) management. We should ensure that clear local guidance is established with all involved in the pathway of care clear as to how to assess the patient and how to facilitate their further journey to appropriate treatment.
- Patients with recent onset (less than 48 hours) should be referred urgently for cardioversion. This could be facilitated through the medical admission units. We feel it would be more appropriate to be accessed through the cardiology service to ensure their expert review and the appropriateness of the procedure.
- Patients with atrial fibrillation of greater than 48 hour duration where it is felt that a rhythm strategy is appropriate there should be a cardioversion service established. This should work in conjunction with community rapid access anticoagulation services and the assistance of the Arrhythmia Care Coordinator. This should ensure that the minimal time from decision to cardiovert to safe and appropriate procedure.
- We feel that post cardioversion care can be undertaken in primary care either with the arrhythmia care coordinator or through the established intermediate cardiology services. The cardiologist of course following up patients they feel require further support, investigation and interventions of their service.
- Clearly in patients admitted to hospital the hospital cardiology service has an implicit role in coordinating atrial fibrillation guidance and care. We feel that primary care should assist our colleagues in secondary care cardiology by allowing them simple pathways of discharge to Intermediate Cardiology services, the Arrhythmia Care Coordinator or general practice as appropriate. With the establishment of these pathways we would hope that the work load of atrial fibrillation is shared where capacity is available and as close to the patients home as possible.

**Role of Tertiary Care Services**

Clear referral criteria have previously been established for referral of atrial fibrillation issues from intermediate and secondary care to the tertiary, invasive care of the Yorkshire Heart Centre.

- **Atrial Flutter**
  - In a single episode consider expectant treatment. Ablation or antiarrhythmic drug therapy may be appropriate if high risk of recurrence.
  - Recurrent: Consider trial of antiarrhythmic drug therapy. Refer if drug therapy unacceptable or ineffective.
  - Atrial flutter with 1:1 AV conduction: AV node blockade and urgent OP referral.
  - 1:1 atrial flutter with no antiarrhythmic drug option.

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• **Atrial Fibrillation**
  o In patients with known pre-excitation an **urgent in-patient** referral
  o In patient without pre-excitation consider routine referral if drug therapy ineffective or unacceptable
  o Persistently symptomatic atrial fibrillation despite two or more antiarrhythmic drugs
  o Patients with paroxysmal atrial fibrillation where drug therapy is ineffective or unacceptable

**Summary**

We feel that Atrial Fibrillation is a significant problem within clinical care bringing significant mortality and morbidity to the population through lack of awareness in the public, unidentified suffers in the community, incomplete assessment in general practice and a delay to appropriate interventions.

Although we can look to redefine the pathway locally, this has been reviewed by PACE previously with associated primary care education and problems still persist.

We feel it is only through a whole system redesign strategy with clear demarcation of responsibility and incentivisation of the appropriate members of the pathway can we actually bring about the service improvement that our local population should expect.

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