Future Hospital Journal 2015 Vol 2, No 2: s32

Bringing outpatient cardiology into the community: an alternative to hospital-based clinics

Authors: John Caplin, Alan Fussey and Jane Sargent

Aims

To assess the patient numbers, investigations and outcomes in a community-based consultant-run cardiology clinic.

Methods

In April 2013, the City Health Care Partnership began community-based cardiology clinics in Hull. The clinics commenced as one session per week, and from October 2013 increased to two sessions per week. GPs requested investigations (12-lead electrocardiogram (ECG); 24-hour ECG; 24-hour blood pressure (BP); transthoracic echocardiography), and indicated whether they wished for a consultant opinion. The patients were seen by a nurse practitioner prior to the tests. The results were telephoned back to the GP. If there was a significant abnormality, a clinic appointment was made. All patients with an initial diagnosis of chest pain were seen by the consultant. The clinic was paperless, with patient data entered onto a specifically designed cardiology template on System One. Anonymous data were obtained from the IT system, and analysed with regard to the numbers of patients, the types of initial investigations, and the outcomes. We report the data for the first year of operation.

Results

830 new patients were assessed (69 per month). 523 (63%) were seen by the consultant (44 per month), and 102 (20%) required a follow-up appointment (nine per month). The new:follow-up ratio was 1:0.2. The median wait from referral to clinic was 13 days for all patients, and 6 days for patients with chest pain. A total of 1,345 investigations were performed, an average of 1.6 per patient. These consisted of: 706 12-lead ECGs (59 per month); 325 24-hour ECGs (27 per month); 222 transthoracic echocardiograms (19 per month); and 92 24-hour BPs (eight per month). 129 patients (25% of those assessed by the consultant) were referred on to either the local NHS trust (56%) or a private provider (44%), dependent upon patient choice and diagnosis. The majority of referrals were for possible ischaemic heart disease (79%); of these, 38% went to the NHS provider and 62% to the private provider. 17% of referrals were for possible arrhythmias, and the remainder (4%) for various other diagnoses including adult congenital heart disease, heart failure, mitral valve dysfunction and device problems.

Conclusions

A community-based consultant-run cardiology clinic speedily assessed stable cardiology patients, and reduced onward cardiology referral by 75%. Widespread introduction is likely to free up clinic spaces in secondary and tertiary providers, and reduce waiting times.

Conflict of interest statement

None. ■

Authors: City Health Care Partnership, Kingston-upon-Hull, UK