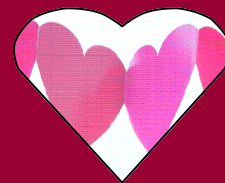


DORSET AND SOMERSET CORONARY HEART DISEASE NEWSLETTER

Issue No. 8

January 2007



GOING FROM STRENGTH TO STRENGTH

The latest quarterly progress report shows further improvements. Particular achievements in the last quarter (to September 2006) are:

- ◆ The Healthcare Commission has rated all Primary Care Trusts as either 'good' or 'excellent' in their recent Improvement Review of Tobacco Control;
- ◆ primary care audit data shows improvement, with 88% of people with Coronary Heart Disease now on a statin and 82% with blood pressure controlled;
- ◆ 78% of people were thrombolysed within 60 minutes of emergency call;
- ◆ 100% of referrals to Rapid Access Chest Pain Clinics were seen within two weeks;
- ◆ waiting times for echocardiography have improved, with virtually all patients waiting less than 12 weeks.

But there is plenty more to do as our services, excellent though they are in comparison to the rest of the country, still do not always match up to the best in Europe. Our services for arrhythmia and sudden cardiac death, for example, have not received investment until recently and a recent mini-review of local services has suggested where services need to be developed further [see page 5].

I am delighted that Debbie Fleming, Chief Executive of Bournemouth and Poole Primary Care Trust, has agreed to chair the Dorset and Somerset CHD Programme Implementation Team – the Network Board. Local Implementation Teams are considering what changes they need to make, if any, following reconfiguration of Primary Care Trusts. Meanwhile they are continuing to drive forward improvements and determining priorities for their local health community. The cardiac network team, led by Val Smyth, continues unchanged - with funding from the centre at least until June 2007, probably longer. And I know that the enthusiasm and commitment of all staff to improve services, which has been so apparent from the outset, will continue as strongly as ever.

On a personal note, I expect to be undertaking a different role in the South West Strategic Health Authority by the time this newsletter is published. I would like to take this opportunity to say that the time I have spent working with colleagues in Dorset and Somerset on heart disease has been one of the most enjoyable and fulfilling of my career.



Geoff Upton, Dorset and Somerset Cardiac Network Director—until January 2007
tel: 01935 384043
e-mail: geoff.upton@southwest.nhs.uk

Thank you all for your support and I wish you continued success.

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TEAM OF THE YEAR

Congratulations to the cardiac team at The Royal Bournemouth Hospital on winning the 'Team of the Year' in the Hospital Doctor Awards 2006. Consultant cardiologists Dr Terry Levy and Dr Mark Sopher, together with Sue Weaver, Norma Cox, and Rose Duncan received the award at a prestigious ceremony in London in November 2006.

Well done to the team for this fantastic achievement.

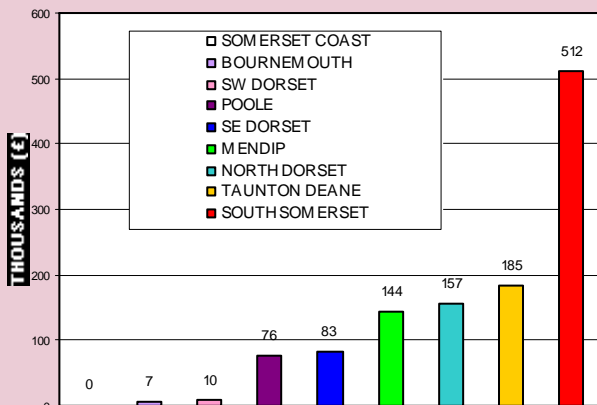
Photo: Charles Creswell (acting editor of Hospital Doctor), Dr Terry Levy, Eamonn Holmes, presenter, and a representative from the awards sponsor Solvay Healthcare

STATIN WINDFALL - OVER £1 MILLION EACH YEAR AVAILABLE TO DORSET AND SOMERSET PRESCRIBERS

Recently released productivity metrics data show that if prescribers in Dorset and Somerset prescribed 70% of statin prescriptions as simvastatin, rather than expensive statins such as atorvastatin, they could release over £1 million pounds per year.

A staggering £512,000 per year could be released from South Somerset prescribers alone.

Savings Available by Achieving 70% Simvastatin



For Q1 2006/07 Somerset Coast achieved a Simvastatin % of 71.44% while South Somerset prescribers achieved only 50.09%. The highest percentage in the country was over 83%.

Commenting on the national picture and evidence base Dr James Moon (co-author of the recent BMJ editorial on 'switching statins') stated:

"there is a real risk that in the future prescribers could be accused of being negligent if they fail to target high

risk patients as per NICE Technology Appraisal 94. Anything between 15% and 25% of the population could be entitled to a statin now we are treating to 20% CVD risk.

Prescribers should choose a statin with the greatest range of indications and evidence base and that has the lowest cost per % LDL reduction of all the statins. This is simvastatin 40mg. The fact that simvastatin 40mg also produces a higher rise in HDL cholesterol than any dose of atorvastatin is an added bonus"

All PCTs in Dorset and Somerset are now endorsing a strategy of increasing simvastatin use, both on initiation and by switching patients from atorvastatin 10mg and 20mg.

It has to be emphasised that the CHD NSF cholesterol targets of 5mmol/l total cholesterol and 3mmol/l LDL cholesterol are still national policy and override any recommendation from Joint British Society guidelines.

Reinvesting savings released by switching to simvastatin in treating patients with a cardiovascular risk greater than 20% over ten years would enable Dorset and Somerset to fully implement NICE guidance on the prescribing of statins for the prevention of cardiovascular disease.



Shaun Green, Director of Prescribing and Medicine Management, Somerset Primary Care Trust
tel: 01823 344401 e-mail: shaun.green@somerset.nhs.uk

18 WEEKS - THE CHALLENGE

Service Improvement Managers from the Dorset and Somerset Cardiac Network are currently working with Trusts to meet this challenge from the Department of Health; www.18weeks.nhs.uk. The 18 week standard is different from previous waiting time targets. Instead of focusing on a single stage of treatment (such as outpatients or inpatients) the 18 week pathway addresses the whole patient journey from referral to treatment. It has been referred to as 'the first target with intelligence' because for the first time, we will be able to identify the *hidden waits* between stages of investigations and treatment that patients have been experiencing in the past.

The 18 week standard requires local health communities to work together to identify bottlenecks, improve services by reducing unnecessary hold-ups and smooth the patients' experience across the whole journey. This target must be reached across all areas by December 2008. Waits have already been dramatically reduced in cardiology with many Trusts already meeting the 18 week standard in some

specialties.

Once achieved, meeting this target should provide real benefits for patients. We want to find out what actually happens to patients from start to finish, and then improve by reducing waits, giving much greater certainty, and reducing the anxiety for patients and their families. The use of patient and carer stories will be vital to capture the real issues in meeting this challenge.

Trusts are reporting their existing waits in preparation for the compulsory national data collection starting in January 2007. The Dorset and Somerset Cardiac Network Team are on hand to help and advise Trusts with any areas of service improvement that will help them in reducing waits and achieving targets.



Sarah Armstrong-Klein, Service Improvement Manager Dorset and Somerset Cardiac Network
tel: 01202 854435 e-mail: sarah.armstrong-klein@ferndown.nhs.uk

INDEPENDENT SECTOR DIAGNOSTIC SERVICES

Atos Origin has been appointed as the provider for independent sector diagnostic services for the south west. The contract is intended to complement NHS diagnostic services by offering rapid, local services for tests that are frequently undertaken.

Atos Origin are keen to work in collaboration with existing NHS services

The contract, which is due to start in April 2007, is expected to provide services in the following locations, although some details could still change:

- ◆ Bournemouth – Alum House, Discovery Court Business Centre, Wallisdown Road (echocardiogram, exercise ECG, 24-hour ECG and 24-hour blood pressure);

- ◆ Taunton – Crown Medical Centre (echocardiogram);
- ◆ Yeovil - Bartec 4, Lynx Trading Estate (exercise ECG, 24-hour ECG and 24-hour blood pressure);
- ◆ Glastonbury – West Mendip Hospital (echocardiogram, exercise ECG, 24-hour ECG and 24-hour blood pressure);
- ◆ Weymouth – Weymouth Community Hospital (exercise ECG, 24-hour ECG and 24-hour blood pressure).

Atos Origin are keen to work in collaboration with existing NHS services to avoid unnecessary repeat tests and to share results and images for future reference. They plan to meet key NHS staff before the contract starts to discuss working arrangements.

**Geoff Upton, Dorset and Somerset Cardiac Network
Director—until January 2007
tel: 01935 384043
e-mail: geoff.upton@southwest.nhs.uk**

A FOCUS ON ARRHYTHMIAS

“That’s my irregular heart beat, but yours and yours and yours and yours may be very differentthere are many irregular heart beats, there are many treatments and many causes.”

Dorset Patient (July 2006)

Earlier this year a series of focus groups were held in Dorset to gain insight into the needs of people living with cardiac arrhythmias. The intention is that people’s views and experiences should be given due consideration and play a part in informing work being carried out locally to meet the NSF quality requirements, whilst also providing an opportunity to consider how people’s views compare to current practice.

The focus group technique is a qualitative tool which can yield useful information for service providers. It is designed to obtain people’s perceptions, feelings and attitudes about a specific area of interest, with the objective of making improvements to the services provided. The approach is based on social interaction between individuals who have shared similar experiences and so can give a richer more measured view of issues.

The value of the technique lies in the findings obtained from a free flowing group discussion.

Three focus groups were carried out in Dorchester, Bournemouth and Poole and through following the focus group methodology certain themes and common perceptions became apparent.

Particularly strong themes to emerge were concerned with the difficulties of diagnosis, the importance of timely and effective information provision, ongoing and accessible support, and awareness of existing services. The areas that are important to local people closely mirror the NHS quality requirement topics.

Many of the views expressed supported local action that is already being taken or is being planned, such as the development of guidelines and care pathways and the provision of information and support by specialist arrhythmia nurses.

The Focus Group reports and action plans have been agreed and will shortly be available on the Dorset and Somerset Cardiac Network Website www.dscn.nhs.uk.



**Frances Aviss, PPI Lead
Dorset and Somerset Cardiac Network
tel: 07876 104752 e-mail: frances.aviss@ferndown.nhs.uk**

THE ARRHYTHMIA ALLIANCE

The Arrhythmia Alliance was founded in May 2004, and is committed to improving the awareness, diagnosis and treatment of cardiac arrhythmias, in order to improve the lives of sufferers and their families.

The origins of the Alliance lie in the 2004 Arrhythmia Awareness Week, when a coalition of charities campaigned to extend the National Service Framework for Coronary Heart Disease (NSF). Partners argued that the existing NSF had done much to improve the provision of services for coronary disease, but those who suffered from rhythm disturbances could be forgiven for thinking that they had the wrong sort of heart problem. Indeed the word "arrhythmia" appeared only once in the entire document. From a small initial group of interested parties, the campaign quickly gained momentum and support, and by the time the awareness week was launched, could even boast support from the Prime Minister himself.

Subsequent to the announcement of the new Chapter – Arrhythmias and Sudden Cardiac Death – the Alliance worked hard with all stakeholders to ensure comprehensive input and consultation to the Chapter, and partnered with the Department of Health to launch the new document during the second awareness week in March 2005. This year the week concentrated on supporting implementation, and led directly into the first UK Heart Rhythm Congress, at which many of the lessons learned so far were shared amongst the 800 delegates.

The Arrhythmia Alliance

a broad and inclusive

alliance of those

committed to our

aims and objectives



A key strength of the Alliance is the fact it is exactly that – a broad and inclusive alliance of those committed to our aims and objectives. As well as many individuals, our membership includes independent patient advocacy groups, NHS organisations – hospitals, PCTs, and networks - and industry partners. Together, I think it is fair to say, that we have made good progress in our short life, but there is much more to be done in terms of merely defining the true nature of the problem, yet alone in beginning to address it more fully. To do this we need your support both in the admirable work you are doing already, but also as members of the Alliance. Visit us at www.arrhythmiaalliance.org.uk

*Trudie Lobban, Arrhythmia Alliance Trustee/STARS CEO,
Arrhythmia Alliance, Helpline: 01789 450787
e-mail: info@arrhythmiaalliance.org.uk*

SUDDEN CARDIAC DEATH UPDATE

On 7 November 2006 we held what we believe to be the first process mapping event by a network for sudden cardiac death in the country at the Royal Bournemouth Hospital. Those present included a patient representative, cardiologists, a geneticist, hospital chaplains, specialist nurses, technicians, paramedics, GPs, Primary Care Trust managers, and representatives from the Department of Health and from Cardiac Risk in the Young (CRY) and the Cardiomyopathy Association.



Process mapping on 7 November 2006

Val Smyth, Network lead, led the event and key stages in the patient journey were identified for action and further joint working. All present commented on the need to make strong links between different specialities, the coroner's officers and local patient groups.

A further meeting is planned for January 2007 where the senior coroner's officer will be making a presentation. This will be an opportunity to strengthen the links which are vital in ensuring that sudden cardiac death and its implications are given the priority it deserves, so that future deaths can be prevented.

*Liz Mackenzie, Service Improvement Manager
Dorset and Somerset Strategic Cardiac Network
tel: 01935 384061
e-mail liz.mackenzie@southwest.nhs.uk*

LOCAL REVIEW OF CHAPTER EIGHT

A local review of progress with Chapter Eight took place during the summer. Chapter Eight, 'Arrhythmias and Sudden Cardiac Death' came out in March 2005 and progress with implementing it initially was somewhat slow. However, in the review it was clear that all Local Implementation Teams are giving arrhythmia serious attention. Action plans have been agreed with each Local Implementation Team.

Common themes in the action plans are:

- ◆ review membership of Local Implementation Team to ensure specialist input from appropriate specialists including voluntary organisations and patients;
- ◆ strengthen links with paediatric cardiologists and ensure that there is smooth transition from child to adult services;
- ◆ strengthen links with voluntary organisations that specialise in arrhythmia and sudden cardiac death;
- ◆ ensure people with arrhythmia have an assessment of their support needs and a named care co-ordinator;
- ◆ set up arrhythmia / blackout clinics in every hospital, perhaps along a nurse-led model;
- ◆ examine reasons for low implantation rate for pacemakers and Implantable Cardioverter Defibrillators (ICDs), in areas where rates are low;
- ◆ process map the communications and care pathways for sudden cardiac death and implement new procedures / pathways where appropriate.

The report on the local review can be obtained from jill.madgwick@southwest.nhs.uk

Geoff Upton, Dorset and Somerset Cardiac Network Director—until January 2007
tel: 01935 384043 e-mail: geoff.upton@southwest.nhs.uk

STOP PRESS....

DORSET AND SOMERSET CARDIAC NETWORK

- ◆ The Cardiac Network sadly has to say goodbye to Geoff Upton who is taking up the post of Strategic Service Change Manager with the new South West Strategic Health Authority. Val Smyth will be the Cardiac Network Lead with Debbie Fleming as chair;
- ◆ Page 15 of the Winter 2006 edition of 'You and Your Health' shows the good work being undertaken by the Patient and Public Involvement team with patient and carer representatives;
- ◆ The network team are currently working with the Department of Health interviewing patients who have suffered a stroke, to learn from their experience whilst in the care of the NHS. This is in its early stages but look out for progress in the next edition of this newsletter.

DORSET COUNTY HOSPITAL ARRHYTHMIA NURSE

Kay Elliott has been employed as British Heart Foundation arrhythmia nurse for West Dorset General Hospitals NHS Trust since September 2006.

Prior to this Kay was based in Gloucestershire, working most recently as a community matron. Before that she was a lead nurse for the Coronary Heart Disease nursing team in primary care. Kay has also worked in the coronary care unit at Gloucestershire Hospitals NHS Trust.



Kay Elliott

The initial priority of the new service is to look at the pathways that patients with arrhythmia follow in order to eradicate unnecessary delay and improve the support and education available to them. At a recent steering group meeting the possibility of developing a 'Rapid Access Atrial Fibrillation' service might be a key development in terms of service improvement. A rapid access service could decrease risk of cardiovascular complications (and possibly hospital admissions) such as stroke or heart failure. Further benefits would be to improve the patient experience and promote their ability to contribute towards the ongoing management of their condition.

Another development is the planned ICD service in West Dorset General Hospital next year. Research strongly supports the need for patients and their families to receive education and support before and after the insertion of this life-saving device. Kay, Dr Tim Edwards (cardiologist) and the physiologists (who will provide the technical support) are working together in order to plan a multi-disciplinary care programme. Kay has visited the Bournemouth ICD support group with a view to developing a similar initiative at some point on this side of the county. Many patients currently do not feel able to travel as far as Bournemouth and so miss out on this invaluable peer support.

Planning has started on providing additional support and a more coherent pathway for patients at risk of 'sudden cardiac death' and families who have lost someone to this devastating experience.

The ultimate outcomes of looking at this area of care will include:

- ◆ increased screening/detection and treatment of people at risk; and
- ◆ readily available support and guidance to remaining family members with screening for hereditary conditions where appropriate.

Kay Elliott, BHF arrhythmia nurse
West Dorset General Hospitals NHS Trust
tel: 01305 251150 e-mail: kay.elliott@wdgh.nhs.uk

CARDIAC REHABILITATION

CARDIAC REHABILITATION AT BROADSTONE LEISURE CENTRE

For the first time in Poole, patients now have a choice in where they access cardiac rehabilitation. They can complete their Phase Three programme either at Poole Hospital or Broadstone Leisure Centre. This is thanks to a new partnership initiative between Borough of Poole Leisure Services, Poole Heart Support Group and Poole Hospital.

Four ten-week programmes will run from July 2006 until the end of March 2007. If successful it is hoped that the service will continue on a longer term basis.

The programme at the leisure centre is supervised by a British Association of Cardiac Rehabilitation exercise instructor from Poole Heart Support Group and a cardiac rehabilitation nurse from Poole Hospital. Health education talks are given by the nurse at the end of each session. To enable patients to continue with regular exercise on completion of Phase Three, the Heart Support Group are running Phase Four sessions at the same venue.



Evaluations from the first group of eight patients have been good, showing them to be pleased with the venue and parking facilities.

Linda Everett, Senior Cardiac Rehabilitation Nurse, Poole Hospital NHS Trust
tel: 01202 665511 e-mail: Linda.everett@pht.nhs.uk

CARDIAC REHABILITATION IN SWANAGE

Since April 2006, cardiac patients in the Purbeck area (Swanage, Wareham and surrounding villages) have been able to access a Phase Three programme nearer to home.

With funding from South East Dorset Primary Care Trust it has been possible for the Cardiac Rehabilitation department to provide an eight-week programme, three times a year at Swanage Hospital.



A maximum of eight patients can be accommodated. The exercise sessions are supervised by a British Association of Cardiac Rehabilitation exercise instructor and a cardiac rehabilitation nurse from Poole Hospital.

Health education information is provided by a local general practitioner, dietitian, health visitor, cardiac rehabilitation nurse, exercise instructor and Poole Heart Support Group.

The first programme in May/June 2006 was well received by the patients. They all appreciated being able to attend a local venue, and the free parking outside the hospital was a bonus.

Vicky Tite, Cardiac Rehabilitation Specialist Nurse Poole Hospital NHS Trust
tel: 01202 665511 e-mail: Vicki.tite@pht.nhs.uk

UPDATE ON THE BHF ARRHYTHMIA NURSE SERVICE IN SOMERSET

The three posts are well on the way to being filled. Interviews were held at Musgrove Park Hospital on Wednesday 8 November 2006. Three candidates gave presentations on their vision for the cross-county service which were attended by cardiologists, patient representatives, a representative from the British Heart Foundation and other members of the multi-disciplinary cardiology team from both Taunton and Somerset Hospital Trust and Yeovil District Hospital Foundation Trust. These presentations were followed by interviews resulting in the two part-time posts at Musgrove Park Hospital being successfully filled by Janice Bailey and Jackie Kemp, both of whom are already working within the cardiology department at Taunton. These nurses will commence their new posts in January 2007 and will be attending a two day British Heart Foundation study day in London at the end of January to introduce them to the principles of working for the British Heart Foundation.

Unfortunately, Yeovil District Hospital Foundation NHS Trust was unable to appoint to its part-time post at this time. Since then the Trust has enhanced the post to 30 hours per week and four candidates will be interviewed at Yeovil on Friday 22 December 2006 following presentations entitled "Utilising Collaborative Working in Setting up the Yeovil Part of the Cross-County Arrhythmia Service". It is hoped that the person appointed at this interview will be able to join cross-county colleagues at the British Heart Foundation study day at the end of January 2007.



Ashley Davidson, Senior Cardiology Nurse, Yeovil District Hospital NHS Foundation Trust
tel: 01935 475122
e mail: ashley.davidson@ydh.nhs.uk

UPDATE ON INTER-HOSPITAL TRANSFERS

The second national audit of cardiac inter-hospital transfers, conducted in October 2005, showed that measurable reductions in waiting times and improvements in the quality of care had been achieved. However, cardiac patients in Dorset and Somerset still experienced some of the longest waits for inter-hospital transfer in the country.

Project teams in both Dorset and Somerset have made significant progress in improving inter-hospital transfers. Much of this work is focused on making quality improvements 'in house'- for example, by streamlining the management of patients with acute coronary syndromes. In addition, the Cardiac Referrals Co-ordinators- in four out of five hospitals across the patch- are working alongside other front line staff to co-ordinate the patient journey every step of the way from admission through to transfer or treatment.

Patients and staff within the local health community are also working closely with the neighbouring tertiary centres (Bristol Royal Infirmary and Southampton General Hospital) to drive down inpatient waits and improve care for patients requiring urgent revascularisation.

As a result of a concerted effort by the Trust to tackle the issue, waiting times for urgent inpatients requiring cardiac surgery at Bristol fell from well over five weeks before the summer, to approximately two weeks by August. A similar collaborative approach at Southampton General Hospital has resulted in the development of an auditable 'Standard' for the referral of non-elective cardiac surgery patients. Amongst other important elements, the 'Standard' specifies what the

Trust will deliver in terms of communication regarding the status of the Whiteboard and the position of patients on it, a minimum time (one working day) for the surgeon to review referral documentation, and mechanisms for discussing/assessing complex cases with cardiology colleagues. In return, the Standard stipulates that referring hospitals will be expected to ensure that patients are fully 'worked up', and that the correct referral documentation is fully completed and sent on the same day as the diagnostic angiogram and /or echo.

Project teams in both Dorset and Somerset have made significant progress in improving inter-hospital transfers

December will see the long-awaited 'go live' date for the electronic transfer of angiograms to Southampton across the NHS N3 Network via the Medcon cardiology system. It is anticipated that the new system will be simpler, cheaper and quicker than producing and sending angiogram CDs.

Although we are still a long way from achieving the recommended 72 hours from admission to treatment for acute coronary syndromes and seven days for patients requiring cardiac surgery, the collaborative approach adopted by teams across the Network is certainly paying off for both patients and staff.



***Mel Varvel, Senior Service Improvement manager, Dorset and Somerset Cardiac Network
tel: 01202 8506321 e-mail: mel.varvel@ferndown.nhs.uk***

SOMERSET PCT BHF HEART FAILURE SPECIALIST NURSE SERVICE

Following the British Heart Foundation funding, the Somerset Heart Failure team is now established. The team comprises Mel Billison, Karen Bird, Kate Douglas, and Carley Huish.

The aim of the service is to improve the management of patients with chronic heart failure, to reduce unnecessary hospital readmissions, length of stay, improve quality of life and provide seamless care between primary and secondary care. The first few months of the team coming to post will be spent looking at service development, care needs and networking with all key members of the multi-disciplinary team. During this time we will be developing protocols, referral criteria and care pathways in consultation with primary and secondary care. In order to provide a seamless journey for the heart failure patients we intend to make contact with GP surgeries and community staff to explore ways of achieving a community-based patient focused service.

The team very much look forward to meeting with primary and secondary healthcare staff and working closely with them



Kate Douglas, Mel Billison, Karen Bird, and Carley Huish

**Mel Billison,
BHF Lead Heart Failure Specialist Nurse, Somerset PCT.
e-mail: melanie.billison@somcoastpct.nhs.uk**

PRIMARY CORONARY ANGIOPLASTY AT THE ROYAL BOURNEMOUTH HOSPITAL

A Primary Percutaneous Coronary Intervention (PCI) programme commenced on 1 April 2006 at the Royal Bournemouth Hospital (RBH). Prior to this programme patients with ST elevation myocardial infarction (STEMI) were initially thrombolysed and then, prior to discharge, had an angiogram followed by an angioplasty procedure at around day 7-10. With the new programme patients suffering a STEMI are brought straight to the cardiac catheter lab by the ambulance crew for an emergency primary PCI.

The programme was set up in consultation with the Dorset Ambulance service at the time and in the first seven months we have performed 45 Primary PCIs (55% of all STEMIs presenting to the RBH). The age range of the patients treated with Primary PCI has been between 32-88 years and the average Door to Balloon time has been 45 minutes (range 8-113 minutes). The procedural success rate has been 98%.

Clinical trial data has clearly demonstrated that by using this strategy of primary PCI it is possible to reduce the overall mortality rate from ST elevation myocardial infarction significantly. In addition to that there is also a reduction in the rates of re-infarction, stroke and bleeding complications with PCI as compared to thrombolysis. We have demonstrated an improvement in the outcome of patients and have saved on both the cost of thrombolysis as well as the risks from thrombolysis. We have significantly reduced in-hospital stay by around 5-7 days

as patients undergoing a primary angioplasty are now discharged home within 48-72 hours.

The European Society of Cardiology PCI guidelines, published in 2005, state that Primary PCI should be the treatment of choice for patients with STEMI if the patients present to a hospital with a PCI facility. They emphasize the importance of short response times (door to balloon times). Data has also shown that the results from Primary PCI are best if a high volume operator in a high volume PCI centre performs the procedure (Such as at the RBH). If patients are thrombolysed, it should not be considered to be the final treatment. Even after successful thrombolysis, coronary angiography within 24 hours and PCI, if applicable, should be considered according to the ESC guidelines.

The service is currently only a limited weekday service to treat Bournemouth patients however we have now had discussions with our cardiology colleagues at Poole Hospital and the plan is to roll out the programme to Poole patients from 2007.



Suneel Talwar
Consultant Interventional Cardiologist & Clinical lead for Percutaneous Coronary Intervention, Royal Bournemouth Hospital
tel: 01202 303626 e-mail: suneel.talwar@rbch.nhs.uk

SOUTHAMPTON EXPANDS ITS CARDIAC FACILITIES

As part of the major capital scheme to expand cardiac facilities, as announced by the Secretary of State in November 2001, four new catheter laboratories and two additional cardiac surgery intensive care beds opened at Southampton General Hospital in late summer 2006, this will be followed by two more additional intensive care beds in January 2007. Further improvements to surgical beds and theatres will take place during 2007, along with redesign work to make the best use of the capacity.

Liz Ward, Care Group Manager for the Cardiothoracic Care Group, said "The new facilities will help towards our goal of meeting National Access times. The main limiting factor for surgery has been the intensive care beds so having four extra will make a huge difference. We are working internally on reconfiguring wards, refurbishing theatres and redesigning the patient pathway. Our goal is to take all the surgical patients from our catchment, including Dorset, so that they don't have to travel to London. We are committed to reducing waiting times for Dorset non-elective patients to seven days and we are talking with Dorset commissioners about how we can achieve this. Any patient that wants to choose to come to Southampton will be seen within national waiting times."

UPDATE ON THE REGIONAL ADULT CARDIOTHORACIC CENTRE AT BRISTOL

Planning permission has now been granted subject to the usual reserved matters relating to landscaping details. Legal agreements have also been signed and agreed with Bristol City Council regarding traffic and transport undertakings, such as additional bus stops and a Trust commitment to a Green Travel Plan.

The Full Business Case has now been formally approved by the Department of Health. Works on the ground are progressing with the first section of piled foundations well underway and the contractors now have one of the biggest cranes in Bristol circling above their site.