

Cardiology networks will deliver better access to care, says GIRFT national report

GIRFT's national review of NHS cardiology services across England has highlighted the importance of digital transformation, alongside the introduction of cardiology networks, to improve access to services and to better integrate pathways across acute, primary and community care.

The cardiology report presents a detailed review of the ways in which services are delivered and who is delivering them. It makes 25 recommendations aimed at closing gaps in provision, improving clinical pathways and improving access to imaging and workforce.

Cardiology is one of the largest medical specialties, focusing on the diagnosis and treatment of disorders of the heart and circulatory system. Cardiologists' work is wide-ranging from conducting therapeutic interventions in catheter labs to imaging and care on hospital wards.

The report's authors **Dr Sarah Clarke** and **Professor Simon Ray** make the case for a network model of delivery for cardiac services with care organised around pathways rather than hospital sites. This will reduce duplication of provision and ensure equitable access to care, helping to sustain ever-stretched services.

COVID-19 has also highlighted the fragilities of the system and makes a further case for changing the way cardiology services are delivered. In particular, the report recommends better and widespread use of digital healthcare technologies to support community diagnostics and outpatient care, for example by using digital booking systems and virtual clinics as default.

A key aim is to create stronger systems via networks that will provide clearer care pathways between primary, secondary and tertiary care, supporting colleagues to be able to deliver the very best in treatment and care through better organisation of services.

The report's 25 recommendations focus on:

- **Improving access to care** – clinical cardiology networks should be established to match demand to capacity and make the best use of hospital resources. Crucially, they should be shaped by function and local need rather than geography.

The networks must ensure that all hospitals within the network are able to provide:

- 24/7 access to emergency echo;
 - access either on site or at network level to computerised tomography coronary angiography (CTCA) including CT-fractional flow reserve (CT-FFR), with all of the images reported by appropriately trained cardiologists and/or radiologists;
 - dedicated sessions of cardiovascular magnetic resonance imaging (CMR), including stress CMR, with all of the images reported by appropriately trained cardiologists and/or radiologists.
- **Delivering a comprehensive multidisciplinary service** – The report recommends 24/7 on-call rotas to ensure consultant cardiologists are available for acute medical admissions. The report emphasises that well co-ordinated multidisciplinary meetings (MDMs) - comprising different professionals such as cardiac physiologists, pharmacists, radiologists and others - are vital to delivering optimal treatment strategies. It details requirements for specialty-specific MDMs to function fully across cardiology networks.

- **Workforce development** – to provide a comprehensive 24/7 service, the wider heart team should be supported to work in extended roles. The report also supports the concept of a mobile workforce with the development of ‘staff passports’ enabling advanced practitioner roles to work more flexibly across clinical networks.
- **Transforming delivery of outpatient care** – diagnostic hubs in the community would help to reduce the number of referrals that require consultation in secondary care. The use of digital platforms between primary and secondary care would allow these hubs to triage and provide initial diagnosis in the community supported by remote/ virtual secondary care consultations as default.
- **Digital transformation** – the report highlights digital tools as a way to improve communication between patients and clinicians and to help forestall deterioration that might lead to hospital admission, which could have been avoided. The report recommends using digital tools to design and improve patient-centred cardiology pathways.

The report also proposes that upskilling the workforce is key to meeting challenges presented by workforce shortages, and will help to increase retention by creating opportunities for career progression.

Potential savings

The report concludes that there are opportunities to reduce costs by improving the care pathways and patient flow from triage, investigation to treatment, particularly between primary and secondary care. With better implementation of certain care pathways, reductions can be achieved in the patient’s length of hospital stay; re-operation rates; readmissions; and unnecessary procedures and appointments. These improvements have the potential to release **up to £28.6m** each year through enabling patients to go home sooner, have simple cardiac procedures as day case surgery, and access heart failure rehabilitation services.

In addition, the report highlights further potential efficiencies of between **£35m and £40m** each year through better surveillance of implanted cardiac devices and any variation in costs for these devices, and improved contractual arrangements. It recommends a clinician-led assessment of cardiac devices to ensure product choices are evidence-based.

The Medical Device Safety Programme has been established between GIRFT, NHSX, NHS Digital, HQIP, and NICOR to improve surveillance of device safety and outcomes.

Report recommendations

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 who is able to return to the hospital as required.
3. All NHS consultant cardiologists should, by default, participate in an on-call rota for general and/or specialist cardiology.
4. All members of the wider heart team should be supported to work in extended roles and trusts should ensure that appropriate staff (including advanced clinical practitioners (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 the provision of 24/7 emergency temporary pacing and 7/7 permanent pacing.

6. All outpatient referrals should be triaged with maximum use made of the Electronic Referral Service (ERS) Advice and Guidance function. 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.
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 percutaneous coronary intervention (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.
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.
10. For the acute chest pain pathway, all networks should provide 7/7 acute coronary syndrome (ACS) lists, accessible to all hospitals in the network. Where cardiac surgery is required, this should by default be undertaken within seven days of coronary angiography.
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).
12. All networks should ensure that rehabilitation is offered to all eligible patients, including those with HF.
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.
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.
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.
16. Networks should ensure that all hospitals have ready access either on site or at network level to computerised tomography coronary angiography (CTCA) including CT-fractional flow reserve (CT-FFR), with all of the images reported by appropriately trained cardiologists and/or radiologists.
17. Networks should ensure that all hospitals have ready access on a network basis to dedicated sessions of cardiovascular magnetic resonance imaging (CMR), including stress CMR, with all of the images reported by appropriately trained cardiologists and/or radiologists.
18. Nuclear cardiology services, including PET and PET-CT, should be available at a regional level.
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.
20. All trusts should ensure that audit teams are appropriately resourced to provide weekly uploads of data to the national cardiac registries.
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

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.
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.
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 linked to outcomes through the national cardiac registries to ensure their safety and efficacy.
25. Trusts should work to reduce litigation costs by adopting the *GIRFT 5-point plan*.