Cardiac Outreach for Acute Medicine – Phase 1: Stable Chest Pain.

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Introduction:

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Chest pain presentation to the ED is considerable and represents the most abundant patient cohort at MFT. There is a lack of a clear clinical pathway for acute chest pain presentation that falls outside of ACS / emergent pathology or clear stable symptoms in the ED population. Coupled with difficulty in obtaining direct advice from Cardiology there is often a delay in patients receiving timely access to appropriate first-line investigation, an over-reliance on Cardiology registrar opinion, lack of understanding from acute medicine regarding Cardiac provision and severed relationships between acute medicine and Cardiology. National reports have highlighted importance of timely access to diagnosis and management in CV disorders and it is clear that as a profession we need to facilitate 7/7, 24hr working, develop effective clinical pathways and adopt novel ways of working to help achieve this in a strained system [(1)].

Objectives:

1. Scope current provision.
    1. Delays to expert opinion
    2. Over-reliance on Cardiology registrar.
    3. Delay to appropriate investigation.
    4. No clear pathway outside of acute / emergent pathology.
    5. Strained relationships.
2. Develop an ideal solution.
    1. Advanced clinical practitioners.
    2. Same-day assessment of patients.
    3. Access to most appropriate investigation.
    4. E-referral / virtual ward.

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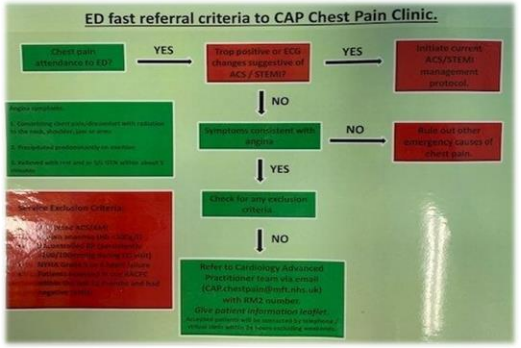
Methodology:

Pilot programme to facilitate timely access to Cardiology opinion, assessment, investigation and management – to encompass all presentations but phase 1 – stable chest pain.

All CP visits to ED that are non-emergent and hence deemed stable. Set criteria for admittance to the clinic (see figure 1) no change to acute emergent presentation pathway.

Initial plans were virtual ward but restricted due to IT.



Accepted patients contacted within 24 hours (excluding weekends) initially. Timely access to investigation and results. Patients given results and management plan immediately following investigations.

Pilot data collected for first 100 patients (x1 FTE staff) over a 15 week period. Patient feedback via Survey Monkey online.

Results of initial pilot audit:

Cardiac Outreach Stable Chest Pain Pilot (4 months)	
Total number of patients.	108
Gender.	48 male (44%) 60 female (56%)
Age.	Males 58yrs (range 32 – 78) Female 55yrs (range 29 – 78)
Avg. time to (initial referral received).	1 day (range same day – 6 days).
Avg. time to (clinic contact with pt).	2 days (range 1 day – 8 days).
Suitability of referral (accepted).	98% (x2 rejected both low Hb, one also significant HTN).
Typical symptoms	6%
Atypical symptoms	94%
Avg. Qrisk 3	27%
Avg. PTP (Diamond Forrester)	14%
Known IHD	11%
Other previous cardiac history	4%
Avg. time of tele-consult.	~15mins
Avg. admin time per patient.	~30mins
Discharged after initial consult.	2%

Cardiac Outreach Stable Chest Pain Pilot (4 months)	
Further 1st line investigations required after initial consult	
TTE	5%
Ambulatory ECG monitor	<1%
ESE	61%
DSE	30%
CTCA	2%
Avg. time to initial investigation.	45 days (range 6 days – 94 days**)
Avg. time to 2nd line investigation (initial consult)	
Angiogram	42 days (3% of patients)
TTE	64 days (6% of patients)
DSE	74 days (6% of patients)
CTCA	Still awaiting....**
Ambulatory ECG monitor	91 days (2% of patients)
Avg. time to initiation of treatment (initial consult)	
Medication	47 days (range 8 days – 68 days).
PCI	23 days (range 14 – 45 days).

Comparison to current GP referral RACPC:

1. Current wait 3 weeks for clinic consult.
2. More reliance on CTCA – delay to diagnosis given 20+ week wait.
3. Average time to d/c back to GP range is 10-48 weeks.
4. Less adaptability to cope with alternative diagnosis and treatment avenues (e.g. palps, HVD).

Results continued:

Cardiac Outreach Stable Chest Pain Pilot (4 months)	
Avg. time result letter sent to GP / patient	
From initial referral	47 days
From after final investigation / consult	2 days
Number pts referred into another service	2 (2%)
Number pts providing feedback of service	24

***Patient feedback example**:*

"I was worried about my symptoms so came to A+E on advice of my GP. Now I am happy that my symptoms are not related to my heart".
"I was surprised to receive a call so quickly after my visit to the hospital".
"I am happy my heart seems okay, but still don't know why I am getting symptoms!".

Successes:

- ***Timely access to clinical assessment and diagnostic testing in majority of patients.***
- ***Typically re-assurance and reduced return to ED, getting back to work and normal life patterns.***
- ***Expert opinion outside of 'stable chest pain' – e.g. valve pathway, palpitation pathway.***
- ***Timely access to angiography +/- PCI.***
- ***Knowledge of local landscape so timely access to investigation or further escalation.***

Challenges:

- ***Staff resource.***
- ***Covid.***
- ***EPR and Hive (IT systems).***
- ***Directorate / Trust support for resources.***
- ***ED Logistics / ways of working.***
- ***CT waiting times.***
- ***Clinical decision making with respect to patient anxiety.***

Conclusions:

Findings: More effective and efficient pathway for the rapid diagnosis and investigation of stable chest pain presentation to ED.

Limitations: One man band, financial restrictions, waiting time for diagnostics.

Future targets: Resource allocation to allow for full service provision and expansion. Awaiting approval of business case to facilitate this.

References:

1. Clarke S. and Ray S. Cardiology. GIRFT Programme National Speciality Report. (Feb 2021). https://www.gettingitrightfirsttime.co.uk/medical-specialties/cardiology/

NO CONFLICT OF INTEREST DECLARED