NHS
South London
Cardiac Operational Delivery Network

South London Cardiovascular Networks

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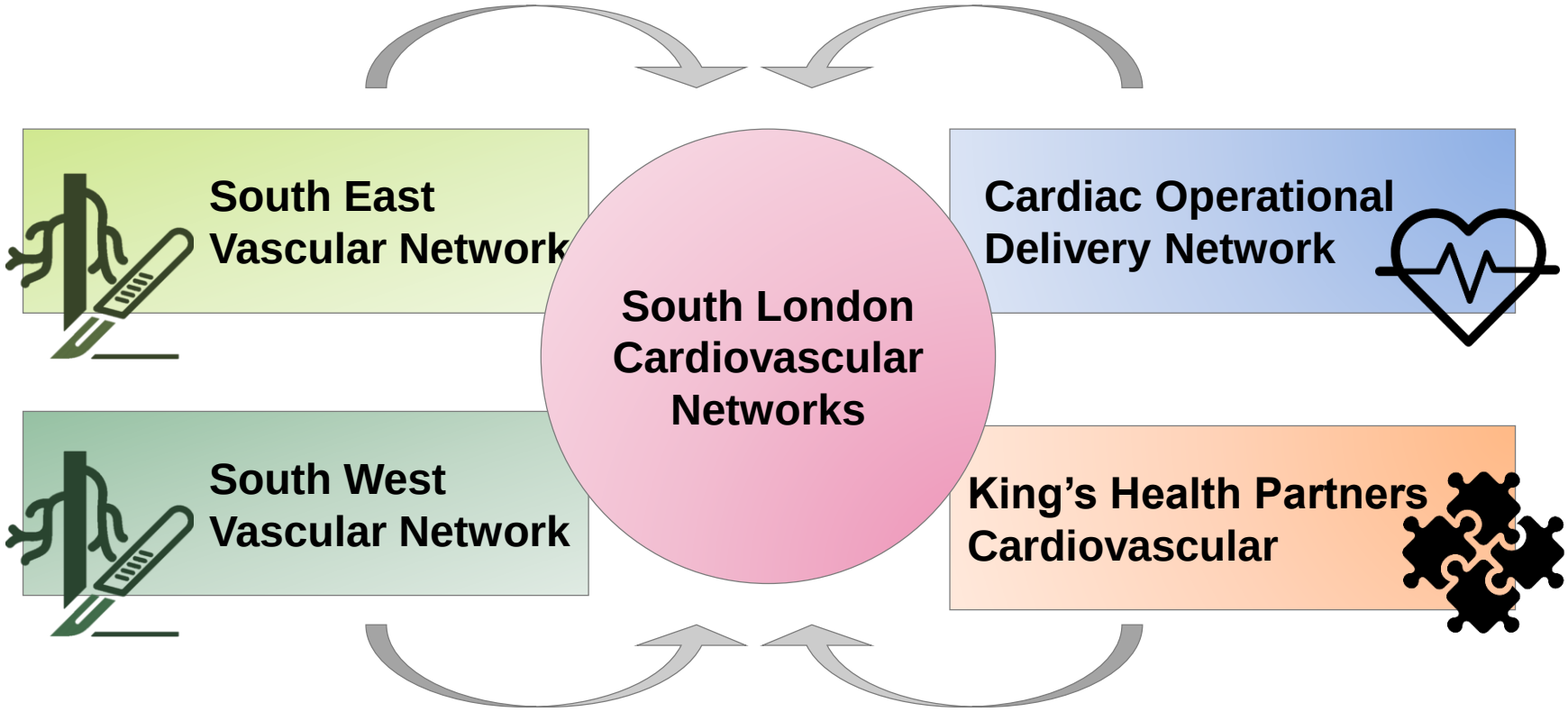
Linking together for greater impact



Improve patient experience
Improve quality
Reduce variations

→

Best value healthcare
Increase efficiencies

Cardiac ODN Objectives

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- **To improve patient experience**
  - To redesign services that, where possible, support patient led care. Patients, carers and families are sufficiently informed and supported to make the best choice for them, regarding their treatment. Their view are taken into consideration when reviewing/improving services
- **To reduce unwarranted variation**
  - To ensure patients are treated by the right people, in the right place, at the right time across the south London footprint
- **To improve quality**
  - To provide safe, high quality services which are in line with recognised best practice standards
- **To increase value for money**
  - To bridge the gap between the rate of growth in service funding allocated and spend. This will require effective use of drugs/devices, demand management and implementation of best practice pathways

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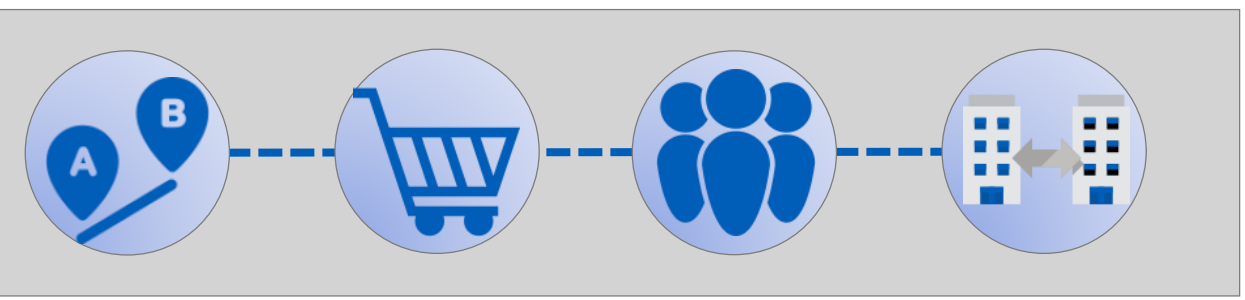
Overview of the 4 Cardiac ODN workstreams

Right care, right time, right place



Clinical pathways

Creating best value pathways, looking at standardisation and consistency (heart failure, AF, valve, EP, ICC, ACHD, complex devices)

Collective purchasing

Strategic procurement, South London Trusts working together for best value

Strengthening MDT working

Improving structure, consistency and technology for decision making

Inter hospital transfers

Quicker transfer for better patient care, managing flow across South London

Pioneering better health for all

King's Health Partners Cardiovascular (KHP-C)

KHP-C integrates the School of Cardiovascular Medicine & Sciences of King's College London and the adult cardiology, cardiac surgery and vascular surgery units at Guy's and St Thomas' and King's College Hospital NHS Foundation Trusts. KHP-C aims to build upon individual strengths to bring together clinicians and academics across clinical practice, research and education to combine their expertise to achieve better outcomes for our patients and service users. Clinical operational integration is a vital step, one team working ensures that no matter where patients are treated across the partnership, they receive the quickest access to care.

In practice, this means that in the future:

- Patients can be treated anywhere across the partnership and receive seamless care
- Staff will be able to work across both sites with ease
- There will be an aligned management structure, including operational priorities and joint decision making
- Key pathways, policies and processes (clinical and administrative) will be aligned

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Annual Report

- **For a detailed summary of the progress so far across all areas, please see the annual report.**

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South London Cardiac Operational Delivery Network
Atrial Fibrillation Pathway Workstream

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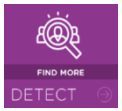
Atrial Fibrillation Pathway Workstream

- **Rapid and Accurate Diagnosis**
  - Opportunistic checks, getting the right tests ordered, effective diagnosis



- **Timely and Effective Anticoagulation**
  - Access to local clinics, in a timely fashion

- **Efficient Secondary Care Services**
  - The right patients referred, to the right person, at the right time and effective and efficient onward referral where appropriate
- **Guidance on AF Ablation**
  - The right patients listed, for the right procedure, in a timely manner
- **Lifestyle and Risk Factor Modification**
  - Making every contact count, the vital 5

Atrial fibrillation (AF) primary care pathway

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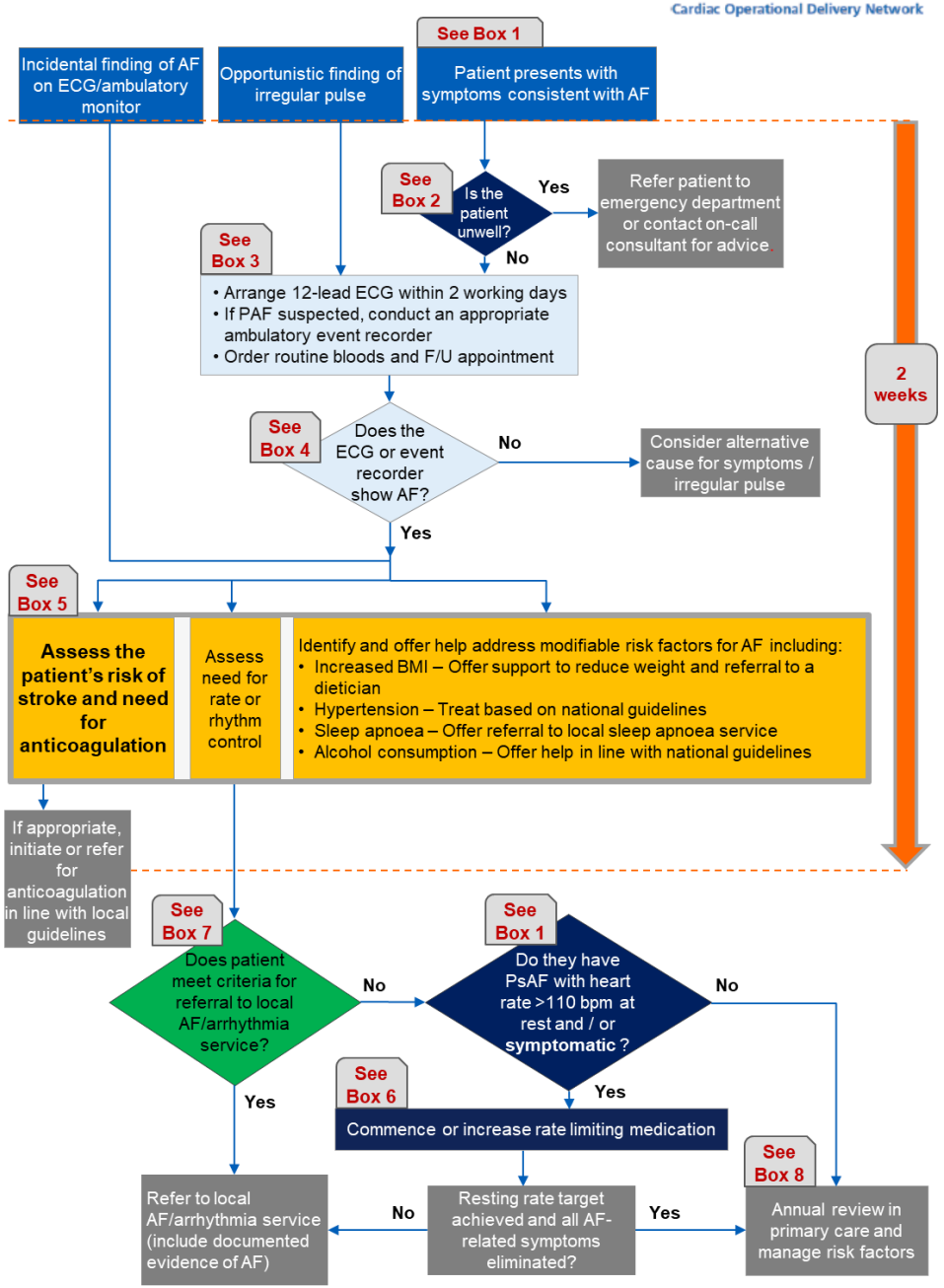

Last updated 11 November 2019

If referral is not indicated, advice and guidance can be obtained from the local AF/arrhythmia service via the **Advice and Guidance** function on ERS.

Atrial fibrillation primary care pathway

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AF is classified according to the pattern of episodes:

- **Paroxysmal AF (PAF)**— episodes lasting longer than 30 seconds but less than 7 days (often less than 48 hours) that are self-terminating and recurrent.
- **Persistent AF (PsAF)** — episodes lasting longer than 7 days (spontaneous termination of the arrhythmia is unlikely to occur after this time) or less than seven days but requiring pharmacological or electrical cardioversion.

Box 1	• **Typical AF symptoms include**: Fatigue, reduced exercise tolerance, shortness of breath, dizziness, chest discomfort, palpitation, syncope or pre-syncope
Box 2	Signs/symptoms of the unwell AF patient include: • HR >120 bpm at rest • Haemodynamically unstable • Severe breathlessness • Chest pain • Acute heart failure • For all patients arrange for 12 lead ECG within two working days
Box 3	• If symptoms are intermittent type of monitoring chosen should reflect frequency of symptoms (eg if symptoms are < 24 hrs apart, arrange a 24 hr tape; if symptoms are > 24 hrs apart, arrange an event recorder) • Bloods include: FBC, U&Es, TFTs, LFTs, HbA1c (if not done within the last year) • Check BNP/NT-proBNP ONLY if heart failure is suspected and refer to heart failure clinic if BNP/NT-proBNP raised • Consider echocardiogram if underlying structural/valve disease is suspected **OR** the findings are likely to alter management • Consider and investigate for underlying respiratory and metabolic causes
Box 4	• Episodes of AF are continuous for > 30 seconds • Frequent SVEs, short run atrial arrhythmia do not confirm diagnosis
Box 5	• Use the CHA_2DS_2-VASc score to determine if patient should be started on anticoagulation, and initiate anticoagulation if necessary, in line with local guidelines and arrangements • Anti-coagulate if score is ≥ 2, and consider anticoagulation for men with a score of 1 • Consider risk factors for HASBLED and modify bleeding risk factors where possible • Do not withhold anticoagulation solely due to elevated risk of bleeding or falls • See www.dontwaittoanticoagulate.com

Box 6	• Commence rate control medication (eg bisoprolol 2.5mg, if tolerated, and titrate up to eg 5mg). If beta blocker is contraindicated, consider verapamil or diltiazem.
	• Aim for resting heart rate of:
	  • <110 bpm if asymptomatic
	  • <90 bpm if symptomatic
	• If rate control difficult to achieve, or patient remains symptomatic despite good rate control, refer to **local AF/arrhythmia service** (see box 7)

Box 7	**Refer to local AF/arrhythmia service promptly if:** • Patient has PAF (episodes last longer than 30 seconds and less than 7 days) AND is symptomatic • Patient has PsAF (episodes lasting longer than 7 days) AND is symptomatic despite rate control (resting HR <90 bpm) • Patient has inadequate rate control despite drug therapy (persistently > 110 bpm at rest) irrespective of symptoms • Patient is unable to tolerate necessary rate control medication • Concern about associated cardiac disease e.g. LV dysfunction, valve disease, bradycardia on 24 hr ECG • Patient has elevated, CHA2DsVasc score but is not suitable for anticoagulation e.g. high bleeding risk • Patient or doctor wish to discuss rhythm control options including DC cardioversion, ablation or drug therapy. ***Needs documented evidence of AF with referral.***
Box 8	• Annual review to include symptom control, CHA2DsVasc, HASBLED, signs of bleeding/anaemia, renal function if on a DOAC, body weight.

Atrial fibrillation secondary care outpatient pathway

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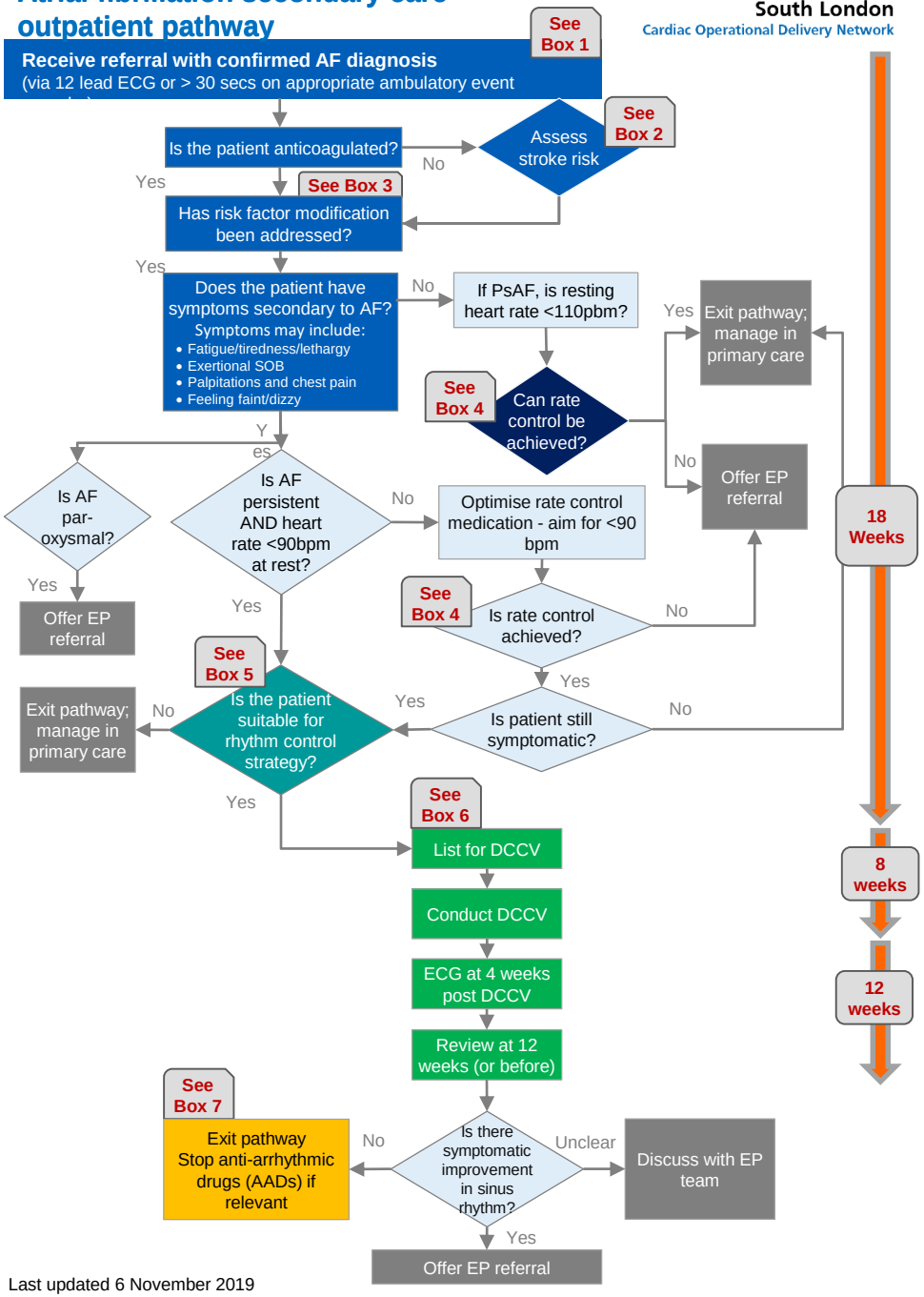

Last updated 6 November 2019

Atrial fibrillation secondary care outpatient pathway

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General guidance

- In patients with symptomatic paroxysmal AF (PAF), early referral to an electrophysiologist should be offered, as outcomes from a rhythm control strategy in this group are good.
- In patients with persistent AF (PsAF), outcomes from a rhythm control strategy are significantly worse where AF has been continuous for > 12 months. Therefore, referral for these patients should be performed in a timely manner.
- In selected symptomatic PsAF patients, where it is clear a rhythm control strategy is likely to be followed, early referral to an electrophysiologist prior to cardioversion may be considered.
- In patients with PsAF, often the only way to determine whether a patient's symptoms are due to AF is cardioversion to enable a period of time in sinus rhythm to assess symptom improvement.

Box 1

- Episodes of AF are >30sec of sustained AF: an irregularly irregular rhythm in the absence of P waves. Frequent SVEs, short run atrial arrhythmia do not confirm diagnosis.
- Ensure all investigations are complete including: FBC, U&Es, coagulation, HbA1c, TFTs, LFTs.
- Check BNP ONLY if heart failure is suspected.
- Arrange transthoracic echocardiogram at first outpatient visit if not already done.
- If significant reduction in LVEF (<40%) **refer to HF specialist**.

Box 2

Assess stroke risk by calculating CHA_2DS_2-VASc and HAS-BLED scores to determine whether patient should be started on anticoagulation, and initiate anticoagulation if necessary, in line with local guidelines and arrangements.

- Offer oral anticoagulants if CHA2DSVasc ≥ 2.
- In men consider oral anticoagulants if CHA2DSVasc ≥1.

Box 3

Risk factor modification should include:

- Obesity
- Hypertension
- Sleep apnoea
- Alcohol consumption

Box 4

Rate control is considered *not* achieved if:

- Asymptomatic >110 bpm at rest.
- Symptomatic >90 bpm at rest.

OR

- Patient is unable to tolerate rate control medication.

If there is uncertainty about the best approach discuss with the local EP team.

Box 5

Factors associated with a good rhythm control candidate:

- Continuous AF <12 months.
- LA size <5 cm.
- No major structural heart disease.
- No major life-limiting comorbidity.
- Able to take oral anticoagulants.

If unsure, discuss with EP team.

Box 6

Attempt no more than two DCCVs before offering referral to an EP consultant.

Pre DCCV – Commence oral anticoagulants, if patient not already anticoagulated

- Consider pre-treatment with anti-arrhythmic drugs (amiodarone preferred) if:
  - Previous DCCV failure.
  - Large LA >5cm.
  - AF present > 6 months.
  - Patient has heart failure.

Post DCCV

- ECG 4 weeks post DCCV to document rhythm.
- Appointment 12 weeks (or before) post DCCV to assess rhythm and symptom response.

Box 7

Stop anti-arrhythmic drugs (if relevant) UNLESS management plan is to maintain patient on AADs for rhythm control.