Executive Summary

Daiichi Sankyo UK and South Western Ambulance Service NHS Foundation Trust (SWAST)

The aim of this joint working project is to develop a new AF Referral Pathway for the identification and management of asymptomatic AF in the community.

The project is called „South Western Ambulance Service Opportunistic Screening for Atrial Fibrillation - Developing an Electronic Referral Pathway". This joint working project is the UK"s first electronic program of opportunistic screening for atrial fibrillation (AF) conducted by ambulance service clinicians. This project includes the development of an electronic referral pathway to transfer 12 lead ECGs directly from the scene to the appropriate General Practitioner, via the Ambulance Trust. Ambulance clinicians routinely assess the rate, depth and regularity of the radial pulse, in every patient they attend. 12 lead ECG units are carried on all front line ambulance vehicles and are frequently used as a diagnostic tool, by ambulance clinicians skilled in ECG recognition. Whilst there are no pre-hospital guidelines for the management of asymptomatic cases of AF, the majority of patients remain at home, are advised to telephone their GP practice the next working day, to inform them that an irregular pulse has been diagnosed by an ambulance clinician. Symptomatic AF patients are admitted to an Emergency Department according to Resuscitation Council UK guidelines. Currently ambulance clinicians have the option of utilising a non-conveyance telephone line, facilitated by Devon Doctors, both in hours and out-of-hours, to inform the patient"s GP of a possible diagnosis of AF. However this function does not allow for ECG/data transfer, and is only used in approximately 40% of cases. This agreement commences from 1/3/2013 and lasts for 14 months (inclusive).

Benefits for patients

- The early identification of previously unrecognised patients with AF will reduce future complications and morbidity, such as stroke, for the patient.

- Strokes cost more than their direct burden on healthcare budgets. The long-term care required for stroke survivors is usually informal, and often overlooked. Yet this also comes with a tremendous cost to society. Then there is the human cost, which is incalculable.

- The direct cost of stroke to the NHS has been estimated to be £2.8 billion every year. The indirect costs to the wider economy are £1.8 billion and the costs of informal post-stroke care amount to an estimated £2.4 billion.

Benefits for SWAST

- The proposed pilot supports the recommendations of the National Stroke Strategy,

  NICE AF guidelines, National Service Framework for Coronary Heart Disease Chapter Eight, the Quality Outcomes Framework (QOF), National Service Framework for Older People and Taking Healthcare to the Patient.

  - The incidence of AF (NICE 2006) is 0.175% . Annually, the number of new cases of AF is 1,925. The annual number of patients seen by SWAST equates to 1 million, which provides a huge possibility to screen patients for AF, in order to improve diagnosis rates.

  - The early identification of previously unrecognised patients with AF will reduce future complications and morbidity, saving further PCT resources. Other potential savings include the provision of a diagnosed ECG, against the cost of obtaining an ECG within general practice (£27.70).

Benefits for Daiichi Sankyo UK

- This Joint Working project highlights the Daiichi Sankyo brand: “passion for innovation, compassion for patients” as it involves the use of technology to identify patients with atrial fibrillation who are undiagnosed in the community, so they can be managed early so they do not succumb to the devastating effects of a stroke. • This Joint Working project also raises the corporate profile of Daiichi Sankyo in the cardiovascular therapeutic area, and in the field of atrial fibrillation.

  - This project involves the development of an atrial fibrillation screening pathway with potentially national implications.

  - It will also potentially provide valuable, real life data around the incidence/prevalence of atrial fibrillation in Devon.

Executive Summary

Daiichi Sankyo UK and Heart of England Foundation Trust (HEFT)

The aim of this joint working project is to assess compliance with medication in the resistant hypertension population using urine drug analysis and to improve compliance by optimising medication regimes. The project is called the 'Resistant Hypertension Service'. Hypertension is a major risk factor for cardiovascular disease and chronic renal disease. Most hypertensive patients can be adequately controlled with appropriate lifestyle changes and/or antihypertensive medications (in combination, as required) if hypertension persists. For a significant minority of patients their hypertension persists in spite of treatment with 3 or more antihypertensive medications and the National Institute for Health and Clinical Excellence (NICE) have described this as "Resistant Hypertension". It is important to note that the term "Resistant Hypertension" may include individuals who are truly resistant (with, or without secondary causes) and those who are pseudo resistant such as those who:

- may be non-concordant with medication,
- may be intolerant of medication,
- may have white coat hypertension.

This means a rigorous clinical assessment of these patients by a hypertension specialist is needed to confirm true resistance before patients are referred for consideration for more invasive interventions e.g. sympathetic renal denervation. There is no currently available service for GPs local to the Heart of England Foundation Trust (NHS Birmingham CrossCity CCG, NHS Solihull CCG and NHS South East Staffs and Seisdon Peninsula CCG) for the rigorous clinical assessment of these patients. The resistant hypertension service described in this agreement outlines a new service into which these patients can now be referred.

The treatment protocol for the resistant hypertension service employs urine drug analysis to identify patients who are not concordant with their medicines. For those patients who are not concordant with medication and for whom, the absolute number of tablets they are expected to take is a significant issue, fixed dose combinations (FDCs) i.e. tablet, capsules or pills containing two or more active ingredients will be considered as a potential solution.

The availability of this new service is intended to reduce the number of resistant hypertensive patients in the primary care population and to support the appropriate assessment of patients for sympathetic renal denervation.

Benefits for patients

Long standing uncontrolled high blood pressure is a major risk factor for cardiovascular disease and chronic renal disease.

Patients referred into this service have proved difficult for their GPs to control with usual treatment and are at higher risk of heart attack and stroke if their "resistant hypertension" is not addressed.

Comprehensively addressing the causes of "resistant hypertension" in relevant patients will decrease the likelihood of debilitating and potentially fatal illness

Benefits for HEFT

"Resistant Hypertension" often presents to the appropriate physicians either unexpectedly (unplanned medical admissions) or opportunistically

The Resistant Hypertension Service provides local GP's with a structured referral process that will direct appropriate patients for assessment so that treatment of resistant patients can be 'planned'

The appropriate referral and treatment of resistant hypertension will facilitate the identification of patients that require sympathetic renal denervation and HEFT is a centre of excellence for that procedure

Benefits for Daiichi Sankyo UK

Daiichi Sankyo is dedicated to optimising the management of patients with uncontrolled hypertension. This Joint Working Project may lead to an increase in prescribing of FDCs including those marketed by Daiichi Sankyo.

Executive Summary

Daiichi Sankyo UK and North Staffordshire CCG

The aim of this joint working project is to improve the care, both health and social, for people aged 75 and above. It is called the Over 75 year old Risk assessment project.

The objective of the project is to establish whether the use of a screening model in this patient population improves patient outcomes, promotes collaboration between support services at a local level and is cost effective.
There is an increasing elderly population, and increasing longevity incurs health and social problems.

NHS costs rise disproportionately with age. Hospital stays in England for patients aged 75 and over rose by two thirds in the last decade and now comprise almost one in four hospital admissions. The Department of Health estimates that the average cost of providing hospital and community health services for a person aged 85 years or more is around three times greater than for a person aged 65 to 74 years.
GPs are in a unique position to identify at risk patients because they have a defined population registered at the practice, with an accurate database of medical and administrative information, personal knowledge of patients and the goodwill and ability to contact and engage with them.

The problems experienced by patients are a combination of multiple medical, social and mental issues. Action on identified problems will involve collaborative working between support services, and knowledge of age related issues within the community.

The workload in screening this population is considerable and extends outside normal General Medical Services. There is currently no national or local policy for this area of work.

A pilot project showed that this initiative was successful on a smaller scale (one practice) and now it will be extended to include all 6 practices of Newcastle South Locality within North Staffordshire CCG.

The project will;
1 Develop an early warning system which will identify frail, elderly people in the community
2. Offer a home assessment to appropriate patients aged 75 – 84. The decision will be informed by information from a self-perceived health questionnaire. Patients aged over 85 and patients with dementia offered a home assessment automatically.
3 Promote collaboration between support services at a local level and the development of coordinated care plans
4 Provide a system of referral to other support services; professional and voluntary, after assessment of patient needs
5 Make elderly people aware of local resources

6 Enhance health professional and public awareness of local services and assistance available to patients who are aged over 75 years and their carers
7 Identify carers and offer them support
8 Evaluate the need for a practice based coordinator of elderly care services who would act as a central contact point for patients, carers, professional and voluntary agencies
10 Assess the workload and costs involved of implementing an early warning screening model locally
11 Assess medical and social benefits and quantify new referrals made
12 Allow better management of long term conditions, including hypertension, in this group of vulnerable patients

Benefits for patients

- Better identification and treatment of a range of long term conditions, including hypertension will reduce the chance of debilitating and potentially fatal illness
- An increase in benefits claims is anticipated

Benefits for the NHS

- Improved health and social care for patients aged 75 and above
- Improvements in process and prescribing and reduction in hospital referrals amongst other benefits are anticipated

Benefits for Daiichi Sankyo UK

- Identification of appropriate patients who are suitable for treatment with single tablet regimens
- Increased usage of anti-hypertensive therapy in line with the current market share in this population
- Improvement in the corporate reputation of Daiichi Sankyo