Appendix 1 (HOSC Overview Cardiology Reconfiguration July 21)

MTW GIRFT Compliance 2020

Recommendation	Current compliance	Actions required	Timescale
1. All hospitals must deliver cardiology services as part of a defined and agreed network model.	**Essential services level 1 onsite – non-compliant** 7/7 consultant ward review for all cardiology in-patients 7/7 elective/urgent echocardiography **Level 2 (onsite/network level) – non-compliant** 7/7 permanent pacing, 7/7 PCI with 24/7 on call for return to lab **Workforce** Consultant cardiologists 1 per 36,000 (currently 1 per 71,420) Heart failure nurse specialists 3.5 per 100,000 (currently 1.8 in the hospital, 4.3 for West Kent, 1.5 for ES) Chest pain & arrhythmia pathways 7.5 WTE per million (currently chest pain clinic 1.2 WTE in post, rehab 4.24 in post & 0.6 vacancy and currently ANS 1.53 WTE in post for 500,000)	Single siting cardiology and additional recruitment is required to achieve level 1 and level 2 compliance Total of 14 consultants required to achieve compliance (further 7 consultants to be recruited) Additional recruitment for specialist nurses tbc	Feb 2023
2. All hospitals receiving acute medical admissions must have a consultant cardiologist on-call 24/7 who 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 (note this may be the same consultant) to deliver 7/7 review of other inpatients, ensuring continuity of care.	**Non-compliant** Consultant on call 24/7 is currently in place, however this is a 1 in 4 rota at each site and minimum recommended rota in the GIRFT report is a 1 in 6. Consultant to deliver 7 day review of all cardiology patients will require a change in job plan as current rotas accommodate a ward round to see CCU patients and any urgent referrals only.	Single siting required to achieve basic compliance, but additional recruitment required to staff weekend cold site cover & intervention & pacing rotas Additional PAs required on job plans to accommodate longer working hours at weekends, but this is not sustainable until at a rota frequency of at least 1 in 6	Feb 2023

3. All NHS consultant cardiologists should, by default, participate in an on-call rota for general and/or specialist cardiology.	**Compliant**	No action required	n/a
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.	**Non-compliant** Current hospital based specialist nurses 3 out of 5 are prescribers. The remaining 2 have both have applied, but no guarantee that there will places available this year on the course	Ensure study leave available for specialist nurses to attend prescribers course when secure a place	Feb 2023
5. Each network must ensure that there are clearly defined patient pathways covering all acute hospitals for the provision of 24/7 emergency temporary pacing and 7/7 permanent pacing.	**Non-compliant** 24/7 emergency temporary pacing is provided at both sites, but there are safety concerns regarding the current set-up and use of emergency theatres. Permanent pacing is currently only available on weekdays during normal working hours (not including bank holidays).	Single siting to pool physiologist & radiographer rotas to staff a 24/7 temporary pacing service in the cardiac catheter lab. Single siting to pool cardiologist, physiologist & radiographer rotas to staff 7/7 permanent pacing. Additional recruitment required: Currently 3 consultants to staff 7 day pacing and 3 consultants to staff 7 day angiography. Additional numbers physiologists, radiographers tbc	Feb 2023

6. All outpatient referrals should be triaged with maximum use made of the ERS–Advice and Guidance function. Appropriate investigations should be requested so that all results are available for advice or review in clinic. Clinics should, by default, be conducted virtually unless not feasible for the patient or if 'face-to-face' is required to progress clinical decision-making.	**Partial compliance** (currently non-compliant at TW site)	Increase non-invasive CR capacity and reorganise clinics to ensure investigations are requested & performed in advance of clinics such that results are available in time for clinic.	Feb 2022
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 PCI-enabled cath lab by a PCI-trained operator.	**Non-compliant** Currently we have two lists /week (capacity 6-8 patients per list) – only at TWH scanner. 2nd list each week covered by SP doesn't occur every week. Chest pain/ACS angiography at Maidstone site is currently only performed by an interventional consultant (BM), but PCI kit is an emergency 'bail-out' kit only and cases are not ?proceed Invasive coronary angiography in advance of non-coronary cardiac surgery currently performed by non-PCI enabled operator at Maidstone lab.	Significant increase in CTCA capacity required with 2 to 3 lists each week at both sites, requiring x cardiologists Whilst Trust remains as two separate cath lab sites a substantial investment in PCI kit (including pressure wire) at Maidstone site is required to have two PCI enabled labs, or alternatively stop angiography at the Maidstone site All coronary angiography to be performed by PCI enabled operators only	Feb 2022
8. Networks must ensure that all hospitals performing PCI have a 24/7 on-site rota for urgent return to the cath lab.	**Non-compliant** Current rota is Monday to Thursday up until midnight only staffed by 3 physiologists, 4 radiographers and 3 cath lab nurses	Single siting to pool staff to provide 24/7 on call rota. Required numbers tbc: Nurses Physiologists Radiographers	Feb 2022

9. All designated PPCI centres must provide a 24/7/365 service and all PCI operators should, by default, participate in a PPCI on-call rota.	**Not currently applicable** PPCI must be carried out in designated heart attack centres, operating 24/7 and not performing PCI for limited hours	No action currently required, but intention is to bid for 2nd Kent PPCI service and need to plan bed capacity, ITU support & intervention rota	n/a
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 features, within 24 hours for high risk patients and within 2 hours for the highest risk patients. Where cardiac surgery is required, this should by default be undertaken within seven days of coronary angiography.	**Non-compliant** Coronary angiography currently available normal working weekdays and currently non-compliant with targets for ACS.	Single site plus three additional interventional consultants (or network protocol) to provide 7/7 coronary angiography ?proceed	Feb 2022
11. In each hospital there should be a specialist consultant lead for HF, supported by a multidisciplinary HF team. Secondary care services should be integrated with community teams, with regular joint multidisciplinary meetings (MDMs).	**Non-compliant** No current heart failure lead (but job currently advertised)	Recruit to heart failure lead post (funding in place for substantive post)	Feb 2022
12. All networks should ensure that rehabilitation is offered to all eligible patients, including those with HF.	**Compliant**	No action required	n/a

13. All networks should ensure pathways are in place for the diagnosis and management of patients with heart valve disease, including referral to specialist aortic and mitral/tricuspid teams at a tertiary centre.	**Compliant**	No action required	n/a
14. Arrhythmia pathways should incorporate rapid access clinics, which may be led by ACPs, specialist nurses or cardiac physiologists, for the assessment of palpitations and suspected or confirmed AF. Cardioversions should, by default, be nurse, physiologist or ACP led and undertaken outside the cath lab.	**Partial compliance** DC cardioversion is led by specialist arrhythmia nurses and performed outside of the catheter lab at Maidstone site. Valve clinics currently run by echo physiologists. Specialist nurses involved with rapid access heart failure clinics.	Compliant if single siting the service to the acute site. Explore additional advanced practitioner roles for cardiac physiologists	Feb 2022
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 and delivered on a network basis).	**Non-compliant** 24/7 emergency echo is currently provided by the consultant on call (1 in 4 rota at each site) Elective/urgent echocardiography is not currently routinely available 7/7 (although there has been some additional funded weekend work to catch up lists). Currently 2 substantive consultants, 1 fixed term consultant and 1 staff grade are TOE capable	Will need echo physiologist rota for 7/7 care (this will require additional staff, number tbc), and echo specialists to contribute to network TOE rota. Will need to decide if going to provide echo cover at both sites at weekends – or whether to transfer patients to acute site if require an echo.	Feb 2022

16. Networks should ensure that all hospitals have ready access either on site or at network level to CTCA including CT-FFR, with all of the images reported by appropriately trained cardiologists and/or radiologists.	**Compliant** (although current capacity is significantly under-resourced o see recommendation 7)	See entry for recommendation 7	Feb 2022
17. Networks should ensure that all hospitals have ready access on a network basis to dedicated sessions of CMR, including stress CMR, with all of the images reported by appropriately trained cardiologists and/or radiologists.	**Compliant**	Plan to develop in-house service by recruiting an imaging consultant (post to be advertised this year) with CMR sessions at a tertiary centre	Feb 2022
18. Nuclear cardiology services, including PET and PET-CT, should be available at a regional level.	**Partially compliant**	Need to formalise PET-CT service rather than current ad-hoc provision	Feb 2022
19. All networks should ensure that: (a) there are MDMs for HF and device implantation for all relevant patients within the network; b) there are MDMs for review of patients for revascularisation, aortic valve disease, mitral/tricuspid valve disease, endocarditis and EP at network level; and (c) there are pathways to access external MDMs in ICC, ACHD, advanced HF and low volume interventions if these are not provided within the network.	**Compliant** All complex device implants are subject to MDT at Maidstone. Have access to regional valve, endocarditis, ICC and ACHD MDT.	No action required	n/a

20. All trusts should ensure that audit teams are appropriately resourced to provide weekly uploads of data to the national cardiac registries.	**Partially compliant** Regular contribution to NICOR, MINAP registries	Need funded audit staff MINAP currently 0.2 WTE in post	Feb 2022
21. Trusts must ensure that there is regular clinical validation of coded data, that all relevant clinical information is captured and readily available to coders and that clinical staff are fully aware of the importance of accurate coding, especially that of co-morbidities.	**Compliant**	No action required	n/a
22. Care pathway redesign using digital tools needs to be clinically led and patient centred. Examples of good practice can be found in the NHSX Cardiology Digital Playbook and appropriate governance standards should be adhered to.			Feb 2022
23. All networks should implement robust evidence-based prescribing guidelines which are regularly reviewed and cover both primary and secondary care, ensuring optimal outcomes for patients across the clinical interface.			Feb 2022

24. NHSX and the Department of Health and Social Care should work to ensure that there is clinical engagement with the procurement of cardiac devices and that all devices are subject to systematic surveillance to ensure their safety and efficacy.			ongoing
25. Trusts should work to reduce litigation costs by adopting the GIRFT 5-point plan.			ongoing