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Welsh Health Specialised  
Services Committee (WHSSC)

# **Specialised Services Commissioning Policy: CP197a**

## **Electrophysiology and Ablation Services (16 years and older)**

*January 2021*

*Version 1.0*



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## **Policy 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 policy.

In creating this document WHSSC has reviewed this clinical condition and the options for its treatment. It has considered the place of Electrophysiology and Ablation in current clinical practice, whether scientific research has shown the treatment to be of benefit to patients, (including how any benefit is balanced against possible risks) and whether its use represents the best use of NHS resources.

## **Disclaimer**

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

This policy 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 policy.

## **1. Introduction**

This policy has been developed 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 Plain Language Summary**

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 (irregular heart rhythm) can be cured by catheter ablation, in which steerable thin probes (catheters) are threaded along vessels and guided into the relevant locations within the heart. Ablation is then performed, creating a scar most commonly by passing an electrical current into the tissue (radiofrequency, RFA), but sometimes by using freezing or other energy sources. 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 rhythm 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. Treatment can be with medication or by ablation 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 (racing 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.<sup>1</sup>

### **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 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

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<sup>1</sup> [Overview | Atrial fibrillation: management | Guidance | NICE](#)

([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 re-entrant 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.

## 1.2 Aims and Objectives

This policy aims to define the commissioning position of WHSSC on the provision of Electrophysiology and Ablation services for people with a fast abnormal heart rhythm (i.e. supraventricular tachycardia, atrial flutter, atrial fibrillation and ventricular arrhythmias).

The objectives of this policy are to:

- ensure commissioning for the use of Electrophysiology and Ablation services is evidence based
- ensure equitable access to Electrophysiology and Ablation services
- define criteria for people with an abnormal heart rhythm (arrhythmias), to access treatment
- improve outcomes for people accessing Electrophysiology and Ablation services.

## 1.3 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<sup>2</sup>. 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%<sup>3</sup>. 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<sup>4</sup>.

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<sup>2</sup> 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

<sup>3</sup> 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>

<sup>4</sup>Clinical Commissioning Policy: Catheter ablation for paroxysmal and persistent atrial fibrillation 1903

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<sup>5</sup>.

#### **1.4 Current Treatment**

Catheter ablation is recommended as first line treatment for all regular supraventricular tachycardias (SVTs), and has a high rate of cure, >90%.

Catheter ablation can also be used effectively to treat atrial fibrillation. Whilst the majority of patients with AF are medically managed with anti-arrhythmic medications, they are not always tolerated or effective and catheter ablation procedures should be considered in these circumstances<sup>6</sup>.

Percutaneous left atrial ablation is an invasive procedure that can be offered to people with symptomatic paroxysmal or persistent atrial fibrillation as an alternative to anti-arrhythmic medications. It is aimed at targeting and disrupting the conduction of abnormal electrical activity throughout the atria.

Catheter ablation is an effective treatment for symptomatic AF in suitable patients, and numerous studies have shown it to be far more effective at reducing arrhythmia burden and improving symptoms and quality of life than antiarrhythmic drug therapy. In people with paroxysmal AF, approximately 80% obtain symptomatic improvement after ablation, the majority of who will be able to discontinue anti-arrhythmic medications. In people with persistent AF, between 50 and 70% will obtain symptomatic improvement in the short to medium term. Between 33% and 50% of all people undergoing catheter ablation for AF will require at least one further procedure. However, there is uncertainty around the additional benefit of multiple repeat procedures<sup>7</sup>.

There is a wide range in technical complexity of catheter ablation procedures depending on the rhythm being treated and whether or not there is underlying structural heart disease. In summary ablation treatments are categorised as standard and complex procedures:

- **Standard catheter ablation includes:**
  - Electrophysiological study
  - Ablation of the atrioventricular (AV) node (with pacing)
  - Ablation of atrioventricular nodal re-entry tachycardia

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<sup>5</sup> British Heart Rhythm Society: Standards for Interventional Electrophysiology Study and Catheter Ablation in Adults –<https://bhrrs.com/wp-content/uploads/2020/04/British-Heart-Rhythm-Society-Standards-Ablation-2020-1.pdf>

<sup>6</sup> Clinical Commissioning Policy: Catheter ablation for paroxysmal and persistent atrial fibrillation 1903

<sup>7</sup> Clinical Commissioning Policy: Catheter ablation for paroxysmal and persistent atrial fibrillation 1903

- Ablation of accessory pathways
  - Ablation of right atrial isthmus dependent atrial flutter
  - Ablation of regular sustained atrial tachycardia
  - Ablation of focal ventricular tachycardia in normal hearts
- **Complex catheter ablation includes:**
    - Ablation of atrial fibrillation
    - Ablation of left atrial tachycardia
    - Ablation of non-sustained regular atrial tachycardia
    - Ablation of ventricular tachycardia in patients with structural heart disease
    - Ablation of arrhythmia in patients with complex congenital heart disease

The British Heart Rhythm Society (BHRS) recommends that ablation is offered as:

- **First line treatment for:**

All regular supraventricular tachycardia's (SVTs) including cavo-tricuspid isthmus dependent atrial flutter that are either causing symptoms or have potential to produce tachycardia-related cardiomyopathy

- **Second line treatment for:**

Symptomatic AF

- AF (symptomatic or asymptomatic) that has potential to produce or be associated with tachycardia cardiomyopathy (rate control with AV node ablation and pacing or rhythm control with AF ablation)
- Symptomatic VT, VT storm or VT leading to intolerable or very frequent ICD therapy
- VT with the potential to produce tachycardia-related cardiomyopathy<sup>8</sup>

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

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<sup>8</sup> British Heart Rhythm Society: Standards for Interventional Electrophysiology Study and Catheter Ablation in Adults – February 2016 <https://bhrrs.com/wp-content/uploads/2019/03/160216-Standards-Interventional-electrophysiology-study.pdf>

It is important that ablation is commissioned as an entire service, that is with outpatient assessment, diagnostic testing, the procedure and then follow-up.

The preferred model is at least one pre procedure consultation. The number of follow-up appointments is dependent on the procedure, SVT ablations normally only have one follow up while AF ablations require three or more.

However, while there is evidence that supports catheter ablation in reducing the symptoms of AF. It is not clear how many times this procedure should be repeated if the symptoms return.

Discharge is generally to General Practitioner (GP) or referring cardiologist however a small number of patients will require longer follow-up by the EP ablation service where symptoms persist.

## **1.5 What NHS Wales has decided**

WHSSC has carefully reviewed the evidence of Electrophysiology (EP) and Ablation for the treatment of abnormal heart rhythms. We have concluded that there is enough evidence to fund the use of EP and ablation, within the criteria set out in section 2.1.

## **1.6 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**
  - [CP197b, 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>

- **Other published documents**

- British Heart Rhythm Society: Standards for Interventional Electrophysiology Study and Catheter Ablation in Adults – February 2016 <https://bhhs.com/wp-content/uploads/2019/03/160216-Standards-Interventional-electrophysiology-study.pdf>

## **2. Criteria for Commissioning**

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

### **2.1 Inclusion Criteria**

The access criteria to ablation services are deliberately wide. Ablation services provide specialist assessment for people aged 16 years and older<sup>9</sup> with those abnormal heart rhythms as described in Section 1.1.1

People aged 16 years and over with the following arrhythmias should meet the criteria below:

#### **Paroxysmal and Persistent AF**

- Have no previous history of congenital heart disease. For adults with pre-existing congenital heart disease, cardiologists should refer to existing guidance on the management of congenital heart disease, as this is outside the scope of this policy.
- Have ongoing symptoms despite the use of antiarrhythmic drug therapy. Antiarrhythmic drugs for this purpose are defined as beta-blockers, rate-limiting calcium channel blockers, Vaughan Williams Class I or Class III agents.
- All patients being considered for AF ablation should be managed holistically with focus on lifestyle modification and weight management. Patients with a BMI>35 should be enrolled in an intensive weight reduction programme before proceeding to catheter ablation.
- Redo procedures should only be considered in patients with documented ongoing symptomatic episodes of atrial fibrillation.
- In certain circumstances a further ablation procedure can be considered but this needs to be reviewed and agreed following MDT discussion.

#### **Persistent AF only**

- Persistent AF is defined as at least one episode of AF lasting more than 7 days but less than 1 year.
- A clear temporal link should be established between the onset of atrial fibrillation and symptoms. Where this cannot be established a cardioversion should be performed prior to considering for ablation.

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<sup>9</sup> Select 16-18 year old are treated in collaboration with paediatric cardiology colleagues.

- In patients with long-standing persistent AF (defined as continuous AF of greater than 12 months' duration) a cardioversion should be performed following pre-treatment with an anti-arrhythmic drug. If sinus rhythm cannot be maintained for a sufficient length of time to demonstrate symptomatic improvement catheter ablation should not be pursued.
- Patients should remain symptomatic and have evidence of attempted rate control for at least 3 months.
- Left atrial diameter is <60 mm or left atrial volume index <50ml/m.
- Patients should not have had more than 2 previous ablations for AF or atrial tachycardia.

## **2.2 Exclusion Criteria**

### **Paroxysmal and Persistent AF**

- Life expectancy  $\leq$  5 years as with the inclusion of re-do procedures, the benefit is not likely to be fully achieved for 2 years.
- Planned cardiovascular intervention.
- Contraindication to long-term anticoagulation therapy or heparin.
- AF secondary to a transient or correctable abnormality, including electrolyte imbalance, trauma, recent surgery, infection, toxin ingestion, and endocrinopathy (including hypo and hyperthyroidism).
- Liver failure –mild liver disease can be considered on an individual patient's basis.
- Acute coronary syndrome, cardiac surgery, angioplasty, or cerebrovascular accident within 3 months prior to treatment.
- Uncontrolled hypertension.

### **Paroxysmal AF only**

- NYHA class III and IV when not in AF.

### **Persistent AF only**

- NYHA class IV.
- Duration of AF greater than 2 years.
- Significant mitral valve disease, defined as severe mitral stenosis or regurgitation as defined by [European Society of Cardiology](#) (ESC) guidelines or a mechanical mitral valve replacement.

## **2.3 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.

## 2.4 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.

## 2.5 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 Service Specification for Electrophysiology and Ablation (16 years and older) (CP197b) (In Development).

### South Wales and South Powys

University Hospital of Wales

Heath Park Way  
Cardiff  
CF14 4XW

- Morryston 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

## **2.6 MDT**

For complex ablation, the development of a multidisciplinary approach to patient selection, management and follow up is recommended. Refer to WHSSC Service Specification for Electrophysiology and Ablation (16 years and older) (CP197b) (In Development) for further information.

## **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](#)

## **2.8 Clinical Outcome and Quality Measures**

The Provider must work to written quality standards and provide monitoring information to the lead commissioner.

## **Clinical Outcomes**

The following information must be collected:

- Treatment success rates.
- Adverse incidents or SUIs.
- Post procedure complication rates.
- Post-procedure mortality.
- Patient Reported Outcome Measures (PROMS).
- Patient Reported Experience Measures (PREMS).

## **Quality Measures**

Providers need to:

- 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<sup>10</sup>
- ensure that Operators performing fewer than 100 catheter ablations / year average 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 an 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

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<sup>10</sup>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>

- 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
- 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 Responsibilities

## **2.9 Responsibilities**

Referrers should:

- inform the patient that this treatment is not routinely funded outside the criteria in this policy, and
- refer via the agreed pathway

Clinician considering treatment should:

- discuss all the alternative treatment with the patient;
- advise the patient of any side effects and risks of the potential treatment
- inform the patient that treatment is not routinely funded outside of the criteria in the policy, and
- confirm that there is contractual agreement with WHSSC for the treatment

In all other circumstances an IPFR must be submitted.

### **3. Evidence**

WHSSC is committed to regularly reviewing and updating all of its commissioning policies based upon the best available evidence of both clinical and cost effectiveness.

#### **3.1 References**

- British Heart Rhythm Society: Standards for Interventional Electrophysiology Study and Catheter Ablation in Adults (2016) <https://bhhs.com/wp-content/uploads/2019/03/160216-Standards-Interventional-electrophysiology-study.pdf>
- 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>
- National Institute of Health and Care Excellence guidance Atrial fibrillation: management [CG180] (2014) <https://www.nice.org.uk/guidance/cg180>
- 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>
- NHS Wales Cardiovascular Atlas of Variation: <http://www.wcn.wales.nhs.uk/sitesplus/documents/1193/12959%20PHW%20Atlas%20report.pdf>

#### **3.2 Date of Review**

This document is scheduled for review before 2024, where we will check if any new evidence is available. If no new evidence or intervention is available the review date will be progressed.

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

## **4. 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.

## **5. Putting Things Right:**

### **5.1 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.

### **5.2 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

<b>Code Category</b>	<b>Code</b>	<b>Description</b>
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**

<b>AWMSG</b>	All Wales Medicines Strategy Group
<b>IPFR</b>	Individual Patient Funding Request
<b>WHSSC</b>	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 than 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-arrhythmic drugs**

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

#### **Percutaneous**

Performed through the skin