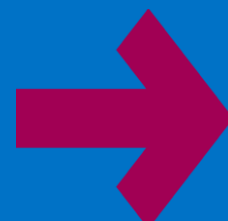


## Cardiac patient workshop Pre-read document – extended version

- Proposed interventions (detailed)
- Background to programme
- Glossary

Please note that we **do not** expect you to have read this fully, however we know that some people will want to read further detail. The interventions will be explained by clinicians at the workshop.



## Summary of the proposed opportunities within cardiac

Below is a summary of all ten proposed intervention for cardiac services. The following pages go into further detail about each intervention.

No.	Cardiac interventions
1	Improve multi-disciplinary team (MDT) working by better utilising technology for meetings, creating protocols for MDT meetings which are in line with best practice, and then monitoring compliance with these protocols.
2	Provide consistent cardiac services across the south London hospitals, so that patients across the area receive a consistent service/ experience which is in line with best practice. This includes optimal pathways from start to end (patient to GP, role of local and specialist hospitals, and follow up care/rehabilitation and discharge).
3	Expand the current inter-hospital transfer system that exists in south London to include all hospitals and all cardiac surgery services. Also, resolve current issues in the system, for example the regarding the patient selection process.
4	Improve the system for getting patients back to their local District General Hospitals (DGHS) after they have received the care they needed at the specialist (tertiary) centres.
5	Create a shared daily and weekly staffing rota across hospitals in south London, to support the delivery of appropriate cardiac services. This will result in one hospital offering certain cardiac treatments on a given day and week.
6	Improve the way healthcare for valve disease is provided across south London.
7	Improve patient experience during the end of life period, and avoid unnecessary treatment.
8	Enhance IT systems to support improved data sharing across south London hospitals.
9	Improve the support provided to patients who have been discharged from hospital after receiving heart services (such as rehabilitation)
10	Introduce collective purchasing (i.e. join up procurement) across south London hospitals where beneficial to do so.

Should we decide to proceed with each of these interventions, we acknowledge that change will not be easy. There are challenges involved with successfully implementing each of the proposed interventions and many additional individuals (including clinicians) within the health system will need to be involved in discussions to help shape the way forward.

**Intervention 1: Improve multi-disciplinary team (MDT) working by better utilising technology for meetings, creating protocols for MDT meetings which are in line with best practice, and then monitoring compliance with these protocols.**

### **Current situation:**

A multi-disciplinary team (MDT) meeting can be defined as a meeting that takes place between a range of healthcare professionals to discuss a patient's care. Sometimes the professionals involved in the meeting will be from different staff groups (e.g. nurse, doctor, physiotherapist) and other times they may be from the same staff group but have different specialities, e.g. x-ray doctor (radiologist), a heart doctor (cardiologist), a surgeon (e.g. cardiovascular or cardiothoracic surgeon). Some MDT meetings have attendee lists that fit both of these categories. Sometimes a patient will be present at an MDT meeting where their care is being discussed, but other times the patient will not be present.

Currently different MDT meetings operate differently, and some run better than others. Also, some clinicians will travel for up to an hour each way in order to attend an MDT meeting at another hospital.

### **What is the opportunity?**

There is an opportunity to improve how MDT meetings work in cardiac services. Specific ways this might happen are shared below.

- **Ensuring the right individuals are present at MDT meetings, so that the best decisions are made:** MDT meeting practice could be standardised across south London hospitals, so that all clinical teams work consistently and in line with best practice. It is suggested that standardised protocols should be established, to inform how MDT meetings should be run. These protocols should include minimum attendance requirements for MDT meetings to take place - to make sure that they are truly 'multi-disciplinary'. Compliance will need to be measured. Enforcing 'multi-disciplinary' staff representation in MDT meetings will create an environment with a wide range of views and perspectives, increasing the likelihood that the right decisions regarding a patient's treatment are made. Suitable MDT attendance should be agreed by clinical leaders.
- The presence of GPs and patients themselves at MDT meetings should also receive more consideration. Currently meetings do not always have strong links with GPs, meaning that knowledge about the patient that the GP holds may not always be taken into account with appropriate proportion. Where helpful, patients should also be more included in the MDT meeting process. Sometimes this could be achieved through patients attending the meetings themselves, so that they fully understand their treatment options. By involving patients more heavily in the MDT meeting process, they should become more educated about their treatment options, and as a result, more informed to make the most appropriate treatment decisions along with clinical staff.
- **Giving clinical staff more time to spend on patient care:** Introducing more video technology will enable MDT meetings to take place without clinicians having to travel between sites. This is likely to improve attendance and it will also reduce the cost and time waste associated with travel. If MDT meetings are better supported by technology this is likely to result in reduced travel time between sites for specialist clinicians and other staff. As a result, clinical staff will have more availability to undertake clinical work/ provide patient care.

**Intervention 2: Provide consistent cardiac services across the south London hospitals, so that patients across the area receive a consistent service/ experience which is in line with best practice.**

## **Current situation:**

Currently the service and experience that cardiac patients experience differs depending on which hospital they attend. This means that, depending upon which hospital is visited, a patient's experience can vary. It also means that some hospitals follow processes that are more efficient than others.

## **What is the opportunity?**

As much as possible, patients should receive similar services which are in line with best practice, regardless of whether they access cardiac services at Guy's and St Thomas', King's College Hospital or St George's Hospital. A single approach should be agreed, aiming for best practice whenever possible, and then hospitals should work to deliver care in line with this. Inter-hospital clinical teams should be established so that research and best practice is shared, and to create a more collaborative environment across different hospitals.

A number of cardiac conditions or services have been identified as areas for specific focus in developing consistent care across hospitals:

- Primary angioplasty
- Heart failure
- Endocarditis
- Coronary artery
- Valvular heart

These services have been highlighted because clinicians had particular opportunities for improvement in mind for each of these areas.

Any work that has already been undertaken, focused on identifying best practice 'patient pathways' (i.e. best practice clinical care and patient experience) should be taken into account and help to inform this intervention. This might include work that was undertaken within previous national or London-focused cardiovascular projects. For example, service specifications that are still applicable from the 2010 Cardiovascular Commissioning Project and Atrial Fibrillation (AF) service work that has already begun should very much be taken into account. Once protocols have been agreed they will need to be managed by Clinical Leadership Groups (made up of clinical representatives from hospitals, CCGs, Public Health, GPs etc) in order to sustain support and compliance.

Staff working in a consistent way across the area and in line with best practice processes whenever possible should mean that patients are consistently provided with the best level of care available and should not experience the variation that currently exists between sites. Additionally if best practice is shared between clinicians through collaborative working then, as a result, some clinicians should become more skilled at their profession and provide higher quality healthcare to patients.

It is also often the case that providing 'best practice' care involves providing patients with a better education about their care and the options that are available to them. Therefore this intervention means that patients will be better informed to make the best decisions for them regarding their care options.

**Intervention 3: Expand the current inter-hospital transfer system that exists in south London to include all hospitals and all cardiac surgery services. Also, resolve current issues in the system, for example the regarding the patient selection process.**

### **Current situation:**

There is currently an inter-hospital transfer system that enables smaller hospitals (district general hospitals) to transfer patients who need more expert/ specialist care to the larger hospitals (tertiary centres). This system currently allows district general hospitals to add patients who require a specialist cardiac bed in a tertiary/ specialist centre onto a shared database which the specialist centres view and select patients from. It is not always that case that all specialist hospitals can see/view the whole list of patients waiting to be transferred from DGHs. Currently, patients are not always selected chronologically off the system and specialists can choose which patients they provide a bed to. Sometimes there are incentives for specialist centres to take/select patients outside of chronological order.

Currently patients experience long waiting times for specialist cardiac treatment.

### **What is the opportunity?**

There is an opportunity to improve the capability and the reach of the current inter-hospital transfer system, so that *all* south London hospitals are included on the system and so that current inefficiencies in the way the system operates are removed. Proposed enhancements to the existing system include:

- Patients at the district general hospitals (DGHs) should be selected for transfer to the larger, specialist hospitals in chronological order (i.e. on a first come first served). This should be unless specific care requirements exist - for example, if a patient is clinically urgent then they should be given priority for a specialist bed. Implementing this chronological selection process, should create equal access opportunities and it is fairer for patients.
- All specialist hospitals should have access to patient listings across *all* DGHs in chronological order. This should further increase the likelihood of patients receiving a bed in a specialist cardiac service in chronological order. However this capability will require guidelines to be agreed to prevent sites that are particularly unsuitable for the patient's needs from being able to select that patient.
- Protocols should be developed and implemented to support cardiac services in south London hospitals to use the system correctly and in a consistent way.
- The suggested improvements above relate to the flow of patient's being sent (referred) from DGHs to the specialist centres. However the existing processes that determine how patients leave the specialist centres and return to the district general hospitals (something referred to as 'repatriation') could also be improved. For example, the current system only supports repatriation of patients from St George's Hospital. Improving the way that repatriation takes place is already being developed by a company called Teleologic Ltd, who currently provide the inter-hospital transfer system.
- In the 2010 Cardiovascular Commissioning Project it was suggested that commissioner payments to hospitals should be linked to how the hospitals use the proposed electronic referral system. It is proposed that a similar payment structure should be put in place in order to incentivise hospitals to effectively and appropriately use the inter-hospital transfer system.

This opportunity is likely to reduce waiting times for patients by matching demand for specialist cardiac services with the capacity of specialist services across south London. If patients receive the specialist care they need more quickly then there should be less deterioration in their condition. This is better for patient experience and it often also means there are likely to be improved health outcomes following the receipt of the specialist clinical input.

### Intervention 4: Improve the system for getting patients back to their local DGHs after they have received the care they needed at the specialist (tertiary) centres

#### Current situation

Specialist/ tertiary hospitals report difficulty in returning patients who have been transferred to them for specialist treatment or care, back to the district general hospital (DGH), once the patient no longer requires specialist input. As a result of the district generals not having beds available for these patients, the patients unnecessarily remain in specialist beds until they can be discharged into the community or home. This contributes to capacity issues in specialist services. This problem is reported to be particularly exacerbated in cardiology patients because it is common for cardiology patients to be suitable for transfer from a bed in specialist centre to a bed in a district general hospital. The beds that these patients continue to occupy could otherwise be given to patients who do require specialist input. This issue unnecessarily wastes money because the specialist beds/ units are the most expensive to run and it also means that some patients in need of specialist clinical attention are waiting longer for it.

#### What is the opportunity?

**Introduce protocols which will help to support the repatriation of patients from tertiary centres to DGHs.** This will help to support the efficient use of tertiary/ specialist cardiac beds and will increase bed availability at the specialist centres (i.e. King's College, St George's and Guy's and St Thomas' hospitals). The protocols will outline to clinical staff at DGHs and specialist centres the process that should be followed when a patient needs to be repatriated from a specialist centre back to a DGH. Clinical staff from DGHs and specialist services should both help to develop/ the protocols, which will outline the rules and standards to follow regarding repatriation. Appropriate consideration will also be given to how DGHs receive payment for patient care and whether any changes will need to be made in order to support behaviour change and compliance with the protocols that are created.

Some of the other interventions that are being proposed focus on improving the efficiency of patients entering specialised services. It is also important that patients have somewhere suitable to go so that they can quickly leave specialist services when they are ready to do so.

This intervention could be implemented alongside the inter-hospital transfer opportunity (intervention 3). The two interventions are linked because they both involve the transfer of patients from one site to another. Currently, the electronic inter-hospital transfer system used in south London only supports repatriation of patients from St George's hospital, but the idea is that this should be expanded to include King's and Guy's and St Thomas'. The protocols developed within this intervention should be integrated into the way the IT system is set-up.

Better flow of patients out of tertiary centres, when patients are ready to be cared for in a DGH, should result in reduced waiting times for some patients waiting for specialist input. Shorter waiting times improve patients experience and also means there is less time for a patient's condition to deteriorate which often means improved health outcomes following treatment.

If more patients are transferred to their local district general hospitals when they are ready to leave specialist care then this often moves the patient closer to home, making it easier for loved ones to visit.



**Intervention 5: Create a shared daily and weekly staffing rota across hospitals in south London, to support the delivery of the specialist cardiac services that would benefit from this. This will result in one hospital offering certain cardiac treatments on a given day and week.**

### **Current situation**

Currently, for some of the specialist cardiac services in south London hospitals there is an issue of high 'demand' (i.e. lots of patients requiring clinical input) and the way that these services are delivered means that the hospitals do not always have the clinical capacity to match this demand. This is particularly an issue during the night, when staff rota constraints mean all hospitals are not always able to have every kind of cardiac specialist available overnight. Often cardiac specialists are spread thinly overnight, with the three tertiary hospitals trying to cover rotas as best they can individually. This can mean longer waiting times for patients to receive clinical input.

### **What is the opportunity?**

There is the opportunity for a shared rota to be implemented across south London where a particular hospital is responsible for carrying out a certain procedure on a certain day. It is proposed that this would only be for certain specialist cardiac services (where it is deemed beneficial to make this change) and not for all specialist cardiac services. Having a shared rota will only be beneficial for procedures/ services which are completed in small volumes and which are emergency (non-elective) in nature. Some of the services that have been determined as potentially suitable for a shared rota are outlined below:

- Mitral surgery – surgery undertaken on the mitral valve in the heart.
- Aortic surgery - – surgery undertaken on the aortic valve in the heart.

This model will enable some patients to be seen more quickly by a specialist, and so their condition has less time in which to deteriorate. In addition, this model means clinical staff will be working within high volume units where they see more patients with the same condition. This will allow the clinical staff to enhance their specialist skills and expertise and is likely to improve decision making, meaning that the quality of patient care improves.

With this intervention there is also the opportunity to share clinical staff across hospitals in south London. This should reduce help to agency fees, bringing a financial benefit to hospitals.

This intervention would need to be implemented in close partnership with London Ambulance Service to ensure that patients are taken to the 'on call' centre on the correct day.

Please note - a shared rota currently exists between King's College Hospital and Guy's and St Thomas' for aortic dissection. The rota was introduced following the 2010 Cardiovascular Commissioning Project which highlighted a 20% death rate for patients suffering from an aortic dissection. The rota was put in place so that patients receive the appropriate quality of care that the condition demands and it's introduction has been beneficial.

If this intervention is implemented, and there is only one on rota on a certain day, then patients will have less choice of which hospital to go to for their care. Patients may have to travel past a closer hospital in south London (i.e. Kings College, Guy's and St Thomas' or St George's Hospitals) if it is not on the rota on the day/ night of their cardiac health incident. However this additional travel needs to be balanced against the improvements in clinical care will come from the intervention. The new model means it will be known that the required cardiac specialist is available at the designated hospital.

## Intervention 6: Improve the way in which healthcare for valve disease is provided across south London.

### Current situation

If one or more of your heart valves becomes damaged or diseased, it can affect the flow of blood through your heart.

TAVI is the abbreviation for 'Transcatheter aortic valve implantation' which is a procedure used on patients with a diseased or damaged valve. This is a non-surgical alternative to open heart surgery in which a catheter (hollow tube) with a balloon at its tip is inserted into an artery and passed up to the aortic valve in the heart. The balloon is inflated, opening the space and a new valve is put in place. There is room for improvement with the way TAVI services are currently provided:

- In some instances tertiary centres (the specialist hospitals) receive patients at a late stage in relation to the valve disease.
- many patients referred to a tertiary centres for a TAVI haven't had an angiogram (a special type of x-ray), meaning that the angiogram then needs to take place at the specialist centre. To increase the efficiency of the system, it would be beneficial for patients to have had angiograms by the time they arrive at the specialist/ tertiary hospital.
- There are cases of patients being referred to tertiary hospitals for TAVIs that do not actually need them. Many of these patients receive clinical input to prepare them for a TAVI procedure only to then find out that the TAVI is not necessary. Correct diagnosis would reduce unnecessary referrals to the specialist hospitals and would reduce unnecessary preparatory work from being undertaken. This will mean that specialist hospitals are not wasting clinical time and money "working up" patients for whom a TAVI is unsuitable. Correct diagnosis would also improve the quality of care, if patients receive the appropriate treatment from the outset, and it would reduce waiting times for those patients who are in need of a TAVI because inappropriate demand would be removed.

### What is the opportunity?

**Create specialist valve clinics:** Currently each hospital in south London has its own valve clinic. To increase the quality of treatment received by valve disease patients, the creation of specialist valve clinics in south London should be considered. Introducing specialist valve clinics is likely to tackle all of the service issues outlined above. A specialist in the field who sees a high number of patients with similar symptoms is likely to make a better decision about whether a TAVI is required or not and so is only likely to refer a patient to a specialist centre when clinically appropriate to do so. They are also more likely to refer in a timely manner. A specialist in a valve clinic will also know to order an angiogram in advance, due to seeing patients with this condition daily.

If specialist valve clinics are not pursued then more individual steps will need to be taken:

- **Ensure that patients referred to specialist centres for a TAVI have already had an angiogram:** Protocols should be created across south London GP practices, DGHs, and the specialist hospitals that provide TAVIs to ensure that patients referred to specialist centres for a TAVI have already had an angiogram. This spreads the demand for angiograms out across hospitals rather than all the demand being at specialist centres and should reduce time delays for patients because they are likely to have the angiogram sooner than they are at present.
- **Ensure that patients are only referred for a TAVI when they need one, and that patients who require a TAVI are seen by a specialist more quickly:** Protocols should be created across the south London region which support GPs and staff in DGHs to determine when patients need to be seen by a specialist and when they do not. To help inform the content of such protocols a review should be undertaken to determine the level at which it is no longer the best option for TAVI treatment to occur because it will worsen patient outcomes and quality of life.



### Intervention 7: Improve patient experience during the end of life period and avoid unnecessary treatment.

#### Current situation

'End of life' refers to the period of time over which someone is approaching the end of their life. This can be weeks, months or even years. Like all care, end of life care should help people to live as well as possible until they die.

It is recognised that 'end of life' is a particularly sensitive time for everyone involved and sometimes it is difficult for clinical staff to have frank conversations with patients and their families. In some cases, treatment provided during end of life is futile (i.e. it does not provide any benefit to patients). Some aggressive treatments also have the potential to create more damage than benefit, and can actually have negative implications for a patient's quality of life. Some patients are likely to have a better experience and quality of life if they do not spend their final months and weeks of life in hospital receiving futile treatments.

While end of life discussions do currently occur between clinical staff, patients and their families, the extent and effectiveness of these conversations varies very much between individual cases. There are a number of reasons why futile clinical interventions are currently given to patients:

- A common reaction is for patients and families to want a clinical intervention because they think it is likely to be beneficial compared to no clinical intervention, which is not always the case.
- Evidence-based protocols to inform clinicians, patients and families of the pros and cons associated with treatment at the end of life do not exist. This makes it harder for clinical staff to confidently inform patients and their families when they believe an intervention is futile.
- Clinical staff do not always have adequate time available to have in depth conversations with patients and their families about the best care plan for them, and as a result a futile intervention is often the default, "easier" and less controversial option (largely because of the two points above).

#### What is the opportunity?

**Reduce clinical interventions that are deemed to have no positive impact on patient's quality of life in the final months of life.** It was identified in focus group discussions with clinicians that this intervention is particularly relevant to TAVIs and other cardiology services. Steps to support this intervention are outlined below:

- **Form evidence based, best practice protocols for consistent implementation:** Services should undergo logical prioritisation to inform where to focus efforts initially. If TAVI were to be a priority area of focus, as has been indicated, then the a review of the 'patient reported outcome measures' (PROMs) for TAVIs should take place to determine when a TAVI is futile and this information should to used build best practice protocols. These protocols should then be consistently implemented across south London. These protocols will better equip clinicians to have honest conversations with patients and their families concerning futility of interventions.

### Intervention 7 (continued): Improve patient experience during end of life period and avoid unnecessary treatment.

- **Provide training to clinicians (e.g. doctors and nurses) so that they are better prepared and informed to have conversations around end of life care, and whether treatment is the best option or not:** This step should be taken in alignment with the introduction of evidence-based protocols. This step in turn should result in better education being provided to patients regarding their best treatment options.

The aggressive nature of some treatments on unwell patients can result in negative implications on their quality of life. Patient experience can be improved by these treatments do not go ahead.

Consistency in approach and protocols are helpful and knowing that all clinicians will be giving similar advice (based on evidence) around when a treatment is likely to be helpful or futile is reassuring. However, it is important to note that any decision around the best treatment/ care options will still sit with patients and their families. Forming evidence based protocols will simply better equip clinical staff to confidently provide sensitive information to patients.

### Intervention 8: Enhance IT systems to support improved data sharing across south London hospitals by creating a standardised format for data, for example for diagnostics.

#### Current situation

Currently patient information is not always shared well between hospitals. Issues with poor sharing of information are reported to be most pronounced in imaging and other diagnostic services, and is a particular issue when patients are transferred from one hospital to another. For example, an x-ray may be undertaken at a district general hospital (DGH) and then the patient is referred to a tertiary hospital (e.g. King's College Hospital). Often the clinical staff in the tertiary hospital are not able to view the x-ray. This could be because the x-ray is not shared/ made available or because the format in which the x-ray is shared is incompatible with the format used by the receiving service. As a result there are high levels of test duplication, which wastes both time and money. The time wasted includes both clinical staff time as well as the time of the patient in question. It also has negative consequences for other patients in the queue for the diagnostic test at the tertiary centre, because the queue length unnecessarily increases.

#### What is the opportunity?

##### Enhance the sharing of information between district generals and specialist hospitals by:

- **Improving connectivity in technology** - either through identifying shared systems across hospitals, or by utilising methods to convert data between systems
- **Developing common protocols for the transfer of information**, particularly when patients are being transferred between hospitals. Although initial focus should be given to inter-hospital relationships, protocols concerning the sharing of helpful information should also include transfers from primary care, e.g. GPs and community organisations. Compliance with these protocols will need to be monitored, and consideration will need to be given to how best to encourage compliance (which sometimes will require behaviour changes from clinical staff).

It is proposed that initial focus should be given to improving the sharing of information for diagnostic imaging e.g. Echo.

Reducing duplicative testing will have multiple benefits, including:

- Reduced staff/ resource time wastage in the specialist hospitals. This saves money that can be spent elsewhere, on services that benefit patients. This also means that the waiting times for diagnostics in the specialist centres should be shortened because fewer people will be in the queue for them.
- It should improve patient experience because patients will have quicker access to care and will not need to go through the same procedure multiple times.
- A decrease in waiting times and reducing any delays to treatment should help minimise deterioration of patients conditions and lead to better health outcomes.

## Intervention 9: Improve the support provided to patients who have been discharged from hospital following receipt of heart services

### Current situation

There is currently variation in the care available to patients who have been discharged from specialist hospitals, after receiving heart services. After a patient has received treatment at a specialist hospital they often require close attention in the community to ensure they stay as well as possible – for example to encourage them to eat healthily and exercise appropriately. Currently in some areas there is little education and a lack of structured care programmes in the community for patients to follow in order to help prevent them from having to return to hospital again.

### What is the opportunity?

#### **Improve the out-of-hospital care available for patients who have been discharged from hospital services, in order to help prevent the need to return (i.e. re-admission) to hospital:**

Further work is required to develop a comprehensive plan of exactly how support in the community could best be provided and improved, however it has been identified that:

- A review is required to determine the priority areas for improvement regarding cardiac rehabilitation programmes in the community (i.e. areas where there is little support available).
- A standardised set of protocols should be developed in partnership with primary care providers (i.e. GPs and broader community services) to ensure that best practice is followed as much as possible when establishing community services tailored for patients who have been discharged from specialist services. These protocols should then be applied consistently across south London so that patients receive consistent services which are evidence based and in line with best practice. Forming the protocols with input from both cardiac specialists and primary care clinicians will ensure a broad range of perspectives inform how community care is provided for this cohort of patients.
- Additional support could be provided to primary care through improved linkage between clinical staff in specialist hospital services (i.e. cardiac specialists) and GPs.
- Consideration should be given to how technology could help rehabilitation, and help to prevent the need for readmission into hospital. E.g. could mobile phone apps increase patients engagement and keep them following a rehabilitation programme?

Improving education and the management of patients who return to the community after receiving specialist cardiac hospital services should mean that patients will better understand of their condition and the steps that they need to take to prevent it from returning. If patients are better educated and better supported to live in a way that reduces their likelihood of needing to be readmitted into hospital (i.e. a healthier lifestyle) then this should mean improved health outcomes and improved patient experience.

Improved linkages between the specialised services and primary care, and the creation of a standardised set of protocols will also result in a system where clinicians in the specialist hospital remain more involved in a patients care once they are discharged from hospital, and they will be more able to influence the patient's care post-discharge. Again, the outcome of this should be that the quality of care received is improved and GP knowledge should also improve as a result.

Additionally, if fewer patients need to return to hospitals for further specialist input then this reduce the pressure on specialist services. It could mean an improved care/ shorter waits for those patients that are visiting specialist services for the first time and it could also help to reduce the amount of money that needs to be spend on high cost, specialist services because there should be less demand for the services, compared to the demand there will be if this intervention is not implemented.

### Intervention 10: Introduce collective purchasing (i.e. join up procurement) across South London hospitals where beneficial to do so.

#### Current situation

There is currently little collaboration between hospitals who provide specialised cardiac services in south London when it comes to buying/ procuring things needed to support patient care. Therefore opportunities for saving money through shared, 'bulk buying' are potentially being missed.

#### What is the opportunity?

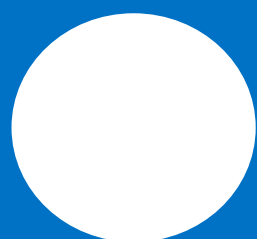
**There is an opportunity to save money if collaborative/ joint procurement is introduced across cardiac services in south London:** By procuring jointly, and thus buying in larger quantities, there could be increased purchasing power, allowing the negotiation of more favourable terms in procurement contracts (between the hospitals and the organisation providing the items or services in question).

Further work is required to establish the details of this intervention. Both the 'what' and the 'how' need to be considered further:

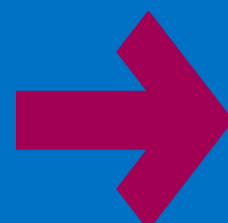
- The 'what': The hospital procurement teams and cardiac services involved will need to decide what items should be collaboratively purchased (e.g. drugs, equipment etc). Deciding upon the what to procure collectively will involve clinical teams and procurement teams from different hospitals across south London (primarily St George's, King's College and Guy's and St Thomas' Hospitals) discussing which products they will all use and the preferred choice of supplier. To some extent this activity complements the 'standardisation of best practice care/ provide consistent cardiac services' intervention (intervention 2). For some items it is likely to be the case that all three specialist hospitals already separately procure from the same supplier, and for these items it should be easier and faster to combine procurement/ 'bulk buy'. Where the different hospitals currently procure different items or use different suppliers then more preliminary work will be required.
- The 'how': The hospital procurement teams and cardiac services across south London will need to decide how best to manage this process. For example, whether a shared 'purchasing body' should be created and there is one contract between suppliers and this shared body, or whether multiple services/ hospitals will hold a contract with suppliers.

The direct impact on patient care that this intervention has is likely to be limited, but there will be indirect impacts:

- Collective procurement, if completed optimally, should support standardisation of services in line with best practice care. Therefore the benefits of best practice care consistently being delivered (i.e. improved patient care, patient experience and health outcomes) can be associated with collective procurement.
- If collective purchasing saves money then the money that is saved will help to bridge the gap between the growing demand for services and the growth in money available to fund these services. If this gap can be bridged by minimising wasted spend (as this intervention does) then it means this funding gap will not need to be bridged in ways that could compromise patient care.



# Appendix 1: Prioritisation criteria

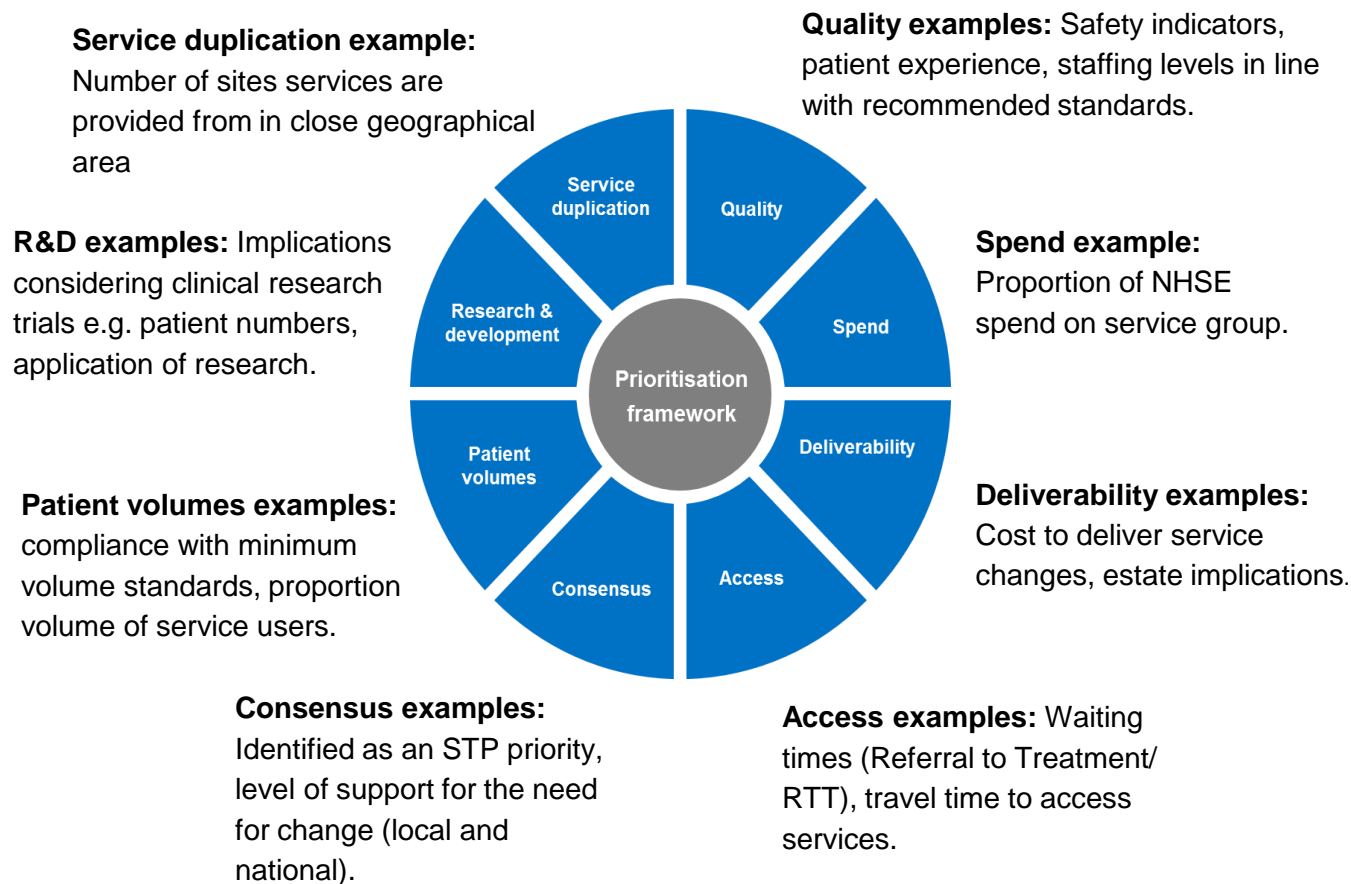




## Prioritisation criteria

### Deciding which specialist services were the priority areas for focus

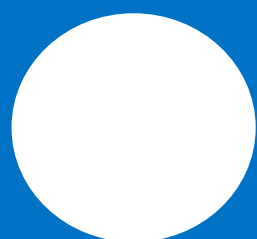
In order to identify which clinical services it was most sensible to focus initial transformation efforts on, a prioritisation exercise was undertaken. Eight criteria against which to assess each service group were identified for use in the prioritisation exercise. These criteria are shown in the figure below. The criteria contain a mix of qualitative and quantitative, as well as clinical and non-clinical indicators.



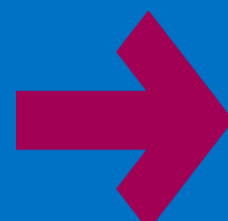
These eight criteria were selected for the framework from:

- Prioritisation frameworks adopted in preceding work on specialised commissioned services which have been previously developed with patient feedback
- Best practice principles and the professional judgement of the programme team
- Consultation with staff within NHS England
- Co-designing and validating with Steering Group members.

The service groups that were identified using this criteria are stated within the main document.



## Appendix 2: Glossary



<b>Angiogram</b>	An X-ray test that uses a special dye and camera (fluoroscopy) to take pictures of the blood flow in an artery (such as the aorta) or a vein (such as the vena cava). An angiogram can be used to look at the arteries or veins in the head, arms, legs, chest, back, or belly
<b>Aortic surgery</b>	Surgery performed on the aorta. The aorta is the main artery in the human body which is connected to the heart via the left ventricle. Oxygenated blood will pass from the heart through the left ventricle to the aorta from which it will travel to the remainder of the body.
<b>Atrial Fibrillation (AF)</b>	A heart condition that causes an irregular and often abnormally fast heart rate.
<b>Cardiovascular Commissioning Project (2010)</b>	A project aimed at reviewing cardiovascular services in London and supporting commissioning of improved services for Londoners with cardiovascular disease.
<b>Clinical Commissioning Group (CCG)</b>	NHS organisations set up by the Health and Social Care Act 2012 to organise the delivery of NHS services in England. CCGs are clinically led groups that include all of the GP groups in their geographical area. The aim of this is to give GPs and other clinicians the power to influence commissioning decisions for their patients. Clinical commissioning groups are supposed to work with patients and healthcare professionals and in partnership with local communities and local authorities. Clinical commissioning groups are responsible for arranging emergency and urgent care services within their boundaries, and for commissioning services for any unregistered patients who live in their area.
<b>Coronary artery</b>	The heart muscle has its own blood supply to support it functioning through coronary arteries and ventricles. The aorta from the heart branches into two coronary arteries which supply blood to the heart itself.
<b>DGH</b>	District general hospital. These services are generally major providers of hospital care in local communities. These differ to specialist (tertiary) providers who provide more specialised and complex care for patients.
<b>Echo</b>	Abbreviation of 'echocardiography'. Echocardiography, also known as a cardiac ultrasound is a diagnostic procedure which uses sound waves to take 'pictures' of the main components of the heart (e.g. chambers, valves, walls, blood vessels).
<b>Endocarditis</b>	Infection of the inner lining of the heart (known as the endocardium). This is most commonly caused by bacteria entering the blood and travelling to the heart.
<b>EP</b>	Abbreviation of 'electrophysiology'. Electrophysiology studies are tests that records the electrical activity and electrical pathways of the heart to be able to study the health rhythm. The teams performing these studies are known as Electrophysiologists.
<b>Heart failure</b>	Severe failure of the heart to function properly. Often it is referred to as 'congestive heart failure' which is the condition where the heart is unable to pump sufficient blood to meet the needs of the body. There are a number of reasons as to why this is the case, but often is related to the heart either being too weak, or stiffening.
<b>Mitral surgery</b>	Surgery performed on the mitral valve, either to repair or replace it. The mitral valve, also known as the bicuspid valve or left atrioventricular valve is a dual-flap valve in the heart that sits between the left atrium and left ventricle. As the mitral valve supports blood flowing into the left ventricle prior to being pumped to the aorta and the body, poor functioning of the valve can effect blood supply to the body.

<b>Multidisciplinary team (MDT) meeting</b>	Involves the meeting of a group of professionals from one or more clinical disciplines (e.g. medical professionals, nurses, allied health) who together make decisions regarding recommended treatment of individual patients. These meetings can also include patients and their families and carers.
<b>Primary angioplasty</b>	A procedure often in response to a myocardial infarction (heart attack). A primary angioplasty is completed to clear a blockage in the artery. A catheter (hollow tube) with a balloon at its tip is guided through the aorta to the blocked artery in the heart. The balloon is inflated to clear the blockage, a thin metal tube, called a stent, surrounds the balloon.
<b>Patient pathway</b>	The route that a patient will take from their first contact with an NHS member of staff (usually their GP), through referral, to the completion of their treatment. It also covers the period from entry into a hospital or a Treatment Centre, until the patient leaves.
<b>Primary care</b>	Primary health care is the first point of contact for health care for most people. It is mainly provided by GPs (general practitioners) but community pharmacists, opticians and dentists are also primary healthcare providers.
<b>PROMs</b>	Abbreviation for 'Patient Reported Outcome Measures'. These are a series of questions patients are asked to gauge their views on their health. They are not focused on a patient's experience of the service, but of their health and health-related quality of life. They are often used in place, or in addition to other quality measures through physiological outcomes.
<b>Provider</b>	Usually refers to a hospital. There are different types of providers (hospitals). Some will provide secondary care, which is sometimes referred to as 'hospital and community care', can either be planned (elective) care such as a cataract operation, or urgent and emergency care such as treatment for a fracture. Tertiary care refers to highly specialised treatment such as neurosurgery, transplants and secure forensic mental health services.
<b>Repatriation</b>	Repatriation is the process of returning a person - voluntarily or forcibly - to its owner or their place of origin or citizenship.
<b>Rota</b>	Staff schedule or roster. The allocation and assignment of staff to work.
<b>RTT</b>	Abbreviation for 'Referral to Treatment'. The NHS Constitution gives patients the right to access services within maximum waiting times, or for the NHS to take all reasonable steps to offer a range of suitable providers if this is not possible. The NHS Constitution sets out that patients should wait no longer than 18 weeks from GP referral to treatment.
<b>STP</b>	STPs are five-year plans covering all aspects of NHS spending in England, as well as focusing on better integration with social care and other local authority services. The scope of the STPs is to address population needs in each assigned geographical 'footprint' by improving quality and developing new models of care; improving health and wellbeing; and improving efficiency of services in a financially sustainable way. Forty-four areas have been identified as the geographical 'footprints' on which the plans are based, with an average population size of 1.2 million. Most STP leaders come from clinical commissioning groups (CCGs) and NHS trusts or foundation trusts, but a small number come from local government.
<b>Tertiary provider/hospital</b>	A tertiary provider (or centre) is a hospital that provides specialist patient care. They will have staff that are specialist in their field and specialist equipment that is not available at all hospitals. Patients will be referred to a tertiary centre if they require specialist services. Patients care be referred to a tertiary centre or service from a smaller, less equipped hospital (e.g. a district general) or directly from a GP.
<b>TAVI</b>	Abbreviation for 'Transcatheter aortic valve implantation'. It is a non-surgical alternative to open heart surgery in which a catheter (hollow tube) with a balloon at its tip is inserted into an artery and passed up to the aortic valve. The balloon is inflated, opening the space and a new valve is put in place.