Improving care for patients with heart disease: implications of the Fifth report on the provision of services for patients with heart disease

Details of the 'Fifth report on the provision of services for patients with heart disease', compiled jointly by the British Cardiac Society and the Royal College of Physicians, were published recently. We recommend that all health workers concerned with the care and management of patients with cardiovascular disorders should be aware of the report and contribute to its implementation.

This article provides a concise summary of the report's main findings and highlights some of the substantive changes that are required to ensure that a patient-centred service is able to deliver a minimum standard of care that the population of the UK not only needs but has every right to expect. The full 56-page report is published in *Heart*[1] and is also available on the British Cardiac Society website (www.bcs.com). The inclusion of comprehensive lay summaries will help ensure that important information will be freely available in the public domain and readily accessible to patients, their relatives and carers.

It is now nine years since the Fourth report provided a template for the planning of cardiovascular services in the UK. The Fifth report was written in co-operation with a wide range of health-care professionals. The fact that so many took part exemplifies the need for a co-ordinated multidisciplinary approach to the care of patients with cardiovascular disease. Invaluable input from patients' representatives and lay members has helped to ensure that the planning and development of future cardiac care remains patient-centred. This latter point cannot be overstated at a time when significant changes in health service financing and the structure of primary care and its interface with secondary/tertiary care are in progress or underway.

While the Fifth report highlights current inadequacies in the provision of care for cardiac patients, it also recognises the important advances in the organisation and structure of cardiovascular care over the past few years. To respond to both extensive periods of chronic under-funding and continuing technological advances within interventional (including surgery) and non-interventional cardiology, still further dramatic changes are required. These will provide an accepted standardised minimal level of care that is available to all patients irrespective of their background or post-code.

Main findings

The main findings of the Fifth report are:

- Conditions not included in the National Service Framework (NSF) for Coronary Heart Disease (CHD) should receive the same degree of attention. The NSF should be implemented consistently throughout the entire UK.

  The NSF for CHD has helped improve current management of this condition in England. No equivalent of the NSF has yet been implemented in Northern Ireland, Scotland and Wales. Similar recommendations are urgently required for patients with other disabling and potential lethal conditions including heart failure, valvular and congenital heart disease.
- Patients need to be brought into the process of planning cardiovascular services to ensure that the service truly becomes patient-centred.
- There is a severe shortage of all types of properly trained health professionals. More cardiologists, cardiac surgeons, cardiac nurses, technicians (cardiac clinical scientific officers, CCSOs) and support staff are needed to provide a modern and effective cardiovascular service.

  Problems in staffing are particularly apparent for cardiac nurses and CCSOs and more so in urban areas where the cost of living is higher. Approximately twice as many consultant cardiologists are required to bring the total from 630 to 1,200. Changes as a consequence of the European Working Time Directive means that an estimated 1,500 consultant cardiologists will be needed by 2010.
- Information technology (IT) must be improved to facilitate communication of patient details, for education, training and data collection. It is the only way to guarantee effective audit and clinical governance.

  Improvements in IT are required throughout the network of care for patients – these must be linked at primary, secondary and tertiary care levels. Alongside improving IT systems, clerical and computing staff must also be increased.
- Reorganisation of working practices to ensure that staff

are used more efficiently, particularly by reviewing and revising their roles.

- Quality will only be maintained if levels of training and continuing professional development (CPD) for all staff are high and there is effective clinical governance. Here, time and resources must be allocated rather than expecting that this can be 'squeezed' into the existing service.

Implications

It is beyond the scope of this article to discuss all aspects of the report and mechanisms needed to implement the recommendations. It is worth remembering that while the Fifth report focuses on patients with cardiac disease, the majority of recommendations are relevant to all medical disciplines. Expanding and improving cardiac services, for example, must be linked to increasing manpower elsewhere. As we work towards a 24 hours a day, seven days a week, consultant-led cardiology service for acute coronary syndromes and other cardiac conditions, it is inevitable that a district general hospital cardiologist will have restricted time for general medical commitments. An increase in the number of consultant cardiologists therefore needs to be mirrored in other medical specialties and in primary care. Each of the last two years has seen an increase of 25 National Training Numbers (NTNs) in cardiology, which currently total 405 in the UK. A further increase in the number of trainees will inevitably be required to meet the expansion in consultant numbers (including anticipated retirements). Planning is not straightforward – the trainees recruited today represent the consultants of six to seven years' time. Any expansion of trainee numbers now must also take into consideration further structural changes anticipated in these intervening years.

Primary Care Organisations (PCOs) should spearhead the primary care effort. This will both necessitate an appropriate skill mix and require an estimated 30% expansion of the GP workforce. By the year 2004 some 75% of the NHS budget will be directed through PCOs, who will plan and support new models of care. Integral to this will be 'GPs with special interests' (GPSIs), who will have to meet a nationally agreed minimum set of standards for training and accreditation. Cardiac nurses will also have a key role in the link with primary care, rehabilitation and in rapid access chest pain clinics.

It is always disappointing when inadequacies of patient care are highlighted. Many involved in the provision of health care already feel undervalued and overworked. The Fifth report documents the substantial changes required in the development of cardiac services in the UK that, if implemented, will not only improve patient care but also working conditions. Implementing change will require major increases in funding, manpower, and up-to-date information technology. All disciplines involved in the provision of care to patients with heart problems must co-ordinate their efforts. A commitment to improved staffing, career structure, working conditions and pay, is also fundamental to improving recruitment in other disciplines (in particular cardiac nurses and CCSOs) and to boost the low morale of those already in position. These changes will not be achieved overnight and funding is not limitless. Prioritisation must occur. The goal, however, is clear: patients in the UK deserve first-rate cardiac care and should not feel that their management is inferior to other European or North American countries.

Reference

1. Hall R. Fifth Report on the Provision of Services for Patients with Heart Disease. *Heart* 2002;**88** (suppl III):1-59.

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