

From the Chief Medical Officer  
**Dr Michael McBride**



Department of  
**Health, Social Services  
and Public Safety**

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## **Circular HSC (SQSD) (NICE CG180) 18/14**

**Subject: NICE Clinical Guideline CG180 – The management of atrial fibrillation**

**For action by:**

Chief Executive of HSC Board – **for distribution to:**  
All HSC Board Directors – for cascade to relevant staff

Director of Integrated Care, HSC Board – **for cascade to:**  
Head of Pharmacy and Medicines Management  
Family Practitioner Services Leads – for cascade to relevant  
Family Practitioner groups

Chief Executive of Public Health Agency – **for distribution to:**  
Director of Public Health and Medical Director – for cascade  
to relevant staff  
Director of Nursing and AHPs – for cascade to relevant staff

Chief Executives of HSC Trusts – **for distribution to:**  
Medical Directors – for cascade to relevant staff  
Directors of Nursing – for cascade to relevant staff  
Heads of Pharmaceutical Services – for cascade to relevant  
staff  
Directors of Acute Services – for cascade to relevant staff  
HSC Clinical and Social Governance Leads  
Directors of Social Services – for cascade to relevant staff  
Directors of Finance – for cascade to relevant staff

Chief Executive, Regulation & Quality Improvement Authority – **for cascade to:** relevant independent healthcare establishments

Chief Executives of HSC Special Agencies and NDPBs

**For Information to:**

Chair of HSC Board  
Chair of Public Health Agency  
Chairs of HSC Trusts  
Chair of RQIA  
NICE Implementation Facilitator NI  
Members of NI NICE Managers' Forum

**Summary of Contents:**

This guideline updates and replaces NICE clinical guideline 36 (published June 2006). It offers evidence-based advice on the care and treatment of people with atrial fibrillation.

**Enquiries:**

Any enquiries about the content of this Circular should be addressed to:

Standards & Guidelines Quality Unit  
DHSSPS  
Room D1.4  
Castle Buildings  
Stormont Estate  
BELFAST  
BT4 3SQ

[SGU-NICEGuidance@dhsspsni.gov.uk](mailto:SGU-NICEGuidance@dhsspsni.gov.uk)

**Circular Reference: HSC (SQSD) (NICE CG180) 18/14**

**Date of Issue: 07 August 2014**

**Related documents:**

**HSC (SQSD) 3/13**

**Superseded documents**

Updates and replaces CG36

**Status of Contents:**

Action

**Implementation:**

As per circular. Generally, Clinical Guidelines should be implemented within 12 months of endorsement.

**Additional copies:**

Available to download from

<http://www.dhsspsni.gov.uk/index/phealth/sqs/sqsd-guidance.htm>

**Dear Colleagues**

**NICE Clinical Guideline CG180 - The management of atrial fibrillation**

<http://guidance.nice.org.uk/CG180>

The Department has recently reviewed the above NICE guidance and has formally endorsed it as applicable in Northern Ireland. It should be noted that this guidance updates and replaces NICE Clinical Guideline CG36 on Atrial Fibrillation. The Trusts should have recently completed their planning processes for the implementation of CG36; therefore the actions outlined below should build on this work. For information, additional appendices (Appendix 2 and 3) have been included with this circular and these provide update information and details on recommendations from NICE Clinical Guideline CG36 that have been amended.

In accordance with the process outlined in circular HSC (SQSD) 3/13

[http://www.dhsspsni.gov.uk/hsc\\_sqsd\\_3\\_13.pdf](http://www.dhsspsni.gov.uk/hsc_sqsd_3_13.pdf)), the following actions should be taken

**1. HSC Board / PHA**

- a. Identify a Professional Lead who will consider the commissioning implications of the Clinical Guideline and co-ordinate with any other relevant commissioning teams. This Lead will identify any areas where regional planning / investment / commissioning are required, or where there is material risk to safety or quality. These will then be actioned immediately through normal commissioning arrangements or through bespoke arrangements reflecting the nature of the issue / risk.
- b. Ensure that relevant guidance is sent to the appropriate Family Practitioners.
- c. Seek positive assurance from the HSC Trusts that the required initial actions have been undertaken within a 3 month period, and that the Guideline has been implemented within a further 9 months (unless otherwise notified by the HSC Trusts).
- d. Where significant investment/ commissioning needs cannot be met within the usual timeframe, agree appropriate arrangements with HSC Trusts. Report to DHSSPS as required at 6 monthly accountability meetings.

**2. HSC Trusts**

- a. Proceed with targeted dissemination, agree a clinical/management lead to coordinate implementation and consider what has to be done to achieve implementation using a risk based assessment and baseline review as appropriate to support planning. These initial actions should be undertaken within a three month period.
- b. Implement the Guideline within a further 9 months (apart from any elements where significant issues have been raised with the HSC Board/PHA).
- c. Provide positive assurances to the HSC Board that required initial actions have been taken within the 3 month planning period and that the Guideline has been implemented within a further 9 months, where appropriate.
- d. Where significant investment/ commissioning needs cannot be met within the usual timeframe, notify the HSC Board/PHA at the earliest opportunity through the bi-monthly director level meetings and agree appropriate arrangements with them to achieve implementation.

**3. RQIA**

- a. Disseminate the Guideline to the independent sector as appropriate.

4. HSC Special Agencies and NDPBs
  - a. Take account of this Guideline in training and other developments as appropriate.

To inform the planning process, please find attached details from the Departmental review including estimates of costs / savings based on the NICE costing template, where this is applicable. You should also consider and take account of other relevant Departmental policies and strategies in your planning, as well as any legislative / policy caveats identified in the course of the Departmental review.

A full current list of NICE guidance endorsed for application in Northern Ireland can be found on the Department's website (<http://www.dhsspsni.gov.uk/index/phealth/sqs/sqsd-guidance/sqsd-guidance-nice-guidance.htm>).

**Dr Michael McBride**  
**Chief Medical Officer**



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## Appendix 1

### Endorsed NICE guidance - Details from Departmental review

Reference Number	<a href="#">NICE Clinical Guideline - CG180</a>
Title	The management of atrial fibrillation
Summary of guidance	<p>This guideline (published by NICE in June 2014) updates and replaces NICE clinical guideline 36 (published by NICE in June 2006 and endorsed by the Department in July 2012).</p> <p>It offers evidence-based advice on the care and treatment of people with atrial fibrillation. New recommendations have been added for a personalised package of care and information, referral for specialised management, stroke prevention, rate and rhythm control and the management of acute atrial fibrillation.</p>
Number of people expected to take up or benefit from the service / therapy	It is estimated that around 25,000 people in NI will benefit from this therapy.
Costs / savings associated with implementation	It is estimated that fully implementing this guidance in NI will result in a recurrent annual net additional cost of around £1.6m.
Related strategically relevant DHSSPS policies	None
Inter-Departmental interest	None
Legislative / policy caveats	<p>This advice does not override or replace the individual responsibility of health professionals to make appropriate decisions in the circumstances of their individual patients, in consultation with the patient and/or guardian or carer. This would, for example, include situations where individual patients have other conditions or complications that need to be taken into account in determining whether the NICE guidance is fully appropriate in their case.</p> <p>The Mental Capacity Act 2005 and the Department of Health document 'Reference Guide to Consent for Treatment or Examination' do not apply in NI, but work is under way to bring forward similar legislation</p>

	<p>for NI, incorporating mental capacity and mental health provisions. The DHSSPS guidance 'Reference Guide to Consent for Examination, Treatment or Care (2003)', which is available on the DHSSPS website, gives advice on determining whether a person has capacity and on what action may be taken where the person lacks capacity. Available from: <a href="http://www.dhsspsni.gov.uk/consent-referenceguide.pdf">http://www.dhsspsni.gov.uk/consent-referenceguide.pdf</a></p>
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### Update information

This guideline updates and replaces NICE clinical guideline 36 (published June 2006). New recommendations have been added for a personalised package of care and information, referral for specialised management, stroke prevention, rate and rhythm control and the management of acute atrial fibrillation.

Recommendations are marked as **[2006]**, **[2006, amended 2014]**, **[2010, amended 2012]**, **[2012]**, **[2013]** or **[new 2014]**:

- **[2006]** indicates that the evidence has not been reviewed since 2006
- **[2006, amended 2014]** indicates that the evidence has not been reviewed since 2007, but changes have been made to the recommendation wording that change the meaning
- **[2010, amended 2012]** applies to guidance from NICE technology appraisal 197, published in 2010 and amended in 2012
- **[2012]** applies to guidance from NICE technology appraisal 249, published in 2012
- **[2013]** applies to guidance from NICE technology appraisal 275, published in 2013
- **[new 2014]** indicates that the evidence has been reviewed and the recommendation has been updated or added to.

## Recommendations from NICE clinical guideline 36 that have been amended

Recommendations are labelled **[2006, amended 2014]** if the evidence has not been reviewed but changes have been made to the recommendation wording that change the meaning.

Recommendations 1.6.13 and 1.6.14 (labelled **[2010, amended 2012]**) are from NICE technology appraisal guidance 197, which was amended and reissued in December 2012 to reflect changes to dronedarone's UK marketing authorisation.

Recommendation in 2006 guideline	Recommendation in current guideline	Reason for change
<p>1.1.4.1 Transthoracic echocardiography (TTE) should be performed in patients with AF:</p> <ul style="list-style-type: none"> <li>• for whom a baseline echocardiogram is important for long-term management, such as younger patients</li> <li>• for whom a rhythm-control strategy that includes cardioversion (electrical or pharmacological) is being considered</li> <li>• in whom there is a high risk or a suspicion of underlying structural/functional heart disease (such as heart failure or heart murmur) that influences their subsequent management (for example, choice of antiarrhythmic drug)</li> <li>• in whom refinement of clinical risk stratification for antithrombotic therapy is needed (see section 1.8.6).</li> </ul>	<p>1.1.4 Perform transthoracic echocardiography (TTE) in people with atrial fibrillation:</p> <ul style="list-style-type: none"> <li>• for whom a baseline echocardiogram is important for long-term management</li> <li>• for whom a rhythm-control strategy that includes cardioversion (electrical or pharmacological) is being considered</li> <li>• in whom there is a high risk or a suspicion of underlying structural/functional heart disease (such as heart failure or heart murmur) that influences their subsequent management (for example, choice of antiarrhythmic drug)</li> <li>• in whom refinement of clinical risk stratification for antithrombotic therapy is needed (see section 1.4 Assessment of stroke and bleeding risks and section 1.5 Interventions to prevent stroke). <b>[2006, amended 2014]</b></li> </ul>	<p>'Such as younger patients' has been removed to ensure that all people with atrial fibrillation are included and not just younger patients, for equality purposes.</p> <p>The cross-reference to section 1.8.6 has been amended to cross-refer to the recommendations on assessment of stroke and bleeding risks and interventions to prevent stroke in the 2014 guideline.</p>

<p>1.1.4.2 Do not routinely perform TTE solely for the purpose of further stroke risk stratification in people with atrial fibrillation for whom the need to initiate anticoagulation therapy has already been agreed on appropriate clinical criteria (see stroke risk stratification algorithm in the full guideline).</p>	<p>1.1.5 Do not routinely perform TTE solely for the purpose of further stroke risk stratification in people with atrial fibrillation for whom the need to initiate anticoagulation therapy has already been agreed on appropriate clinical criteria (see section 1.4 Assessment of stroke and bleeding risks and section 1.5 Interventions to prevent stroke ). <b>[2006, amended 2014]</b></p>	<p>The cross-reference to the stroke risk stratification algorithm has been amended to cross-refer to the recommendations on assessment of stroke and bleeding risk and interventions to prevent stroke in the 2014 guideline.</p>
<p>1.2.6.1 In people with acute atrial fibrillation who are receiving no, or subtherapeutic, anticoagulation therapy:</p> <ul style="list-style-type: none"> <li>• in the absence of contraindications, heparin should be started at initial presentation</li> <li>• continue heparin until a full assessment has been made and appropriate antithrombotic therapy has been started, based on risk stratification (see section 1.8.6).</li> </ul>	<p>1.7.5 In people with new-onset atrial fibrillation who are receiving no, or subtherapeutic, anticoagulation therapy:</p> <ul style="list-style-type: none"> <li>• in the absence of contraindications, offer heparin at initial presentation</li> <li>• continue heparin until a full assessment has been made and appropriate antithrombotic therapy has been started, based on risk stratification (see section 1.4 Assessment of stroke and bleeding risks and section 1.5 Interventions to prevent stroke). <b>[2006, amended 2014]</b></li> </ul>	<p>‘Acute’ has been amended to ‘new-onset’ for clarification and consistency. In the 2006 guideline ‘acute’ denotes new-onset atrial fibrillation. In the 2014 draft guideline ‘acute’ refers to the nature of the presentation of atrial fibrillation.</p> <p>The cross-reference to section 1.8.6 has been amended to cross-refer to the recommendations on assessment of stroke and bleeding risks and interventions to prevent stroke in the 2014 guideline.</p>

<p>1.3.3.1 Before cardioversion, patients should be maintained on therapeutic anticoagulation with warfarin (INR 2.5, range 2.0 to 3.0) for a minimum of 3 weeks.</p>	<p>1.7.5 In people with atrial fibrillation in whom the duration of the arrhythmia is greater than 48 hours or uncertain and considered for long-term rhythm control, delay cardioversion until they have been maintained on therapeutic anticoagulation for a minimum of 3 weeks. During this period offer rate control as appropriate. <b>[2006, amended 2014]</b></p>	<p>The 2006 recommendation has been updated to make the recommendation more consistent with the pathway of the updated 2014 guideline.</p>
<p>1.6.2.2 In patients with a confirmed diagnosis of acute AF of recent onset (less than 48 hours since onset), oral anticoagulation should be used if:</p> <ul style="list-style-type: none"> <li>• stable sinus rhythm is not successfully restored within the same 48-hour period following onset of acute AF; or</li> <li>• there are factors indicating a high risk of AF recurrence; or</li> <li>• it is recommended by the stroke risk stratification algorithm (see appendix E, page 47).</li> </ul>	<p>1.7.6 In people with a confirmed diagnosis of atrial fibrillation of recent onset (less than 48 hours since onset), offer oral anticoagulation if:</p> <ul style="list-style-type: none"> <li>• stable sinus rhythm is not successfully restored within the same 48-hour period following onset of acute atrial fibrillation or</li> <li>• there are factors indicating a high risk of atrial fibrillation recurrence<sup>1</sup> or</li> <li>• it is recommended in section 1.4 Assessment of stroke and bleeding risks and section 1.5 Interventions to prevent stroke <b>[2006, amended 2014]</b></li> </ul> <p><sup>1</sup> Factors indicating a high risk of atrial fibrillation recurrence include: a history of failed attempts at cardioversion; structural heart disease (mitral valve</p>	<p>‘Acute’ has been deleted for clarification and consistency. In the 2006 guideline ‘acute’ denotes new-onset atrial fibrillation. In the 2014 draft guideline ‘acute’ refers to the nature of the presentation of atrial fibrillation.</p> <p>The cross-reference to the stroke risk stratification algorithm has been amended to cross-refer to the recommendations on assessment of stroke and bleeding risks and interventions to prevent stroke in the 2014 guideline.</p>

	disease, left ventricular dysfunction or an enlarged left atrium); a prolonged history of atrial fibrillation (more than 12 months); previous recurrences of atrial fibrillation	
1.6.2.3 In patients with acute AF where there is uncertainty over the precise time since onset, oral anticoagulation should be used, as for persistent AF (see section 1.3.3).	1.7.7 In people with new-onset atrial fibrillation where there is uncertainty over the precise time since onset, offer oral anticoagulation as for persistent atrial fibrillation (see section 1.4 Assessment of stroke and bleeding risks and section 1.5 Interventions to prevent stroke). <b>[2006, amended 2014]</b>	‘Acute’ has been amended to ‘new-onset’ for clarification and consistency. In the 2006 guideline ‘acute’ denotes new-onset atrial fibrillation. In the 2014 draft guideline ‘acute’ refers to the nature of the presentation of atrial fibrillation.  The cross-reference to the stroke risk stratification algorithm has been amended to cross-refer to the recommendations on assessment of stroke and bleeding risks and interventions to prevent stroke in the 2014 guideline.
1.7.1.1 In patients undergoing cardiothoracic surgery: <ul style="list-style-type: none"> <li>• the risk of postoperative AF should be reduced by the administration of one of the following: <ul style="list-style-type: none"> <li>– amiodarone</li> <li>– a beta-blocker</li> <li>– sotalol</li> <li>– a rate-limiting calcium</li> </ul> </li> </ul>	1.9.1 In people undergoing cardiothoracic surgery: <ul style="list-style-type: none"> <li>• reduce the risk of postoperative atrial fibrillation by offering 1 of the following: <ul style="list-style-type: none"> <li>– amiodarone</li> <li>– a standard beta-blocker (that is, a beta-blocker other than sotalol)</li> <li>– a rate-limiting calcium antagonist</li> </ul> </li> </ul>	Deleted option of sotalol in the 2014 guideline recommendation because it is no longer recommended as an option.

<p>antagonist</p> <ul style="list-style-type: none"> <li>digoxin should not be used.</li> </ul>	<ul style="list-style-type: none"> <li>do not offer digoxin. <b>[2006, amended 2014]</b></li> </ul>	
<p>1.7.1.2 In patients undergoing cardiac surgery on pre-existing beta-blocker therapy, this treatment should be continued unless contraindications develop (such as post-operative bradycardia or hypotension).</p>	<p>1.9.2 In people undergoing cardiothoracic surgery on pre-existing beta-blocker therapy, continue this treatment unless contraindications develop (such as postoperative bradycardia or hypotension). <b>[2006, amended 2014]</b></p>	<p>'Cardiac' has been amended to 'cardiothoracic' for clarification and consistency. The Guideline Development Group assumes that no distinction between the 2 terms was intended in the 2006 guideline.</p>
<p>1.7.2.2 Unless contraindicated, post-operative AF following non-cardiothoracic surgery should be managed as for acute-onset AF with any other precipitant.</p>	<p>1.9.4 Unless contraindicated, manage postoperative atrial fibrillation following non-cardiothoracic surgery as for new-onset atrial fibrillation with any other precipitant. <b>[2006, amended 2014]</b></p>	<p>'Acute' has been deleted for clarification and consistency. In the 2006 guideline 'acute' denotes new-onset atrial fibrillation. In the 2014 draft guideline 'acute' refers to the nature of the presentation of atrial fibrillation.</p>