UCLPartners Proactive Care Framework:

Atrial Fibrillation – Stroke Prevention and Managing Cardiovascular Risk

Version 9

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The Proactive Care Frameworks (PCF) can be used independently or in conjunction with CVDACTION

To request the PCF search tools please visit:
UCLPartners Proactive Care Frameworks - UCLPartners

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Background to the Frameworks

The Challenge of Long-Term Condition Management in Primary Care

Historical challenge in long term condition care

- Late diagnosis, suboptimal treatment, unwarranted variation
- Focus on reactive rather than proactive care
- Limited support for self-management

Real World Primary Care

- Complexity, multimorbidity and time pressures
- Often asymptomatic conditions
- Soaring demand and shifting priorities

This is a wicked problem

- Despite decades of QOF incentives, NICE guidance and myriad quality schemes, improvement has been marginal at best
- Primary care needs support to do things differently and at scale

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UCLPartners Proactive Care Frameworks Address Core Challenges in Primary Care

Aim

Help people with long term conditions to stay well longer

Objectives

1. Mobilise data - Identify patients whose care needs optimising and prioritise those at highest risk
2. Harness wider workforce - standardise delivery of holistic proactive care by wider primary care team
3. Support GPs to safely manage workflow, improve care and outcomes by releasing capacity

Framework components

- ✓ Risk stratification & prioritisation tools
- ✓ Locally adaptable resources to support real world management
- ✓ Systematic use of wider primary care team (eg ARRS* roles) to deliver structured support for education, self-management and behaviour change

Framework Development

- Led by primary care clinicians
- Based on NICE guidelines and clinical consensus
- Patient and public support

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*Additional Roles Reimbursement Scheme

Why Atrial Fibrillation? The Case for Change

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Why the Focus on Atrial Fibrillation and Cardiovascular Risk?

1. Atrial fibrillation (AF) leads to a 5-fold increased risk in stroke and is responsible for 20% of all strokes. Anticoagulation reduces the risk of stroke by up to two thirds[1].

2. If not anticoagulated, 25% of people who experience an AF-related stroke will die and over 50% of people will be left with moderate to severe disability[2]. Each stroke costs the NHS and social care over £45k over 5 years[3].

3. For most people, the benefits of anticoagulation significantly outweigh the risks.

4. People with AF are more likely to also have high blood pressure, high cholesterol, obesity or smoke. These factors should be addressed routinely to reduce the risk of heart attack, peripheral arterial disease, and dementia.

References: 1. Hart et al, 2007; 2. Stroke Association, 2018; 3. Xu et al, 2017;

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Stratification and Management of Atrial Fibrillation (AF)

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AF: Stratification and Management of Stroke Risk

ARRS[$] roles/ other appropriately trained staff

Gather information: Up to date bloods, BP, weight, smoking status, run CHA_2DS_2VASc, HASBLED, QRISK* score.

Self-management: Education (AF/stroke risk, bleeding risk, CVD risk reduction), signpost to shared decision making resources.

Behaviour change: Brief interventions and signposting e.g., smoking, weight, diet, exercise, alcohol.

Stratification

Priority One	**Priority Two**	**Priority Three**	**Priority Four**	**Priority Five**
Not on anticoagulant	On anticoagulant & antiplatelet/s	On Warfarin (or other Vitamin K antagonists)	On DOAC CrCl documented ≥12m ago	On DOAC CrCl documented <12m ago
Offer anticoagulant if indicated	Review need for antiplatelets	Consider DOAC	Check CrCl and review dosage	Routine annual review

Prescribing clinician

Optimise anticoagulation therapy and CVD risk reduction

1. Review: blood results, risk scores & symptoms.
2. Initiate or optimise anticoagulant.
3. For patients on warfarin consider switch to DOAC at next routine review.
4. Check adherence and review any side effects.
5. Review and mitigate bleeding risk: BP control, medication, alcohol, PPI.
6. Optimise BP and lipid management to reduce cardiovascular risk.
7. Address rate and rhythm control as needed.

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*QRISK 3 score is recommended to assess CV risk for patients with Severe Mental Illness, Rheumatoid Arthritis , Systemic Lupus Erythematosus, those taking antipsychotics or oral steroids

[$]Additional Roles Reimbursement Scheme

Pathways and Resources

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Pathways and Resources

1. Initiating Direct Oral Anticoagulants (DOACs)
2. Assessing stroke and bleeding risk
3. DOACs: Calculating creatinine clearance
4. DOACs: Dosing in non-valvular atrial fibrillation
5. DOACs: Reviewing condition management
6. DOACs: Considerations
7. Anticoagulation in people taking antiplatelet therapy
8. Warfarin: Time in therapeutic range (TTR) monitoring
9. Warfarin to DOAC switching
10. DOAC to DOAC switching

Initiating Direct Oral Anticoagulants (DOACs)*

Action	Resource
1 Check the patient has Non-Valvular AF (NVAF) and has no other contraindications to therapy	DOAC contraindicated if mechanical prosthetic valve or known moderate to severe mitral stenosis DOAC contraindicated if pre-existing clotting disorder, such antiphospholipid syndrome (APS) pregnant, breastfeeding or planning pregnancy, mechanical heart valves – seek specialist advice. For full list of contraindications see SmPCs at www.medicines.org.uk
2 Check CHA_2DS_2VASc	Offer anticoagulation if **CHA_2DS_2VASc** ≥ 2 (consider if = 1 in men)
3 Check: • Bloods for renal function, LFTs, clotting and FBC • Bodyweight • Creatinine Clearance (CrCl)	**Creatinine clearance calculation** Dabigatran contraindicated if CrCl < 30ml/min Apixaban, Edoxaban, Rivaroxaban, are not recommended if CrCl < 15ml/min
4 Check bleeding risk with HASBLED score or ORBIT score, in line with local guidance	Address modifiable risks identified by **ORBIT score** to reduce bleeding risk. Review other medication – including antiplatelets and NSAIDs; consider PPIs
5 Shared Decision Making (SDM) - agree which DOAC to initiate. Correct choice of dose	**DOAC dosing**
6 Counsel patient and agree a plan for follow up including monitoring blood tests	**DOAC monitoring** Provide written information, an anticoagulant alert card and point of contact should issues arise

***NICE guidance 2021 recommends DOACs first line.**
If DOAC is unsuitable, consider warfarin following local pathways for initiation & monitoring

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Stroke Risk Assessment

Stroke Risk			
CHA_2DS_2VASc		CHA_2DS_2VASc Score	Number of AF-related strokes avoided per 1,000 AF patients treated with anticoagulant therapy per year*
Congestive Heart failure	1	1	4
Hypertension	1	2	17
Age >75 years	2	3	25
Diabetes	1	4	38
Prior stroke/TIA	2	5	57
Vascular disease	1		
Age 65-74 years	1		
Female	1		

Interpretation

1. Offer anticoagulation to all patients (male or female) with $CHA_2DS_2VASc \geq 2$
2. Consider anticoagulation in all men with $CHA_2DS_2VASc = 1$
3. Antiplatelet monotherapy (Aspirin/Clopidogrel) is not recommended for stroke prevention in AF

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*Tables adapted from Y Javaid

Bleeding Risk Assessment

Bleeding Risk - ORBIT

ORBIT Score**	
Haemoglobin <13 mg/dL for males and <12 mg/dL for females, or haematocrit <40% for males and <36% for females	2
Age >74 years	1
Bleeding history - Any history of GI bleeding, intracranial bleeding, or haemorrhagic stroke	2
GFR <60 mL/min/1.73 m2	1
Treatment with antiplatelet agents	1

ORBIT Score	Risk level	Number of major bleeds caused per 1,000 AF patients treated with anticoagulant therapy per year
0-2	Low	24
3	Medium	47
4-7	High	81

***NICE 2021 indicated that ORBIT is the best tool for bleeding risk assessment, other tools may need to be used until it is embedded in clinical pathways and electronic systems*

Interpretation

1. Address modifiable bleeding risk factors to reduce bleeding risk e.g. lower BP, review concomitant drug therapy, reduce alcohol intake
2. Consider a proton pump inhibitor to reduce upper GI bleeding

ORBIT Calculation: https://www.mdcalc.com/orbit-bleeding-risk-score-atrial-fibrillation

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*Tables adapted from Y Javaid

Ref: European Heart Journal, Volume 36, Issue 46, 7 December 2015, Pages 3258–3264, https://doi.org/10.1093/eurheartj/ehv476

DOACs: Calculating Creatinine Clearance

eGFR should not be used to guide dosing decisions for DOACs[1]

Use actual bodyweight (within 1 year) to calculate Creatinine Clearance (CrCl)
- If weight < 50kg or > 120kg or if BMI >40 : seek specialist advice

Use renal function checked within last 3 months

Calculate CrCl using Cockcroft Gault equation
- Be cautious with calculators integrated into GP IT systems as they may default to ideal bodyweight resulting in underdosing of DOAC
- Use MDCalc

Adjust DOAC dose if necessary
See slide on **DOAC dosing in NVAF**

Creatinine Clearance	Monitoring interval
>60ml/min	Annually
30-60ml/min	6-monthly
<30ml/min	3-monthly

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1. https://bmjopen.bmj.com/content/3/9/e003343

DOACs: Dosing in Non-Valvular AF

	Apixaban*	Dabigatran*	Edoxaban*	Rivaroxaban*
Standard dose	5mg BD	150mg BD	60mg OD	20mg OD
Reduced dose	2.5mg BD	110mg BD	30mg OD	15mg OD
Criteria for dose reduction	**2 or more of:** • Age ≥80 • Body weight ≤60kg • Cr ≥133µmol/L **Or** CrCl 15-29ml/min	1. Age≥80 2. On verapamil 3. Consider ↓dose: • Reflux/gastritis • Age75-80 • CrCl 30-50ml/min • "Bleed risk"	**1 or more of:** • CrCl 15-50ml/min • Body weight ≤60kg • On ciclosporin, dronedarone, erythromycin, ketoconazole	CrCl 15-49ml/min
Contraindicated / Not recommended	**CrCl <15ml/min**	**CrCl <30ml/min**	**CrCl <15ml/min**	**CrCl <15ml/min**

Check for common drug interactions & possible contraindications	Bleeding risk increased by
Antifungal agents	NSAIDs
Rifampicin	Antiplatelets
Phenytoin and anti-epileptics	Long term oral steroid use
Antiretrovirals	Antidepressants: SSRIs/SNRIs
Chemotherapy	

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* SmPCs all available at www.medicines.org.uk;

DOACs: Reviewing Management

This review template is designed for review 1 month after initiation and according to the monitoring interval

Eligibility	Monitoring interval	Parameter
• All patients on DOAC	Annually	FBC, Renal & Liver function (calculate CrCl, weight)
• CrCl 30–60 ml/min	6 monthly	Renal function
• Patients over 75 years and / or frail	4 monthly*	FBC, Renal & Liver function, weight
• CrCl 15–30 ml/ml	3 monthly	Renal function
• Other e.g. intercurrent illness that may impact on renal or hepatic function	Individually agreed	Renal & Liver function +/- FBC

Annual clinical review to include:**

- Stroke risk assessment using CHA_2DS_2VASc
- Review of QRISK and manage CVD risk factors including BP and lipids
- Address bleeding risk
- Check adherence
- Medicines review and check appropriate dosing
- Missed/delayed dose advice
- Alert card check

Alternatively, NICE CKS recommends that where CrCl < 60ml/min, monitoring frequency should be guided by the CrCl divided by 10. For example, every 3 months if CrCl is 30 ml/minute. https://cks.nice.org.uk/topics/anticoagulation-oral/management/edoxaban/

*Reference: 2021 European Heart Rhythm Association Practical Guide on the Use of Non-Vitamin K Antagonist Oral Anticoagulants in Patients with Atrial Fibrillation | EP Europace | Oxford Academic

** Follow local DOAC clinical review protocols where available

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DOACs: Considerations

Consideration	Option	Most suitable DOAC
Frequency of tablets/capsules	One tablet once a day	Edoxaban/rivaroxaban
	One tablet or capsule twice a day	Apixaban/dabigatran
With or without food	Take with or without food	Apixaban/dabigatran/edoxaban
	Take with food	Rivaroxaban
Use of a compliance aid (dosette box)	Suitable to go in compliance aid (Cannot use dabigatran in dosette box)	Apixaban/edoxaban/rivaroxaban
Swallowing difficulties or feeding tube	CAN be crushed	Apixaban/edoxaban/rivaroxaban
	Capsules CANNOT be opened	Dabigatran
Lactose intolerant patient		Dabigatran/edoxaban

Anticoagulation in People Taking Antiplatelet Therapy

- Antiplatelet therapy is not recommended for stroke prevention in AF; oral anticoagulants should be used.
- Some patients with AF are on antiplatelet therapy as treatment for vascular disease. See guidance below

Indication for antiplatelets	Antiplatelet	Action when initiating anticoagulation for AF
Primary prevention of CVD	Antiplatelet monotherapy	Stop antiplatelet therapy (antiplatelet therapy not recommended for primary prevention of CVD)
Secondary prevention of CVD • Stroke / Transient Ischaemic Attack (TIA) • Stable coronary heart disease (CHD) • Peripheral arterial disease (PAD)	Antiplatelet monotherapy or Low dose rivaroxaban with aspirin	Stop antiplatelet therapy Increase DOAC dose (to AF stroke prevention dose) and stop aspirin
Patients within 12 months of an ACS or stent placement (cardiac or vascular)	Aspirin plus clopidogrel, ticagrelor or prasugrel	Seek specialist advice to agree the preferred drug regimen. Triple therapy (dual antiplatelet plus anticoagulant) duration must be clearly defined.
Patients more than 12 months after an ACS or stent placement (cardiac or other vascular)	Antiplatelet monotherapy / dual antiplatelet therapy If discharge summary indicates dual antiplatelet required long-term	Stop antiplatelet therapy, unless otherwise advised by specialist (check discharge summary) Seek specialist advice – do not add anticoagulant to dual antiplatelet therapy without advice

When using an anticoagulant plus an antiplatelet – add a proton pump inhibitor (PPI)

Adapted from: https://b-s-h.org.uk/guidelines/guidelines/oral-anticoagulation-with-warfarin-4th-edition/ Page 318-319
and https://www.escardio.org/Guidelines/Clinical-Practice-Guidelines/Atrial-Fibrillation-Management Page 61

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Warfarin: Time in Therapeutic Range (TTR) monitoring

- For effective stroke prevention with warfarin, time in therapeutic range (TTR) should be maintained ≥ 65%
- INR should be checked at least 12 weekly in patients with stable INR – target INR in AF is 2.5 (range 2-3)
- All patients should have TTR calculated at each INR visit
- Reassess anticoagulation if poor control as shown by:
  - 2 INR values > 5 or 1 INR value > 8 within the past 6 months
  - 2 INR values < 1.5 within the past 6 months
  - TTR less than 65%
- If possible, address modifiable factors that may contribute to poor control:
  - Adherence, illness, interacting drugs, diet and alcohol consumption

NICE guidance recommends that patients prescribed warfarin for stroke prevention in AF should be considered for a swich to DOAC. Switching to a DOAC should be discussed with patients who are stable on warfarin at their next routine review, taking into account their time in therapeutic range.

Warfarin to DOAC Switching

1. Confirm the indication for warfarin is stroke prevention in AF
2. Exclude patients with contraindications to DOACs
3. Involve the patient in a shared decision to switch from warfarin to a DOAC
4. Check bodyweight and bloods for INR, renal function, LFTs, and FBC
5. Calculate CrCl using Cockcroft Gault equation
6. Decide which DOAC to use and what dose
7. Advise patient when to stop the warfarin and start the DOAC:
   - INR should be <2.5 before initiating DOAC
   - DOAC may need to be withheld or 24-48 hours after stopping warfarin depending on the measured INR
8. Provide written information, an anticoagulant alert card and ensure they have a point of contact should issues arise

NICE guidance recommends that patients prescribed warfarin for stroke prevention in AF should be considered for a swich to DOAC. **Switching to a DOAC should be discussed with patients who are stable on warfarin** at their next routine review, taking into account their time in therapeutic range.

The FRAIL-AF trail demonstrated that switching **frail older patients** with AF from well-controlled warfarin to a DOAC was associated with more bleeding complications compared with continuing warfarin treatment, without an associated reduction in thromboembolic complications.
https://doi.org/10.1161/CIRCULATIONAHA.123.066485

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DOAC to DOAC Switching

1. Confirm the indication for DOAC is stroke prevention in AF
2. Identify any reasons why a switch to an alternate DOAC may not be suitable e.g, specific contraindications or cautions etc
3. Involve the patient in a **shared decision** to switch to an alternative DOAC
4. Check bodyweight and bloods for INR, renal function, LFTs, and FBC
5. Calculate CrCl using **Cockcroft Gault equation**
6. Decide which **DOAC to use** and what **dose**
7. Advise patient when to stop the existing DOAC and to start the alternative DOAC:
   - Continue existing DOAC as normal on day before the switch
   - Initiate alternative DOAC when next dose is due on day of switch.
   - Ensure patient understands if dosing is once or twice daily, depending on DOAC
8. Provide written information, an anticoagulant alert card and ensure they have a point of contact should issues arise

Why Switch?
Patients may require switching from one DOAC to another, for example, to manage adverse effects or improve adherence.

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Hypertension in Patients with Atrial Fibrillation

Detection and Management of Hypertension in Patients with Atrial Fibrillation

- Blood pressure should be checked in patients with AF to identify undiagnosed hypertension. If hypertension is suspected due to a high BP reading, the diagnosis should be confirmed using ABPM or home BP checks over 7 days.

- Checking BP in patients with established hypertension:
  - Patients **with** AF:
    - Submit 2 BP readings each morning and evening over 4 days. Calculate the average systolic and diastolic values.

- Please refer to UCLP hypertension pathway for detailed guidance: CVD resources - UCLPartners

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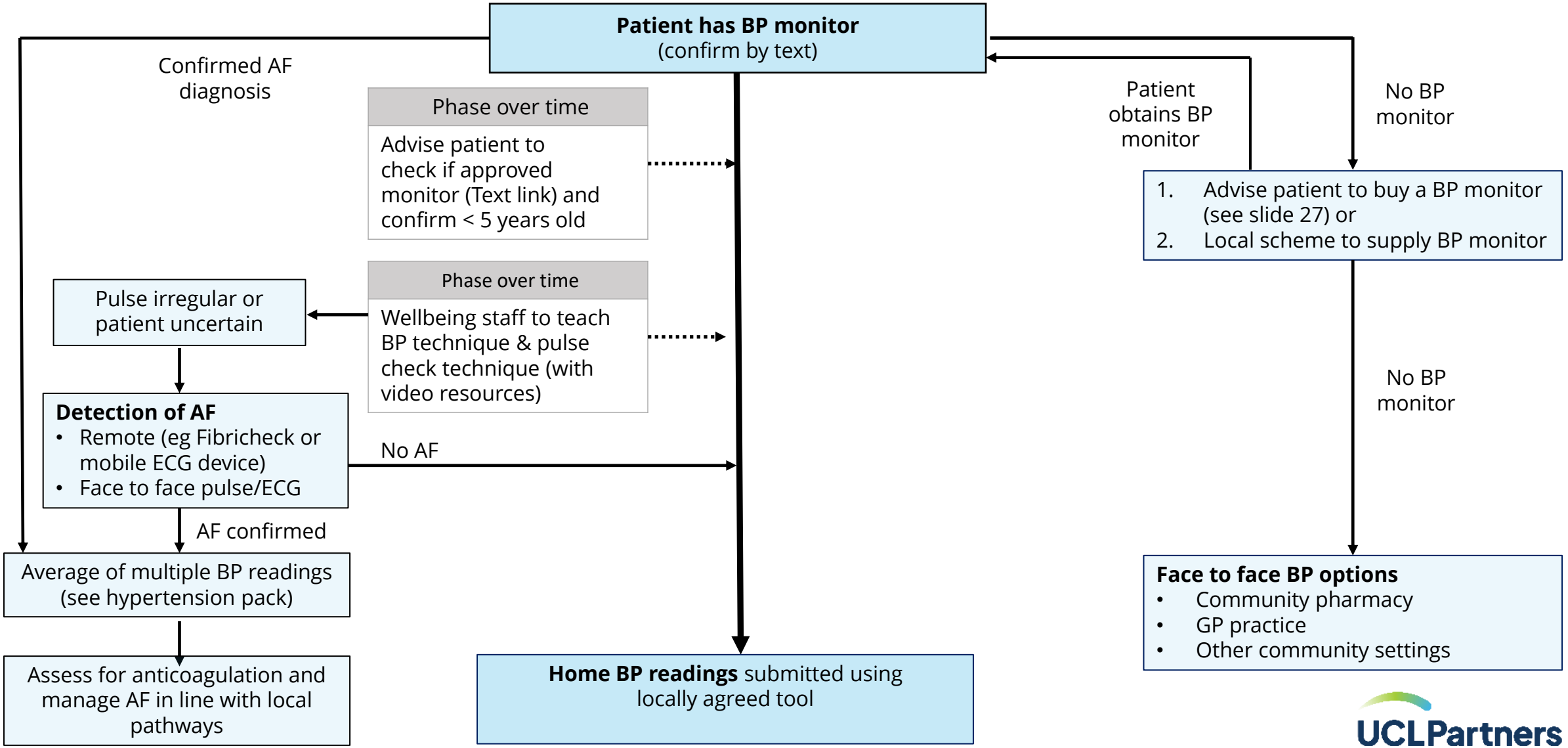
Home Blood Pressure Monitoring Pathway



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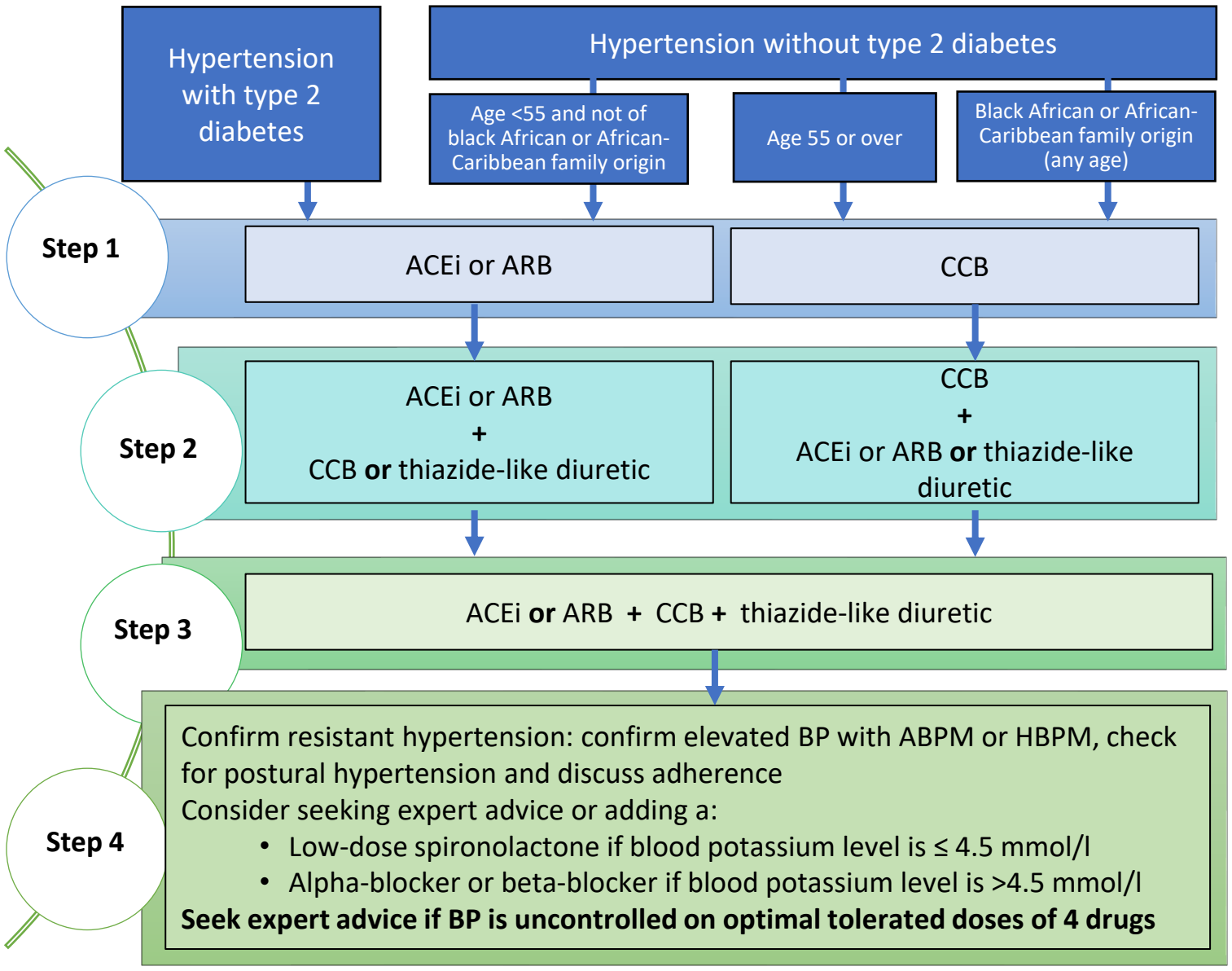
NICE Hypertension Treatment Pathway (NG136)



Use clinical judgement for people with frailty or multimorbidity

Offer lifestyle advice and continue to offer it periodically

Monitoring treatment

Use clinic BP to monitor treatment

Measure standing and sitting BP in people with:

- Type 2 diabetes or
- Symptoms of postural hypotension or
- Aged 80 and over

Advice people who want to self monitor to use HBPM. Provide training and advice

Consider AMPM or HBPM, in addition to clinic BP, for people with white-coat effect or masked hypertension

BP targets

Reduce and maintain BP to the following targets:

Age <80 years:

- Clinic BP <140/90 mmHg
- ABPM/HBPM <135/85mmHg

Postural hypotension:

- Base target on standing BP

Frailty or multimorbidity:

- Use clinical judgement

Pathway adapted from NICE Guidelines (NG136) Visual Summary
https://www.nice.org.uk/guidance/ng136/resources/visual-summary-pdf-6899919517
Abbreviations: ACEi: ACE inhibitor, ARB: Angiotensin II Receptor Blocker, CCB: Calcium Channel Blocker, ABPM: Ambulatory Blood Pressure Monitoring, HBPM: Home Blood Pressure Monitoring

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Management of Broader Cardiovascular Risk in AF:

Cholesterol Management

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Managing High Cholesterol and Cardiovascular Risk in People with Atrial Fibrillation

The following slides will help clinicians manage the broader cardiovascular risk in people with atrial fibrillation:

- **Pre-existing cardiovascular disease**
  - Optimise lifestyle
  - Use of high intensity statins at maximal appropriate dose
- **No pre-existing cardiovascular disease**
  - Optimise lifestyle and lipid lowering therapy as primary prevention in people with:
    - QRisk >10% in ten years
    - CKD 3-5
    - Type 1 Diabetes for >10 years or over age 40
- **All patients:**
  - Responding to possible statin intolerance
  - Managing muscle symptoms and abnormal LFTs in people taking statins
- **Please refer to UCLP lipid pathway for detailed guidance:**

  https://uclpartners.com/our-priorities/cardiovascular/proactive-care/cvd-resources/

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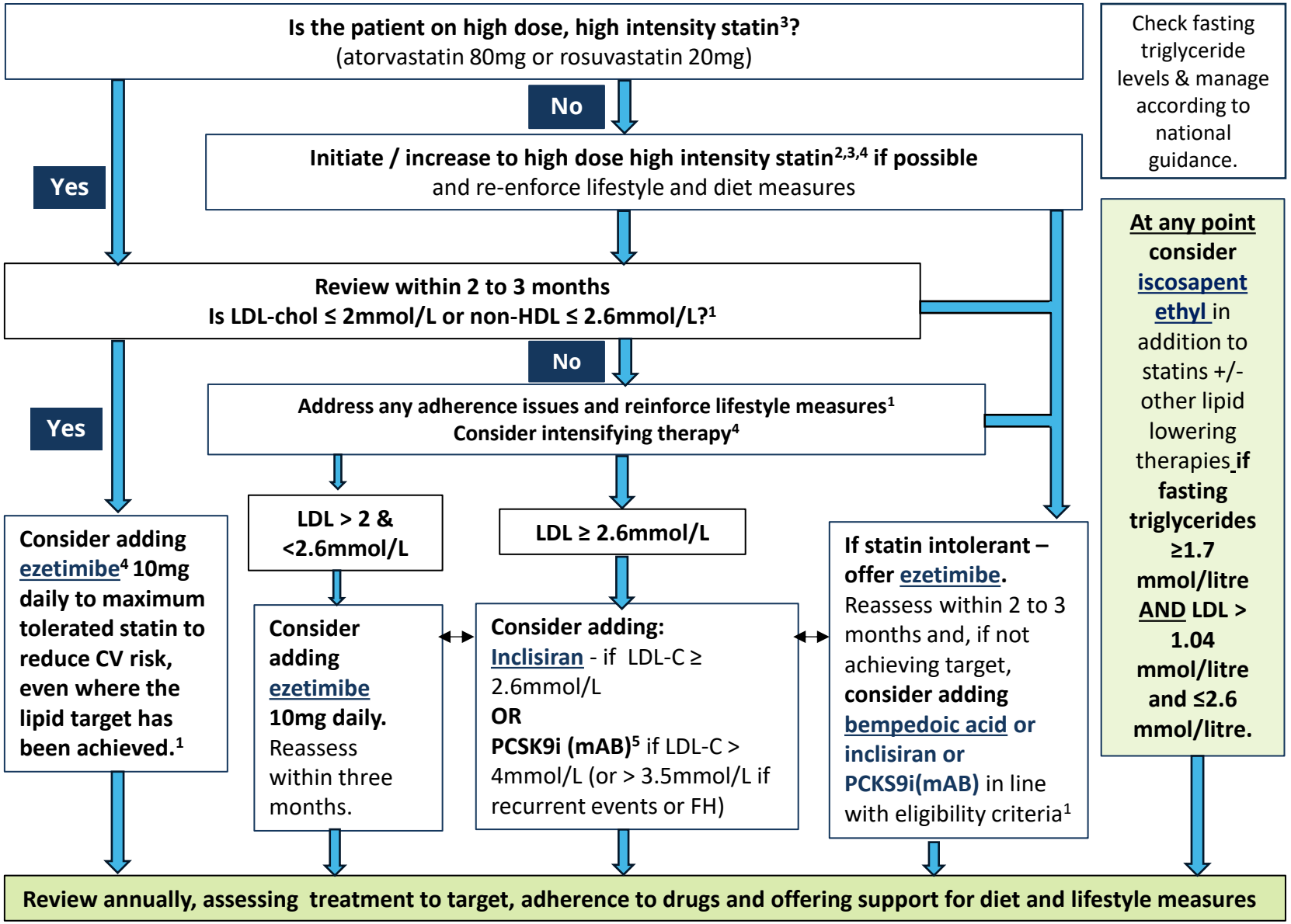
Lipid Optimisation Pathway for Secondary Prevention[1]



Check fasting triglyceride levels & manage according to national guidance.

At any point consider iscosapent ethyl in addition to statins +/- other lipid lowering therapies if fasting triglycerides ≥1.7 mmol/litre AND LDL > 1.04 mmol/litre and ≤2.6 mmol/litre.

Lipid lowering therapy should be offered to all patients with established CVD[1]

1. NICE NG238: Cardiovascular disease: risk assessment and reduction, including lipid modification
2. Dose may be limited, for example if:
   - CKD: eGFR<60ml/min – recommended starting dose - atorvastatin 20mg
   - Drug interactions
   - Drug intolerance
   - Older age / frailty
3. See statin intensity table.
4. Use shared-decision making and incorporate patient preference in treatment and care decisions.
5. NICE Guidance PCSK9i(mAB): Evolocumab, Alirocumab

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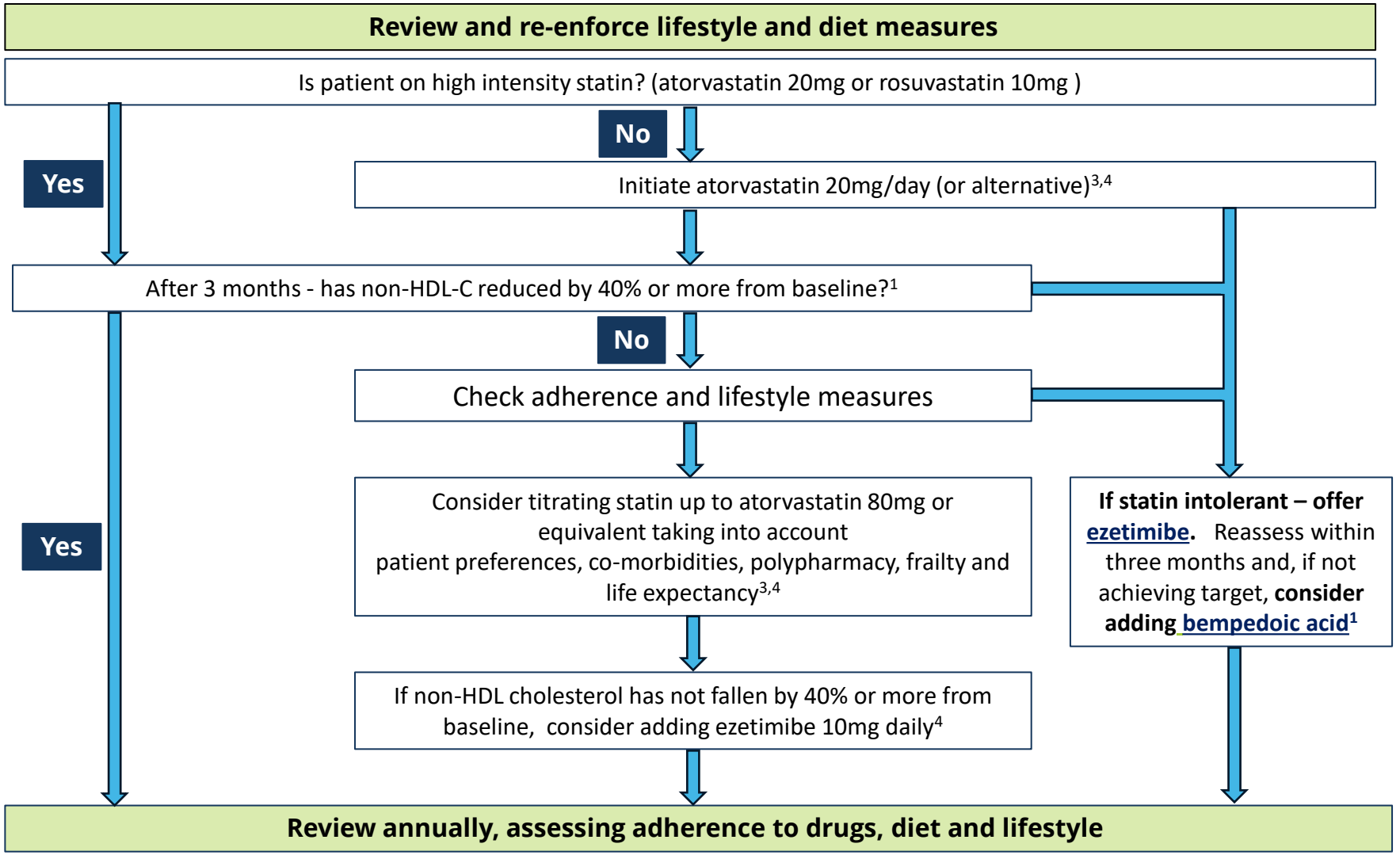
Optimisation Pathway for Patients with High Cardiovascular Risk – Primary Prevention[1,2]



Lipid lowering therapy should be offered to all patients at high CV risk[2] . (It may also be considered in individuals with QRIsk < 10%)[1]

People living with HIV should be offered statin therapy regardless of QRisk score [5]

1. NICE NG238: Cardiovascular disease: risk assessment and reduction, including lipid modification
2. High cardiovascular risk:
   - QRisk ≥ 10% in ten years
   - CKD: eGFR<60ml/min or albuminuria
   - Type 1 Diabetes for >10 years or over age 40, nephropathy or other CV risk factors
3. See statin intensity table.
4. Use shared-decision making and incorporate patient preference in treatment and care decisions.
5. BHIVA rapid guidance on the use of statins for primary prevention of cardiovascular disease in people living with HIV v2

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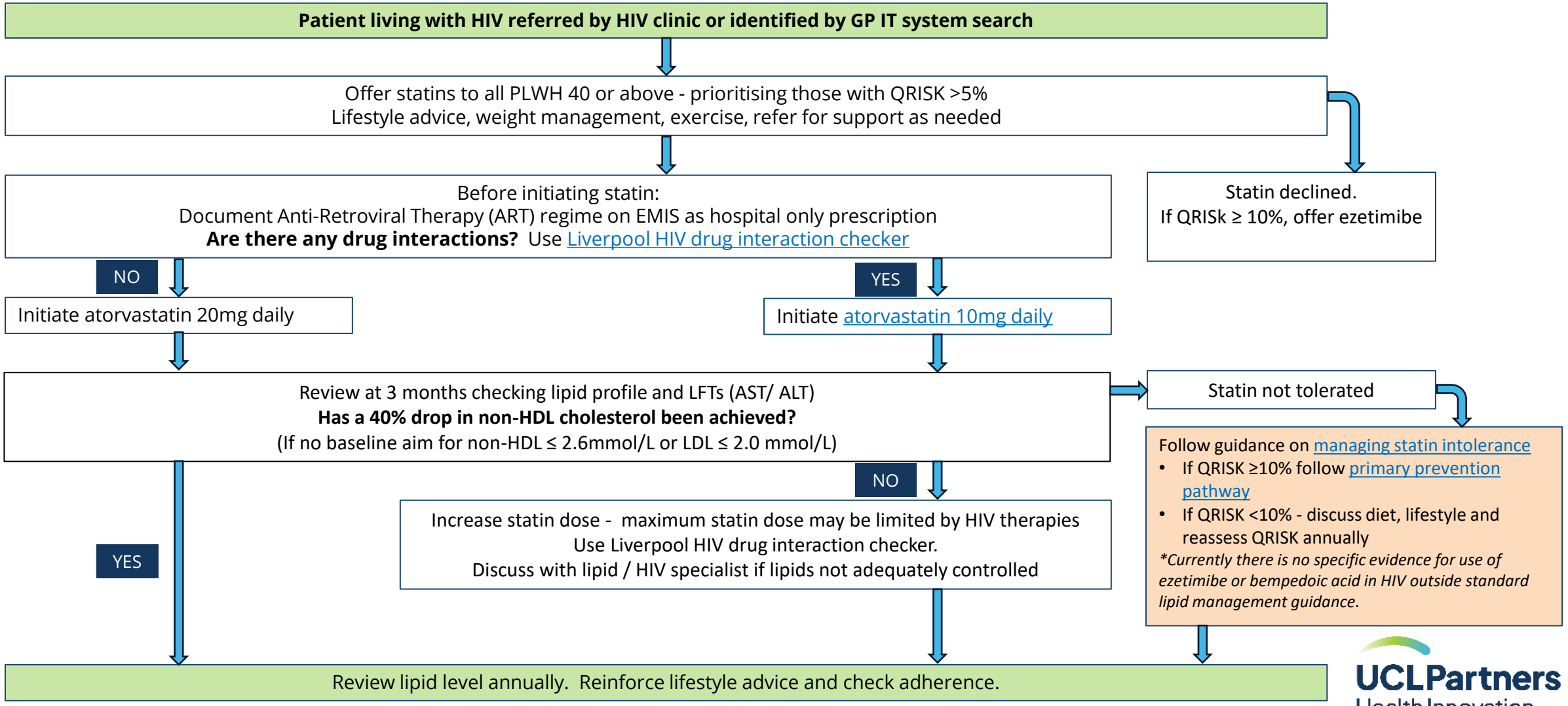
Statin Initiation for Primary Prevention for People Living with HIV (PLWH) 40 years and above*



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Adapted from a pathway initially developed by SE London ICB; Based on BHIVA rapid guidance on the use of statins for primary prevention of cardiovascular disease in people living with HIV v2

Common Statin/ARV Interactions and Recommended Doses for PLWH

ARV Regimen	Effect on Statins	Recommended atorvastatin starting dose	Maximum atorvastatin dose	Recommended rosuvastatin starting dose	Maximum rosuvastatin dose
Ritonavir- or cobicistat-boosted darunavir	Increased atorvastatin and rosuvastatin concentrations.	10mg	40mg	5mg	20mg
Ritonavir- or cobicistat-boosted elvitegravir	Increased atorvastatin and rosuvastatin concentrations.	10mg	40mg	5mg	20mg
Ritonavir- or cobicistat-boosted atazanavir	Significantly higher atorvastatin and rosuvastatin levels.	10mg	10mg	5mg	10mg
Lopinavir/ritonavir	Significantly higher atorvastatin and rosuvastatin levels.	10mg	20mg	5mg	10mg
Efavirenz	Variable reductions in atorvastatin. Rosuvastatin preferred first line.	20mg	80mg	10mg	40mg
Other ARV regimens	See resources below or seek advice from a lipid / HIV specialist				

Standard dosing of Ezetimibe is advised for all ARV regimes

Please note some antiretrovirals, such as boosted protease inhibitors (e.g. darunavir/ritonavir/cobicistat/atazanavir) and efavirenz can increase lipids, while others are more lipid-friendly. Consider referring patients with persistently elevated lipids to their HIV clinic for optimisation of their antiretroviral regimen.

For further information and advice about interactions: https://www.hiv-druginteractions.org/checker

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Adapted from a pathway initially developed by SE London ICB

Statin Intolerance Pathway

Important considerations

- Most adverse events attributed to statins are no more common than placebo[1]
- Consider food and drug interactions which may be contributing to adverse effects – see Summary of Product Characteristics (SmPC)[2,3]
- Stopping statin therapy is associated with an increased risk of major CV events. It is important not to label patients as 'statin intolerant' without structured assessment
- If a person is not able to tolerate a high-intensity statin, aim to treat with the maximum tolerated dose
- A statin at any dose reduces CVD risk – consider annual review for patients not taking statins to review cardiovascular risk and interventions

A structured approach to reported adverse effects of statins

- Stop for 4-6 weeks.
- If symptoms persist, they are unlikely to be due to statin
- Restart and consider lower initial dose
- If symptoms recur, consider trial with alternative statin
- If symptoms persist, consider ezetimibe +/- bempedoic acid

1. (Collins et al systematic review, Lancet 2016)
2. SmPC: Atorvastatin https://www.medicines.org.uk/emc/product/5274/smpc#gref
3. SmPC: Rosuvastatin https://www.medicines.org.uk/emc/product/4366/smpc#gref

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Resources

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Digital Resources to Support Self-Management: AF

Living with Atrial Fibrillation
British Heart Foundation Living with Atrial Fibrillation; AF causes, symptoms and treatments
The AF Association Patient resources
NHS website – Anticoagulant medicines
Stroke Association – Blood thinning medication and stroke, AF symptoms, diagnosis and treatment, AF and stroke

Blood Pressure
British Heart Foundation Managing blood pressure at home

Starting anticoagulation
Starting anticoagulation with Jack - https://vimeo.com/206257430

Educational video resources for patients created by UCLPartners - https://uclpartners.com/work/anti-coagulation-videos/

Diet
Providing information and recipes for easy ways to eat better from the 'Better Health' website
NHS advice on lowering cholesterol levels & what is cholesterol and how do I lower it?

Smoking cessation
NHS support, stop smoking aids, tools and practical tips

Alcohol
Heart UK alcohol guidance & NHS Drink Less guidance

Exercise
NHS 'Better Health'
Tips, advice and guidance on how to keep or get active in and around the home: Getting active around the home
Dance to health: Online dance programme especially tailored to people over 55 years old
The Richmond Group of Charities: Physical activity videos and information

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Digital Resources to Support Clinical Management: AF

Video resources (*What is anticoagulation; I am on a DOAC; Starting a DOAC; Anticoagulation in VT; Anticoagulation in atrial fibrillation; Switching from warfarin to a DOAC)* created by UCLPartners https://uclpartners.com/work/anti-coagulation-videos/

Cockcroft-Gault Equation https://www.mdcalc.com/creatinine-clearance-cockcroft-gault-equation

RCGP Module
The Royal College of General Practitioners e-module on Atrial Fibrillation: diagnosis and management. Access here (log in details required)

UCLP Proactive Care resources to address additional CVD and respiratory conditions can be accessed here

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Implementation Support

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Implementation & Support Package

Implementation Support is critical to enable sustainable and consistent spread. UCLPartners has developed a support package for the Integrated Care Systems within our geography covering the following components. The resources below can be accessed via the UCLP website: Proactive care frameworks – UCLPartners.

UCLPartners is one of 15 Health Innovation Networks (HINs) across England and all 15 have a priority around CVD. Please reach out to your local HIN to understand what support they might be able to provide. Please note each varies in its approach and offer.

Search and stratify	**Comprehensive search tools** for EMIS and SystmOne to stratify patients • Pre-recorded webinar as to how to use the searches. • Online FAQs to troubleshoot challenges with delivery of the search tools.
Workforce training and support	**Training tailored to each staff grouping (e.g. some ARRS* roles) and level of experience** • **Delivery:** Scripts provided as well as training on how to use these underpinned with motivational interviewing/ health coaching training to enable adult-to-adult conversations. • **Practical support**: Recommended training e.g. correct inhaler technique; correct BP technique, Very Brief Advice for smoking cessation, physical activity etc. • **Digital implementation** support: how to get patients set up with appropriate digital. • **Education** sessions on conditions. • **Communities of Practice.**
Digital support tools	**Digital resources** to support remote management and self-management in each condition. **Implementation** toolkits available where required, e.g. MyCOPD. Support available from UCLP's commercial and innovation team for implementation.

UCLPartners
Health Innovation

Thank you

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Version tracker

Version	Edition	Changes Made	Date amended	Review due
2	2.0	• Incorporated hypertension and cholesterol management content for patients with multi-morbidity		
2	2.1	• Amended version control table to include dates and removed date from first slide	June 2021	December 2021
3	3.0	• Removed slide on resources for remote diagnostics and monitoring • Amended information on cholesterol management • Removed statistics on statins and statin intensity table • Added ORBIT bleeding risk tool • Added option of bempedoic acid	August 2021	February 2022
4	4.0	• Updated warfarin to DOAC slide • Updated DOAC to DOAC slide • Updated cholesterol pathways • Updated resource slides	October 2022	October 2023
5	5.0	• Introduction slides updated • HCA roles amended to ARRS roles • Lipid pathway treatment targets updated to align with NICE and AAC guidance	December 2022	December 2023
5	5.1	• Updated cholesterol pathway slides • Amended introduction slides	September 2023	September 2024
6	6.0	• Cholesterol pathways updated • Implementation slide updated	January 2024	January 2025
6	6.1	• New UCLP template	April 2024	January 2025
7	7.0	• Lipid Optimisation pathway for secondary prevention updated.	June 2024	January 2025
8	8.0	• Removed HASBLED information • Updated to align with current best practice – amended renal monitoring frequency for frail/over 75 • Streamlined DOAC switching information	April 2025	April 2026
9	9.0	• Updated lipid optimisation pathway for secondary prevention and priority 4 and 5 descriptions	Feb 2026	Feb 2027