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 GPs 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

RESULTS
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 pressure 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 have 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 a future 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 formalising a business case to the CCG and will require further data.

CONCLUSIONS
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.

REFERENCES