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Welsh Health Specialised Services Committee (WHSSC)

Specialised Services
Service Specification: CP197b

Electrophysiology and Ablation Services (16 years and older)

January 2021

Version 1.0

PARCH - RESPECT

PARTNERIAETH - PARTNERSHIP

GWELLA AC ARLOESI - IMPROVEMENT & INNOVATION

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Description	NHS Wales routinely commission this specialised service in accordance with the criteria described in this document
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Contents

Statement

Welsh Health Specialised Services Committee (WHSSC) commission Electrophysiology and Ablation services for people aged 16 years and older with an abnormal heart rhythm in accordance with the criteria outlined in this specification.

In creating this document WHSSC has reviewed the requirements and standards of care that are expected to deliver this service.

Disclaimer

WHSSC assumes that healthcare professionals will use their clinical judgment, knowledge and expertise when deciding whether it is appropriate to apply this document.

This document may not be clinically appropriate for use in all situations and does not override the responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or their carer or guardian.

WHSSC disclaims any responsibility for damages arising out of the use or non-use of this document.

1. Introduction

This document has been developed as the Service Specification for the planning and delivery of Electrophysiology and Ablation services for people aged 16 years and older with an abnormal heart rhythm resident in Wales. This service will only be commissioned by the Welsh Health Specialised Services Committee (WHSSC) and applies to residents of all seven Health Boards in Wales.

1.1. Background

Electrophysiology studies (EP) and ablations are usually performed for symptomatic fast heart beats (rhythms). Electrophysiological (EP) study is a test which looks at a patient's heart electrical activity in more detail. It is used to diagnose and treat a wide variety of abnormal heart rhythms. It allows the specialist to diagnose the precise problem and judge where to perform ablation.

Many arrhythmias (abnormal heart rhythm disorders) can be cured by catheter ablation, in which steerable thin electrodes (catheters) are threaded along vessels and guided into the relevant locations within the heart. Ablation is then performed, creating a scar most commonly by heating the tissue using an electrical current (radiofrequency ablation – RFA), but sometimes by using freezing (cryoablation) or other energy source. Ablation procedures are carried out in people that have non-permanent atrial fibrillation when medicines are not working or tolerated. Catheter ablation is an ablation procedure that is carried out under sedation or a general anaesthetic.

1.1.1 Types of Tachycardia

Supraventricular tachycardia (SVT)

Supraventricular tachycardia (SVT) is as an abnormal fast heartbeat. It is a general term that includes many forms of heart rhythms problems (heart arrhythmias). Typical symptoms are a sudden onset of a rapid heartbeat (generally 150-200/min) with or without dizziness, shortness of breath, chest pain or transient loss of consciousness. Wolff-Parkinson-White (WPW) syndrome is a serious form of SVT and patients diagnosed with this condition require urgent assessment by a heart rhythm specialist and are usually treated by an ablation strategy. Atrioventricular node (AV node) dependent tachycardias are usually adenosine sensitive and patients with recurrent adenosine sensitive tachycardias should be considered for ablation. Focal atrial tachycardia is usually treated medically but symptomatic patients who have failed one antiarrhythmic drug should be considered for an ablation strategy.

Atrial fibrillation (AF)

Atrial fibrillation (AF) is an irregularly irregular heart rhythm that starts in the heart's upper chambers (atria). It is the most common form of cardiac arrhythmia (abnormal heart beat). In most cases patients experience palpitations, breathlessness, tiredness, light-headedness or a feeling of the heart beating rapidly (known as palpitations). Sometimes patients do not feel these symptoms and are unaware that they have AF. Individuals can experience AF continuously or in periodic attacks lasting hours or days. AF significantly increases the risk of a stroke. AF related strokes are more disabling and can prove fatal, more so than any other type of stroke. AF can also cause heart failure in some people if their heart rate remains too fast for a long time (tachycardia-induced cardiomyopathy).

People with AF can be offered a range of medicines, known as anti-arrhythmic drugs, either to try to restore and maintain sinus rhythm (rhythm control strategy) or to slow the heart rate down (rate control strategy). These medicines may not always be successful or tolerated by people. In such cases, catheter ablation can be considered[1]

Atrial flutter

Atrial flutter has a characteristic "saw-tooth" pattern on an ECG. Patients can have Atrial Flutter only or frequently can have both atrial flutter and atrial fibrillation. Atrial flutter is difficult to treat with medication and with high levels of ablation success, ablation is recommended for any individual with recurrent atrial flutter or a high likelihood of recurrence after a first clinical event.

Ventricular Tachycardia/Ventricular Arrhythmia

Ventricular Tachycardia in contrast to most supraventricular arrhythmia, Ventricular Arrhythmia (ventricular tachycardia – VT, and ventricular fibrillation – VF) are serious and life threatening. These arrhythmias are most common in scarred ventricles. Prior myocardial infarction is the commonest cause of scarring but other condition such as dilated cardiomyopathy, etc can result in scar tissue. Normal heart VT which is not life-threatening can also occur in young individuals with apparently normal hearts. Patients who experience ventricular arrhythmia or who are at risk of ventricular arrhythmia require careful expert clinical assessment by a Heart Rhythm Specialist. Patients require treatment of their underlying heart condition and risk stratification for the development of future life-threatening arrhythmia. Patients at high risk of these arrhythmia usually require an implantable cardioverter defibrillator (ICD).

Ablation therapy is used increasingly in the management of patients with ventricular arrhythmia though its use remains less frequent than in patients

[1] NICE Guidance 2014: Atrial Fibrillation Management. Clinical Guidance 180. https://www.nice.org/guidance/CG180

with SVT. Ablation may be used as the primary treatment for VT (usually patients with a normal or near normal heart) but in patients with structural heart disease it is usually adjunctive therapy to an ICD. Patients who experience ICD shocks (VT storm) due to recurrent VT suffer higher morbidity and mortality and VT ablation is recommended in this group (European Society of Cardiology/American Heart Association Class 1 recommendation).

Grown-up Congenital Heart Disease Arrhythmias (GUCH)

GUCH patients are a heterogeneous cohort of individuals. Arrhythmia problems in this patient population may include arrhythmias seen and managed in non GUCH patients and which are suitable for ablation in their local heart rhythm centre. Patients may be high risk either due to their arrhythmia, cardiac anatomy or cardio-respiratory status and are better managed in a quaternary centre. Select GUCH patients can be treated in their local ablation centre but usually in collaboration with their GUCH consultant and if necessary after MDT discussion at the quaternary centre.

1.1.2 Types of Ablation

Standard ablation

Standard ablation uses a multi-channel recorder and point to point mapping via an ablation electrode. This technique is used to ablate WPW syndrome, AV node dependent tachycardia (AVNRT) or Atrioventricular reentrant tachycardia (AVRT) utilising a concealed accessory pathway), Atrial Flutter tricuspid isthmus ablation and to AV node ablation. Overall these procedures are performed with a success rate > 90%, a recurrence risk < 5% and a procedure complication rate of 3%-4%.

Pulmonary Vein isolation

Pulmonary vein isolation (PVI) is the mainstay of treatment for all atrial fibrillation patients. A significant proportion of AF patients only require PVI. This can be achieved either by using a 3D mapping system and performing wide atrial circumferential ablation using irrigated RF energy or by cryoablation using a cryoablation balloon. Approximately 2/3 AF ablations require PVI alone.

3D Mapping and Complex ablation

Complex ablation employs a computerised 3D mapping system to generate a computerised image of the chamber which is being targeted (e.g. Left atrium for AF or Left or right ventricle for ventricular tachycardia). Intracardia electrogram information is superimposed on the anatomical image (electro-anatomical mapping) and this data is used to decide how best to target RF energy delivery. Frequently this system is required to create linear lesions and create accurate lines of electrical block. This form of ablation is required for select persistent AF cases, regular atrial

tachycardias, non-isthmus dependent atrial flutter, normal heart VT and scar related VT.

The demand for atrial fibrillation ablation has increased significantly in the last 5 years largely due to increasing ablation success rates, shorter procedure times and decreasing complication rates. In contrast medical treatment for AF has changed little in the last 10 years with no significant medical or pharmacological advances. In 2020 AF ablation accounts for between ½ and ⅔ of all ablations in most large European centres.

Epidemiology

Atrial fibrillation (AF) is the most common cardiac arrhythmia. AF has an estimated prevalence of 3% in persons over 20 years old and approximately 1.4 million people in England have AF[2]. AF is much more common in the elderly. Compared to England and Scotland, Wales has the highest percentage of the population who are aged 65 or older (Office of National Statistics 2011 Census). Across Primary Care clusters in Wales the prevalence of AF varies from 1.3% to 2.1%[3]. Because AF is frequently asymptomatic it is difficult to identify, suggesting prevalence is under estimated.

The 2016/17 National Audit of Cardiac Rhythm management Devices and Ablation shows that approximately 9,000 ablations are performed for AF each year in England and Wales. This figure is growing by approximately 6% per year. Data comparing the UK with Western Europe show that the UK performs less than half the number of ablations per million population compared to these countries, therefore, it is anticipated that the growth in ablation procedures will continue.

The demand for the use of cardiac ablation has increased significantly over the past 10 years in the UK, in 2014 a total of 17,578 ablation procedures were performed[4].

Current Service

Due to the need for specialist equipment and facilities and the limited number of trained healthcare professionals (doctors and cardiac physiologists), Electrophysiology (EP) and ablation services are provided in tertiary cardiac centres and larger secondary care centres. There is some

[2] Adderley NJ, Ryan R, Nirantharakumar K, Marshall T. 2019. Prevalence and treatment of atrial fibrillation in the UK general practice from 2000 to 2016 Heart, 105:27-33.
[3] NHS Wales Cardiovascular Atlas of Variation: Produced by the Cardiovascular Atlas of Variation Sub groups on behalf of NHS Wales http://www.wcn.wales.nhs.uk/sitesplus/documents/1193/12959%20PHW%20Atlas%20report.pdf
[4] British Heart Rhythm Society: Standards for Interventional Electrophysiology Study and Catheter Ablation in Adults – February 2016 https://bhrs.com/wp-content/uploads/2019/03/160216-Standards-Interventional-electrophysiology-study.pdf

variation in ablation provision across the UK (see section 2.6 for service providers/ designated centres).

1.2. Aims and Objectives

The aim of this service specification is to define the commissioning position of WHSSC on the use of Electrophysiology and Ablation for people with a fast abnormal heart rhythm (i.e. supraventricular tachycardia, atrial flutter, atrial fibrillation and ventricular arrhythmias).

The objectives of this service specification are to:

- detail the specifications required to deliver Electrophysiology and Ablation services for people who are residents in Wales
- ensure standards of care are met for the use of Electrophysiology and Ablation services
- ensure commissioning for the use of Electrophysiology and Ablation services is evidence based
- ensure equitable access to Electrophysiology and Ablation services
- identify centres that are able to provide Electrophysiology and Ablation services for Welsh patients
- provide the infrastructure requirements to support safe and high quality care for patients
- ensure that procedures are performed by appropriately skilled operators in a suitably staffed and equipped environment
- provide timely diagnosis and appropriate specialised treatment to patients affected by symptomatic fast heart rhythms
- improve outcomes for people accessing Electrophysiology and Ablation services
- perform Electrophysiology and Ablation procedures with ongoing audit of performance.

1.3. Relationship with other documents

This document should be read in conjunction with the following documents:

- **NHS Wales**
  - All Wales Policy: Making Decisions in Individual Patient Funding requests (IPFR).

- **WHSSC policies and service specifications**
  - CP197a, Electrophysiology and Ablation Services (16 years and older). January 2021

- **National Institute of Health and Care Excellence (NICE) guidance**
    - Atrial fibrillation: management [CG180] Published June 2014, https://www.nice.org.uk/guidance/cg180

- **Relevant NHS England policies**
    - NHS Standard Contract for cardiology: electrophysiology and ablation services (adult)(2013) https://www.england.nhs.uk/wp-content/uploads/2013/06/a09-cardi-electrophysiology.pdf
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- **Other published documents**
    - British Heart Rhythm Society: Standards for Interventional Electrophysiology Study and Catheter Ablation in Adults – February 2016 https://bhrs.com/wp-content/uploads/2019/03/160216-Standards-Interventional-electrophysiology-study.pdf

2. Service Delivery

The Welsh Health Specialised Services Committee commission the Electrophysiology and Ablation Services for people aged 16 years and older with an abnormal heart rhythm in-line with the criteria identified in this specification.

2.1. Access Criteria

The service is for people aged 16 years and older[5] with an abnormal heart rhythm who require access to Electrophysiology and Ablation services, and meet the criteria for treatment as defined in WHSSC Commissioning policy for Electrophysiology and Ablation (16 years and older) CP197a (in Development).

2.2. Service description

EP and ablation services are mainly located in major Cardiology centres, and select 16-18 years older are treated in collaboration with paediatric cardiology services.

Cardiac imaging to assess cardiac structure and function is recommended prior to catheter ablation. Cardiac CT scan is frequently performed before catheter ablation of atrial fibrillation (AF) in order to clarify the anatomical variations that exist in the pulmonary veins, and anticipating potential difficulties during the procedure.

EP and ablation procedures are performed in a cardiac catheter laboratory which allows invasive monitoring of the patient and X-ray (fluoroscopic) imaging to allow catheter manipulation and placement. In addition specialist equipment is needed. The electrical signals from inside the heart are recorded on a specialised EP system. All major centres also have advanced navigation systems. This allows a map of the heart to be built using the electrical signals from inside the heart and allows the doctor to see the catheters without the use of an X-ray. These mapping systems greatly improve the ability to diagnose and treat more complicated heart racing problems with a higher degree of success.

In addition to the standards required within the Contract, specific quality standards and measures will be expected. The provider must also meet the standards as set out below.

[5] Select 16-18 year old are treated in collaboration with paediatric cardiology colleagues.

Facilities and equipment

Centres performing standard ablation

Centres performing standard catheter ablation procedures should have a minimum set of equipment to safely carry out these procedures. This includes:

- Wards with bedside monitoring equipment with effective alarm systems and capable of storing ECG data.
- Nursing staff experienced in care and management of cardiac arrhythmias.
- Facilities for haemodynamic monitoring in the ward and cardiac catheter laboratory.
- Facilities for cardiopulmonary resuscitation, temporary and permanent pacing.
- Pacemaker and implantable defibrillator programmers.
- Modern X-ray equipment capable of imaging with radiation doses comparable with the majority of X-ray systems currently used in the UK.
- Facilities for anaesthesia and assisted ventilation within the catheter laboratory.
- A digital electrophysiological recording system with at least 16 intracardiac channels and a programme stimulator.
- Radiofrequency generator systems capable of temperature control.
- Equipment for pericardiocentesis.
- A computerised database capable of submitting data to the Central Cardiac Audit Database (CCAD).
- Echocardiography.
- Bedside anticoagulation monitoring (e.g. Activated Clotting Time ACT).

Centres performing PVI

Centres performing PVI should have the minimum set of equipment to safely carry out standard ablation, and:

- Access to emergency cardiac surgery.
- Routine access to general anaesthesia as needed.

Centres performing complex ablation

Centres performing complex ablation should have access to emergency cardiothoracic surgery. Where not available on-site an agreed written protocol will be in place with the local cardiac surgical centre, and local

ambulance service, to provide emergency surgical cover. In addition, the time taken for a patient to undergo sternotomy should be of a similar order to that possible with on-site surgical facilities where a surgical team is not on stand-by.

Centres undertaking complex ablation should also have access to:

- Routine access to general anaesthesia
- 3D mapping and navigation systems
- facilities for cardiac catheterisation
- transoesophageal echocardiography
- access to MRI/CT scanning
- intensive therapy unit availability for planned high risk cases

Staffing

For complex ablation, the development of a multidisciplinary approach to patient selection, management and follow up is recommended. The MDT should include:

- Interventional cardiac electrophysiologists
- Imaging and heart failure specialists
- Physiologists
- Specialist arrhythmia nurses.

Specialist teams

The specialist team should include:

- A minimum of two active interventional cardiac electrophysiologists at each centre (one of whom should be British Heart Rhythm Society, European Heart Rhythm Association or International Board of Heart Rhythm Examiners certified or substantive consultant cardiologist(s) fully trained in cardiac ablation)
- A cardiologist who can perform cardiac ablation. However, this has to be in a centre where at least one other specialist accredited to perform complex ablation is practicing
- A cardiologist who will have completed appropriate training in standard catheter ablation and undertaken retraining as a consultant if ablation has not been performed for >12 months
    - all cardiologists performing catheter ablation will undertake appropriate CPD in catheter ablation
    - each cardiologist performing standard catheter ablation will perform >50 catheter ablations/year as first operator (performing complex ablation can be included in this number for those physicians performing both standard and complex ablation)

    - cardiologists performing catheter ablation will audit their procedures including their complication and share these in an anonymised form. If a cardiologist's complications were to exceed accepted limits practice will be reviewed and advice sought from within the centre or elsewhere
    - Cardiologists performing fewer than 100 catheter ablations/year will need to average their outcome figures over 2 or more years to account for random variation.
- At least two physiologists who are actively involved in catheter ablation at each centre:
    - each physiologist will have had appropriate training in assisting with catheter ablation and the use of the equipment required for catheter ablation and resuscitation
    - at least one physiologist should have current accreditation in catheter ablation and electrophysiology (BHRS, EHRA or IBHRE)
    - all physiologists will undertake appropriate continuing professional development in catheter ablation and resources made available for them to do so
    - each physiologist will be actively involved in >30 catheter ablations/year
- At least two specialist arrhythmia nurses at each centre
    - nurses will undertake appropriate CPD in heart rhythm management and resources made available for them to do so
    - where nurses are running outpatient clinics independently they will have the opportunity to meet with a consultant with a special interest in heart rhythm management at least once a fortnight to discuss cases and protocols
    - audit will be carried out on a regular basis

Follow up

- All patients who undergo catheter ablation should be followed up to allow audit of the outcomes of the ablation performed.
- Patients who have undergone ablation should be provided with a contact number at the ablating centre and advised to report symptoms occurring within the first six weeks following ablation.
- Some centres may choose to use remote follow up but time must be set aside to talk to patients (even by phone), examine their follow up data (Electrocardiogram (ECG)/Holter arranged locally) and log the outcome in a database.
- For ablation of atrial fibrillation where symptoms may not be an accurate marker of success, extended Holter monitoring or transtelephonic monitoring should be available for use in those

patients where asymptomatic AF may be important (e.g. asymptomatic AF associated with heart failure).

- Outcomes and complications should be recorded and reported to National Institute for Cardiovascular Outcomes Research (NICOR).

Clinical Standards

Providers must work to the following clinical and quality standards.

- National Institute of Health and Care Excellence (NICE) guidance Atrial Fibrillation: Management (CG180) Published June 2014, https://www.nice.org.uk/guidance/cg180

- British Heart Rhythm Society: Standards for Interventional Electrophysiology Study and Catheter Ablation in Adults. April 2020 https://www.bhrs.com/wp-content/uploads/2020/04/British-Heart-Rhythm-Society-Standards-Ablation-2020-1.pdf

- NHS Standard Contract for Cardiology: electrophysiology and ablation services (adults 2013) https://www.england.nhs.uk/wp-content/uploads/2013/06/a09-cardi-electrophysiology.pdf

2.3. Interdependencies with other services or providers

Close links are required with both Primary and secondary care to ensure appropriate referral for patients with symptomatic AF for ablation.

Co-located services

Complex ablation services invariably also provide complex device therapies. Heart Rhythm UK recommends that in general complex ablation services are co- localised with cardiac surgery services.

Access to invasive and interventional cardiology services is mandatory for centres undertaking VT ablations.

2.4. Acceptance Criteria

The service outlined in this specification is for patients ordinarily resident in Wales, or otherwise the commissioning responsibility of the NHS in Wales. This excludes patients who whilst resident in Wales, are registered with a GP practice in England, but includes patients resident in England who are registered with a GP Practice in Wales.

2.5. Patient Pathway

The patient groups served by EP and ablation services are diverse and there is currently no specific single pathway that patients will follow.

The majority of individuals with SVT and many with AF are of a working age leading active lifestyles in good health apart from their heart rhythm problem, which can often be cured by ablation.

Access to ablation services is from all areas:

- **Primary Care**: some primary care physicians, who are familiar with the benefits of ablation, refer directly to ablation services. Referrals are based on symptoms and/or concerns about possible life threatening heart rhythm problem.
- **Secondary Care:** the majority of ablation referrals come from secondary care. Most are seen as outpatients following assessment and treatment by a cardiologist in secondary care. Less commonly, referral is as an inpatient transfer when the symptoms are severe or the heart rhythm problem possibly life threatening.
- **Tertiary Care:** patients undergoing treatment by interventional cardiologists or cardiac surgeons may have heart rhythm problems and be referred for ablation.

2.6. Service Provider/Designated Centre

All electrophysiology and ablations should be performed in centres that meet or exceed the quality standards, including the requirements detailed in the WHSSC Commissioning Policy for Electrophysiology and Ablation (16 years and older) (CP197a) (In Development).

South Wales and South Powys

University Hospital of Wales
Heath Park Way
Cardiff
CF14 4XW

- Morriston Hospital
  Heol Maes Eglwys
  Cwmrhydyceirw,
  Swansea
  SA6 6NL

- Queen Elizabeth Hospital
  Birmingham
  Mindelsohn Way
  Edgebaston
  Birmingham
  B15 2TH

North Wales and Mid and North Powys

- Liverpool Heart and Chest Hospital
  Thomas Drive
  Liverpool
  L14 3PE

- Queen Elizabeth Hospital
  Birmingham
  Mindelsohn Way
  Edgebaston
  Birmingham
  B15 2TH

2.7. Exceptions

If the patient does not meet the criteria for treatment as outlined in this policy, an Individual Patient Funding Request (IPFR) can be submitted for consideration in line with the All Wales Policy: Making Decisions on Individual Patient Funding Requests. The request will then be considered by the All Wales IPFR Panel.

If the patient wishes to be referred to a provider outside of the agreed pathway, and IPFR should be submitted.

Further information on making IPFR requests can be found at: Welsh Health Specialised Services Committee (WHSSC) | Individual Patient Funding Requests

3. Quality and Patient Safety

The provider must work to written quality standards and provide monitoring information to the lead commissioner. The quality management systems must be externally audited and accredited.

3.1. Quality Indicators (Standards)

Locally defined and Provider outcomes

The provider must:

- ensure that the complex ablation activity at the centre(s) is in line with agreed national guidelines to ensure that the skill of performing the procedure is maintained. If the activity is below the guideline levels, particular vigilance for the appropriateness of the procedures and their complications is recommended, and the sustainability of the service should be considered[6]
- ensure that Operators performing fewer than 100 catheter ablations a year average out their outcome figures over 2 or more years to account for random variation
- review activity to ensure figures are correctly uploaded and reported
- review data completeness as this affects all quality measures
- provide appropriate clinical support to the clinical audit teams. Each clinical audit should have and identified clinical lead assigned to support this activity
- submit accurate and timely procedural audit data to the National Institute for Cardiovascular Outcomes Research (NICOR)
- submit accurate and timely procedural data to the National CRM database
- evaluate the centre(s) performance against the quality standards, and compare the centre(s) with other hospitals with better performance and institute quality improvement measures where necessary
- ensure that there is a structured patient experience data collection and analysis programme in place
- produce information leaflets (clinical indications, clinical benefits, complications, need for follow up, current evidence base and its limitations) for patients about percutaneous left atrial catheter ablation
- have the ability to undertake formal shared decision making; inform and provide information on PROMS and issue questionnaires

[6]National Audit of Cardiac Rhythm Management Devices and Ablation 2016/17 Summary Report: https://www.nicor.org.uk/wp-content/uploads/2019/07/CRM-Report-2016-2017.pdf

- enable the patient's, carer's and advocate's informed participation and to be able to demonstrate this. Provision should be made for patients with communication difficulties.

3.2. National Standards

The provider must:

- ensure that the Electrophysiology and complex ablation service at the centre(s) is delivered in line with the British Heart Rhythm Society, Standards for Interventional Electrophysiology and Catheter Ablation in Adults
- ensure that each centre demonstrates compliance with NICE guidance for Atrial fibrillation: management [CG180].

3.3. Other quality requirements

- The provider will have a recognised system to demonstrate service quality and standards.
- The provider will have detailed clinical protocols setting out nationally (and local where appropriate) recognised good practice for each treatment site.
- The quality system and its treatment protocols will be subject to regular clinical and management audit.
- The provider is required to undertake regular patient surveys and develop and implement an action plan based on findings.

4. Performance monitoring and Information Requirement

4.1. Performance Monitoring

WHSSC will be responsible for commissioning services in line with this policy. This will include agreeing appropriate information and procedures to monitor the performance of organisations.

For the services defined in this policy the following approach will be adopted:

- service providers to evidence quality and performance controls
- service providers to evidence compliance with standards of care

WHSSC will conduct performance and quality reviews on an annual basis.

4.2. Key Performance Indicators

The providers will be expected to monitor against the full list of Quality Indicators derived from the service description components described in Section 2.2.

The provider should also monitor the appropriateness of referrals into the service and provide regular feedback to referrers on inappropriate referrals, identifying any trends or potential educational needs.

In particular, the provider will be expected to monitor against the following target outcomes:

- activity and waiting times
- clinical outcomes:
    - Treatment success rates
    - Adverse incidents or SUIs
    - Post procedure complication rates
    - Post-procedure mortality
- Patient Reported Outcome Measures (PROMS)
- Patient Reported Experience Measures (PREMS)

4.3. Date of Review

This document is scheduled for review before 2024, where we will check if any new evidence is available.

If an update is carried out the policy will remain extant until the revised policy is published.

5. Equality Impact and Assessment

The Equality Impact Assessment (EQIA) process has been developed to help promote fair and equal treatment in the delivery of health services. It aims to enable Welsh Health Specialised Services Committee to identify and eliminate detrimental treatment caused by the adverse impact of health service policies upon groups and individuals for reasons of race, gender re-assignment, disability, sex, sexual orientation, age, religion and belief, marriage and civil partnership, pregnancy and maternity and language (Welsh).

This policy has been subjected to an Equality Impact Assessment.

The Assessment demonstrates the policy is robust and there is no potential for discrimination or adverse impact. All opportunities to promote equality have been taken.

6. Putting Things Right

6.1. Raising a Concern

Whilst every effort has been made to ensure that decisions made under this policy are robust and appropriate for the patient group, it is acknowledged that there may be occasions when the patient or their representative are not happy with decisions made or the treatment provided.

The patient or their representative should be guided by the clinician, or the member of NHS staff with whom the concern is raised, to the appropriate arrangements for management of their concern.

If a patient or their representative is unhappy with the care provided during the treatment or the clinical decision to withdraw treatment provided under this policy, the patient and/or their representative should be guided to the LHB for NHS Putting Things Right. For services provided outside NHS Wales the patient or their representative should be guided to the NHS Trust Concerns Procedure, with a copy of the concern being sent to WHSSC.

6.2. Individual Patient Funding Request (IPFR)

If the patient does not meet the criteria for treatment as outlined in this policy, an Individual Patient Funding Request (IPFR) can be submitted for consideration in line with the All Wales Policy: Making Decisions on Individual Patient Funding Requests. The request will then be considered by the All Wales IPFR Panel.

If an IPFR is declined by the Panel, a patient and/or their NHS clinician has the right to request information about how the decision was reached. If the patient and their NHS clinician feel the process has not been followed in accordance with this policy, arrangements can be made for an independent review of the process to be undertaken by the patient's Local Health Board. The ground for the review, which are detailed in the All Wales Policy: Making Decisions on Individual Patient Funding Requests (IPFR), must be clearly stated

If the patient wishes to be referred to a provider outside of the agreed pathway, and IPFR should be submitted.

Further information on making IPFR requests can be found at: Welsh Health Specialised Services Committee (WHSSC) | Individual Patient Funding Requests

Annex i Codes

Code Category	Code	Description
ICD-10	148	Atrial fibrillation and flutter
OPCS	K62.2	Percutaneous transluminal ablation of atrial wall for atrial flutter
OPCS	K62.3	Percutaneous transluminal ablation of conducting system of heart for atrial flutter NEC
OPCS	K57.1	Percutaneous transluminal ablation of atrioventricular node

Annex ii Abbreviations and Glossary

Abbreviations

IPFR Individual Patient Funding Request

WHSSC Welsh Health Specialised Services Committee

Glossary

Individual Patient Funding Request (IPFR)

An IPFR is a request to Welsh Health Specialised Services Committee (WHSSC) to fund an intervention, device or treatment for patients that fall outside the range of services and treatments routinely provided across Wales.

Welsh Health Specialised Services Committee (WHSSC)

WHSSC is a joint committee of the seven local health boards in Wales. The purpose of WHSSC is to ensure that the population of Wales has fair and equitable access to the full range of Specialised Services and Tertiary Services. WHSSC ensures that specialised services are commissioned from providers that have the appropriate experience and expertise. They ensure that these providers are able to provide a robust, high quality and sustainable services, which are safe for patients and are cost effective for NHS Wales.

Centre

For the purposes of this document as the Health Boards include multiple hospital sites, a centre is taken to mean a single hospital site where invasive electrophysiology and ablation procedures are performed rather that the Health Board as a whole. It is accepted that operators may work at more than one centre but each centre should conform to the standards within this document.

Anti-arrythmic drugs

This is a group of medicines that are used to slow or changes an abnormal heart rhythm to a normal rhythm.

Percutaneous

Performed through the skin.