Cardiology Service Reconfiguration

Outline of Proposal to develop a specialist cardiology service to deliver both the GIRFT standards and MTWs clinical strategy aspirations

HOSC Briefing
21/07/2021

MTW

NHS
Maidstone and Tunbridge Wells
NHS Trust

Contents

Introduction and background

The current cardiology service outline

The **inpatient cardiology service at MTW is currently provided at both the Maidstone and Tunbridge Wells hospital sites**.

There is a **cardiac catheter laboratory on both sites** with the Tunbridge Wells site providing angioplasty intervention and simple pacing procedures, and the Maidstone site providing simple & complex cardiac pacing and electrophysiological intervention.

On this basis **if patients at Maidstone hospital require an angioplasty intervention they will be transferred to Tunbridge Wells Hospital**. **If patients at Tunbridge Wells Hospital require complex cardiac pacing or electrophysiological intervention they will be transferred to Maidstone Hospital.**

Both sites have a 6 bedded Coronary Care Unit (CCU), and patients' inpatient stays outside of CCU are managed in the general medical wards with some sub specialisation.

Both sites have Outpatients and other diagnostics (ECG, echocardiography)

The case for change

The case for change

Patients are having their treatment delayed due to requiring transfers between the two hospital sites for procedures during their in-patient stay

Inability to provide specialist cardiology services in a dedicated cardiology ward outside of CCU at either site

Diluted services due to necessary duplication across two sites

The **complicated clinical model** results in:

- **Difficulty in recruiting and retaining specialist staff** of all disciplines
- **Non compliance with 9 of 25 clinical standards** set out in the National GIRFT report of 2020 (Getting it Right First Time) (see opposite)

  -Seven non compliant standards relate to inpatient management and access

The Cardiology GIRFT report from 2020 sets out 25 standards for NHS Trusts to deliver to provide optimum cardiology care.

(See appendix 1 for complete list of standards)

MTW non-complaint GIRFT standards

Standard	Recommendation
1	All hospitals must deliver cardiology services as part of a defined and agreed network model
2	All hospitals receiving acute medical admissions must have a consultant cardiologist on call 24/7 that is able to return to the hospital as required. There should be a consultant job planned specifically to review newly admitted and acutely unwell inpatients 7/7 and a consultant job planned to deliver review of other inpatients ensuring continuity of care
4	All members of the wider heart team should be supported to work in extended roles and trusts should ensure that appropriate staff (including ACPs, specialist nurses and cardiac physiologists) are trained accredited and authorised to prescribe medications relevant to their role
5	Each network must ensure that there are clearly defined patient pathways covering all acute hospitals for provision of 24/7 emergency temporary pacing and 7/7 permanent pacing
7	Networks should ensure that stable chest pain pathways are consistent with the recommendations of NICE CG95. Invasive angiography should as a default be performed as '? Proceed' and must be performed in a PCI-enabled cath lab by a PCI trained operator
8	Networks must ensure that all hospitals performing PCI have a 24/7 on site rota for urgent return to the cath lab
10	For the acute chest pain pathway all networks should provide 7/7 ACS lists accessible to all hospitals in the network. Coronary angiography '? Proceed' should be performed within 72 hours for patients without high risk factors and within 24 hours for high risk patients and within 2 hours for highest risk patients. Cardiac surgery should be undertaken within 7 day of angiography
11	In each hospital there should be a specialist consultant lead for heart failure supported by a multidisciplinary HF team. Secondary care services should be integrated with community teams with regular joint MDMs
15	Networks should ensure that all hospitals admitting acute cardiology patients have 24/7 access to emergency echo including the facility for immediate remote expert review as required. Elective/urgent echo should be routinely undertaken 7/7. Urgent TOE should be available 7/7

Cardiology Activity and Dedicated Staffing

Procedure, diagnostics and outpatient activity:

Average annual Cath Lab activity:

Electrophysiology	200
Implanted Devices	712
Angiography	1049
Angioplasty	272

Annual OPA: *(as per 2021-22 demand & capacity templates)*

Grade	New Total	Follow-up Total
Consultant	3,238	2,735
Registrar	765	1,309
SHO	-	207
Nurse	2,648	13,683
Total	6,651	17,934

Annual OP diagnostics:

Echocardiography	2394
BP / ECG / Cardiac Event recorders	4620
Pacing clinics	4200

Staffing:

Consultants	8 WTE *
Associate Specilaists	2 WTE
Specialist nurses	8.97 WTE
Radiographers	2 WTE
Cardiac Physiologists	11.68 WTE
Cardiac Physiology support staff	10.64 WTE

*Current on call commitments
MH = 1 in 4
TWH = 1 in 5 (due to Associate Specialist cover)

Also:
2x6 bedded CCU's with staffing in line with national standards
Beds within the medical directorate for cardiology patients are not dedicated to cardiology

Working towards the reconfiguration of the cardiology service

Centralisation of specialist cardiology inpatient care for the provision of a cardiology specialist unit in line with the Kent Health and Wellbeing Strategy and the JSNA 2015

Proposed Changes

Inpatient cardiology services would be centralised onto one 'hot site' providing:

- 12 CCU beds
- 2 co-located cardiac catheter labs for both elective and emergency procedures
- up to 24 dedicated cardiology beds
- consolidated skills and facilities onto one site for the provision of care to the most complex cardiology conditions
- consolidation of lab staff to one site facilitates provision of 24/7 on call and weekend lab activity

A robust transfer protocol will ensure patients on the 'cold' site are managed safely, quickly and appropriately for their condition.

The 'cold' site would continue to manage less complex or serious cardiology conditions through the medical ward with support from the cardiologists

Outpatient clinics and non-invasive investigations (ECG, echocardiograms) will remain on both sites. This will provide daily (weekday) consultant cardiology presence on the 'cold' site

Provision of specialist out-patient clinics at both sites (for example heart failure and arrhythmia clinics)

Link to Kent and Medway Joint Strategic Needs Assessment (JSNA)and Health and Wellbeing Strategy (HWBS)

JSNA

"For those people with more serious or life threatening emergency care needs, we should ensure they are treated in centres with the very best expertise and facilities in order to maximise the chances of survival and a good recovery"

JSNA 2015

HWBS

"One of the key issues that we need to tackle is that of public awareness of the changes that will be taking place over the coming years, namely the move to more care being delivered in local communities and away from acute hospitals. **This will inevitably mean major changes to our big hospitals, with the creation of specialist hospitals where good quality care can be provided with specialist trained staff**, with general services provided in the community or at a local hospital as clinically appropriate. This may mean an increase in journey times to access specialist provision for some people, but conversely will allow people to access much more of the care they need in community settings"

Kent Health and Wellbeing Strategy

Outline case for change

The Challenges of current service

Fragmented care for the patient requiring cardiology intervention in the cardiac catheter lab, with CRM/EP procedures taking place at Maidstone hospital and PCI procedures taking place at Tunbridge Wells hospital. This leads to between site transfers, a fragmented care pathway and less than optimum patient experience

Managing patients with complex cardiology conditions. This is undertaken on both sites and the inpatient ward is not a dedicated cardiology ward on either site. Access to emergency intervention does result in patient transfers between site with inherent risks this presents.

Challenges with recruitment to all cardiology disciplines Fragmented systems of working lead to challenges with recruitment and retention of staff

The Benefits of new configuration

Improve ability to provide a 7 day service and emergency service with consolidated workforce, facilities and the support.

The availability of a nursing and technical teams skilled in complex diagnostics will improve access and impact on quality of care

Improved continuity of clinical personnel on one inpatient site will impact of the streamlining and efficiency of the service and improve patient experience.

Ability to provide more complex care to inpatients with the most complex cardiology conditions

Access to cardiac catheter lab facilities 7 days a week with facilities and staff available to support

Ability to develop the service to further improve access to specialist cardiology care for patients in West Kent

Our engagement plan

Jointly developing an engagement plan

The cardiology service has a robust governance and assurance structure to support the programme of work and as part of that structure a Communications Group is in place with representation from the cardiology service, Trust Patient Experience Team and EK360 (formerly Engage Kent) with the latter supporting the external communication plan with patients and the public.

The engagement plan table outlines the activities completed and being undertaken to include:-

- A preparation phase
- Staff engagement – presentations, Trust communications and staff survey
- Public engagement – survey, face to face patient interviews, focus groups
- Analysis
- Ongoing consultation
- Engagement activity with local MPs, CCG and HOSC

	14.06	21.06	28.06	05.07	12.07	19.07	26.07		Aug-Oct 2021
Phase 1: Preparation (Communications Group)									
EIA Completed									
Stakeholder mapping									
Communication and engagement plan									
Agree engagement questions									
Contacting stakeholders									
Recruit patients for focus groups									
Secure consent from outpatients									
Consent and set up focus group participants									
Phase 2: Staff Engagement (MTW Lead)									
Presentation to cardiology Governance meeting	15.06								
Briefing paper to executive directors		22.06							
Staff communication via CEO bulletin and MTW news using Survey Monkey		25.06							
CEO Stakeholder update		25.06							
Senior Leaders update via corporate Team Brief									
Paper to HSOC									
Phase 3: Public Engagement (EK 360 Lead)									
Launch public			30.06						
Cascade online survey to all channels									
Continue to promote survey on line									
Face to face interviews with MH cath lab patients				01.07					
Face to face interviews with MH cardiology inpatients				02.07					
Face to face interviews with TWH cath lab patients					05.07				
Face to face interviews with TWH cardiology inpatients					06.07				
Four focus groups							19 & 20.07		
Exit interviews with outpatients									
Visits to community/voluntary organisations									
Phase 4: Analysis and ongoing consultation									**TBC**

The level of engagement and consultation required

The MTW programme has considered the level of engagement for the change in light of engagement guidance.

Consideration has been given to both levels 2 and 3 and in light of the challenges with confirming where the programme sits with the level of engagement .

The current plan is to continue with the 12 week programme outlined in the level 3 guidance.

HOSC consideration about the positioning of the level of change will be supportive in confirming the position as level 2 or 3

Level 1 – Ongoing development
A small scale change or a new service
Affecting small numbers and/or having low impact
There is good evidence that the change will improve or enhance service provision
Often requires an information-giving exercise (2-4 weeks)
May require some low level engagement

Level 2 – Minor Change
A small/medium scale change or a new service
Affecting low numbers of people
Often requires a small engagement (4-6 weeks)

Level 3 – Significant change
A significant service change
Affecting large numbers of people and/or having a significant impact on patient experience
A significant change from the way services are currently provided
Potentially controversial with local people or key stakeholders
A service closure
Limited information about the impact of the change
Requires a significant engagement (3 months)

Level 4 – Major change
A major change that requires formal consultation and follows NHS England guidance
Affects majority of the local population and or having a significant impact on patient experience
A substantial change from the way services are currently provided
High risk of controversy with local people or key stakeholders
A service closure
Limited information about the impact of the change
Requires a significant engagement (3 months+)

Next Steps:

- **Confirm the site options** for the development of the hot and cold sites
- **Feedback from the staff, patient and public** communications to inform the ongoing engagement and consultation plan
- Complete the **Equality Impact Assessment** (EIA) to ensure all potential risks are mitigated
- Through the local governance structure **confirm the clinical pathway** from the cold to hot site
- **Engage with SECAMB** to confirm any impact on change in flows as a result of reconfiguration of the specialist cardiology inpatient and cardiac catheter lab services
- **Develop a SOC** to confirm the changes and inform a robust risk assessment
- Through the programme governance **work on the service design, clinical model and service development**
- Complete the business planning cycle to **confirm the development timeli**ne

Indicative Timeline

Patient feedback collated	Early August 2021
Ongoing engagement activity	July/August – October 2021
SOC to Cardiology Programme Board	August 2021
Medicine Divisional Board and Executive team	August 2021
MTW Trust Board	October 2021
Kent HOSC detailed update	October 2021
Timeline for completion of reconfiguration	October 2021

Appendix 1 (embedded) – MTW performance against GIRFT Standards 2020

Adobe Acrobat Document