Foreword

Atrial Fibrillation (AF) is the most common sustained arrhythmia (heart rhythm disorder) and is estimated to affect 1-2% of the population. Country level data from across Europe indicates that AF is likely to be more prevalent than previously reported international estimates. Close to 10 million people in Europe have AF currently and this figure is expected to at least double by 2050 due to the ageing of the population and improved survival from other heart conditions.

AF is associated with hugely debilitating and potentially fatal consequences including AF-related stroke, heart failure, hospitalisations, reduced quality of life and premature death. AF therefore needs to be rapidly detected, appropriate anticoagulation therapy initiated to reduce the high number of preventable AF-related strokes across Europe and treatment given to reduce/manage symptoms of AF. Yet unfortunately AF is under-detected, with an estimated 10-45% of cases of AF undetected. It is often asymptomatic and there is a lack of routine pulse checks to detect AF. Furthermore, there is widespread evidence that existing European Society of Cardiology (ESC) guidelines for managing patients with AF are poorly implemented in practice and the arrhythmia is often poorly managed. A vast number of patients that are diagnosed with AF still do not receive the anticoagulation they require to reduce their risk of an AF-related stroke, with unsatisfactory levels of access to non-vitamin K antagonist oral anticoagulants (NOACs) and often under-treatment or even ignored despite a choice of available drugs and non-pharmacological interventions.

We are pleased to present the 2016 EU Healthcare Pioneers Report which supports the AF Association’s objectives to ‘Detect, Protect, Correct’ AF and its associated risks. In October 2015, an AF Association European Medical Advisory Committee (EU MAC) was established with eight expert clinicians from six countries across Europe: Denmark, Italy, Poland, Spain, Turkey and the UK. The EU MAC recognise the challenges facing healthcare professionals and patients across Europe to adequately address AF and this report takes these challenges into account by providing best practice guidance on how they can practically be overcome. We would like to encourage healthcare professionals and commissioners across Europe to review the principles of best practice included in the report and consider how they might be applied to improve their own processes. Two inspirational case studies are also included in the report to demonstrate successful implementation of some best practice principles.

There is a considerable amount of work to do but raising awareness of best practice principles and success stories will facilitate practical action to improve detection, protection and correction for the millions of people with AF across Europe.

Trudie Lobban, Chief Executive and Co-Founder
AF ASSOCIATION, UK

Each person has a 1 in 4 lifetime chance of developing AF and AF is responsible for 20% of all strokes. AF-related strokes tend to be more severe than strokes not due to AF, with devastating outcomes to the individual and their loved-ones as well as the high economic burden to health care providers. Despite the prevalence of AF and its associated stroke risk, it remains under-detected. Yet there is a quick, simple and extremely low-cost way of detecting AF – a pulse check. By checking an individual’s pulse, a fast or unsteady heart rhythm may be noticed. The Arrhythmia Alliance (A-A) and AF Association advocate national awareness of AF and detection by way of a pulse check. They believe the importance of pulse checks should be widely publicized and undertaken both inside and outside of medical practices. In addition to potentially detecting AF, AF screening will educate individuals on AF and the risk of AF-related stroke thus raising overall awareness, education, understanding and enable prompt assessment to reduce the risk of AF-related strokes.

By checking an individual’s pulse, a fast or unsteady heart rhythm may be noticed.”

Working collaboratively, A-A and AF Association started running ‘Know Your Pulse’ events in 2009. These events have been regularly held throughout the UK and Ireland, as well as across Europe and internationally. These events have been hosted in the Houses of Parliament in 2013, 2014, 2015 and planned for 2016, where many politicians and peers acknowledged and welcomed the simple and yet effective screening test for AF. Some even went on to be diagnosed with AF following a ‘Know Your Pulse’ event hosted by A-A & AF Association.

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Key Points

• AF is under-detected, under-diagnosed, under-anticoagulated and under-treated
• There is lack of awareness, education or information for the general public and those at high risk of developing AF; recognising symptoms of AF or the consequences of an AF-related stroke, heart failure and life-changing or life-limiting consequences.
• Early detection of AF leading to correct diagnosis is essential to avoid preventable AF-related strokes and reduce the associated burden to both the patient, their families and national healthcare systems.
• The cheapest, effective and easiest way to detect AF is with a manual pulse check.
• Successful ‘Know Your Pulse’ pulse check campaigns have been and will continue to run in several regions of the UK and Ireland by Arrhythmia Alliance and AF Association, as well as across Europe and internationally through their affiliated organisations.
• The campaigns ensure that the pulse check rationale and results are explained to the public and patients. Educational materials and information is provided so that patients and the public have a ‘take-home’ package to self-monitor their pulse and encouraged to discuss with their healthcare professional. People are also encouraged to share the information with their friends and family.
• Anyone identified as having an ‘irregular pulse’ during the ‘Know Your Pulse’ campaign events are also offered an immediate handheld ECG monitor which can confirm if AF is present. The results of which are sent to the persons primary care physician where permission is given.
• Recommendation is given to anyone identified as a higher-risk AF patient to visit their relevant healthcare professional soon.
Some of the ‘Know Your Pulse’ activities carried out over the past years include:

- Pulse check events run in both community and NHS settings to:
  - Raise awareness of the pulse
  - Share information on why and how to ‘know your pulse’
  - Offer pulse checks, in particular but not exclusively, to over 65 year olds. Single-lead ECG also offered for those with a fast or irregular pulse/heart rhythm
  - Provide and share information on pulse taking, arrhythmias, AF and AF-related stroke risk
  - Provide pulse check feedback to the individual
  - Follow up with local primary care teams to facilitate appropriate management and support also provided to ensure anticoagulation therapy to reduce the risk of AF-related stroke and referral for appropriate treatment for AF

- Community events held in collaboration with a leading pharmacy chain in the UK, with events hosted at a number of their outlets

- NHS events held at medical centres to offer pulse checks to patients attending flu vaccination clinics

- NHS events in hospitals as well as primary care/GP surgeries and medical centres

- Contact with GP and primary care centres close to/at the pulse check event sites. Educational resources and, where appropriate, update training on AF and AF management in particular AF-stroke management, were provided

- Publicity in local and national media

- Posters advertisements placed in event locations prior to the event date as well as flyers in local media encouraging people to attend and doubting to raise awareness and educate the public on AF and possible consequences. Advertising and notifications also distributed through the AF Association database, with e bulletins to encourage the recipient’s participation and for them to share with family and friends

- ‘Know Your Pulse’ is publicised in local media, further raising awareness of the importance of a pulse check, understanding AF and the associated risks such as AF-related stroke.

- Through the AF Association’s ‘Detect Protect Correct’ programme the public and patients are also made aware of the treatment options for AF as well as the importance of anticoagulation therapy to reduce the risk of AF-related stroke. The ‘Stop Aspirin – Start Anticoagulation’ message is also key to highlighting that aspirin is no longer recommended by NICE as a therapy to reduce the risk of AF-related stroke. By educating the public and healthcare professionals with this message more people will be requesting anticoagulation therapy if currently being prescribed aspirin and it ensures the message is reinforced to healthcare professionals to review their current patients and all newly identified AF patients and to not prescribe aspirin as an option.

At ‘Know Your Pulse’ events held in Scotland, 53 out of 586 individuals were identified as having an abnormal heart rhythm, meaning that approximately 10% of individuals tested were advised to visit their GP for further tests or when permission given A-A and AF Association wrote to the individual’s doctor.

A-A & AF Association are involved in various research screening projects across the UK and have encouraged, supported and partnered with AHSN’s, CCG’s, pharmacies, primary, secondary and tertiary centres to develop research and pathways to gather evidence and submit data to the National Screening Committee which is due to review the data for recommendations of national screening for AF in early 2017.

The ‘Know Your Pulse’ campaign has great potential to generate considerable efficiency savings through the prevention of costs associated with late AF diagnosis and subsequent complications. With earlier diagnosis and the instigation of appropriate anticoagulation therapy, it is estimated that 50-70% of AF-related strokes could be avoided. It is also important that once diagnosed and receiving anticoagulation therapy to reduce the risk of AF-related stroke the patient should also be referred for treatment for AF.

If you are interested in running a ‘Know Your Pulse’ event, please contact Trudie Lobban on +44 (0) 1789 867 502, mobile: +44 (0) 7778 233 999 or alternatively email trudie@afa.org.uk at AF Association, who can provide you with a ‘Know Your Pulse’ pack and support or alternatively arrange an event for you.

At ‘Know Your Pulse’ events held in Scotland, 53 out of 586 individuals were identified as having an abnormal heart rhythm, meaning that approximately 10% of individuals tested were advised to visit their GP for further tests or when permission given A-A and AF Association wrote to the individual’s doctor.

Further ‘Know Your Pulse’ event plans are underway for 2016, with visits scheduled at numerous different locations within the UK to raise further awareness of AF and encourage individuals to check their pulse manually at home. A roundtable meeting will also be held at some of these locations to bring together AHSN’s (Academic Health Science Networks), CCG’s (Clinical Commissioning Groups), pharmacists, primary, secondary, tertiary professionals and local MPs to discuss and explore the AF treatment gap and improve the AF referral and management in each area.
The Primary Care Atrial Fibrillation (PCAF) service was first launched in Meneside in June 2012 by Inspira Health Solutions in collaboration with clinicians at Liverpool Heart and Chest Hospital. It is an innovative consultant-led pathway that provides expert hospital-based resources within GP practices with the aim of improving the provision of anticoagulation treatments among high-risk AF patients.

The service was developed in response to the fact that AF-related stroke-risk can be significantly reduced through appropriate treatment but, as NICE have estimated, 46% of patients that should be anti-coagulated are not. The service is available nationwide and as of November 2015, has been delivered in 364 GP practices within 84 CCGs across England, and in two Local Health Boards in Wales and in two Health Boards in Scotland.

The service comprises four phases:

1. In phase one, a comprehensive case note review is undertaken of all patients who are not already on the AF register but have been identified as possibly having AF based on Read code triggers such as abnormal electrocardiogram (ECG), irregular pulse or a prescription for digoxin. Where required, patients are referred for investigations to confirm the diagnosis.

2. In phase two, using a range of PRIMIS audit tools such as GRASP-AF; high risk patients (CHA2DS2-VASc >1) who would benefit from a formal review are identified, including those patients on warfarin with a sub-optimal time in therapeutic range (TTR).

3. Phase three sees an administrator send out invitation letters and information to patients, inviting them to review. They are also contacted by telephone one week before, and then again one day prior to their appointment, to minimise non-attendance.

4. In the final phase, AF and anticoagulation assessment clinics are delivered within the patients’ GP practice and led by a consultant cardiologist or consultant stroke physician from secondary care. The patients’ condition and treatment is reviewed alongside their primary care healthcare team and, where appropriate, anticoagulation treatment is prescribed.

In a sub-set of data including 56 GP practices, with a patient population of 386,624, a total of 1063 previously untreated high risk patients attended for review and were offered anticoagulation. Of these, 53% were prescribed a NOAC, 43% were prescribed warfarin whilst 4% declined anticoagulation. It is estimated that these increased treatment rates have prevented around 30-35 strokes per year.

This strategy has two distinct advantages. Firstly, patients currently managed solely within primary care are reviewed and, where appropriate, their anticoagulation treatment is optimised. Secondly, the educational legacy left within the GP practice following completion of the PCAF pathway enables such optimal treatment to be carried forward for future patients.

For more information on the PCAF Service, please contact Lee Panter on 0151 244 3275 or at lee@inspirahealth.co.uk.

Key Points
- Consultant-led pathway providing expert resources within GP practices with the aim of improving the provision of anticoagulation treatments among high-risk AF patients.
- The PCAF service is available across the UK.
- The service has demonstrated a 96% uptake to anticoagulation within previously untreated high risk patients.
- In a sub-set of 1063 previously untreated patients, it is estimated that PCAF prevented around 30-35 strokes per year.
- As of Nov 2015, the service has been delivered in 364 GP practices across 84 Clinical Commissioning Groups in England.
- Educational legacy left within the GP practice following completion of the PCAF pathway.

...evaluation and treatment of AF and AF-related stroke risk is variable and inconsistent.

Having recognised this shortfall, some areas within European countries have successfully set up AF outpatient clinics to enable a streamlined pathway for this patient group with a fully integrated multidisciplinary approach. Key objectives include guideline implementation and providing access to coordinated and consistent care, treatment, support and information.

There will be some variation in how each AF clinic is structured and performed by healthcare professionals with relevant experience and knowledge. Levels of experience and knowledge and collaboration between disciplines often requires improvement. Adherence to guidelines and therefore the use of recommended therapy and treatment has also been shown to be insufficient across Europe.

Key Points
- Many AF-related strokes can be prevented and AF symptoms can be reduced/managed through effective oral anticoagulation therapy and symptom treatment.
- Yet a vast number of patients across Europe that are diagnosed with AF do not receive the oral anticoagulation therapy and symptom treatment they require and are left both symptomatic and at an increased risk of AF-related stroke.
- There are a combination of reasons for this poor management, some of which are addressed here.
- Findings from across Europe indicate that evaluation and treatment of AF and AF-related stroke risk is variable and inconsistent.
- Many healthcare professionals involved in the treatment pathway have limited knowledge and experience in managing AF and stroke risk management and collaboration between disciplines often requires improved coordination.
- Adherence to guidelines and therefore use of recommended therapy and treatment has also been shown to be insufficient across Europe.

Key Points
- A vast number of AF patients do not receive the oral anticoagulation therapy and symptom treatment they require and are left both symptomatic and at an increased risk of AF-related stroke.
- AF patient access to evaluation, symptom treatment and protection against risk of AF-related stroke is variable and inconsistent.
- Patients with AF are seen by members of the healthcare team with varying levels of experience and knowledge and multidisciplinary collaboration is often limited.
- Structured guideline based management of AF is often not implemented resulting in available therapy options not being offered to patients with AF.
- Patient involvement in the management of their disease and associated stroke risk needs to be maximised.
- An AF outpatient clinic provides a channel for: - A structured and thorough patient centred consultation process including follow-up and performed by healthcare professionals with relevant experience and knowledge. - Streamlined multidisciplinary collaboration to coordinate and improve AF management.
- Implementing guideline adherence and therefore provision of appropriate AF symptom management and anticoagulation therapy to all patients.
- Achieving greater stroke prevention and symptom control among the AF patient population.

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The service provided will include:

- Access to a multidisciplinary team with relevant AF training/experience
- Comprehensive assessment of the patient at first consultation within the clinic using relevant diagnostic procedures
- Guideline adherence for all management. Clear understanding. To cover both anticoagulation therapy and the role of oral anticoagulation therapy. If patients do not understand the link between AF and risk of stroke it is less likely that they will take action to reduce their risk of AF-related stroke resulting in poor adherence to anticoagulation therapy. Improving patient education to ensure that patients understand their own personal risk of AF-related stroke and the purpose of anticoagulation therapy will encourage and motivate them to take preventative action.
- Comprehensive assessment of the patient at first consultation within the clinic using relevant diagnostic procedures
- Systematic review and follow-up involving coordination between primary, secondary and tertiary care. Follow-up requirements and frequency will vary according to individual patient need. Follow-up can be with a nurse specialist to monitor condition, check medication, discuss lifestyle changes and address questions and concerns. Initial follow-up usually face to face. Depending on patient needs, some subsequent follow-ups may be done via telephone.
- Contact details for patient to use should questions arise in between consultations.
- The follow-up at the AF clinic may terminate and the patient can be referred back to primary care if their situation is stable and no further adjustments of the patient’s treatment is necessary for the time being. Should any subsequent concerns arise or the patients’ condition change requiring major adjustments of the treatment, they can be referred back to the AF clinic.

Findings from a number of countries across Europe suggest that many AF patients are poorly informed about their condition, the link between AF and increased risk of stroke and the purpose of oral anticoagulation therapy. If patients do not understand the link between AF and risk of stroke it is less likely that they will take action to reduce their risk of AF-related stroke resulting in poor adherence to anticoagulation therapy. Improving patient education to ensure that patients understand their own personal risk of AF-related stroke and the purpose of anticoagulation therapy will encourage and motivate them to take preventative action.

A vast number of AF patient’s symptoms are often under-treated or even ignored despite a choice of available drugs and devices. Correction of AF will be necessary in a significant proportion of patients who are experiencing AF symptoms and ignoring this will lead to greater morbidity in this patient population. The patient needs to be able to make informed choices about their treatment because the patient is making a decision on what treatment they have based on the balance of the benefits and the risks/success rates – only the patient knows how their symptoms feel and therefore only they can judge what benefits they will accrue from treatment. Furthermore it is important that the patient knows the direction of travel and timelines – if they try a particular treatment option then they need to have an alternative option defined and planned if their first choice fails.

A key barrier to patient led care and education is doctors often do not have enough time during the consultation timeframe to provide the necessary level of detail to their AF patients and check that the patient really understands their risk of AF-related stroke and anticoagulation therapy options and the various options available for correcting AF to improve symptoms. One way of overcoming this barrier is to provide a facility or clinic outside of the consultation window that doctors can signpost to patients and/or their carers where they can work through the necessary information about AF, associated stroke risk and recommended therapy options at their own pace.
Providing the clinic online as an ‘e-clinic’ offers the advantage that it will not require significant long-term manpower to run after the initial set-up and it is a low cost option to run once the initial cost outlay has been made for the content development. Where internet access poses a problem for a patient, a carer or family member can be involved.

Important components and features required for a successful e-clinic to be implemented and used include:

- A healthcare professional task force involved in the set-up and endorsement to ensure the e-clinic meets local needs and guidelines and that doctors will be comfortable signposting their patients to it
- Enrollment in e-clinic offered to all new/existing patients with AF and/or a nominated carer via their doctor
- E-clinic hosts online consultation for patients and/or their carers to work through at their own pace
- Online consultation includes clear explanation of the link between AF and stroke supported by patient friendly visuals
- Patients allowed to perform their own CHA2DS2-VASc score as part of the e-clinic consultation process (this is not to replace the CHA2DS2-VASc score recorded with their doctor – performing the CHA2DS2-VASc score themselves will help make the score more meaningful and underpin their own individual risk of AF-related stroke)
- Online consultation includes clear explanation of the aims and objectives of the correction of AF and the range of treatment options available
- Online consultation concludes with telling the patient the appropriate therapy options they should be receiving according to national guidelines
- E-clinic automatically informs the patient’s doctor about the guidance provided to their patient and their CHA2DS2-VASc score
- E-clinic automatically generates an online review. Timeframe for review is determined according to results of initial consultation and the patient’s doctor is kept informed

It should be emphasised that the e-clinic should in no way take away from the importance of the one to one consultation between patient and doctor. It should be fully integrated into the overall management pathway to supplement and enhance the doctor and patient communication by ensuring the patient is well informed and able to contribute to the effective management of AF-related stroke risk and correction of AF to improve symptom control.

Luis Mont, Assistant Professor and Head of Arrhythmia Unit, Hospital Clinic
UNIVERSITY OF BARCELONA, SPAIN

A number of healthcare disciplines are involved in the management of AF patients and to maximise stroke prevention and symptom control it is important that all those involved are working towards the same goals and are following treatment guidelines. However, the various disciplines often work independently with little interaction and have varying levels of experience and knowledge about AF management. Structured guideline based management of AF is rarely implemented with consistency across the disciplines.

Limited resources can make it challenging to improve multidisciplinary coordination. When resources are limited it may be possible to still address disconnect between the various disciplines involved in AF management. Existing systems can still be used but with new organisational steps put in place to enhance interaction and education and share expertise across different healthcare disciplines. It may be that this is a gradual process that involves more and more disciplines / departments over time.

The following considerations are helpful when assessing what organisational measures could be taken to improve multidisciplinary coordination:

- Examine the various AF patient pathways and map out all the healthcare disciplines involved
- Consider the various patient pathways and how improved multidisciplinary coordination can support each and every patient in accessing:
  - a comprehensive assessment using relevant diagnostic procedures
  - a management plan in line with guidelines to control symptoms and protect against the risk of AF-related stroke
  - a systematic review and follow-up as needed involving coordination between primary, secondary and tertiary care
- Consider simple organisational changes to:
  - Optimise the patient flow
  - Establish / enhance two way communications between disciplines to coordinate care of each patient moving forward

Key Points

- Atrial fibrillation is a highly prevalent disease managed by a number of healthcare disciplines.
- The healthcare professionals working with AF patients have varying levels of experience and knowledge and structured guideline based management of AF is rarely implemented across all the disciplines.
- There are a number of different AF patient pathways and multidisciplinary collaboration is limited with each discipline often working independently.
- Coordination of all the healthcare disciplines can improve knowledge and treatment guideline implementation and thus help enable the best possible therapy to be offered to patients with AF. This will lead to greater AF-related stroke prevention and symptom control being achieved among the AF patient population.
- Multidisciplinary coordination can be improved with some organisational change to link the healthcare disciplines involved in AF management. Rather than departments working independently with very little interaction between them, connections can be put in place to coordinate and optimise care of each patient and maximise knowledge sharing and education moving forward.

- Enable each discipline to tap into other specialties as needed to optimise therapy options made available for patients, in line with guidelines. Include specialties that may not traditionally have been collaborating together
- If possible, set up teaching sessions and/or multidisciplinary annual meeting to:
  - Explain and discuss structured guideline based management of AF
  - Share knowledge and experience
  - Establish contacts and two way relationships to facilitate ongoing consultation between disciplines and improve access to specialist knowledge.
Once the primary aims of managing AF have been achieved - detection of the problem, protection from the major consequences of AF - then the management of AF should be largely focused on improving symptoms and quality of life. A vast number of AF patients who are experiencing symptoms often have their symptoms either under-treated or not treated at all despite a choice of available drugs and devices. Healthcare systems need to accept that correction of AF will be necessary in a significant proportion of patients and that ignoring this will lead to greater morbidity in this patient population. Correction of AF is directed to address the symptoms associated with AF because this is the only element that is undoubtedly improved if correction is successful - to date no randomised trials have proven that any form of corrective therapy has any impact on prognosis or complications of AF.

It is important to find a treatment plan that works for each individual patient

With regard to correction to address symptoms, the patient has a number of options involving treatment with drugs and/or procedures. It is important to find a treatment plan that works for each individual patient and many patients will work through the options in order of simplicity in order to find the right treatment for them. Much of this decision making process is informed by the degree of the patient’s symptoms, their own perceptions and preferences of drug treatment compared with operations/procedures and also the risks and success rates that they are given for each treatment option. For example a patient with no other heart disease and early paroxysmal AF has a very high chance of elimination of the AF with catheter ablation and therefore may give this option greater weight and preference than someone with valvular heart disease and persistent AF where the success rates of ablation are much lower.

In order to achieve correction of AF efficiently a culture of enabling the patient to lead the treatment choice is required. This has to be combined with a system wide design that allows sufficient access to expert advice and care that enables patients to have their education and treatment in a timely manner.

Key Points
- Once the primary aims of managing AF have been achieved - detection of the problem, protection from the major consequences of AF - then the management of AF should be largely focused on improving symptoms and quality of life.
- Symptoms of AF, where present, are often under-treated or even ignored despite a choice of available drugs and devices.
- In order to achieve correction of AF to improve symptoms efficiently a culture of enabling the patient to lead the treatment choice is required. This has to be combined with a system wide design that allows sufficient access to expert advice and care that enables patients to have their education and treatment in a timely manner.
- The following processes should be considered to improve and optimise the AF patient journey through their corrective treatment to improve symptoms:
  - Plan the entire journey at the start so that the patient knows the direction of travel and timelines
  - Empower the patient so that they are in a position that allows them to make informed choices about their treatment
  - Provide access to specialist care to enable early and effective treatment.

It is advisable that the following processes are considered to improve and optimise the patient journey through their corrective treatment and thus improve their symptoms and quality of life:
- Plan the entire patient journey at the start. Many patients find it frustrating that they progress through treatment so slowly and feel disappointment should initial treatment fail to abolish their symptoms. If patients are going to try a particular option then they need to have an alternative option defined and planned if their first choice fails. Given that the entire treatment plan and options can be defined at the very start of a patient’s treatment one key element for health care systems is to plan the entire journey with the patient at the beginning so that the patient knows the direction of travel and timelines.
- Empower the patient to make their own informed choices. The patient should be put in a position that allows them to make informed choices about their treatment. It should not be the role of the healthcare professionals to make these choices, their role is to educate the patient. This is because the patient is making a decision on what treatment they have based on the balance of the benefits and the risks/success rates. The only proven benefit the patient will have is an improvement in quality of life. Only the patient knows how their symptoms feel and therefore only they can judge what possible benefits they will accrue from treatment. This education takes time and is often challenging in the primary care setting because of the limited time allocated for each patient. One option to overcome this is to establish and utilise an online ‘e-clinic’ as detailed on page 9. Online AF e-clinics will allow the patient more time to review the current latest information and how it relates to them and their choices.
- Provide access to specialist care. A chronic condition like AF is not going to resolve without treatment, and it is better to treat early and effectively than ignore the problem. Access to specialist advice is fundamental to this. An AF outpatient clinic as detailed on page 9 is one option to improve access to specialist care. When resources are limited, organisational change to improve multidisciplinary coordination and knowledge sharing as outlined on page 11 is a consideration to optimise therapy options for AF patients.
Ablation
A treatment which destroys a very small area of tissue inside the heart and so works to prevent rogue electrical impulses from interfering with the regular rhythm of the heart.

Anticoagulant/Anticoagulate
Drug therapy which helps to slow the natural clotting speed of the blood.

Arrhythmia
Heart rhythm disorder

Atrial Fibrillation (AF)
Irregular heart rhythm

CHA₂DS₂-VASc
A method of assessing stroke risk in patients with Atrial Fibrillation:
- Congestive heart failure
- Hypertension
- Age (75 years or over)
- Diabetes
- Stroke
- Vascular disease
- Age (65 – 74 years)
- Sex (gender)

Electrocardiogram (ECG)
A representation of the heart’s electrical activity taken from electrodes on the skin surface.

Heart failure
The inability (failure) of the heart to pump sufficient oxygenated blood around the body to meet physiological requirements.

Left atrial appendage (LAA)
A small pouch in the heart where clots can form. A procedure can close off (occlude) the pouch and thereby prevent clots from travelling to the brain and causing an AF-stroke.

Oral anticoagulants (OACs)
Oral anticoagulants may be divided into vitamin K antagonists (e.g. warfarin) or non-vitamin K antagonist oral anticoagulants (NOACs).

Paroxysmal AF
Episodes of Atrial Fibrillation which cease without treatment.

Stroke
A medical condition where the brain is deprived of oxygen due to a blockage or a bleed.

Warfarin
A medication used to anticoagulate the blood.

Atrial Fibrillation Association
The Atrial Fibrillation Association (AF Association) is a UK registered international charity which focuses on raising awareness of AF by providing information and support materials for patients and medical professionals involved in detecting, diagnosing and managing atrial fibrillation.

AF Association works closely with medical professionals, the Department of Health, Government, NHS Trusts, CCGs (Clinical Commissioning Groups), patients, carers, patient support group members and allied groups.

All information booklets published by AF Association have been approved by an AF medical panel and endorsed by the Department of Health. AF Association has published patient information booklets, AF checklists and AF fact sheets. Many of the titles are now available in twelve languages and AFA-International is growing throughout the world, from Australia to various countries across the Asia Pacific region, South America, Canada, the United States and many parts of Europe.

AF Association also organises annual events for healthcare professionals involved in the management and treatment of arrhythmias, such as atrial fibrillation. These meetings include our regional Cardiac Update Meetings and our annual conference Heart Rhythm Congress (HRC) – www.heartrhythmcongress.org. These events provide a platform for education as well as sharing best practice and information on the latest topics. As well as this they also provide an opportunity to network with healthcare professionals in all areas of cardiac provision, academic institutions and professional bodies.

Furthermore, AF Association is also involved in the collection of the most up-to-date data on AF services in the NHS and represents a valuable source of statistical information for researchers. If you require any AF-related data, including a recent nationwide review of ablation services, or would like to contribute to developments in the clinical management of AF, please visit www.heartofaf.org or please contact Trudie Lobban MBE FRCP (Edin), AF Association Founder and CEO, at the address to the right.

AF Association aims to:
1. Provide support and information on AF to those affected by this condition
2. Advance the education of the medical profession and the general public on the subject of AF
3. Promote research into the management of AF

AF Association is affiliated to Arrhythmia Alliance (www.aa-international.org). The charity is proud to support World Heart Rhythm Week (www.heartrhythmweek.org), an international campaign dedicated to raising the profile of arrhythmias, including AF.

Trudie Lobban MBE FRCP (Edin)
Founder and CEO
Atrial Fibrillation Association
PO Box 6219
Shipston-on-Stour
Warwickshire
CV37 1NL

Tel: +44 (0) 1789 867 502
Mobile: +44 (0) 7778 233 999
Email: trudie@afa.org.uk

Disclaimer
The development of this resource was made possible thanks to an unconditional educational grant from Boehringer Ingelheim. Arrhythmia Alliance would like to acknowledge that this report was developed by the AF Association and endorsed by Arrhythmia Alliance.

Endorsed by

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Arrhythmia Alliance

Atrial Fibrillation Association
The Atrial Fibrillation Association (AF Association) is a UK registered international charity which focuses on raising awareness of AF by providing information and support materials for patients and medical professionals involved in detecting, diagnosing and managing atrial fibrillation.
EU HEALTHCARE PIONEERS
DEFINING BEST PRACTICE IN AF
2016

Founder & CEO
Trudie Lobban MBE FRCP (Edin)

Registered Charity
No. 1122442

AF Association
PO Box 6219
Shipston-on-Stour
Warwickshire CV37 1NL

E Trudie@afa.org.uk
T +44 (0) 1789 867 502
W www.heartrhythmalliance.org

www.heartrhythmalliance.org