Cardiac & Stroke Networks LANCASHIRE & CUMBRIA

NHS

Cardiac and Stroke Networks in Lancashire & Cumbria

CARDIAC CLINICAL ADVISORY GROUP
MINUTES OF THE MEETING HELD ON 6 APRIL 2011

Present: Kathy Blacker, Adrian Brodison, Lauren Butler, Scott Gall, Emily Ho, Somnath Kumar, John McDonald, Alison Seed & Jennifer Watts

Apologies: Grahame Goode, David Roberts & Gus Tang

1. Apologies for absence

Noted as above.

2. Minutes of previous meeting

The Minutes of the previous meeting were agreed as an accurate record. Kathy Blacker (KB) apologies for the issues raised after the first circulation of the last Minutes.

3. Matters arising/updates

- **Trust updates**

  University Hospitals of Morecambe Bay NHS Foundation Trust

  Adrian Brodison (AB) advised that Peter Clarkson had now left, they did have two locums but one has now left. They are hoping to advertise for 2 – 3 colleagues in the near future. KB advised that she had recently met with an Australian Cardiologist who was visiting the UK re rural networks. He had mentioned that there were a lot of English trainees who could not get jobs in the UK; AB suggested that they would be in Australia to undertake additional training programmes and added that there may be people in the south unable to get jobs but it is proving difficult to tempt them north. Som Kumar (SK) asked if it would be helpful to have a joint appointment at other centres; AB advised that they will advertise for sub-specialty interests.

- **ACS Protocol**

  Following discussions at the last meeting, KB asked AB if he would be willing to be involved in the work required on the review of the ACS Protocol, AB agreed.

- **Definition of MI**

  Assays were discussed and it was agreed that Ranjit More should be requested for a position statement due to the differences across the Network. **Action: Network to request position statement from Ranjit More.** AB also requested that the Pathology Network should advise what is being done. **Action: Lauren Butler to contact Pathology Network**

4. IHT Demonstration

Lauren Butler (LB) outlined the system, advising that discussions had been held with Debbie Kilshaw, Ranjit More and Scott Gall regarding the required fields; different pathways have now been added, including EP/devices. She advised that mandatory fields on the new system will have to be completed before a referral can be made.

Peter Osborne (PO) presented the new system.

AB asked about the GRACE score as there are four readings. **Action: Note to be added requesting in hospital death >3% reading**
PPCI pathway. **Action: Remove from list of pathways**
Electrophysiology & devices pathway. **Action: list alphabetically – reduce the number of fields and include free text boxes against symptoms, procedures and arrhythmia type**
Heart Failure as a symptom. **Action: Remove from the list – not a symptom**

Ravi Singh (RS) advised that there are issues re surgical patients waiting in cardiology beds; KB suggested that the new system could be used as an audit tool to monitor how long patients are waiting. RS suggested it will only be effective if someone takes responsibility for the referrals and it was suggested that the surgical coordinator should flag patients who are waiting over a specified length of time. RS was happy to use the system; the East Lancashire Consultants are using the existing system. Alison Seed (AS) suggested that delays are sometimes due to lack of information so the new system could help the coordinator to be more efficient.

Overall the group were happy with the new system.

Jennifer Watts (JW) advised that when the system was first put out to tender the system included the facility for East Lancashire to refer to their own lab and asked if this facility was still required. RS and John McDonald (JMcD) did not think they would use this facility as theirs is not such a large centre. It was agreed that, if no further payment is required, it will be left dormant but if a further payment is required it will not be included.

SK asked whether there will be a pilot period for the new system; JW advised that there will be a testing phase; AS was keen to avoid any unnecessary delays; Scott Gall (SG) advised that the Network needs to be able to change the system as required as it starts to be used. SK asked how details of the new system would be communicated at 'grass roots' level; LB advised that the Bristol team will arrange training/train the trainer, which will be discussed at the Operational Steering Group meeting. PO advised that the Bristol team will also be providing a support mechanism. He also advised that they are hoping to rollout some time in May 2011.

5. PPCI update

JW advised that Blackpool are planning to roll out PPCI at the beginning of June 2011.

Prasugrel – LB advised that one of the protocols being developed is looking at the use of Prasugrel, which will impact on Primary Care and the PCT Medicines Management teams and she had received a request from NHS Cumbria who were seeing patients discharged from the North East on Prasugrel. LB advised that she has sent a copy of the protocol, NICE guidance and costings for PPCI patients to be on Prasugrel for 12 months, counter-balanced against the extra lives saved; the issue is to be discussed at the Collaborative Medicines Management meeting on 12 April 2011. LB is linking in with PCT pharmacy leads.

JW advised that a launch event is planned on 20 May 2011 for GPs/councillors etc; to be opened by Aidan Kehoe with presentations by Ranjit More and NWAS but there is no further information as yet; she added that the Network has agreed to fund the event, with support from the Communications Teams at Blackpool Teaching Hospitals and NHS East Lancashire. She also advised that the plan would then be to hold a public event within each health economy. SK advised that he would like to be involved in the event and suggested that there needs to be a clear plan when going into the different areas and the Cardiologists need to be involved in those meetings. RS advised that he would not be available on 20 May and was concerned that he had not been advised of the live date prior to this meeting.

JW advised that NHS East Lancashire are leading on the communications for PPCI. She added that the Gujerati Centre in Preston had been provisionally booked for the launch event; events will then need to be organised in each community to target local groups.

AB was concerned about the timing as they will have to ensure that there is time to educate trust staff, for example, patients being transferred from the Emergency Department. JW advised that there will be a Communications Plan put in place. SK voiced his concern about holding the event at the Gujerati Centre as it may alienate groups in the community and suggested holding the events at Town Halls in each area.

KB reported that, at the last meeting, there were concerns raised regarding the decision to adopt the Treat and Discharge model for PPCI and the Network had sent a letter to the Specialised Commissioning Team. A response has been received from Claire Jones from the Specialised Commissioning Team, which is circulated with these Minutes.

6. EP

KB reported that, at the last meeting, there was concerns about EP services and the links with Wythenshawe; she outlined the Network position that, where possible, all activity should remain within the Network. She added that the Specialised Commissioning Team had been in dialogue with Central Lancashire, who were not aware of the set up with Wythenshawe and Central Lancashire have been asked for a position on that. JW reiterated that the Network position within the Cardiac Strategy is to keep services within the Network. SK agreed that he will be standing by that position but there were concerns that Lancashire Teaching Hospitals already have a clinic provided by Wythenshawe so there would need to be a transitional arrangement.

Scott Gall (SG) advised that he does know the people at Wythenshawe and agreed that they provide a good service and, until recently, there was no service at Blackpool. He added that Blackpool can now provide all the services that Wythenshawe offer and is open to see what other services the local trusts want Blackpool to provide; he would be more than happy for people to visit Blackpool/attend for training and advised that there will be some regular training days at Blackpool. In terms of providing a service, he advised that he wanted to know what services were required and will hopefully provide a good and efficient service. KB suggested that SG and his Business Manager should visit each Trust; SG advised that he has had discussions with Ranjit More re visiting the Trusts as they want to provide a good service with minimal disruption; some patients may choose Wythenshawe but Blackpool want to provide a service and give patient choice to provide a comprehensive service that has not been available previously. He added that a new colleague will be starting in post in May 2011.

AB advised that he was concerned about overwhelming SG; SG advised that, for inpatients, they can facilitate early transfers. RS advised that they have developed relationships with Wythenshawe and Central Manchester, which provide a fantastic service; he suggested that it is up to Blackpool to provide evidence that an equivalent service is available.

AS asked about referrals for devices as she was receiving 2 – 3 referrals per week before she went on Maternity leave; she asked whether the referrals were following the EP referrals. She advised that she felt, of all the centres, East Lancashire had selected their patients well; she added that Blackpool could compete well with the service at Wythenshawe and asked CCAG to think again about referring to Blackpool. JMcD commented that it is a competitive market; AS agreed and advised that they are looking to be able to compete. SG added that Blackpool want to provide as good a service to give patients choice.

7. Cardiac Strategy

JW reported that a paper had been taken to the Collaborative Working Board (CWB) (attended by PCT Chief Executives), including updates re Primary PCI, PCI at East Lancashire and the Heart Failure Project. The CWB asked for the Strategy to be refreshed and JW advised that it is currently being updated.

8. TAVI

KB advised that, since the last meeting, a letter has been circulated from the Specialised Commissioning Team confirming that they have now agreed to commission TAVI, with a minimum of 30 procedures at each of the four Tertiary Centres in the north west (equating to 18 TAVIs per 1M population), an upper limit has been imposed of 35 per centre per year. RS asked how many that would be per health economy as he was keen that each health economy had an equal share per population size. KB advised that the letter indicated that they will manage those patients who have already been told they are suitable for the procedure first. RS suggested that the 'gatekeepers' should be those providing the service, he added that Blackpool have a very robust process. KB will ask Blackpool to advise re the selection criteria. **Action: KB to circulate the criteria.** AS suggested that 35 is not an unreasonable number. KB advised that a meeting is being planned with the centres re the 35 procedures done in months 1 and 2; they need to understand how the work will progress throughout the rest of the year.

SK requested a guideline outlining where patients should be referred in the first instance, for surgery or TAVI, and what tests should be undertaken; he suggested that David Roberts could develop a protocol but KB advised that the process has to be the same across the north west and more work is to be undertaken.

9. MDT

KB advised that Lancashire Teaching Hospitals are having the kit installed so will be able to be involved in MDTs; all sites will then have the kit. RS commented that it is a great system and has improved the service; KB asked him for a quote to include in a newsletter re video conferencing for MDT. JW added that she had spoken to Rita Briggs, who had advised that there is a tariff for MDT; RS advised that it is included in their job plans to set aside one hour for MDT.

RS advised that the system is well set up, with an email received same day; they are allocated one hour, he added that Blackpool need to ensure that there is an interventional cardiologist and a surgeon available; they now rely on MDT and tell patients that they are going to discuss them with colleagues. **Action: KB to contact RS for quotes**

AB advised that he has not had such a good experience with MDT as he is not an interventional cardiologist, he needs the involvement of an interventional cardiologist and a surgeon at Blackpool so they are still having difficulties getting a true MDT for interventional cases, he has not been listing patients because they cannot guarantee the MDT will happen. AS advised that she would raise the issue at the Trust Divisional Board meeting; KB will raise at the Operational Steering Group. **Action: AS to raise at Trust Divisional Board/KB to raise at Operational Steering Group.** RS asked whether the interventional cardiologists are timetabled for MDT; AS advised that, with PPCI, job plans are being changed to have a cardiologist on call, which will include involvement in MDTs.

10. ACS Protocol

SK advised that the ACS Protocol needs to be changed. He will contact Jonas Eichhofer about including Prasugrel; he asked if there would be much to change apart from the drugs. AB suggested that the Protocol is restrictive as regards ETT and needs to be updated; he added that they have deferred updating the local protocol until the Network Protocol has been updated so he was keen for it to progress; he confirmed that he was happy to be involved in updating the document; RS also agreed to be involved in email discussions.

11. Chest Pain Guidelines in Primary Care

SK advised that a question had been raised by a GP regarding training for receptionists and had sent the Essex Network Guidelines as an example; he asked whether these should be adopted. After some discussion it was agreed that BHF guidance should be used. **Action: Network to distribute BHF publications**

12. North Cumbria update

JW advised that North Cumbria have appointed one interventional cardiologist who is to start in June 2011; there are four further posts and interviews are being held in May. They plan to start PCI in September 2011; they have one lab and are looking into a portable lab; she added that the Network has offered to help with pathways/clinics etc; the pathways have not yet been defined. She also advised that they hope to move to PPCI within 18 months. RS asked whether they have trained cath lab staff; JW advised that staff are being sent to Newcastle for training but they will also be recruiting. RS thought the timescales were unrealistic because, from the date of appointment at East Lancashire, it had taken 2 ½ - 3 years to get accredited. They were accredited in June 2010 and had met all the people involved in the accreditation before their first PCI case. AS commented that Carlisle is an unusual prospect; JMcD added that there is insufficient population and workforce unless they take from South Cumbria.

AB advised that there will be an issue on MDT if sending PCIs to Carlisle because there is no surgical consultant there; he added that there are issues that require local discussions. JW confirmed that NHS Cumbria had indicated that the South Cumbria patients should still go to Blackpool for surgery. KB suggested asking the North Cumbria Consultants to be involved with CCAG.

13. Any Other Business

SK raised the issue around chest pain and the pressure from local networks to move away from ETT in RACPCs. RS advised that they do not have access to CT Imaging at East Lancashire; he added that they had undertaken a large audit of 600 – 700 patients and the outcome data stands up and the service would stand up to the criteria; he highlighted that it is NICE **guidance**. He also advised that the imaging lead is busy doing other things. SK advised that Manchester have changed their stance and no longer do ETT.

Emily Ho (EH) advised that a lot of hospitals are going with the change but it depends on capacity; common sense has to rule. If intermediate risk with normal ECG and can exercise it provide a lot of information. LB added that not everyone has stress echo. AB suggested that NICE have over-stressed the issue as it depends who is interpreting the tests. AS asked whether CCAG needed to make a statement but KB advised that there is no pressure to change locally because they know there is no imaging capacity. SK advised that they are receiving pressure from their Trust Medical Director and asked about issuing a position statement that clinicians still value ETT when conducted with care by people with the right experience, which can be taken back to the Trusts. KB agreed that the CCAG should look at developing a position statement; AS suggested that the East Lancashire audit would be useful; RS agreed to ask Dr Balachandran for permission to use the data; SK suggested applying the East Lancashire criteria to local populations. **Action: Network to develop position statement/RS to seek Dr Balachandran's permission to use audit**

LB thanked the group for comments received in response to her email re Omacor Guidelines. She advised that she has been contacted concerning the role of nicotinic acid in general and tredaptive in particular. SK suggested the response should be that 'it is not currently in the formulary'. AB did suggest that the evidence is good, particularly in the US and thought that there is some place for it. JMcD suggested looking at the HBS Thrive Study.

14. Date and time of next meeting

13 July 2011 at 6.00 pm, Room 179, Preston Business Centre.