Arrhythmia Care in the DGH – What Still Needs to be Done?

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LOTS!!!

- This presentation confines itself to the situation in the North West.
- The views expressed are my personal views.
- Relationship with Primary and Tertiary Care not forgotten but in view remit of title and time limit of presentation limited discussion only.
- Apologies in advance if there is significant repetition of themes from previous presentations!
Arrhythmia Care in the DGH

- NSF Chapter 8 Quality Requirements excellent
  - Are they being implemented?
- NICE guidance
  - is it being fully implemented?
- Large inequalities geographically in all aspects of care
  - What’s being done about this?
Quality Requirement 1: Patient Support

- People with arrhythmias receive a formal assessment of their support needs and those at significantly increased risk of anxiety, depression or a poor quality of life receive appropriate care.

- People with long-term conditions receive support in managing their illness from a named arrhythmia care co-ordinator.

- Good quality, timely information about arrhythmic conditions is given by appropriately trained staff.
Quality Requirement 1: Patient Support

- People with arrhythmias receive a formal assessment of their support needs and those at significantly increased risk of anxiety, depression or a poor quality of life receive appropriate care.
  - Care tends to be focussed on those patients having interventions (eg ICD etc.) and mainly through tertiary centres
  - Little or no formal support for other groups
Quality Requirement 1: Patient Support

- People with long-term conditions receive support in managing their illness from a named arrhythmia care co-ordinator.
- These posts are currently virtually non-existant in the DGH setting apart from BHF funded nurses on a network level.
Quality Requirement 1: Patient Support

- Good quality, timely information about arrhythmic conditions is given by appropriately trained staff.
  - If patients seen by a Cardiologist or who enter Cardiac Rehabilitation post MI/Revascularisation, then usually appropriate information given
  - Patients not seen by a Cardiologist receive very variable information
Quality Requirement 2: Diagnosis and Treatment

- guidance on making the initial diagnosis and on management by readily accessible approved algorithms;
- improving access to a higher level of expertise by development of rapid access multidisciplinary arrhythmia and/or blackouts clinics;
- focused education of key carers;
- improving access to diagnostics at all stages;
- improving acquisition, storage and availability of clinical information such as ECGs and audit of all interventions.
Quality Requirement 2: Diagnosis and Treatment

- guidance on making the initial diagnosis and on management by readily accessible approved algorithms

- Work on clinical pathways being done on a national and network level but implementation slow
Quality Requirement 2: Diagnosis and Treatment

- improving access to a higher level of expertise by development of rapid access multidisciplinary arrhythmia and/or blackouts clinics
  - Very few specialised clinics being set up in DGH’s, apart from in atrial fibrillation care with Care of the Elderly physicians
  - At present most cases seen in General Cardiology clinics
Quality Requirement 2: Diagnosis and Treatment

- focused education of key carers
  - Again predominantly successful around patients needing interventions or in the post MI/revascularisation patients entering cardiac rehabilitation
  - Other groups still not well served
Quality Requirement 2: Diagnosis and Treatment

- Improving access to diagnostics at all stages
  - As part of 18 week strategy improvement in diagnostics has been targeted by all healthcare organisations
  - Specific diagnostic interventions such as implantable loop recorders etc still problematic re DGH funding.
Quality Requirement 2: Diagnosis and Treatment

Markers of Good Practice

- All patients receive a hard copy of the ECG documenting their arrhythmia and a copy is placed in their records.
  - Being done variably unless patient seen in Cardiology clinics and even then accurate data not available

- Patients who survive out-of-hospital cardiac arrest and patients presenting with pre-excited atrial fibrillation are assessed by a heart rhythm specialist prior to hospital discharge.
  - Most patients are being referred but accurate data not available
Quality Requirement 2: Diagnosis and Treatment

- **Markers of Good Practice**
- The following patients are assessed urgently by a heart rhythm specialist:
  - Patients with syncope or any other symptom(s) suggestive of an arrhythmia and a personal history of structural heart disease or a family history of premature sudden death
  - Patients with recurrent syncope associated with palpitations
  - Patients with syncope and pre-excitations – if recognised
  - Patients with documented 3rd degree AV block (not associated with acute MI)
  - Patients with recurrent syncope in whom a life-threatening cause has not been excluded
  - Patients with documented ventricular tachycardia
The following patients are referred to a heart rhythm specialist:
☑ Patients with a presumed diagnosis of ventricular tachycardia
☑ Patients with Wolff-Parkinson-White (WPW) syndrome or asymptomatic pre-excitation
☑ Patients with symptomatic regular recurrent supraventricular tachycardia which is unsuccessfully treated with one type of medication or who would prefer not to take long-term medication
☑ Patients with recurrent atrial flutter
☑ Patients with symptomatic atrial fibrillation despite optimal medical therapy
☒ First degree relatives of victims of sudden cardiac death who died below the age of 40 years
☒ Patients with recurrent unexplained falls
Quality Requirement 2: Diagnosis and Treatment

- Markers of Good Practice – Ongoing Treatment

- Mechanisms are in place for urgent referral of patients with sustained or compromising arrhythmias for prioritisation of appropriate treatment.
- ICDs are considered in patients presenting with life-threatening ventricular arrhythmias and in those without demonstrable arrhythmia but identified as being at high risk.
- Catheter ablation is considered as the treatment of choice in patients presenting with sustained supraventricular tachycardia (SVT) other than atrial fibrillation, and cardioversion of recent onset atrial fibrillation (AF) is considered as early as is clinically safe.
- Where further hospital treatment is not recommended, a care plan is agreed between the patient, GP and the arrhythmia care team, including follow up and support as required.
Quality Requirement 3: Sudden Cardiac Death

- When sudden cardiac death occurs, NHS services have systems in place to identify family members at risk and provide personally tailored, sensitive and expert support, diagnosis, treatment, information and advice to close relatives.
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Quality Requirement 3: Sudden Cardiac Death

- Individuals who experience episodes of sustained palpitation and/or unexplained impaired consciousness, particularly if repeated or triggered by exercise, have rapid access to cardiac evaluation, including 12-lead and continuous ECG monitoring and 2D echocardiography.
- Suitable bereavement services are available for those who have lost a family member.
- An expert post mortem is carried out and appropriate tissue retained if informed consent is given.
- Evaluation of families who may have inherited cardiac disease takes place in a dedicated clinic, with staff who are trained in diagnosis, management and support for these families. Genetic counselling and further testing is available if appropriate.
Cardiac Pacing and Devices

- Still low levels of implantation of standard bradycardia devices (pacemakers) let alone advanced devices (eg ICD’s)
- Large inequalities in provision
The Challenges

- Everything seems to move at glacial pace!
- Frustration.
- Large numbers of items to address
- Inadequate numbers of trained staff
- No targeted resource
  - Competing for resources with many other worthy causes
- “Fragmentation” / “Competition” between providers vs Collaborative / Network planning
- Inequalities
  - geographical, socio-economic, ethnic etc.
The Drivers for Change

- 18 weeks
- NICE
  - Ensure audit of NICE approved guidance and target delivery (eg ICD’s, Atrial Fibrillation, Heart Failure etc).
  - Engage with PCTs on delivery of current NICE approved guidance in a planned/structured fashion.
Education
- Healthcare staff

Education
- PCTs/Acute Trusts

Education
- Population including existing patient support groups for IHD.
“Networking”

- Use Cardiac Networks to prioritise the order of competing priorities.
- Develop complete pathways of care that can be put forward for funding.
- Action likely to be quicker if chapter 8 priorities become Healthcare Commission priorities.