London Cardiovascular Project

Minutes
Pan London Cardiovascular Project Working Group Arrhythmia Meeting
5th July 2011 3-5pm
Stephenson House

Present:

Dr Michael Cooklin (MC)	**Co-Chair** Lead Clinician for Pan-London EP/Arrhythmia Project and Consultant Cardiologist, St Thomas' Hospital
Hilary Walker (HW)	**Co-Chair** Lead Director for Pan-London EP/Arrhythmia Project and Director NC and NW London Cardiovascular and Stroke Networks
Michelle Bull (MB)	Assistant Director, South London Cardiac and Stroke Network
Robert Edwards (RE)	Physiologist, RBHT
Dr Hugh Bethell	Consultant Cardiologist,
Dr Shoaib Hamid (SH)	Consultant Cardiologist, South London Healthcare Trust
Dr David Lefroy (DL)	Consultant Cardiologist, Imperial Trust
Dr Vias Markides (VM)	Consultant Cardiologist, RBH
Dr Mark Mason(MM)	Consultant Cardiologist, RBH
Dr Edward Rowland (ER)	Consultant Cardiologist, UCLH
Sue Sawyer (SuS)	Assistant Director, NEL Cardiovascular and Stroke Network
Farah Irfan-Khan (FIK)	NC and NW London Cardiovascular and Stroke Network Project Lead
Dr Simon Sporton (SS)	Consultant Cardiologist, BLT
Lyn Wheeler (LW)	Patient Representative, South London Cardiac and Stroke Network
Marsha Abbott (MA)	Chief Physiologist, BLT
Dr Ronald Simon (RS)	Consultant Cardiologist, NMH and UCLH
Swetlana Wolf (SW)	Assistant Director, NC and NW London Cardiovascular and Stroke Network

Date of next meeting:

September 9th, 2011; 9.00-11.00 am
Venue - TBC

Apologies:

Dr Mark Gallagher, Consultant Cardiologist, STG
Dr Nick Bunce, Consultant Cardiologist, STG
Dr Robert Davies, Consultant Cardiologist, Barnet Chase Farm
Daniel Rob, Physiologist, UCLH

1. Welcome and Introduction
Dr Michael Cooklin welcomed everybody to the meeting. Round table introductions were made.

2. Minutes & matters arising
MC stated that any matters arising from previous minutes will be covered by the current meeting agenda.

2.1 Update on Terms of Reference (ToR)
SW reminded the group about the discussions around ToR at the last meeting. The change in the wording of the ToRs had then been agreed so that complex procedures could be delivered at units that meet the quality standards instead of exclusively at central units. The amended ToRs were presented for information.

Action: For group to note updated ToR.

2.2 Membership update
MC stated that new members have joined the workgroup to ensure local unit representation and was happy to see that new members included nurses and physiologists. FIK from NWLCSN joined as the network lead for NWL network.

3. Update on baseline data
SW delivered a presentation on the updated version of the baseline data which now includes complete data from all of the networks.

Key points from the presentation were:
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- **Number of arrhythmia consultants by network** – Workgroup queried whether this was whole time equivalent (WTE). SW confirmed that it was not WTE but it's the number of consultants. Once again it was highlighted that it was important to specify WTE to be able to see arrhythmia workload for each consultant. Local networks to clarify WTE as suggested at a previous meeting..
- **Physiologists by network -** It was recognised that their duties would not always be confined to arrhythmia work.
- **Trusts offering 24/7 telephone emergency service -** SW confirmed that at least 1 centre in each network is offering this service.
- **No. of local units receiving outpatients support –** Workgroup highlighted that this essentially depends on the number of hospitals you have in each network. Therefore it would be better to represent this number as a percentage to show the coverage of outpatients support in each network.

HW reiterated the fact that this data collection process will help inform the workgroup on what further data and analysis will be needed to bring value to the work being undertaken. MC suggested setting up a subgroup to focus on more detailed data to make it more meaningful.

4. Devices quality standards discussion

SH introduced the draft quality standards on devices by stating that most of them are based on the HRUK standards. SH thanked everyone for their feedback on the quality standards and talked through all of the comments received on the document.

One of the main points discussed at length was whether a consultant supervising a trainee performing a procedure should be counted as workload undertaken by the supervising consultant and trainee or the trainee alone. It was agreed amongst the workgroup that numbers as well as outcomes and complications rates should be counted under the consultants name as well as the trainee. The workgroup agreed that although the consultant is less involved practically whilst supervising a trainee, the consultant plays the major part in the decision-making and clinical judgments. However, this may become an issue when collecting data on number of implanted devices as it may lead to double-counting of the same procedures under the supervising Consultants and trainees name. It was suggested that this could be resolved by a local audit whereby an additional field is added – *supervised trainee.*

Each comment received via email from the local workgroup was discussed and the following agreements were reached:

No.	Item	Draft standard	Agreement
2	Consultant Cardiologist	Each consultant/implanter performing implants must personally audit their complication rates. These data are to be shared through CCAD for clinical governance purposes. Audited complications are also to be shared in an anonymised form within the centre.	It was agreed that yearly audits on complication rates should be undertaken and submitted to the networks.
5	Implanting Centres & Cardiologists	Centres implanting complex devices must have access to at least 2 consultant cardiologists who are trained in the implantation and follow-up of complex devices and who are available to treat patients. Device therapy should have been a substantial part of their training, which must have included competence with all means of vascular access, techniques of sub-muscular implant and some experience with subcutaneous arrays. District General Hospitals (DGHs) implanting complex devices should have their own on-site consultant trained in implantation and management of complex devices. The majority of DGHs are unlikely to have two Devices Consultants and they should have access to one or more	The word *'access'* seemed too ambiguous to the workgroup and therefore the workgroup discussed at length how this should really work. It was agreed that formal links between local and tertiary sites should be formed and to develop job plans to ensure close collaboration between both sites. It was agreed that the term DGH was appropriate to use.

		named Devices Consultants via their Network.	
5	ICD follow-up	All patients that have had an ICD/CRT fitted must be offered follow-up in a local clinic and the physiologists undertaking follow-up must be able to count on the support of consultant as necessary.	It was agreed that it was not necessary for a patient to have a follow up at the implanting centre. A recommendation to be included that remote monitoring should be encouraged.
	Patient information on future scenarios and potential deactivation	Quality standards need to include that, as part of the discussion or counselling on implantation of complex devices, patients are given verbal and written information on potential future scenarios including deactivation	To incorporate deactivation local policy in each Network for complex devices including peri-operative deactivation.

Action: SH to make amendments as agreed.

5. Ablations quality standards discussion

VM introduced the draft quality standards on ablations and thanked everyone for their feedback on the quality standards and talked through all of the comments received on the document.

As for the devices standards, it was also agreed for ablations that a procedure undertaken by a trainee whilst being supervised by a consultant should count towards the arrhythmia workload of the supervising consultant. All complications as well as outcomes will also be counted against the supervising consultant.

All comments on including the patient perspective were addressed together. MB had produced specifications on the role of a named patient advocate and also patient passport document.
The advocate, who will be designated by the ward, would deal with all patient or carer concerns, including meals and appointments to see doctors. The patient passport would be a hand held collection of documents that can hold relevant

robust information, appointment records and the up-keep would be the responsibility of the patient/carer.
These specification are to sit over all quality standards and apply to all quality standards.
Comments 1-3 have already been implemented in the most recent draft.

The group discussed at length if a minimum of at least 2 ablation operators per centre need to be specified. All supporting resources need to be in place, as per the other quality standards. Additionally, it was felt that a simple ablation may need to proceed to a more complex ablation and unnecessary multiple, separate procedures were deemed unacceptable. The consensus was reached that sufficiently high minimum numbers and the ability to perform a wide range of EP and ablation procedures would ensure quality provision.

The group also discussed parameters for complication rates. ER advised against being too prescriptive and that measures of outcomes, both acute outcomes and also longer term outcomes were a better measure of quality.

Item	Draft standard	Agreement
4. Standards for data collection, audit and submission	It is essential to collect data on volume, outcome and complications and for these to be both internally audited and submitted to CCAD for national audit	It was agreed that yearly audits on complication and outcomes rates should be undertaken and submitted to the networks.
5. Minimum numbers of consultant	There doesn't appear to be a minimum number of procedures per year required for a consultant operator for simple and complex ablation - only for trainees. In the absence of HRUK guidance, can we come up with a number ? Suggestion of 50 complex and 50 simple per year as first operator was made.	The group agreed on a minimum number of 50 ablations, including simple, complex or a mixture of complex and simple ablations, as per HRUK recommendations.

Action: In regards to comment 4, a formal letter of request is to be sent to CCAD/NICOR, for them to deliver the arrhythmia data to networks as a service in return for submitting the data.

Action: As part of the annual audits, both acute and long term outcomes are to be collected and reported.

Action: VM to make amendments as agreed.

6. Emergency arrhythmia definitions and next steps

MC introduced the draft emergency arrhythmia definitions and thanked everyone for their feedback.

MC began by asking the workgroup if they felt any emergency definition was missing from the document. The workgroup stated that the definition for wide complex tachycardia with haemodynamic compromise should be amended to all narrow and wide complex tachycardia with haemodynamic compromise.

Timescales - Timescales for each of the standards was discussed at length, with some member's view that the phrase *'early discussion'* was ambiguous. 'Early' was deemed to be impossible to measure in this context.

However the clinical members of the group held the view that an *early discussion* would make sense to clinicians. Setting specific time targets for the early discussion for the listed definitions was felt to be clinically inappropriate as a variety of significantly different clinical needs can be found within each category. Clinical appropriateness of the time frame was felt to be paramount. Other group members argued that in the absence of specific time targets, any inequities of provision across a network could not be addressed.

The group agreed that for the list of conditions under discussion, the need to make a specialist aware of these types of patients was important. It was reiterated that early discussion musts be appropriate to the patients' needs.

After much discussion the workgroup agreed on the following wording: "Early discussion with an arrhythmia specialist must take place. Timing of this needs to be clinically appropriate and clearly documented."
This can then be audited.

What constitutes an arrhythmia specialist?
Following on from the discussion on emergency definition, and linked to access to an arrhythmia specialist for these cases the group discussed what constitutes an arrhythmia specialist.

The group agreed that as part of the emergency standards, an arrhythmia specialist needs to be working at every hospital with an A&E. It should always be a doctor and this needs to be formalized through job plans. If there is only one such person working in a hospital then formal arrangements for cover from a tertiary centre must be put in place.

Action: MC to make amendments as suggested and send to workgroup for a final review before being signed off.

Outcomes and metrics
MC stated that for model of care implementation to be evaluated, outcomes and metrics need to be defined. This needs to cover the following 3 areas:

- Care is delivered by the right people at the right place
- Networks are working together as part of an arrhythmia network
- A 24/7 arrhythmia emergency service is available to all hospitals in the London Networks/Clusters.

Measures need to be realistic, measurable and sensitive to the progress that .is being made.

Action: VM, SH and MC to develop outcome measures once quality standards for ablations and devices and emergency arrhythmia definitions are signed off.

7. Any other business

MB stated that the exact definition of an arrhythmic clinic is required which could then be used to inform providers.

Action: MB to draft up a definition and then to discuss with MC and the group.

At the end of the meeting MC thanked all for attending and extended a special thanks to SH, VM and RD for the drafting of the devices and ablations quality standards.