London Cardiovascular Project

Minutes of the Pan London Cardiovascular Project Working Group
Arrhythmia Meeting
19th April 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 and Project Director NC and NW London Cardiac and Stroke Network
Michelle Bull (MB)	Assistant Director, South London Cardiac and Stroke Network
Dr Robert Davies (RD)	Consultant Cardiologist, Barnet Chase Farm Trust
Gulsen Gungor (GG)	Senior Project Manager, NEL Cardiovascular and Stroke Network
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
Mark Scott (MS)	Deputy Director, NC and NW London Cardiac and Stroke Network
Dr Simon Sporton (SS)	Consultant Cardiologist, BLT
Lyn Wheeler (LW)	Patient Representative, South London Cardiac and Stroke Network
Swetlana Wolf (SW)	Assistant Director, NC London Cardiac and Stroke Network

Date of next meeting:

5th July for next meeting
3-5pm.
Venue: Stephenson House.

1. Apologies

Dr Ronald Simon, Consultant Cardiologist, NMH and UCLH
Dr Mark Gallagher, Consultant Cardiologist, STG

2. Welcome and Introduction

Hilary Walker (HW) welcomed everybody to the meeting. Round table introductions were made.

3. Terms of reference

Michael Cooklin (MC) thanked everybody for coming and also thanked everybody who came to the launch meeting. Many of the issues raised at the launch meeting will now be picked up at this meeting.

The first point of discussion was the terms of reference (ToR), including the membership. MC suggested that each network would have at least a central unit and local unit member. The group supported his suggestion. It was thought that inclusion of physiologists and arrhythmia nurses from across London would be beneficial to the membership.

All present agreed that members must cascade information to others within their organizations. Meeting attendance is not enough.

Action: HW requested membership suggestions from all and asked that contacts should be forwarded to Swetlana Wolf (SW).

Michelle Bull (MB) asked if objectives and metrics have been defined. SW responded that these will be developed once the quality standards have been agreed.

MC then asked for the group's views on 50 per cent minimum attendance to retain membership. This would need to be measured over a year and was felt to be useful to ensure that information is disseminated appropriately.

Action: Additional feedback on the terms of reference should be forwarded to SW by the end of the week..

After some discussion, it was agreed to amend the ToR text to say the "Complex electrophysiological procedures should be delivered at units within networks that meet the quality standards." The wording within the Model of Care and Co-Dependencies documents was discussed as part of this. It was decided that the spirit of the documents seek to ensure quality provision which this definition would ensure.

3. Launch meeting

3.1 Baseline data

SW gave an updated version of the baseline data, which now includes data from all central units. Data was still missing from a number of NWL local units in particular. Dr Mark Mason (MM) agreed to help facilitate the process of obtaining these.

Dr Simon Sporton (SS) asked how *arrhythmia specialist* was defined. MC responded that it would also include consultants with a special interest in arrhythmia and not necessarily EP specialists.

Definitions and therefore accuracy of numbers was also discussed in regards to physiologists involved in ablations. HW responded that the most useful data will be selected to inform the work of this group.

Lyn Wheeler (LW) queried why the number of device extractions was higher in SEL. Dr Shoaib Hamid (SH), MC and MB responded that St Thomas' was a national specialist centre for extraction and it was not an indication that the quality of implants was worse in SEL.

Key points from the presentation were:

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- The number of **arrhythmia consultants** ranged from 1-8 per centre. Numbers of specialist personnel are higher in the central units.
- **Arrhythmia nurse** numbers also varied. It was acknowledged that their duties would not always be confined to arrhythmia work.
- There was a marked variation in **physiologist** numbers across Trusts in London.
- **Activity data** were acknowledged still to be incomplete. Private practice data have also not been included.
- The minimum number of device implants recommended by the 1997 British Cardiac Society guidelines for competency in electrophysiology procedures was surpassed by the majority of operators.
- **HRUK 2011 guidance for individual operators** for minimum pacemaker numbers in this survey was met by at least 32 out of 50 operators.
- **24/7 emergency services** were already offered in the form of a telephone support service in all networks. Three out of five networks had also a 24/7 rota in place to attend to emergencies in a central unit.
- Not all local units have **outreach clinics** run by central unit arrhythmia consultants.
- **Perceived barriers** for increasing throughput varied from network to network, with SEL citing cath lab capacity and NEL consultant and physiologist numbers. Lack of medical, allied professional or cath lab capacity was a consistent theme.
- **Suggestions for improvement** beyond those already been mentioned included:
    - 24/7 arrhythmia rotas with specialists ward rounds
    - Syncope and rapid access arrhythmia clinics
    - Local device and ablation services
    - Improved dialogue with commissioners
    - Monitored beds

Sue Sawyer (SuS) pointed out the importance to list whole time equivalent, not just numbers for arrhythmia consultants. She also felt it important to specify whether their workload consists of primarily arrhythmia work as they therefore could be defined as arrhythmia specialists. This was echoed for physiologists.

Mark Scott (MS) asked for clarification on the geographical boundary of the patient populations. Dr Edward Rowland (ER) responded that the Model of Care specified the inclusion of patients within the M25 area. Dr Vias Markides (VM) cautioned that activity in his centre included at least 50 per cent of patients from outside of London. MC responded that the questionnaire responses take this into account as a breakdown of the patient groups according to the local (in-sector), regional and national referral origin had been requested. VM also expressed concern that a report based on this data set could leave an erroneous impression of less-than-actual activity, if circulated beyond this group, and potentially lead to a withdrawal of resources.

Action 1: List caveats and explanations within baseline data report.

Action 2: Create a sub-group to identify specific data requiring clarification or further examination once the quality standards have been agreed.

MC summarized the data:

- Devices and ablation numbers do not meet national targets across London but do tend to be better than those from the rest of the country.
- There are variations across London, especially for staffing levels.
- Central units should have more specialists than local units.
- Central and local units work well together but there potential to improve this.
- Model of Care requires that provisions are in place for emergency patients.
- There is no additional funding for the implementation of this project. Improvements must be made through working together within clinical networks.

3.2 Quality standards

Two sets of quality standards developed by the Surrey Network had been circulated prior to the meeting.
MB gave background information on the development of these, as she had recently met with some of the authors.
These were developed to ensure quality of services at Surrey Hospital for the delivery of ICDs and CRTs and simple ablations. Implementation was phased. During the first year of implementation, it was used as an aspirational framework. Achievement of quality standards was expected in the second year. Additionally, the quality standards were used to ensure adequate resources. Specifically, they were the basis of the business case for additional physiologists. This work was completed before the most recent HRUK guidance was produced.

Dr Mike Hickman was one of the clinicians who was involved in the development of the Surrey quality standards. He has agreed to be a member of this group and gave his permission to use the Surrey quality standards.

VM asked if complication rates should also be included. ER supported this. MB asked about the availability of relevant data on CCAD. ER thought data needs may be met in the future through CCAD but interim arrangements will need to be made.

Action 3: VM volunteered to produce draft quality standards for ablations and include within a list of appropriate acute end points and also include aspirational longitudinal end points by the end of May.

Action 4: All centres to email VM the types of data that are currently being collected locally.

Action 5: Dr Robert Davies (RD) and SH to work on the devices equivalent by the end of May.

3.3 Emergency services

MC referred to SS's presentation at the launch meeting and pointed out that St. Bartholomew's was in a unique position in regards to resources for the provision of a 24/7 arrhythmia emergency care.

HW enquired into the specifics of the delivery of the emergency services at the centres providing this across London. The subsequent discussion showed that in some cases this included formal arrangements embedded into job plans and in others the service is run on a goodwill basis or an informal arrangement.

VM and MM shared with the group recent discussions on how the Brompton and Harefield Trust may set up an emergency rota. Availability of physiologists was identified as a challenge which needs careful negotiations in these plans.

Challenges and benefits of providing out-of-hours permanent pacemakers were discussed.

The group discussed the definition of a 24/7 service, including the conditions for which it needs to be provided and what resources would be necessary. NWL clinicians thought that a DH paper may exist that included recommendations on some of the definitions of 24/7 emergency services.
SS thought it would be beneficial to produce standards that define how soon patients should have emergency pacemakers implanted, especially to support local units. HW suggested this should include patient scenarios and appropriate pathways.

MM then pointed out that resource implications need to be considered. He emphasised that available resources need to be taken into account. MB suggested that resource implications are part of the whole process. The process should include the definition of conditions to be included into the emergency service. Quality standards development would then specify how these conditions would be managed and also specify the resource implication. Local networks need to consider the most appropriate models for local implementation.

SuS reported that they are in the process of quantifying the resources in the NEL emergency service.
MB also raised the point that the NSTEACS project may affect cath lab capacity and such projects need to be taken into consideration when considering local resources.

SS queried if suspected device infections would be included into the list for emergency conditions. MC suggested that this may be included into the devices quality standards or covered under the emergency services section.

Action 6: MC offered to write up emergency definitions.

4. Next steps

MC summarized that VM would produce draft ablation quality standards and RD and SH would produce devices quality standards/complications. These will be circulated to the group for comment.
MC will produce the list of inclusions and definitions of arrhythmia emergency conditions for 24 hour emergency services.

Any other business
MB raised the issue of ensuring that the patient perspective is included into the work of the group. The group agreed to incorporate the patient perspective into the quality standards, drawing on the patient perspective document. .

1. **Current membership of the project group**

Pan-London EP/Arrhythmia project group chairs:	
Dr Michael Cooklin and Ms Hilary Walker	
Network representatives:	
North Central London	
Network project lead	Swetlana Wolf
EP/Arrhythmia clinical representatives	Dr Edward Rowland
	Dr Robert Davies
	Dr Ron Simon
North West London	
Network project lead	TBC
EP/Arrhythmia clinical representatives	Dr Vias Markides
	Dr Mark Mason
	Dr David Lefroy
North East London	
Network project lead	Sue Sawyer
EP/Arrhythmia clinical representatives	Dr Simon Sporton
South East London	
Network project lead	Michelle Bull
EP/Arrhythmia clinical representatives	Dr Michael Cooklin
	Dr Shoaib Hamid
South West London	
Network project lead	Gillian Wilson
EP/Arrhythmia clinical representatives	Dr Mark Gallagher
	Dr Michael Hickman