included in the final analysis. Patients were divided in to 2 groups depending on the duration of their symptoms. Group A (symptoms <48 h, n = 49) were seen in clinic on the same day. After clinical assessment, patients were cardioverted with flecanide and if failed underwent electrical cardioversion. Group B (symptoms >48 h, n = 105) were advised rate control medications, anticoagulants and arranged for cardioversion after 6 weeks when maintained in therapeutic INR. Those with poor rate control or early signs of instability, underwent TOE guided cardioversion. Follow-up ranged from 3 months to a year.

Results The mean age of the patients was 63.8 ± 13.8 years and 67.5% were male. Patients characteristics at baseline are shown in Table 1 and final outcomes in Table 2. Worryingly 57.1% of the patients scored 2 or above on CHADS2Vasc risk assessment of which 61.4% were not on anticoagulants. During follow-up, a high proportion of patients (63.9%) were asymptomatic and 66.7% maintained in sinus rhythm. **The average length of stay was 2.72 ± 8.44 h.** Only 4 patients (0.04%) were readmitted prior to their initial follow-up due to recurrence of AF. Two patients in group B developed complications related to thromboembolism. One had left femoral artery embolism requiring embolectomy and the other had TIA 2 days following TOE guided cardioversion. The patient who had embolic event had CHADS2Vasc score of 2 and developed symptoms 3 days after commencing warfarin when INR was subtherapeutic.

Conclusions RAAFC appear very effective in preventing hospital admissions, reduce length of stay and also helpful in identifying high risk patients who benefit from anticoagulation. We recommend RAAFC initiated in each trust to lower morbidity, mortality and also costs to NHS.

REFERENCE

1 Camm AJ, Kirchhof P, Lip GY, *et al*. Guidelines for the management of atrial fibrillation. The task force for the management of atrial fibrillation of the European Society of Cardiology. *Eur Heart J*. 2010;**31**(19):2369–-429

Abstract 49 Table 1 Baseline characteristics clinical outcomes

Variable (n = =154)	< 48 h (n = 49) (%)	> 48 h (n = 105) (%)
Female	14 (28.6%)	34 (32.3%)
Source of referral	15 (30.6%)	70 (66.7%)
Primary	20 (40.8%)	18 (17.1%)
Secondary	14 (28.6%)	17 (16.2%)
Self		
CHA2DS2-VASc score	28 (57.1%)	19 (18.1%)
0	7 (14.3%)	14 (13.3%)
1	8 (16.3%)	22 (21.0%)
2	6 (12.2%)	50 (47.6%)
3+		
HASBLED	37 (75.5%)	37 (35.2%)
<1	12 (24.5%)	68 (64.8%)
>1		
Anticoagulation	11 (22.4%)	41 (39.0%)
Already established	9 (81.8%)	40 (97.6%)
Warfarin	2 (18.2%)	1 (2.4%)
NOAC	38 (77.6%)	64 (61.0%)
None		

Abtract 49 Table 2 Clinical outcomes

Variable	n	Percentage
Maintaining Sinus Rhythm	72	66.7%
In AF	36	33.3%
Readmissions prior to first follow up	4	0.04%
Complication	0	0.01%
Stroke	1	0.01%
TIA	1	
VTE		
Symptomatic	39	36.1%
Asymptomatic	69	63.9%

50 A MEASURABLE CLINICAL PATHWAY FOR ATRIAL FIBRILLATION: WHAT ARE THE BENEFITS FOR PATIENTS, CLINICIANS, COMMISSIONERS AND CARDIAC NETWORKS?

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Introduction The Strategic Clinical Network CM SCN has developed a unique clinical pathway for atrial fibrillation (AF) as part of a 3 phase approach to improve outcomes for people with AF or at risk of AF. Phases 1 and 2: promotion of NICE guidance (with audit review) on anticoagulation (AC) and education and support to primary care are complete.

The pathway includes key process and outcome measures based on best practice and guidance. This facilitates robust clinical management of AF and reduces associated morbidity and mortality. Clinicians, providers, cardiac networks and commissioning organisations can now measure the validity and effectiveness of clinical interventions across the full pathway of AF-related care in addition to promoting effective collaborative working.

Methods The CM SCN identified and brought together an expert panel of clinicians and managers to create the pathway. The experience of the expert panel ranged from public health, primary, secondary and tertiary care and included specialists from general practice, general cardiology, nursing, pharmacy, electrophysiology and interventionists.

An independent external facilitator (funded by Boehringer Ingelheim) managed the process and delivered the pathway on time. The pathway was developed by email (Delphi technique) and required three half day meetings. Process and outcome measures were agreed by both clinicians and managers.

Aims of the pathway are: Prevention of atrial fibrillation, early detection of atrial fibrillation, treatment of atrial fibrillation in acute and long-term settings, reduction of complications and support at the end of life.

There are four sections to the pathway 1) Screening 2) Identification and assessment of AF 3) Initial management 4) Long-term management. Each section contains a flow chart, key points on the purpose, importance and consequence of each section, specific notes on each section and a table with indicators, standards, guidelines and competencies.

Conclusion We have shown that it is possible within nine months to produce a comprehensive pathway for people with

AF that is measurable, fits within the current NHS landscape and maximises clinicians and managers time effectively. We have educated over 100 clinicians in the use of the pathway to date.

We anticipate the this pathway will increase the detection of AF, increase in the number of people with AF treated with effective and appropriate AC, reduce the number of people with AF related stroke and increase support to clinicians, providers and commissioning organisations.

We are currently evaluating this pathway over a 24 month period at both general practice and network level using GRASP-AF, CHA_2DS_2-VASc and other KPIs within the pathway. We anticipate that this pathway will benefit all professional stakeholders involved in AF care but more importantly, improve outcomes for people with AF.

51 IMPACT OF THE INTRODUCTION OF A STANDARDISED ICD PROGRAMMING PROTOCOL: REAL-WORLD DATA FROM A SINGLE CENTRE

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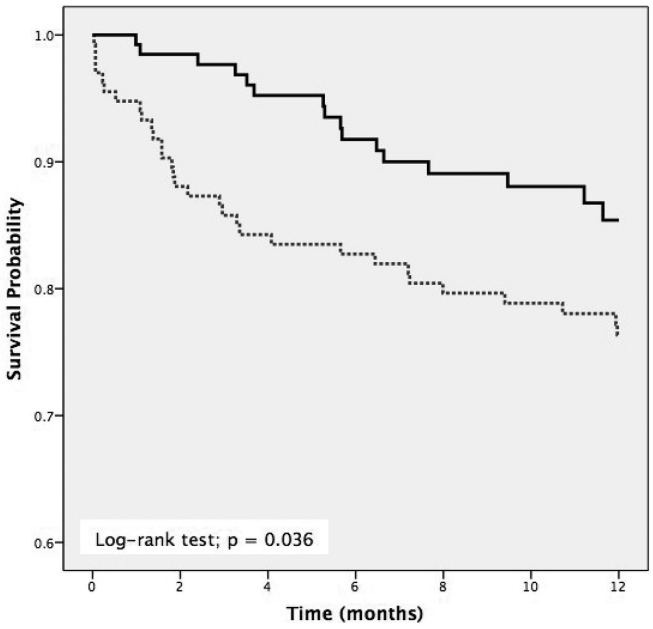
Aims Randomised trials have shown that empiric ICD programming, using long detection times and high detection zones, reduces device therapy in ICD recipients. However, there is less data on its effectiveness in a "real-world" setting, especially secondary prevention patients. Our aim was to evaluate the introduction of a standardised programming protocol in a "real-world" setting of unselected ICD recipients.

Methods We analysed 270 consecutive ICD recipients implanted in a single centre – 135 implanted prior to protocol implementation (Physician-Led group) and 135 after (Standardised group). The protocol included long arrhythmia detection times (30/40 or equivalent) and high rate detection zones (primary prevention lower treatment zone 200 bpm). Programming in the Physician-Led group was at the discretion of the implanter. The primary endpoint was time-to-any therapy (ATP or shocks). Secondary endpoints were time-to-inappropriate therapy and time-to-appropriate therapy. The safety endpoints were syncopal episodes, hospital admissions, and death.

Results At 12 months follow-up, 47 patients had received any ICD therapy (Physician-Led group, n = 31 vs. Standardised group, n = 16). There was a 47% risk reduction in any device therapy (p = 0.04) and an 86% risk reduction in inappropriate therapy (p = 0.009) in the Standardised compared to the Physician-led group. Results were consistent across primary and secondary prevention patients. There were no significant differences in the rates of syncope, hospitalization and death.

Conclusions In unselected patients in a "real-world" setting introduction of a standardised programming protocol, using long detection times and high detection zones, significantly reduces the burden of ICD therapy without an increase in adverse outcomes.



Abstract 51 Figure 1 Kaplan-Meier curves for survival from any-therapy. Physician-Led (dotted) vs. Standardised (black)

52 IMMEDIATE MANAGEMENT FOLLOWING CARDIAC IMPLANTABLE ELECTRONIC DEVICE PROCEDURES; WIDE VARIATION IN PRACTICE FROM A UK SURVEY

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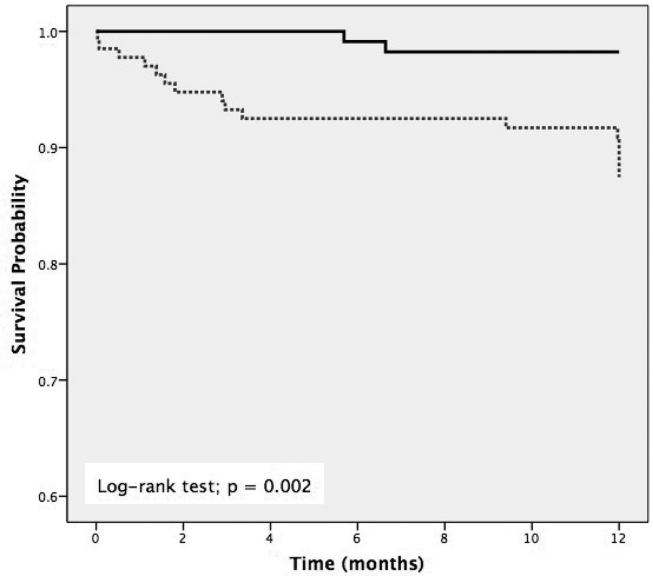
Introduction Following the implantation of a CIED a number of checks are made to document device function and exclude procedure complications. Traditionally these have been performed the day after the procedure, mandating an overnight admission. Recently, both the need for these investigations and



Abstract 51 Figure 2 Kaplan-Meier curves for survival from inappropriate therapy. Physician-led (dotted) vs. Standardised (black)