Stroke Prevention in Atrial Fibrillation – Project Report

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Stroke Prevention in Atrial Fibrillation – Project report

Introduction and Overview

Atrial fibrillation (AF) is a heart condition that causes an irregular and often abnormally fast heart rate; it is the most common sustained cardiac arrhythmia and estimates suggest its prevalence is increasing. People with AF are more at risk of having a stroke than people without AF. This therapeutic area is subject of many national and local guidelines and systems, including but limited to the following:

- NICE Clinical Guideline 180
- QoF targets for 2015-16
- A European wide call to action by Anticoagulation Europe (ACE) and the Atrial Fibrillation Association) AFA
- Fylde and Wyre CCG 2030 vision for health

Fylde and Wyre patients said they wanted their health service to help keep them and their families well, and to make it as easy as possible for them to make health choices. One of the CCG aims in the 2030 vision is to create a health service that supports people to be as fit and well as possible.

Since the European Call for Action report there has been a call for an urgent focus on AF within the NHS and specifically for six actions. If implemented, these actions would prevent thousands of fatal and debilitating cases of stroke; saving significant amounts of money from stretched healthcare budgets across the UK. To achieve these goals, the six actions called for were:

1. Targeted screening: The introduction of a targeted national screening programme drawing on routine manual pulse checks and ECG readings
2. Guideline adherence: The development and adoption of policies that increase GP motivation to follow international guidelines
3. Public awareness, patient empowerment: The use of existing materials to fuel a national public and patient education campaign to improve detection and patient empowerment
4. Equity of treatment: The imposition of equal access to AF treatments and services for all patients using the NHS regardless of location
5. GP education: An AF education campaign for GPs to illustrate the importance of symptomatic control, appropriate referral and the value of patient empowerment
6. AF research: Government support for research into the causes, prevention and treatment of AF

Not only are strokes tragic, fatal and debilitating, they are extremely expensive. It has been estimated that a single stroke directly costs the NHS between £9,500 and £14,000. People with AF tend to have more severe strokes with worse outcomes which are consequently more expensive. AF strokes are cardioembolic which leads the increased risk of more brain damage and also AF almost doubles the death rate from stroke.

Direct costs do not represent even half of the total costs however; the indirect costs to the wider economy are huge and informal post-stroke care amounts to an estimated £2.4 billion nationally. If just the avoidable strokes arising because of AF were prevented, the NHS would save nearly £60 million in direct stroke costs alone.
Project Overview

The project delivery period spanned February 2015 to April 2016 and aimed to implement the new NICE guidelines (CG180) by offering anticoagulants to people at highest risk of stroke, stopping aspirin monotherapy prescribed solely for AF, updating and enhancing patient registers for AF and investigating why patients may be out of range for Time in Treatment (TTR). Additionally it aimed to address equity of treatment across the CCG practices and provide education for clinicians.

The key objectives aligned to NICE CG180 were:

1. To identify and offer anticoagulation to people with a CHA$_2$DS$_2$-VASc score of 2 or above, taking bleeding risk into account. To consider anticoagulation for men with a CHA$_2$DS$_2$-VASc score of 1.
2. To stop aspirin monotherapy solely for stroke prevention to people with atrial fibrillation
3. To identify further patients with AF who are not currently on treatment registers and Read code appropriately
4. To identify patients on warfarin with TTR <65% or consistently outside of range, identify the reasons why this is and explore alternative options if patient is compliant to treatment
5. Identify innovative ways of opportunistically identifying patients with AF. i.e. ‘know your pulse’

The business case for the project estimated the project costs based on a 50:50 prescribing rate of warfarin verses the new oral anticoagulants (NOACs); these costs are shown in table 1 below. The estimated project costs do not take into account the indirect costs of a stroke, which are picked up by social care, or the costs of the burden on society. The direct cost of a stroke was taken from the value used in the NICE costing template for CG180.

Table 1: Estimated project costs

<table>
<thead>
<tr>
<th></th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Additional Prescribing Budget costs</td>
<td>£176,656</td>
</tr>
<tr>
<td>Major bleeds @ £1,173 per case</td>
<td>£3,720</td>
</tr>
<tr>
<td>Additional ADAS clinic costs for 200 patients @ £144</td>
<td>£30,600</td>
</tr>
<tr>
<td>Direct cost saving 11.48 strokes @ £12,228 per stroke saved</td>
<td>- £140,457</td>
</tr>
<tr>
<td>Total cost</td>
<td>£70,519</td>
</tr>
</tbody>
</table>

The benefits realisation of the project were to potentially prevent an extra 11.5 strokes across the CCG in the following year; this benefit would be extended over subsequent years however the evidence for stroke prevention can only be associated within the following year as this is based on trial evidence.

The project looked at the GRASP-AF data from August 2014 and aimed to increase the prescribing rates of preventative anticoagulants in patients who are at high risk of a stroke and therefore eligible for an anticoagulant. The aim was to increase to 75% of all high risk patients (or 425 extra patients) prescribed an anticoagulant.

Project Plan

Stage one

An important part of the first stage of the project consisted of organising a training event. This was to raise awareness of the project, to ensure that prescribers were familiar with the new NICE guidelines and prescribers were confident in prescribing anticoagulants to prevent strokes in patients with AF. There had been reports that some prescribers were reluctant to prescribe
anticoagulants in the frail elderly due to perceived risks associated with falls and also that GPs were hesitant in prescribing the NOACs due to lack of experience of using these new agents and perceived safety concerns.

To maximise the outcomes and objectives of the educational event an electronic survey was carried out to explore the learning needs of GPs and nurses. The survey showed that the main learning requirements of prescribers were:

- The changes to clinical practice with the NICE guidelines of 2014 (CG180) and an overview of the guidelines
- Implementation of the NICE guidelines (CG180)
- Initiation and choice of medication and how to discuss the risks and benefits with patients
- When to prescribe and how to undertake risk assessments using HAS-BLED scores
- How to switch between the different agents

The event was then organised around these needs and speakers were briefed on the learning objectives.

The educational event took place on the evening of 10th June 2015; the speakers were Jeannie Hayhurst, cardiovascular specialist nurse; Dr Mammen Ninan, GPwSI in cardiology and Shajil Chalil, consultant cardiologist and cardiac electrophysiologist at Lancashire Cardiac Centre.

Around the time of initiation of the project there had been a few pieces of guideline developed by the Midlands and Lancashire Commissioning Support Unit (MLCSU) and approved by the Lancashire Medicines Management Group (LMMG). These relevant guidelines were adopted by the CCG via the Medicines Group and promoted at the education event, with copies give out in the packs, and further promotion of the guidelines was via an article in Practice Bulletin and the practice pharmacists discussions in practices. An EMIS template was developed by MLCSU using the anticoagulation decision support tool and this was trialled and utilised by practices in the CCG. The guidelines developed by LMMG were:

- Anticoagulation decision support tool
- NOACs in AF prescribing guideline
- Oral anticoagulation for stroke prevention consensus statement
- Stroke Prevention

The main part of the first stage was around reviewing existing patients on AF registers for appropriate treatment and case finding. To enable this, the Practice Pharmacist team developed work processes and plans to:

- Identify patients on the AF register at high risk of a stroke and not on an anticoagulant
- Read code all patients appropriately
- Offer all patients with CHA₂DS₂-VASc score of 2 or above an anticoagulant
- Consider an anticoagulant in all men with a score of 1
- Develop actions for complex patients
- Stop aspirin prescribed solely for stroke prevention in patients with AF

The data quality team developed baseline and monitoring data using Chart Online to enable evaluation of the project.

The project was promoted with practices via the Practice Managers forum and a briefing paper was sent to all practices to further enhance engagement and thus the project success.

A meeting was arranged with key members of the local Anticoagulation Dosing Advisory Service (ADAS) at Blackpool Teaching Hospitals to inform them of the project and the anticipated increase in referrals. At this meeting initial discussions were held around the possibility of patients self-testing for warfarin.
Stage two

The work undertaken as part of stage one also continued into the second stage of the project.

The second stage also comprised of a campaign around AF awareness and ‘know your pulse’. This was planned around national AF aware week in November 2015. A press release – “Know your pulse – help prevent stroke” – was issued to the local media, which also featured on the news section of the CCG website. The Blackpool Gazette and Fleetwood Weekly News also ran the story. See appendix 1.

Each day throughout week commencing 23rd November 2015, the CCG Facebook and Twitter accounts were updated with AF specific messages aimed at raising awareness and encouraging people to check their pulse. The posts and tweets linked through to the news section of the CCG website for more information, which resulted in 35 visits. This is in comparison to the 17 hits which the previous news article on the CCG website achieved and the five visits the following news article achieved. There were seven Facebook posts and 15 tweets which reached a potential total of 46,057 people.

The Communications and Engagement team at the CCG also developed and distributed posters and leaflets for GP practices and community pharmacies. The leaflets showed patients how to take their own pulse and how to detect pulse irregularity. The posters raised the awareness of the dangers associated with AF.

Any new patients identified as part of the awareness campaign were added to practice AF registers, Read coded and offered treatment, where appropriate, as per stage one.

Measures for the new GP quality contract for 2016-17 were developed which built on the existing QoF indicators. The new quality contract states that patients on warfarin are to have INR results from ADAS written into their patient notes and to have an appropriate result within the last 3 months before issuing a repeat prescription. Additionally time in Treatment Ranges (TTR) are to be recorded in patient notes at least 6 monthly and action to be taken if TTR is inadequate, as per Lancashire Medicines Management Group (LMMG) guidelines.

The ADAS service was asked to provide TTRs to all practices; previously practices were not getting this data. Starting from April 2016 ADAS will be sending the data to practices electronically.

Results

Education event

The evaluation received from attendees was very positive; there were no scores received that were under the value of good.

The diagrams below show some of the evaluation results:
Some of the individual comments included:
- Very informative
- All excellent
- Exceeded expectation
- Excellent top tips from all 3 presenters
- Interesting and informative
- Very well organised

Objectives

The data used to monitor the project was taken from Chart Online using the GRASF-AF data. The MLCSU data quality team uploaded the individual practice data onto GRASP-AF each quarter throughout the project; following upload the data was then retrieved via Chart Online.

There are limitations in the comparison data with the national figures in Chart Online as the national data only uses the figures uploaded by practices and therefore there may be gaps in the data and this may not be a true representation of national figures. However as the data quality team uploaded Fylde and Wyre CCG practice data regularly the CCG data can be relied upon. It should be noted that this data from Chart Online includes patients with a Read code of AF resolved.

Objective 1
- To identify and offer anticoagulation to people with a CHA\textsubscript{2}DS\textsubscript{2}-VASc score of 2 or above, taking bleeding risk into account. To consider anticoagulation for men with a CHA\textsubscript{2}DS\textsubscript{2}-VASc score of 1.
Throughout the time of the project the number of identified high risk patients with a CHA₂DS₂-VASc score of 2 or above increased from 3432 to 3754. A sharp increase was seen mid-2015 and this may be due to the pharmacist reviews and Read coding. A further increase was seen in 2016 and this may have been as a result of the ‘know your pulse’ campaign. Over the course of the project nationally the percentage of patients at high risk of a stroke increased by 0.10%; Fylde and Wyre percentage of patients at high risk of a stroke increased by 0.23% in comparison as shown in graph 1 below.

Graph 1 – Number and Percentage of High Risk patients with a CHA₂DS₂-VASc score of 2 or above

Following identification of patients the aim was to ensure that high risk patients were offered anticoagulation taking bleeding risk into consideration. Nationally the percentage of High Risk patients on an anticoagulant increased by 4.2%; Fylde and Wyre percentage of High Risk patients on an anticoagulant increased by 9.2% as shown in graph 2 below. The number of patients at high risk on an anticoagulant increased from 2246 to 2681 (435 patients and 19% increase) over the course of the project.

Graph 2 – Number and Percentage of High Risk patients with a CHA₂DS₂-VASc score of 2 or above on an anticoagulant
The project aimed to get 75% of all high risk patients onto an anticoagulant or 425 extra patients. The project achieved 71.4% of high risk patients on an anticoagulant and an extra 435 patients. At April 2016 Fylde and Wyre CCG had the 4th highest percentage prescribing rate of anticoagulants out of all 30 CCGs in the North of England who upload their data onto Primis.

As part of the review of patients who were already on the AF registers the practice pharmacists identified 317 patients who were at high risk of stroke, not taking an anticoagulant and had no contraindications or exclusions to taking an anticoagulant. All 317 patients were contacted and invited for an appointment to discuss commencement of an anticoagulant to prevent stroke. 108 patients were seen and started on an anticoagulant, 168 patients declined an anticoagulant and at the end of the project a further 41 were still being followed up. We don’t know the reasons why the 168 patients declined treatment and it may have been useful to understand the motives behind the resistance. This could be considered as a further follow up piece of evaluation work.

In addition to the AF register review work, new patients were being diagnosed and added to AF registers throughout the project period especially following the ‘know your pulse’ campaign. All of these newly diagnosed patients were offered anticoagulation at the earliest opportunity and the majority were initiated on an anticoagulant by the GPs; this high offer rate was most probably due to the raised awareness amongst practices as part of the project work.

Since the start of the project there has been an extra 50 patients in the lower risk categories (CHA2DS2-VASc of 1 or 0) taking an anticoagulant; this is made up of an extra 53 patients with a risk score of 1, and 3 less patients with a risk score of 0. Low risk patients with a CHA2DS2-VASc score of 0 don’t fit the criteria for treatment with an anticoagulant as per NICE CG180; However men with a score of 1 should still be considered for treatment. If we make the assumption that the 53 patients with a CHA2DS2-VASc score of 1 were men who fitted the NICE guidelines then this is appropriate. The reduction is usage of an anticoagulant in patients with a score of 0 can also be assumed as appropriate as the risks of anticoagulant use in these patients outweighs the benefits. There was more of a reduction in anticoagulants use in patients with a score of 0; however this increased again towards the project end. We are exploring this rise in prescribing to determine the reasons.

Graph 3 – Number of patients with a CHA2DS2-VASc score of 1 on an anticoagulant
The change seen in the prescribing rates of anticoagulants in AF across all patient risk groups demonstrates that NICE CG180 has successfully been implemented in the CCG with regards to prescribing anticoagulants for stroke prevention.

There has also been a reduction in variation of the prescribing rates of anticoagulants in high risk patients across GP practices in the CCG. Practice prescribing rates now range from 63.33 to 80%, with 14 out of the 20 practices now achieving over 70%, as shown in graph 5.
As part of the project practices were encouraged and asked to share their data in Chart Online. There are still 14 practices that have not consented to share their data; this may be due to the practice not having a nominated person for GRASP data. Sharing of data has been added to the GP quality contract for 2016/17.

**Objective 2**  
- To stop aspirin monotherapy solely for stroke prevention in people with atrial fibrillation

There is little evidence that aspirin use in AF reduces risk of a stroke and the risk of bleeds outweighs the benefits. NICE CG180 says that aspirin should not be prescribed as monotherapy solely for stroke prevention in AF. The graph below shows that the prescribing of antiplatelets decreased over the project; the decrease in patients with AF on just an antiplatelet was 183 patients (19% decrease). A zero figure for this would never be achievable as we don’t know how many of these patients were taking an antiplatelet solely for their AF or for another indication.

**Graph 6 – Number of patients with AF taking an antiplatelet**

![Graph 6](image)

**Objective 3**  
- To identify further patients with AF who are not currently on treatment registers and Read code appropriately

**Graph 7 – Prevalence of AF compared nationally**

![Graph 7](image)
National prevalence of AF has increased from 1.82% to 1.90%, an increase of 0.08%; Fylde and Wyre CCG prevalence increased from 2.71% to 2.86%, an increase of 0.15%.

**Objective 4**
- To identify patients on warfarin with TTR <65% or consistently outside of range, identify the reasons why this is and explore alternative options if patient is compliant to treatment

This objective was not completed in the time of the project. The ADAS service will be electronically notifying practices of patients’ TTRs as of April 2016 and the GP Quality Contract will ensure that this work will take place in 2016-17.

**Objective 5**
- Identify innovative ways of opportunistically identifying patients with AF. i.e. ‘know your pulse’

A campaign took place in November 2015 as described above. For AF aware week in 2016-17 a more intense campaign could be considered.

The practice pharmacists have added pulse checks to EMIS templates for long term conditions and annual reviews where possible. Additionally elements of the GP quality contract for 2016/17 require pulse checks to be taken in patients with Long Term Conditions at reviews.

**Estimated number of strokes prevented in high risk patients**

During the project the number of strokes prevented in the next 12 months has increased by 18.7 strokes and 21.8%. This has saved the CCG an estimated £228,663 in direct costs of strokes and social care an extra £45,131. It should be noted that these figures only take into account the strokes prevented in patients with a CHA2DS2-VASc score of >1; if we consider the potential men with a CHA2DS2-VASc score of 1 the number of strokes prevented would be higher.

**Revised estimated project costs**

The original estimated costs of the project are shown in table 1 above. The estimated project costs can be revised taking into consideration the GRASP-AF data from April 2016 which shows that the CCG now has 170 more patients with AF, 322 more high risk patients and 435 more high risk patients who are being treated with an anticoagulant.

Practice searches on the EMIS system shows that the ratio of prescribing rates over the project in new initiations for patients with AF of warfarin versus NOACs was 61:39. Table 2 below shows the revised project costs, which were net cost avoidance to the CCG of £72,171. This estimate only takes into account the elements listed in table 2 and does not account for any other costs that may be attributed to the project or the prescribing of anticoagulants.

**Table 2 – Revised estimated project costs using 60:40 prescribing rates**

<table>
<thead>
<tr>
<th>Costs</th>
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<tr>
<td>Additional annual Prescribing Budget costs</td>
<td>£115,188</td>
</tr>
<tr>
<td>Major bleed @ £1,173 per case</td>
<td>£3,720</td>
</tr>
<tr>
<td>Additional ADAS clinic costs for 261 patients @ £144</td>
<td>£37,584</td>
</tr>
<tr>
<td>Direct cost saving 18.7 strokes @ £12,228 per stroke saved</td>
<td>- £228,663</td>
</tr>
<tr>
<td><strong>Total cost</strong></td>
<td>- £72,171</td>
</tr>
</tbody>
</table>
Prescribing data trends of warfarin and NOACs also gives us an understanding of the prescribing patterns. Graphs 8 and 9 show the trends over time; the dotted line represents the start of the project. Since the start of the project there has been an increase of around 330 items of NOACs per month and an increase of around 300 items of warfarin; this is a combined approximate increase of 630 items of anticoagulants per month. Anticoagulants are also used for indications other than stroke prevention in AF. These trends in prescribing show that patients are being offered a choice of agent as per NICE CG180 and the increase since the start of the project seems to support a near 50:50 prescribing rate; however this needs to be interpreted with caution.

Graph 8 – Prescribing of NOACs over time

Graph 9 – Prescribing of warfarin over time
Further work being taken forward

Following the closure of the project work in March 2016, further work not completed in the time of the project has been identified to carry forward as part of the CCG stroke prevention work. This work includes the following:

- Recording of TTRs has been added to the GP quality Contract and ongoing work will be undertaken at practice level
- Exploring the possibility of self-testing INRs for patients on warfarin
- Exploring the possibility of purchasing BP machines accredited by NICE for detecting AF for use in GP practices
- Exploring innovation ideas with the Innovation Agency (former Academic Health Science Network for the North West Coast)

Conclusions

The main aim of the project was to implement aspects of NICE clinical guidelines 180: Atrial Fibrillation: the management of atrial fibrillation. The specifics of these guidelines that the project focussed on were:

1. Offer anticoagulation to people with a CHA₂DS₂-VASc score of 2 or above, taking bleeding risk into account.
2. Consider anticoagulation for men with a CHA₂DS₂-VASc score of 1. Take the bleeding risk into account.
3. Discuss the options for anticoagulation with the person and base the choice on their clinical features and preferences.
4. Reassess anticoagulation for a person with poor anticoagulation control shown by a TTR less than 65%. If poor anticoagulation control cannot be improved, evaluate the risks and benefits of alternative stroke prevention strategies and discuss these with the person
5. Do not offer aspirin monotherapy solely for stroke prevention to people with atrial fibrillation

Additionally the project aimed to:

6. Identify further patients with AF who are not currently on treatment registers and Read code appropriately
7. Identify innovative ways of opportunistically identifying patients with AF. i.e. ‘know your pulse’

The results of the project demonstrate that all aims have been achieved with the exception of point 4 above. This was not achieved as the ADAS service only started to inform practices of their patients TTRs as of April 2016.

Some of the main achievements of the project were:

- A successful education event and raised awareness with GP practices
- An estimated 18.7 extra strokes have been prevent in the next 12 months
- The number of identified high risk patients with a CHA₂DS₂-VASc score of 2 or above increased from 3432 to 3754 (322 patients and 9.4% increase)
- The number of patients at high risk on an anticoagulant increased from 2246 to 2681 (435 patients and 19% increase)
- The CCG has an average of 71.4% of high risk patients on an anticoagulant, variation between practices has been reduced and 14 practices have prescribing rates above 70%
- Fylde and Wyre CCG had the 4th highest percentage prescribing rate of anticoagulants in high risk patients out of all 30 CCGs in the North of England who upload their data onto Primis.
• Prescribing of solely an antiplatelet in AF patients decreased by 183 patients (19% decrease)
• Fylde and Wyre CCG prevalence of AF increased from 2.71% to 2.86%, an increase of 0.15%
• The CCG has saved an estimated £228,663 in direct costs of stokes and an extra £45,131 in social care costs
• The revised project costs show a net saving of £72,171.

References

3. A European wide call to action by Anticoagulation Europe (ACE) and the Atrial Fibrillation Association) AFA. Accessed at http://www.preventaf-strokecrisis.org/report chapter2
7. Chart Online via Primis. https://www.primis.nottingham.ac.uk/registration/
Appendix 1

NEWS RELEASE
[20/11/2015]

Know your pulse – help prevent stroke

NHS Fylde and Wyre Clinical Commission Group (CCG) is urging you to ‘know your pulse’ in a bid to reduce people’s risk of suffering a stroke.

The message comes ahead of AF Aware Week which runs from 23-29 November 2015, which helps to raise awareness of atrial fibrillation, or AF.

If left untreated, AF is the most powerful single risk factor for suffering a deadly or debilitating stroke – every 15 seconds someone suffers an AF-related stroke.

Atrial fibrillation is a heart condition that causes an irregular and often abnormally fast heart rate. It affects an estimated 1.5 million people across the UK, but awareness of this chronic condition still remains low.

The aims of AF Aware Week are simple: detect, protect and correct. As part of the awareness week and in a bid to prevent stroke in patients with AF, posters and leaflets will be displayed in GP practices and pharmacies encouraging people to know and check their pulse.

Thornton GP Dr Felicity Guest, the clinical lead for prescribing at Fylde and Wyre CCG, said: “Atrial fibrillation is the most common heart rhythm disturbance; it can affect adults of any age, but becomes more common as you get older.

“AF can be easily detected with simple manual pulse checks. One of the easiest places to feel your pulse is on your wrist, just below your thumb. Being aware of your pulse is important because it may indicate an abnormal heart rate or rhythm.”

What is a normal pulse?

Between 60 and 100 beats per minute is considered to be a normal pulse, however, there are good reasons why a person’s pulse may be slower or faster.

This may be due to age, medications, caffeine, fitness level and/or any other illness including heart conditions, stress and anxiety.

Dr Guest continued: “If you are feeling unwell and your pulse seems to be either racing or slow some or most of the time, or your pulse feels irregular, even if you do not feel unwell, then please seek further advice from your GP.”

Stroke prevention

The CCG is also working with practice pharmacists and GPs to increase the prescribing rate of anticoagulants in existing AF patients by arranging an appointment for patients with their GP to discuss starting anticoagulation.
Julie Lonsdale, pharmacist lead for medicines optimisation at the CCG, said “There are several treatments available which reduce the risk of an AF-stroke significantly. Mostly this is in the form of anticoagulation, sometimes called blood thinning. It is worth noting, aspirin is no longer recommended to prevent strokes caused by atrial fibrillation.

“Over the past 12 weeks alone we have increased prescribing rates of anticoagulants which will prevent an estimated four strokes over the next year in Fylde and Wyre. We want to prevent even more strokes by continuing this work and detecting more untreated AF in our community.”

ENDS

Notes to editors:

- NHS Fylde and Wyre Clinical Commissioning Group (CCG) is the organisation responsible for planning and buying health services in the area to meet patients’ needs. This is known as ‘commissioning’.

- Led by family doctors (GPs), the CCG currently serves a population of 152,000 people across approximately 320 sq km of coast and countryside. The majority live in the urban towns of Fleetwood, Thornton, Poulton-le-Fylde, Kirkham and Lytham St Annes, but a significant proportion live in rural villages.

- The CCG receives a set amount of money from the government – around £200million in 2014/15 – and is committed to spending this wisely for the benefit of local people.

- Giving you more choice is a priority of the modern NHS. More information is available at www.fyldeandwyreccg.nhs.uk/choice

- The NHS Constitution sets out your rights as an NHS patient: www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution/Pages/Overview.aspx

- There are many ways to get involved in health service developments, including joining our Influence membership scheme or your practice’s patient participation group.

- For more information about the CCG and how to get involved log onto www.fyldeandwyreccg.nhs.uk