Establishing a Priority Acute Cardiology e Referral - PACeR Pathway

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Introduction

There are a significant number of patients who present to hospital with chest pain and are subsequently discharged from the Emergency department (ED), Same Day Emergency Care (SDEC) or from medical wards after an Acute Coronary Syndrome (ACS) has been excluded; many such patients need to be seen promptly and investigated on an outpatient basis.

There is no definitive outpatient pathway to safely manage this cohort of patients unless they go back to GP to be referred into Cardiology. Consequently, this has a negative impact on admission rates, length of stay, reattendances and waiting times.

Demand has outweighed capacity and there is a risk of a Major Adverse Cardiac Event (MACE) due to waiting times, with several patients having been lost to follow up.

There is also disparity between the primary care and secondary care referral pathway. Patients are disadvantaged depending on how care is accessed, and there are unnecessary and often multiple patient encounters.

Objectives

Evaluate existing system and current demands

Create a robust and effective referral pathway with timely review based on risk stratification, together with adequate clinical outpatient resources

Identify those who require a 'fast track' management as outpatients

Reduce patient encounter by streamlining referrals

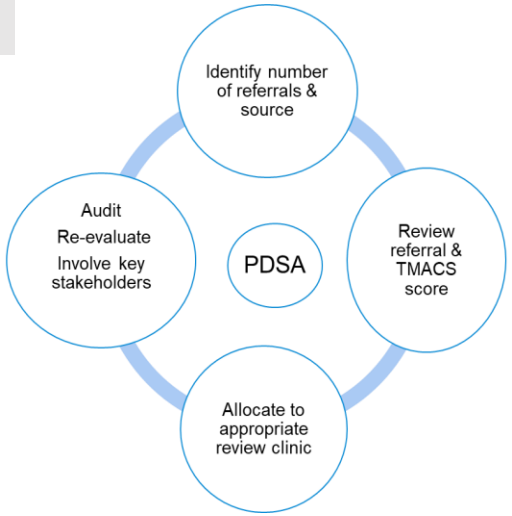
Emerging Leaders Programme
British Cardiovascular Society

Method

We undertook a 2-month audit to identify the number of patients referred to Cardiology from SDEC/ED/Unscheduled care following a hospital attendance with chest pain. The data was collected prospectively as the patients were referred; the outcomes were analysed retrospectively following outpatient clinic reviews.

Patients were risk stratified using the Troponin-only Manchester Acute Coronary Syndromes (T-MACS) decision aid and assigned to a priority clinic based on risk score.

The clinical pathway was designed following a PDSA cycle. By engaging with key stakeholders and service users it allowed forward planning in regards to the additional outpatient clinical activity required. We were able to identify the current demand for clinic slots and optimise the pathway.



Results & Outcome

Audit period - March 2023 to April 2023

72 patients referred via PACeR pathway		
Male	34	47%
Female	38	53%
Triaged within 72 hours	72	100%
T-MACS Very low risk	36	50%
T-MACS Low risk	26	36%
T-MACS Moderate risk	6	8%
T-MACS High risk	0	0%
Readmitted prior to appt	2	3%
Referral inappropriate	2	3%
Appt date within 4 weeks of referral	62	88%
MACE	0	0%

Preliminary figures demonstrate a reduction in duplicated bookings and wasted clinic slots. It has accurately identified moderate/high-risk patients who were brought back for immediate review.

There is potential to reduce reattendances/MACE with a clear follow-up plan, which is communicated to the GP in the discharge letter.

This modified referral system has improved patient experience whilst meeting patient expectation and service demands, with a clear vision for service improvement.

Discussion

The ability to 'Triage to test' (echo / 24-hour tape) has reduced the need for repeated appointments, with results being available at clinic. It has ensured follow-up with appropriate cardiologist, identified the requirement of interpreters or face to face appointments and has optimised clinic appointments. Inappropriate referrals can be filtered out and a telephone follow-up provided. Obtaining lipid profiles and HBA1C prior to the appointment will identify risk factors and facilitate further management and patient advice.

Conclusions

In this quality improvement project, we have designed a clinical pathway for stable chest pain presentations. Referrals received via **PACeR** pathway have been triaged utilising the T-MACS risk stratification tool, which has:
i) enabled very low and low risk patients to be seen within 4 weeks of referral.
ii) identified the need for an allocated regular 6/8 clinic slots per week to accommodate the number of patients.
iii) facilitated service planning, service redesign and effective resource allocation.
iv) allowed early identification and review of moderate/high risk patients within 72 hours of referral on a 'rolling clinic' basis.

We aim to change the terminology of RACPAC to **PACeR** for clarity for the GPs and patients; this will be incorporated and clearly communicated in discharge letters, with a commitment that an appointment will be issued within 4 weeks.

The **PACeR** pathway provides assurance that there is a robust patient follow up in place with a potentially significant reduction in bed occupancy, reattendances and better patient experience, reducing waiting times in ED/SDEC and unnecessary travel back to hospital.

PACeR ensures that the patient is central to care provided with the right treatment with the right person at the right time.

References

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BHF CVD Factsheet (England) 2023