

Establishing a Vascular Optimization Clinic in Greater Manchester



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SUMMARY

Preventive cardiology concentrates on the long-term outcome, emphasising that the modification of risk factors in CAD patients may have a greater impact on longevity than sophisticated interventions [1].

Greater Manchester (GM) currently has the highest premature cardiovascular mortality in England [2]. In the semi-devolved healthcare system of the region (Devo Manc) the CVD Strategic Clinical Network has set a target of reducing cardiovascular death by 600/yr. Secondary prevention for high-risk patients is crucial but currently lacks dedicated structures beyond the immediate post-infarct period.

In a pre-existing arrangement, GM currently enjoys the services of a community based 'Tier 2' cardiology clinic staffed by GPSi and ANPs, previously purposed with seeing low-risk out-patient cardiac presentations. By re-allocating capacity within this structure, in a pilot project supported by the CCG and SCN, we describe the establishment of a vascular disease optimization clinic, freely modelled on similar work elsewhere [3], for survivors of myocardial infarction

OBJECTIVES

To pilot the formation of a vascular optimization clinic to manage lifestyle factors and guide optimization of medical therapy for patients presenting with acute coronary syndromes, utilizing protocolized care in a community setting with 'non-expert' teams

Implement automatic referral systems reducing physician and secretarial time, whilst providing a seamless patient journey

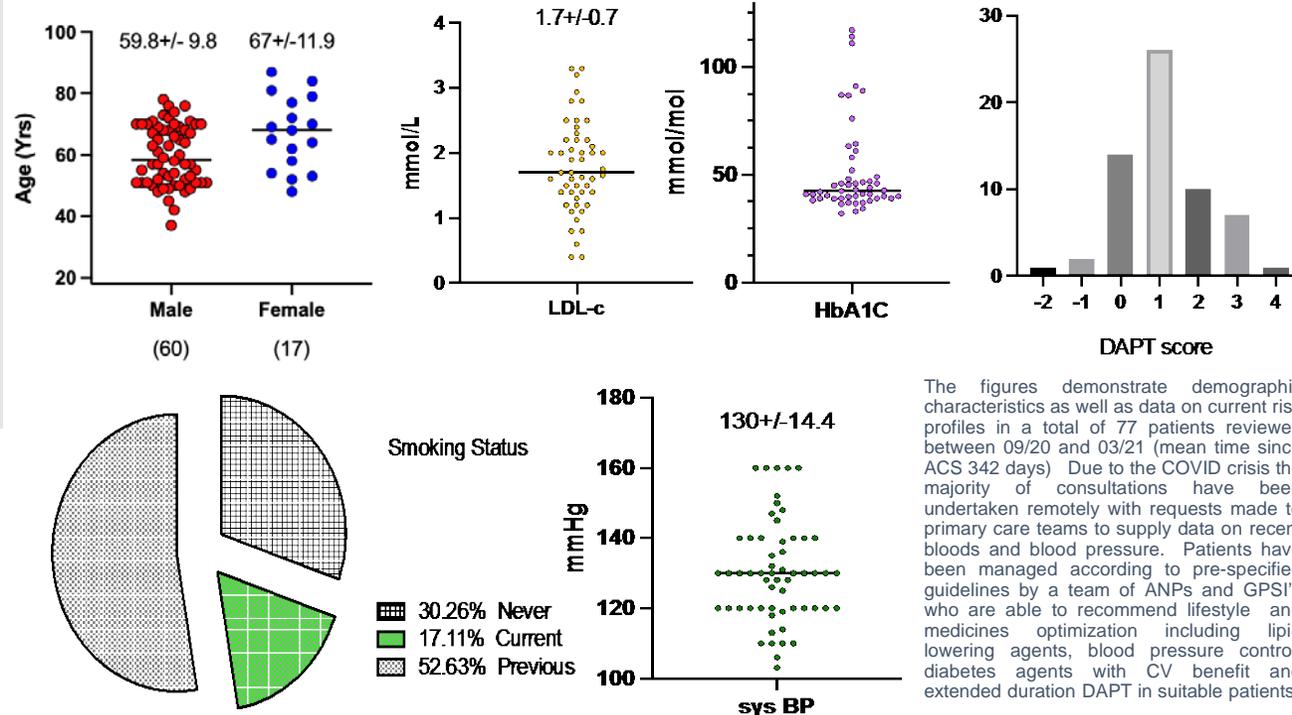
Secure funding commitments with pilot data from the clinic for presentation to the CCG, in a formalized business case utilizing leadership and management strategies learnt during the ELP programme

METHODS

Initial approaches were made shortly before the start of the ELP programme utilizing a wide-ranging engagement strategy to gain support of key regional bodies including the CVD SCN, staff in the Tier 2 clinic and clinical staff working in the cardiology departments of MFT. A brief business case was presented to the CCG who supported re-allocation of clinic space in alignment with goals to reduce CV mortality and encourage community care.

A wide-ranging protocol for medical management was agreed with stringent lipid, blood pressure and diabetes targets allowing protocolized care in the community with the ability for advice and guidance from cardiology staff where necessary, as well as governance and oversight, but without the need for regular clinical involvement. With further engagement with departmental managerial staff, we have implemented cross-site protocols for electronic referrals

RESULTS



which are now automatically generated at the time of discharge, improving efficiency, the likelihood of broad patient capture and simplifying processes, which are ultimately more likely to be sustainable.

CONCLUSIONS

In this pilot project we thus far been able to demonstrate the establishment of a community Vascular Optimization Clinic utilizing protocolized care to deliver a programme designed to optimize risk factors and ultimately to reduce the likelihood of recurrent cardiovascular events. Despite numerous challenges due to COVID we have reviewed 77 individuals, mostly remotely, characterizing residual risk with low cost, easily available data and implemented personalized lifestyle and medical optimization without increasing pressures on secondary or primary care services. We have seen high levels of patient engagement with only 5 individuals thus far declining referral or not attending. We have also been able to establish a robust electronic referral system between hospital and community services, increasing sustainability and reducing the likelihood of missing patients.

A number of challenges remain. At this early stage we have no data on the effects of our interventions in terms of risk reduction and will ultimately need to rely on surrogate markers (e.g. reduction in BP or LDL-c) to demonstrate efficacy rather than clinical end-points. We are currently only able to offer a first appointment at approx. 12 months post ACS due to constraints on clinic time and ultimately this was seen as the most efficient time point in terms of decision making on prolonged DAPT, however it is acknowledged that patients may have already endured significant risk during this time. Finally, other factors such as patient satisfaction, longer term adherence and cost effectiveness will be important in formalizing a business case to the CCG and will require further data.

REFERENCES

- [1] Piepoli MF, Corrà U, Dendale P, Frederix I, Prescott E, Schmid J-P. Secondary prevention after myocardial infarction – key messages document – available at www.escardio.org
- [2] BHF CVD Statistics Factsheet (England) Jan 2021
- [3] Khatib R, Patel N, Laverty U, MCGawley G, McLenachen J, Shield S, Hall AS. Re-engineering the post-myocardial infarction medicines optimisation pathway: a retrospective analysis of a joint consultant pharmacist and cardiologist clinic model. *Open Heart*. 2018 Dec 10;5(2)



The figures demonstrate demographic characteristics as well as data on current risk profiles in a total of 77 patients reviewed between 09/20 and 03/21 (mean time since ACS 342 days) Due to the COVID crisis the majority of consultations have been undertaken remotely with requests made to primary care teams to supply data on recent bloods and blood pressure. Patients have been managed according to pre-specified guidelines by a team of ANPs and GPSi's who are able to recommend lifestyle and medicines optimization including lipid lowering agents, blood pressure control, diabetes agents with CV benefit and extended duration DAPT in suitable patients.