South London Cardiac and Stroke Network

Tuesday 25th May 2010

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South London
Cardiac and Stroke Network

Why have a South London Cardiac and Stroke Network (SLCSN)?

- To ensure that patients, the public and healthcare professionals are connected.

- ‘Networks should be established, to bring together key stakeholders and providers to organise, review and improve delivery of services across the care pathway’

  - National Stroke Strategy.

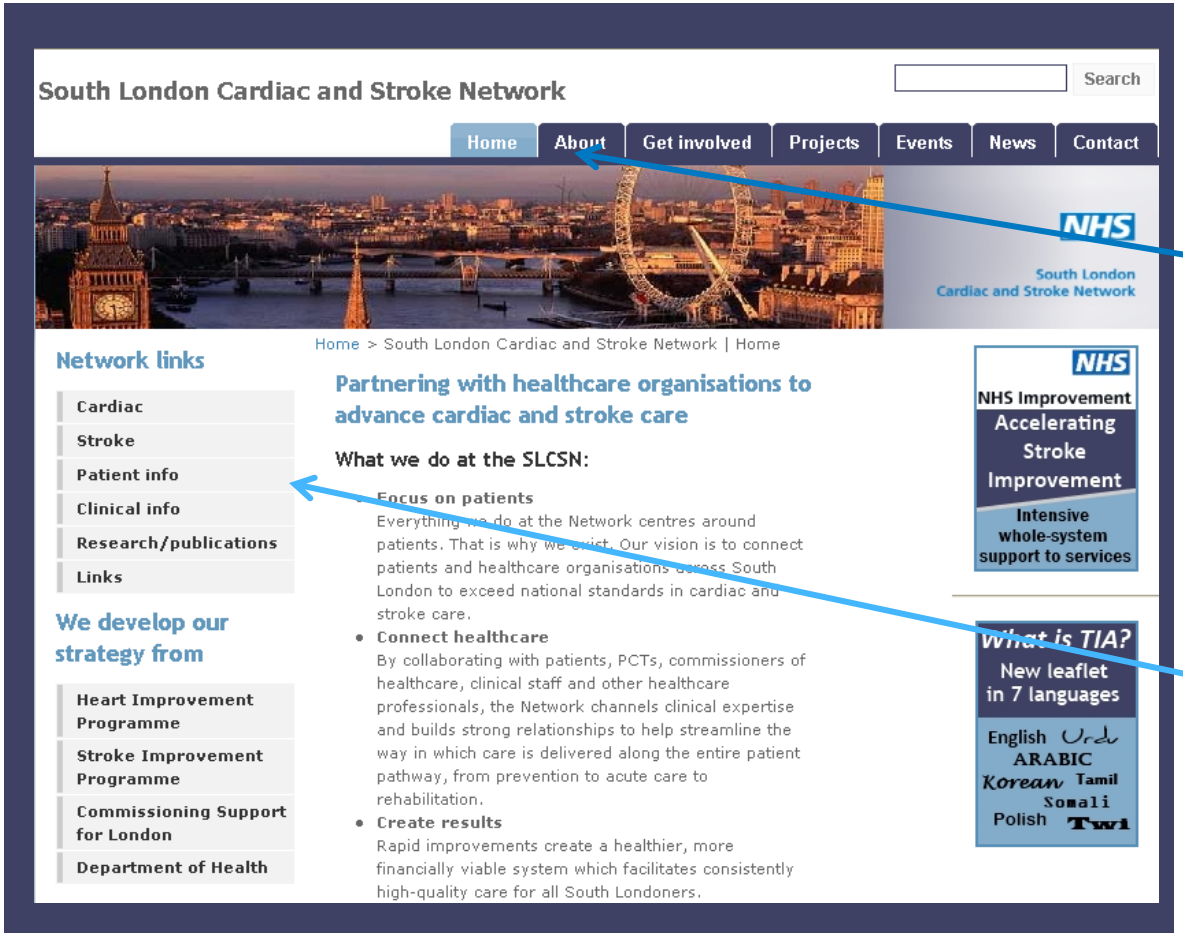
What we do at the SLCSN?

- **Focus on patients** - Everything we do at the Network centres around patients. That is why we exist. Our vision is to connect patients and healthcare organisations across South London.

- **Connect healthcare** - By collaborating with patients, PCTs, commissioners of healthcare, clinical staff and other healthcare professionals, the Network channels clinical expertise and builds strong relationships to help streamline the way in which care is delivered along the entire patient pathway, from prevention to acute care to rehabilitation.

- **Create results** - Rapid improvements create a healthier, more financially viable system which facilitates consistently high-quality care for all South Londoners.

Visit us at….www.slcsn.nhs.uk



- About
- Get involved
- Projects
- Events
- News
- Contact

- Cardiac
- Stroke
- Patient info
- Clinical info
- Research / publications
- Links

Accelerating progress on stroke

- The idea: provide intensive support to services to accelerate implementation of the strategy during 2010/11
- The aim: achieve key ‘milestones’ in care across the stroke pathway covering prevention, acute services, and long-term care
- The methods: combine the efforts and activities of Stroke Networks, SIP and the DH to mobilise local improvement initiatives, supported by SHA, PCT and Trust senior management.
- Following slides show main areas of work, key measures to show progress, and aims to achieve in each area

Main areas of work

Domains	Joining Up Prevention	Implementing Best Practice in Acute Care	Improving Post Hospital and Long Term Care
Key Areas of Focus	• AF Detection and Treatment • Timely and effective management of TIA	• Direct Admission to a Stroke Unit • Timely Brain Scan	• Early Supported Discharge • Joint Care Plans using Single Assessment Process • Review at 6/52, 6/12 and yearly • Carers' Assessment • Psychological Support

Revised measures of progress

Domains	Joining Up Prevention	Implementing Best Practice in Acute Care	Improving Post Hospital and Long Term Care
Key measures (aim)	• Proportion of patients with AF presenting with stroke anti-coagulated on discharge (60% by April 2011) • Proportion of people with high-risk TIA fully investigated and treated within 24 hours (60% by April 2011. *Vital Sign*)	• Proportion of patients admitted directly to an acute stroke unit within 4 hours of hospital arrival (90% by April 2011) • Proportion of patients spending 90% of their inpatient stay on a specialist stroke unit (80% by April 2011. *Vital Sign*) • i) Proportion of stroke patients scanned within one hour of hospital arrival (50% by April 2011) ii) Proportion of stroke patients scanned within 24 hours of hospital arrival (100% by April 2011)	• i) Presence of a stroke skilled Early Supported Discharge team ii) Proportion of patients supported by a stroke skilled Early Supported Discharge team (40% by April 2011) • Proportion of patients and carers with joint care plans on discharge from hospital to final place of residence (85% by April 2011) • Proportion of stroke patients that are reviewed at six months after leaving hospital (95% by April 2011) • Proportion of patients who have received psychological support for mood, behaviour or cognitive disturbance by six months after stroke. (40 % by April 2011)

NHS Improvement project
Atrial fibrillation identification and management in primary care

- Pilot sites:
  - SW London: Wandsworth and Sutton & Merton
  - SE London: Greenwich and Bromley

- Aims: Raise awareness of stroke prevention caused by unmanaged AF
  - Implementing pulse screening pilots
  - Supporting GP practices to use the GRASP-AF toolkit
  - Supporting anticoagulation monitoring pilots in primary care
  - Supporting innovative services to access ECG

http://www.improvement.nhs.uk/graspaf

- Outcomes:
  - Increase uptake of patients on warfarin rather than aspirin
  - Cost efficiencies in ECG service arrangements
  - Pathway development across primary and secondary care

GRASP-AF Query and risk stratification tool is FREE and available for use with all GP clinical systems in England

GRASP-AF provides a set of MIQUEST queries to identify, for your practice, patients with a diagnosis of AF who are not on warfarin.

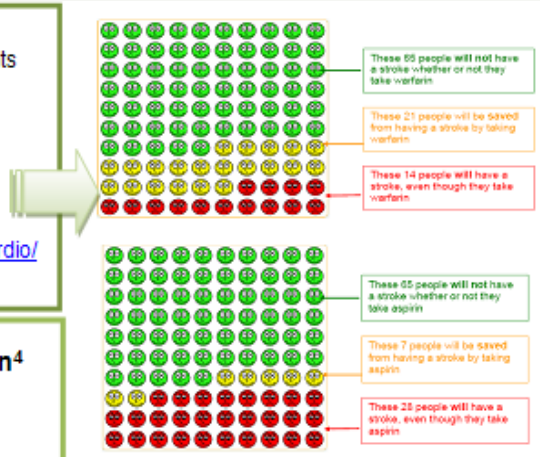
It calculates their risk of stroke using the validated CHADS2 scoring system and highlights patients with a CHADS2 score of 2 or more who are not on warfarin and would benefit from a review to assess the issue of anticoagulation.

To find out more about this new tool and to sign up to run the search simply go to www.improvement.nhs.uk/graspaf

Patient Decision Aids (PDA) can be extremely useful when talking to patients about risks versus benefits of different treatments and medications.

This NPCi PDA poses the question **"Atrial Fibrillation – is warfarin or aspirin better?"**

Download it from:
http://www.npci.org.uk/therapeutics/cardio/atrial/resources/pda_af.pdf



Contraindications to Warfarin[4]

- Pregnancy
- Hypersensitivity to warfarin
- Within 2 days of surgery
- Bacterial endocarditis
- Severe renal or hepatic disease
- Peptic Ulcer
- Severe hypertension

Possible Side Effects[4]

- Bleeding/bruising
- Hypersensitivity
- Rash
- Alopecia
- Diarrhoea
- Purple toes

References

1. National Prescribing Centre. MeReC Bulletin Volume 12 No 5. http://www.medman.nhs.uk/ebt/merec/cardio/atrial/resources/merec_bulletin_vol12_no5.pdf
2. NHS Improvement. Commissioning for Stroke Prevention in Primary Care – the role of atrial fibrillation 06/09
3. Mant et al The Lancet Vol. 370 11th August 2007
4. BNF 57. March 2009. Pharmaceutical Press
5. SIGN Guideline No. 36 http://www.sign.ac.uk/guidelines/fulltext/36/index.html March 1999.

Useful reading
Primary Care Anticoagulation Monitoring Guidelines for patients taking warfarin- Surrey PCT March 2008

Important information for patients

Informing patients with AF about the benefits and risks of taking warfarin will be helped with the right resources.

INR = International Normalised Ratio. It is a method of expressing how long it takes blood to clot

- Warfarin should be taken at roughly the same time each day (preferably 6pm).
- Do not confuse the dose in mg with the number of tablets that you take.
- It is important to tell the dentist that you are taking warfarin.
- Before buying any medicines including alternative remedies tell the pharmacist that you are taking warfarin.
- Do not take aspirin unless advised to by your GP.
- Any major changes in your diet may affect how your body responds to your anticoagulant medication.
- Cranberry juice can affect your INR and should be avoided altogether.
- If your diet changes greatly over a seven-day period, you should have an INR test.
- It is dangerous to 'binge drink' whilst taking anticoagulants.

- **Do patients know why they are taking warfarin, their target INR and the importance of attending for INR tests?**
- **Do patients know what to do if they miss a dose?**

This information is taken from the Yellow Oral anticoagulant therapy booklet which should be given to a patient when they are started on warfarin http://www.npsa.nhs.uk/nrls/alerts-and-directives/alerts/anticoagulant

Patient preference, compliance and facilities for INR monitoring should always be taken into account as well as stroke and bleeding risk[5].

The following organisations offer advice, support and information for patients with AF:

- The Atrial Fibrillation Association (AFA) www.atrialfibrillation.org.uk
- The Stroke Association www.stroke.org.uk
- The Arrhythmia Alliance www.heartrhythm.org.uk

Information for medical professionals:

- The AFA have a Toolkit endorsed by the DH, PCCS and HRUK. Double-sided information sheets on all aspects of AF diagnosis and management written for medical professionals as well as patients can be downloaded from www.atrialfibrillation.org.uk Go to AFA Toolkit.

WARFARIN: DISCUSSING WARFARIN THERAPY WITH YOUR PATIENT

ANTICOAGULATION IS UNDERUSED IN THE TREATMENT OF ATRIAL FIBRILLATION

Starting warfarin can be a daunting prospect for many patients. Informing them about what to expect from therapy, the potential benefits and possible side effects can help them make that decision.

Warfarin is considered to be underused in AF, even though most systematic reviews have shown that it is better than aspirin at reducing the risk of stroke[1]

AF as a Cause of Stroke

National Data

- 18% patients presenting with stroke are in AF at presentation[2]
- This equates to 16,000 strokes, of which **12,500 are thought to be directly attributable to AF[2]**
- AF is therefore directly responsible for 14% of all strokes[2]
- The annual risk of stroke is 5-6 times greater in AF patients than in people with normal heart rhythm[2]
- Warfarin is highly effective in preventing stroke in AF, reducing risk of stroke by 64% compared to placebo[3]
- Aspirin only reduces this risk by 22%[3]
- The 2006 NICE guidance on AF costing report concluded that **46% of patients who should have been receiving warfarin were not[2]**

The BAFTA Trial[3]

- RCT of warfarin (target INR 2.5) vs. aspirin (75mg) in atrial fibrillation
- 973 patients aged 75 years and over recruited from 234 practices (mean trial age = 82yrs)
- Stroke risk was halved in the warfarin group.
- There was no increased bleeding risk with warfarin in comparison with aspirin

20 strokes prevented per 1000 patients with AF treated per year with warfarin vs. aspirin
NNT = 50 for 1 year

Warfarin protects the over 75yrs against risk of stroke associated with AF, the group with the highest incidence of stroke.

Risk of Major Haemorrhage with Age p.a.[3]

Age Range	Warfarin	Aspirin	Relative Risk
75-79	1.1%	0.8%	1.44
80-84	2.3%	2.4%	0.96
85+	2.9%	3.7%	0.77

Does my patient need warfarin?

Assessing Stroke Risk in AF patients.

CHADS2 is an easy-to-use classification scheme that estimates the risk of stroke in people with AF.

Physicians and patients could use CHADS2 to make decisions about antithrombotic therapy based on patient-specific risk of stroke[2].

CHADS2 item	Points
Congestive Heart Failure	1
Hypertension (systolic >160mmHG)	1
Age greater than 75yrs	1
Diabetes	1
Prior Stroke or TIA	2

Risk Calculation for CHADS2[2]

Total Score	Risk of Stroke	Antithrombotic Therapy Indicated
0	Low	Aspirin
1	Moderate	Warfarin or Aspirin
2 or more	High	Warfarin

Help with AF tools

Senior project manager: Jennifer.george@slcsn.nhs.uk
Project manager: Senai.jimenez@slcsn.nhs.uk

National stroke improvement funding

Now available

Get ready to improve stroke care!

Bidding now open for small projects:
Part I: Expression of interest - due 27 May
Part II: Funding application - due11 June

Forms and details:
www.slcsn.nhs.uk/bid

SLCSN welcomes requests for advice on the bidding process. Please direct your enquiries to info@slcsn.nhs.uk.