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Opinion

Perinatal care in primary care for cardiovascular risk reduction ☆

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ABSTRACT

General practitioners (GPs) and multidisciplinary members of the primary care team in the UK have, since the earliest days of the NHS, played a key role in the care of women throughout their perinatal journey, particularly postnatally. With cardiometabolic complications of pregnancy becoming increasingly common, and bringing an associated increased lifetime risk of adverse maternal and neonatal outcomes, GPs and the wider primary care team play a crucial role in risk reduction and management. Managing healthcare effectively to reduce adverse maternal and neonatal outcomes and health inequalities requires a system-wide change in approach where women's pre-conception to postnatal health is optimised. GPs' role in postnatal care, and other opportunistic moments in primary care for health promotion and risk management, is a key part of the solution.

General practitioners and perinatal care

General practitioners (GPs) in the UK have, since the earliest days of the NHS, played a role in caring for women throughout their perinatal journey. Historically, GPs shared antenatal and even intrapartum care with midwifery and obstetric colleagues, but routine GP involvement in antenatal care is now unusual.[1] GPs have, though, retained a pivotal role in the postnatal period, which is often underrepresented and neglected in policy and practice despite demonstrable risks to women during this time.[2] GPs are expert generalists, providing comprehensive care from 'cradle to grave', witnessing and managing the life-course health of patients in their socio-cultural context. This concept is central to the role that GPs have caring for women and their families in the perinatal period, with the 6–8-week maternal postnatal consultation being a key opportunity to deploy these skills.

The 6–8-week postnatal consultation

The '6–8-week GP postnatal check' or 'consultation' has been a concept for decades, but between 2004 and 2020 was not contractually required. Since 2020 the General Medical Services Contract for England has specified that a maternal postnatal consultation should be offered to all women 6–8 weeks after birth.[3] NHS England sets out 'What good looks like' in its guidance[4] and a 6–8-week consultation for the woman, specifically undertaken by a GP, is consistent with National Institute for Health and Care Excellence (NICE) recommendations.[5] However, provision remains variable with many women reporting poor experiences; in 2023, 32% of women reported that the GP did not spend long enough on their physical health and 28% said that the GP did not spend long enough discussing their mental health.[6]

The scope of what GPs should cover in the postnatal consultation is vast; mental health, physical recovery, follow-up of pregnancy-related or long-term conditions, pelvic and perineal health, contraception, breastfeeding and breast health, medication reviews, safeguarding and health promotion. GPs are usually allocated 10 or 15 mins to do this, but many say they need longer,[7] and these complex consultations are arguably inadequately funded.[8] Balancing the woman's agenda and priorities with the medical 'essentials', sometimes with limited or unclear communication from maternity services, is challenging. With maternal mental illness being the leading cause of death between 6 weeks and 12 months postnatally, this is often rightly made central to the consultation. However, MBRRACE reports highlight increasing mortality attributed to cardiac disease associated with rising rates of overweight and obesity, therefore cardiovascular risk identification and prevention are also critical.[2] As the only specifically mandated GP contact, the postnatal consultation is crucial to addressing these risks, especially given that many women will have future pregnancies and are therefore in a new pre-conception period. The postnatal consultation is a key opportunity to plan for ongoing cardiovascular monitoring and risk reduction.

☆ Where we use the terms 'woman' or 'women' in the context of their care, this is inclusive of all people assigned female at birth even if they do not identify as women.

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Cardiometabolic syndrome

Cardiometabolic complications of pregnancy were historically viewed as transient pregnancy-induced illnesses, likely to resolve postnatally. We now appreciate the interrelatedness of complications like gestational diabetes (GDM), hypertensive disorders of pregnancy and intrahepatic cholestasis of pregnancy, and subsequent lifetime risk of adverse cardiometabolic health outcomes.[9-11] MBRRACE demonstrates disparity of UK maternity outcomes, with women from minoritised groups and deprived areas at higher risk of death from all-cause mortality than white women and those from higher socioeconomic groups.[2] It is no coincidence that rates of perinatal cardiometabolic complications are higher in the former groups, and this should prompt immediate reform. Responsibility for identification and management of these issues lies across and between public health, secondary care, maternity services and primary care – at all stages of women's lives.

Risk factors for cardiometabolic disease are well understood; in addition to addressing the lifetime risks postnatally, there is an urgent need to optimise women's pre-pregnancy health, yet responsibility for and provision of periconception assessment and counselling is lacking. Awareness among women of childbearing age of the importance of health preparedness for pregnancy is poor;[12] many become pregnant with high body mass index (BMI), raised HbA1c, and/or no folic acid supplementation, leading to medically complex pregnancies and adverse sequalae. There is also a lack of clinician appreciation and prioritisation of longer-term associated health risks of pregnancies complicated by cardiometabolic disease, resulting in inadequate follow-up postnatally. This leads to underutilisation of preventative interventions which reduce lifelong risk of adverse health outcomes like stroke, diabetes, heart disease, and recurrent complex pregnancies.[13]

Despite global recognition of these risks, no national guidance currently exists for a holistic approach to cardiometabolic disease risk reduction postnatally. Current primary care recommendations are restricted in a condition-specific way, such as an annual HbA1c in women with a history of GDM, or blood pressure measurements in those with a history of a hypertensive disorder in pregnancy. The interconnected risks of pregnancy-related cardiometabolic conditions are neither explicitly addressed nor prioritised within the Quality and Outcomes Framework (QoF) payments to GP practices.[14] Despite the rising prevalence of GDM and the associated risk of type 2 diabetes, QoF still does not recognise GDM as an indicator for diabetes screening, although 'non-diabetic hyperglycaemia' monitoring remains incentivised. This leads to overreliance on opportunistic contacts – increasingly difficult given primary care time pressure, funding constraints and administrative load – with preconception counselling and postnatal follow-up being at the discretion of individual GPs.

Given the clear intergenerational health consequences of cardiometabolic disease, and the economic burden to the NHS, a national consensus involving public health, secondary and primary care, and commissioning bodies is needed. This would standardise preconception counselling and postnatal care leading to improved maternal and neonatal outcomes and prevention of long-term adverse effects of cardiometabolic disease.

Health promotion

Health promotion is arguably one of the most important aspects of cardiometabolic disease prevention and has historically been primary care's 'bread and butter'. Key examples include identification of high-risk patients for statin therapy, and regular follow-up of long-term conditions including hypertension and diabetes; employing a holistic approach to prevent progression of disease. Clinicians must recognise that all women of childbearing age – including those in the postnatal period – are potentially within a preconception period and there must be a proactive system-wide approach to improving periconception health and implementing cardiometabolic risk reduction strategies.

Contraception provision, for example, is an opportunity for preconception counselling, both within primary care and sexual health clinics. BMI, blood pressure, smoking and family history are taken as standard in these consultations and they could be used as educational opportunities. There must also be wider discussion regarding how best to optimise information provision; public health initiatives should focus on how to empower women with knowledge at every stage of the lifespan and provide opportunities for sustainable change. The NHS Diabetes Prevention Programme is a good example of a successful behaviour change intervention, yet remains underutilised among women with a history of GDM.[15] Postnatally, there can be improved motivation for positive behaviour change making this an opportune moment for lifestyle interventions to support long-term health-enhancing and disease-modifying behaviours.[16]

Next steps

Responsibility for the management of cardiovascular risks and conditions in the perinatal period needs to be genuinely shared between secondary and primary care in a meaningful and collaborative way. To optimise women's health, reduce disparity and improve cardiometabolic health outcomes, periconception and postnatal health in the UK needs a multifaceted overhaul with input from all agencies. Achieving cohesive care needs clear and prompt information transfer between services, access to specialist advice for GPs, and clear pathways for referrals and prescribing. We need to empower and educate women to understand their pregnancy-related complications and risks as part of their lifelong health, and provide a clear overview of the long-term management and reviews they may need.

MBRRACE teaches us that one size does not fit all when it comes to perinatal healthcare; perhaps postnatal consultations need to be longer, more bespoke, or more specialist for those at the highest risk of future complications. Research must focus on sustainable, acceptable solutions for women at highest risk of disease. The recently announced NIHR Challenge Maternity Disparities Consortium[17] presents a key opportunity to explore this, and primary care's pivotal role should be considered. Additionally, research investigating the most effective perinatal interventions for improving lifelong health will be critical.

GPs need to be empowered and funded to arrange further appointments when everything cannot be addressed in a single postnatal consultation, potentially utilising other expert members of the primary care team, to ensure that cardiovascular risk reduction opportunities are not missed. Future policy and contracting must recognise the complexity of postnatal care in general practice alongside the potential cost savings to the NHS from appropriate, timely provision of care and advice. Collaboratively we must do more to reduce future obstetric complexity and maternal morbidity, including adequate funding of primary care and training of future GPs to meet this need. Health policy and commissioners should focus on how best to provide a holistic care model, improve continuity between maternity services and primary care, and look to include specific perinatal risk factors for cardiometabolic disease in primary care quality indicators to incentivise comprehensive preventative care.

Declaration of competing interest

The authors declare the following financial interests/personal relationships which may be considered as potential competing interests:

Clare Macdonald reports financial support was provided by NIHR Applied Research Collaboration West Midlands. Elizabeth Dapre reports financial support was provided by National Institute for Health and Care Research. Clare Macdonald reports a relationship with GPs Championing Perinatal Care (GPCPC) that includes: board membership. Elizabeth Dapre reports a relationship with GPs Championing Perinatal Care (GPCPC) that includes: board membership. Both authors are committee

members of GPCPC (there was no option to select this). GPCPC contributed to NHS England guidance for the 6–8 week maternal postnatal consultation. If there are other authors, they declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

CRediT authorship contribution statement

Clare Macdonald: Writing – review & editing, Writing – original draft, Visualization, Validation, Supervision, Software, Resources, Project administration, Methodology, Investigation, Funding acquisition, Formal analysis, Data curation, Conceptualization. **Elizabeth Dapre:** Writing – review & editing, Writing – original draft, Visualization, Validation, Supervision, Software, Resources, Project administration, Methodology, Investigation, Funding acquisition, Formal analysis, Data curation, Conceptualization.

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