

## Long-term cardiovascular conditions:

the role of primary care

Cardiovascular disease is a long-term condition with a serious and often fatal acute presentation. While progress has been made in reducing mortality, there are around 2.7 million people are living with coronary heart disease (CHD) in the UK.<sup>1</sup> The 2010 review of the Coronary Heart Disease National Service Framework (NSF)<sup>2</sup> acknowledged the success in reducing mortality from CHD. This trend has been observed over the past 5 decades. The number of people dying from CHD has more than halved from 166 000 in 1961 to about 80 000 in 2009. The percentage of 55 to 59 year-old females dying after a heart attack nearly halved between 1968 and 1998 while the percentage of males aged 60 to 64 years fell by a third.<sup>3</sup>

### ROLE OF PRIMARY CARE IN REDUCING RISK

Behavioural risk factors, smoking, alcohol consumption, unhealthy diet, and physical inactivity are responsible for 80% of CHD and stroke.<sup>4</sup> However, estimates suggest 25 000 deaths still occur in the UK attributable to smoking alone.<sup>1</sup> We have some way to go in understanding how to motivate and support behaviour change in individuals living with or at high risk of cardiovascular disease (CVD).

*The British Heart Foundation's Factfile on Pre-eclampsia and Cardiovascular Disease Risk can be found with the print issue of the BJGP.*



Primary care in the UK is ideally placed to take on the challenge of long-term management and prevention of CVD, and is arguably the only sector of the health service with the capacity to address the burden of CVD and CVD risk factors.

### CONTINUITY OF CARE

Chronic disease management clinics in the 1990s made a start at systematic care for patients with long-term conditions such as diabetes and heart disease. The General Medical Services Contract 2004 introduced a number of measures that incentivise more systematic long-term condition management, including the Quality and Outcomes Framework. This has had an impact: in 2008, around 266 million prescriptions were issued for CVD in England, nearly five times as many as issued in 1986.<sup>3</sup>

The RCGP policy paper on *Promoting Continuity of Care in General Practice*<sup>5</sup> highlights the importance of both 'relationship continuity' and 'management continuity'. As providers of care and as commissioners of care, primary care will have the responsibility for both.

The importance of the therapeutic relationship is acknowledged as vital by patients and healthcare professionals. International comparisons, however, suggest that UK primary care could do better. While British patients gave more positive reports of UK doctors' communication skills compared to North American patients, British doctors did less well in supporting patients in self-care and self-management.<sup>6</sup>

Continuity of management benefits from the position of primary care to coordinate care, assist the patient in navigating the increasingly complex healthcare environment, and support self-care and self-management.

### CARDIAC REHABILITATION

Evidence shows that comprehensive

cardiac rehabilitation not only improves quality of life, promotes supported self-management, and reduces total cardiac mortality by 26%,<sup>7</sup> but is also highly cost-effective, estimated to cost around £477 per patient,<sup>8</sup> with great potential to deliver significant savings through reducing costly unplanned readmissions.

The 5<sup>th</sup> National Audit of Cardiac Rehabilitation, October 2011, found that in England, Wales, and Northern Ireland, 42% of people who had a heart attack, an angioplasty, or bypass surgery attended cardiac rehabilitation in 2009/10.<sup>9</sup>

Primary care is unlikely to be able to take on this responsibility of long-term condition management alone. Cardiac rehabilitation is a cost-effective model of care that reduces cardiac mortality, as well as promoting self-management and improving quality of life. However, the review of the 2010 NSF states:

*'This report highlights continuing concern around the processes and outcomes of cardiac rehabilitation. Ethnographic interviews with patients indicate that there has been insufficient focus on understanding how to motivate the necessary behaviour changes of individuals living with, or at high risk of, coronary heart disease.'*<sup>2</sup>

Research from the US has found that in patients undergoing primary percutaneous coronary angioplasty following myocardial infarction, 14% will be readmitted within 30 days of discharge.<sup>10</sup> This research also shows that cardiac rehabilitation significantly reduces the 60-day readmission rate (from 23% in the control group to only 6.7% in the group receiving cardiac rehabilitation). There is evidence that these findings could be replicated in the UK: Connecting for Health's Secondary Uses Services data, aligned with National Audit of Cardiac Rehabilitation data, are able to track a reduction in unplanned

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readmissions among those patients who attend cardiac rehabilitation. In developing a case for change, regional and national analysis of unplanned admissions, associated with cardiac rehabilitation, will be completed later this year. Tools to support the effective commissioning of cardiac rehabilitation have been developed by the Department of Health.<sup>8</sup>

### FUTURE REFORMS

The shift in the natural history of CVD from a lethal condition to a long-term condition requires a commensurate shift in the approach to management. Primary care is in a unique position to contribute to commissioning clinically and cost-effective services, providing management and therapeutic continuity of care, and contributing to the public health agenda. If the current NHS and welfare reforms in England, and the response to the challenging financial public sector provision in all four UK administrations are to be beneficial, supporting the strengths of primary care to provide coordinated, holistic, and personalised care will be vital.

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