Grasp
the initiative
ACTION PLAN

This report was initiated by the AF Association and an Alliance between Bristol-Myers Squibb Pharmaceuticals Ltd and Pfizer Ltd (the BMS-Pfizer Alliance), and funded by the BMS-Pfizer Alliance. The content was approved by the AF Association Medical Advisory Committee and reviewed by the BMS-Pfizer Alliance to ensure compliance with the ABPI Code of Practice.

Date of Preparation: August 2014   SPAF177
Dear Colleague,

Since the publication of the AF Association’s Grasp the Initiative report in October 2012, the number of practices using the GRASP-AF clinical audit tool has been rising steadily and we commend the excellent work of NHS Improving Quality, who have done much to promote the use of the tool across the country.

We hope that the number of GP practices using GRASP-AF continues to grow; however, we also recognise that simply running the tool is not enough to reduce the high risk of AF-related stroke. Accurate stroke risk assessment needs to be followed by the administration of appropriate anticoagulation in the vast majority of people with AF in order to achieve optimal AF-related stroke risk reduction. Unfortunately, the available data suggests that only 57 per cent of people at high risk of AF-related stroke (CHADS2 > 1)* are currently prescribed anticoagulation. In addition, just over a third of AF patients at high risk of AF-related stroke continue to be treated with antiplatelets, including aspirin**, which has been shown to have weak efficacy in AF-related stroke prevention.

With the updated NICE clinical guideline on the management of atrial fibrillation published in June 2014, we believe that this Action Plan will be an important benchmark to use going forward. Through the Grasp the Initiative: Action Plan in front of you, we hope to:

• provide a concise overview of the current as well as historical practice in using anticoagulants in the prevention of AF-related stroke in England;
• highlight some of our concerns;
• develop an additional set of recommendations to those presented in the 2012 Grasp the Initiative report, to guide primary care professionals on how to use the GRASP-AF tool to the best of its potential.

I hope that you find this Action Plan useful and that it provides you with further inspiration and the know-how to Grasp the Initiative and make a difference to the lives of people with AF and those close to them.

Trudie C A Lobban MBE FRCP (Edin),
CEO and Founder, AF Association

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* As per the GRASP-AF classification of high risk, which is a CHADS2 score of greater than 1.
** While some AF patients may be taking aspirin for other health conditions, many are likely to have been prescribed aspirin solely for stroke prevention.
FOREWORD BY
NHS IMPROVING QUALITY

The GRASP-AF audit tool was developed shortly after the publication of the NICE guidance on the management of AF in 2006. The guidance suggested that at that time, there were many patients with AF who were not adequately risk assessed and that the management of stroke risk in AF could be improved. The GRASP-AF tool was designed to help GPs audit their management of stroke risk in AF, and also to help identify patients who had presented to their GP, but had not yet been recorded as having AF.

The number of GP practices using the GRASP-AF toolkit has now reached over 2,600\(^1\) - a third of all practices in England, but we need help in engaging with the remainder. The AF Association have been staunch supporters of our work, and we welcome the opportunity this Action Plan gives to provide greater impetus to the GRASP programme, and to increase further the number of practices using GRASP-AF.

To put this work in context, it is important to remember that there is no requirement or payment for practices to use GRASP-AF - it is entirely voluntary - and they are doing it because they are committed to taking positive action to reduce the number of AF-related strokes in their patients.

The detailed data we get from GRASP-AF is intended primarily for those who are actively involved in the management of patients with AF or the improvement of services for those with AF, but the national level data presented here still gives important insights into the current management of AF across the country, and, as you will see, has helped the AF Association to draft this Action Plan.

There is currently much debate about the most appropriate anticoagulant for each individual patient with AF, but taken as a whole the data are showing that far too many patients are still at high risk of stroke and are on antiplatelets, including aspirin, rather than an oral anticoagulant to reduce this risk, or some are not on any medication at all.

We would like to take this opportunity to thank the AF Association for their continued support for the GRASP-AF toolkit and their work to raise awareness of the issues around the management of AF amongst clinicians and patients alike.

We fully endorse their slogan- ‘Protect from AF-stroke using anticoagulation (not aspirin)”.

Dr Richard M. Healicon
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Improvement Manager
NHS Improving Quality
The number of GP practices in England using the GRASP-AF tool continues to rise. Recent data, provided to the AF Association by NHS Improving Quality, indicates that 2,620 practices currently upload their data onto CHART Online (April 2014), with the total number of practices running the tool likely to be higher. This represents almost 33 per cent of all GP practices in the country (2012-2013 QOF prevalence data indicates that there are 8,020 GP practices in England).

Unfortunately, the growth in the number of GP practices uploading data onto the comparative database, CHART Online, appears to be slowing down, with an average of 13 new practices per month uploading data onto CHART Online between May 2013 and April 2014; in comparison, there was an average of 28 new practices per month the previous year and an average of 91 new practices per month in 2011/12 (Figure 1).

GP practices running the GRASP-AF tool are not spread evenly across the country. Data suggests that in the 156 CCGs with at least one practice uploading data, the percentage of practices making uploads onto CHART Online ranges from 1.2 per cent to 100 per cent.

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**Figure 1**

**TOTAL NUMBER OF UPLOADS ONTO CHART ONLINE 2011-2014**

Only anonymised aggregated CHART Online data was supplied in line with NHS Improving Quality’s data sharing agreement. Based on time points relating to the data provided by NHS IQ, including an additional tranche of data provided in May 2014 for this report.

...in the 156 CCGs with at least one practice uploading data, the percentage of practices making uploads onto CHART Online ranges from 1.2 per cent to 100 per cent.
**OVERVIEW:** PREVENTION OF AF-RELATED STROKE IN ENGLAND - GRASP-AF DATA

Table 1

MANAGEMENT OF PATIENTS WITH AF IN ENGLAND: AT MAY 2014

<table>
<thead>
<tr>
<th>CHADS2 SCORE</th>
<th>AF PATIENT NUMBERS</th>
<th>ORAL ANTICOAGULATION</th>
<th>ORAL ANTIPLATELET</th>
<th>ANTICOAGULATION OR ANTIPLATELET</th>
<th>ANTICOAGULATION AND ANTIPLATELET</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Num.</td>
<td>%</td>
<td>Num.</td>
<td>%</td>
<td>Num.</td>
</tr>
<tr>
<td>0</td>
<td>52,748</td>
<td>18.00%</td>
<td>17,691</td>
<td>33.54%</td>
<td>2,988</td>
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<tr>
<td>1</td>
<td>86,343</td>
<td>26.19%</td>
<td>41,803</td>
<td>48.42%</td>
<td>5,405</td>
</tr>
<tr>
<td>GREATER THAN 1</td>
<td>190,569</td>
<td>57.81%</td>
<td>109,237</td>
<td>57.32%</td>
<td>18,657</td>
</tr>
<tr>
<td>TOTAL</td>
<td>329,660</td>
<td>51.18%</td>
<td>270,471</td>
<td>8.20%</td>
<td>10,632</td>
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</tbody>
</table>

Only anonymised aggregated CHART Online data was supplied in line with NHS Improving Quality’s data sharing agreement.
ANTICOAGULATION OF PATIENTS WITH AF AT HIGH RISK OF STROKE

Data from the GRASP-AF toolkit presented here is based on the CHADS\textsubscript{2} scoring scheme, whereby a patient with AF is given points for each of the five stroke risk factors present (congestive cardiac failure, hypertension, age of 75 or over, diabetes mellitus and history of stroke/TIA/thromboembolism). The GRASP-AF tool classifies high risk patients as those with a CHADS\textsubscript{2} score of greater than 1.\textsuperscript{4,5}

National data made available through the GRASP-AF uploads onto CHART Online suggest that a significant proportion of people with AF who may be appropriate for anticoagulation are not receiving it, despite being identified as being at high risk of AF-related stroke. In May 2014, the available data indicated that only 57.32 per cent of people with CHADS\textsubscript{2} score greater than one were being treated with anticoagulants (Figure 2).\textsuperscript{1} While we recognise that it is not appropriate to prescribe anticoagulation to all patients due to contraindications or patients declining treatment, the proportion of patients at high risk of AF-related stroke receiving appropriate anticoagulation needs to increase urgently in order to optimise the prevention of AF-related stroke across the country.

The available data also suggests great geographical variation in anticoagulation rates of patients with AF at high risk of stroke. In the 156 CCGs with at least one practice uploading data onto CHART Online, the average percentage of high risk AF patients receiving anticoagulation ranges from 36 per cent to 70 per cent.\textsuperscript{1}

Only anonymised aggregated CHART Online data was supplied in line with NHS Improving Quality’s data sharing agreement. Based on time points relating to the data provided by NHS IQ, including an additional tranche of data provided in May 2014 for this report.
Evidence for effective AF-related stroke prevention with aspirin is weak, with the risk of major bleeding not being significantly different to that of anticoagulation. In fact, the updated NICE Clinical Guideline on AF (published in June 2014) recommends not to offer aspirin monotherapy solely for stroke prevention to people with AF.

GRASP AF identifies patients with AF who have been prescribed an antiplatelet, which includes those on aspirin. It should be noted that some of these patients may have been prescribed aspirin as anticoagulation is contraindicated. For others they may have been prescribed aspirin for a health condition other than stroke prevention; however it is likely that the vast majority have been prescribed aspirin solely for their stroke prevention and so could still be eligible for anticoagulation.

The available data suggests that 33.98 per cent of AF patients at high risk of stroke (CHADS₂ > 1) have been prescribed an antiplatelet but not anticoagulation. Unfortunately, the use of antiplatelets in the prevention of AF-related stroke does not appear to be falling fast enough across the country, decreasing by just 3 per cent in nearly three years (from 37.03 per cent in July 2011 to 33.98 per cent in May 2014 - Figure 3).

The slow rate of change in prescribing behaviour around antiplatelets may be due to the current incentivisation of aspirin use in AF patients with a CHADS2 score of 1 by the Quality and Outcomes Framework (QOF) or the common misconception that aspirin is “safer” than anticoagulants in the elderly. We therefore welcome the recent recommendation from NICE that the relevant QOF indicator should be retired from the QOF menu in order to remove the incentivisation of aspirin use, in line with the updated NICE Clinical Guideline.

33.98 per cent of AF patients at high risk of stroke (CHADS₂ > 1) are prescribed antiplatelets, including aspirin, to help reduce their risk of stroke. Yet, the efficacy of stroke prevention with aspirin is weak.
MANAGEMENT OF PATIENTS WHERE ANTICOAGULATION IS CONTRAINDICATED OR DECLINED BY THE PATIENT

The latest data (May 2014) suggests that anticoagulation is contraindicated in 9.79 per cent of patients with AF at high risk of stroke. A further 4.05 per cent of high risk patients are not receiving anticoagulation due to declining the therapy. These groups of patients are unable to benefit from anticoagulation and continue to face a high risk of stroke. The proportion of patients at high risk of AF-related stroke where anticoagulation is contraindicated or have declined therapy has been stable, fluctuating between 13 and 14 per cent between January 2012 and May 2014 (Figure 4). Worryingly, a recent study into the use of anticoagulants in England noted that the proportion of patients in whom there was a recorded contraindication to anticoagulation varied considerably by practice (from 2.6 to 12 per cent), possibly indicating inconsistent assessment of what constitutes a “true” contraindication.

Figure 4

PATIENTS WITH AF AT HIGH RISK OF STROKE: ANTICOAGULATION CONTRAINDICATED OR DECLINED BY THE PATIENT

Only anonymised aggregated CHART Online data was supplied in line with NHS Improving Quality’s data sharing agreement. Based on time points relating to the data provided by NHS IQ, including an additional tranche of data provided in May 2014 for this report.

...the proportion of patients in whom there was a recorded contraindication to anticoagulation varied considerably by practice, possibly indicating inconsistent assessment of what constitutes a contraindication.
GRASP THE INITIATIVE 2014: ACTION PLAN RECOMMENDATIONS

With the publication of this Action Plan, we aim to: build on the original Grasp the Initiative report; re-emphasise our commitment to promoting the use of GRASP-AF as a means to improve anticoagulation rates in patients with AF; and make a series of further recommendations on how to use the GRASP-AF tool to the best of its potential in order to deliver the greatest benefit to people affected by AF.

Once installed by the practice, GRASP-AF systematically searches GP practices’ AF registers and calculates individual CHADS₂ and CHA₂DS₂-VASc scores for each AF patient (see Table 2). The European Society of Cardiology now recommends that CHA₂DS₂-VASc should be the preferred scoring tool due to greater sensitivity.³

While the GRASP-AF tool has the potential to facilitate stroke risk assessment, a patient’s risk of stroke is only reduced if the risk stratification process is followed up by the initiation of an appropriate form of anticoagulation (unless anticoagulation is contraindicated or not appropriate). NICE guidance suggests that people with non-valvular AF for whom anticoagulation is recommended, should be offered treatment with warfarin or non-vitamin K oral anticoagulants (NOACs) – apixaban▼, dabigatran and rivaroxaban▼.¹⁰,¹¹,¹² All three NOACs have been reviewed and recommended by NICE as clinically and cost effective in the prevention of non-valvular AF-related stroke.¹⁰,¹¹,¹²

Our recommendations identify some of the steps that primary care professionals can take after running GRASP-AF in order to optimise the treatment of people with AF registered in their practice. They focus on:

• Review of patients with AF at high risk of stroke who currently receive no form of anticoagulation
• Review of patients with AF at high risk of stroke who only receive an antiplatelet for AF-related stroke prevention
• Support for patient choice of anticoagulation and informed discussion
Recommendation 1: AF patients who currently receive no form of anticoagulation should be assessed for their risk of stroke using the latest stroke risk scoring scheme (CHA\textsubscript{2}DS\textsubscript{2}-VASc - see Table 2) and, if deemed to be at risk of stroke (score of 2 or above), should be offered anticoagulation (unless anticoagulation is contraindicated or not appropriate). Patients who have historically declined treatment with warfarin or where anticoagulation is recorded as being contraindicated should be reviewed and considered for alternative treatment options, where appropriate.

We note with concern that, according to the latest data from the GRASP-AF toolkit, 42.68 per cent of people with AF with CHADS\textsubscript{2} score greater than 1 are not currently prescribed anticoagulation. While we recognise that this treatment may be contraindicated or declined by some patients, the proportion of AF patients at high risk of stroke treated with anticoagulants must increase to ensure that people with AF in England receive optimal treatment to reduce their risk of stroke. We would encourage primary care professionals to put in place strategies aimed at increasing the percentage of high-risk AF patients receiving anticoagulation for stroke prevention at a faster rate.

Given the different characteristics of the NOACs compared to warfarin, for example, fewer interactions with food, alcohol and other medications and no requirement for INR monitoring\textsuperscript{10,11,12} patients with non-valvular AF where warfarin was previously deemed to be inappropriate due to lifestyle factors, may be considered suitable for treatment with these agents. Furthermore, some patients with non-valvular AF who have declined treatment with warfarin for stroke prevention in the past may have done so because of these lifestyle factors, and should also be reviewed and considered for treatment with one of the NOACs, where appropriate. However, each patient should be assessed for treatment based on their clinical history and individual preferences.

**Table 2:**
AN OVERVIEW OF CHADS\textsubscript{2} AND CHA\textsubscript{2}DS\textsubscript{2}-VASc: ADAPTED FROM LIP ET AL (2012) AND THE EUROPEAN SOCIETY OF CARDIOLOGY (2010, 2012)\textsuperscript{3,13,14}

<table>
<thead>
<tr>
<th>RISK FACTORS</th>
<th>CHADS\textsubscript{2}</th>
<th>CHA\textsubscript{2}DS\textsubscript{2}-VASc</th>
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</thead>
<tbody>
<tr>
<td>Congestive Cardiac Failure</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Hypertension</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Age (\geq 75) years</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Diabetes mellitus</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Stroke/TIA/Thromboembolism</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Vascular Disease</td>
<td>n/a</td>
<td>1</td>
</tr>
<tr>
<td>Age 65-74 years</td>
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<td>1</td>
</tr>
<tr>
<td>Sex Category (i.e. female)</td>
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<td>1</td>
</tr>
<tr>
<td>Maximum Score</td>
<td>6</td>
<td>9</td>
</tr>
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**Recommended Action**

<table>
<thead>
<tr>
<th>Score</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Risk assess patient using CHA\textsubscript{2}DS\textsubscript{2}-VASc</td>
</tr>
<tr>
<td>0</td>
<td>No antithrombotic is recommended</td>
</tr>
<tr>
<td>≥2</td>
<td>Oral anticoagulation, unless contraindicated</td>
</tr>
<tr>
<td>≥2</td>
<td>Oral anticoagulation should be considered, based upon an assessment of the bleeding complications and patient preferences</td>
</tr>
</tbody>
</table>

Score 0: Risk assess patient using CHA\textsubscript{2}DS\textsubscript{2}-VASc. Score 0: No antithrombotic is recommended. Score ≥2: Oral anticoagulation, unless contraindicated. Score ≥2: Oral anticoagulation should be considered, based upon an assessment of the bleeding complications and patient preferences.
Recommendation 2: The efficacy of AF-related stroke prevention with aspirin is weak. Patients taking aspirin solely for this purpose should be reviewed and initiated on anticoagulation (unless anticoagulation is contraindicated or not appropriate).

According to the ESC guidelines for the management of AF, the evidence for effective stroke prevention with aspirin in AF is weak. In addition, the risk of major bleeding or intracranial haemorrhage with aspirin is not significantly different to that of oral anticoagulation, contrary to the misconception that aspirin is “safer” than warfarin in the elderly population. As such, patients receiving aspirin for the purpose of prevention of AF-related stroke are not benefiting from the same stroke risk reduction as those treated with anticoagulants, while facing similar risks of bleeding. Patients currently solely receiving aspirin for the purpose of prevention of AF-related stroke should be urgently reviewed and initiated on oral anticoagulation (unless anticoagulation is contraindicated or not appropriate). Again, this should be based on their clinical history, personal circumstances, and individual preferences.

PATIENT CHOICE OF ANTICOAGULATION AND INFORMED DISCUSSION

Recommendation 3: The decision about the most appropriate form of anticoagulation should be taken after an informed discussion with the patient, covering the risks and benefits of each treatment as well as the individual patient’s preferences.

Patients’ involvement in decisions about the choice of medicines available has the potential to improve their understanding of the treatment; leading to greater concordance and resulting in improved health outcomes. Shared decision-making also enables patients to tailor their treatment to their personal preferences and allows them to minimise its impact on their lives. Furthermore, the call for wider patient involvement in decisions regarding their treatment is also in line with the broader NHS-wide drive for greater patient empowerment. Warfarin and the NOACs have different characteristics, resulting in different treatment pathways and differing impact on patients’ lives. Depending on individual preference, one form of anticoagulation may be more suitable for a given patient than others. The way to ensure that the patient is prescribed the most appropriate anticoagulant for their needs is to engage them in an informed discussion about all the treatment options available before initiating anticoagulation. Indeed, the updated NICE Clinical Guideline states that clinicians should discuss the options for anticoagulation with the person and base the choice on their clinical features and preferences.

REFERENCES

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9. NICE, New indicators to be added to the NICE QOF menu and amendments to existing QOF indicators, August 2014
10. NICE, Apixaban for preventing stroke and systemic embolism in people with non-valvular atrial fibrillation: NICE technology appraisal guidance 275, 2013
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12. NICE, Rivaroxaban for the prevention of stroke and systemic embolism in people with atrial fibrillation: NICE technology appraisal guidance 256, 2012
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GRASP THE INITIATIVE 2012

The original *Grasp the Initiative* report captured a series of recommendations on what more can be done by commissioners and primary care clinicians to promote the use of the GRASP-AF tool across the country and how to use it most effectively. While the NHS commissioning landscape has changed considerably since the publication of the report, with the NHS England Area Teams assuming the responsibility for commissioning primary care services from the Primary Care Trusts, the recommendations remain relevant in the new NHS and we would encourage you to implement them wherever possible.

For details of the recommendations and more information on the GRASP-AF tool, you can download the report from: