

## Introduction

There are more than seven million people living with heart and circulatory diseases in the UK today. Millions more are at increased risk because of risk factors such as high blood pressure, raised cholesterol, and type 2 diabetes. Heart and circulatory diseases cause a quarter of all deaths in the UK and make up the single biggest driver of health inequalities. Together, they cost the NHS in England at least £7.4 billion<sup>1</sup> a year and form the single biggest area where the NHS can save lives over the next 10 years. The cost of heart and circulatory diseases to the wider economy in England (including premature death, disability and informal costs) is estimated to be £15.8 billion each year<sup>2</sup>.

The British Heart Foundation (BHF) is the largest independent funder of research into heart and circulatory diseases, and the third largest charitable funder of medical research in the UK. Each year, thanks to the generosity of our supporters, we fund around £100 million of new research, which accounts for more than half of the funding for non-commercial research into heart and circulatory diseases in the UK. Our funding portfolio extends from laboratory science to clinical trials and population studies and includes inherited heart conditions, heart attacks, stroke, vascular dementia, high blood pressure and diabetes.

## Summary

In order to achieve our vision of a world free from the fear of heart and circulatory diseases, we are calling on the Government to consider the following priorities for funding in the forthcoming Budget:

**Maintain the UK's position as a research superpower to accelerate advances across the spectrum of heart and circulatory diseases by:**

- Ensuring association with Horizon Europe to allow UK-based researchers to continue to grow existing networks while alternative mechanisms are developed for international collaboration.
- Properly resourcing the National Institute for Health Research (NIHR) both strategically and financially, to allow for an agile and innovative clinical trials system.
- Increasing the Charity Research Support Fund (CRSF) stream of quality-related research (QR) funding to support universities to deliver the aims of the Life Sciences Industrial Strategy by leveraging investment from medical research charities.

**Create healthier environments by:**

- Extending the soft drinks industry levy (SDIL) to include sugar-sweetened dairy drinks.

<sup>1</sup> [BHF England factsheet December 2019.](#)

<sup>2</sup> [BHF England factsheet December 2019.](#)

- Providing adequate funding to local authorities so they can properly discharge their air quality duties.
- Providing financial support for Public Health England to deliver a national campaign on air pollution as soon as possible.
- Supporting a ‘polluter pays’ approach to funding tobacco control, using legislative mechanisms set out in the Health Act 2006.
- Defining and implementing a long-term solution for the funding of local public health services.

**Transform the detection and treatment of heart and circulatory diseases by:**

- Providing sustainable investment in health and care services, including substantial investment in public health, workforce, education and training and capital.
- Increasing funding for social care by £12.2bn

## 1. Maintain the UK’s position as a research superpower to accelerate advances across the spectrum of heart and circulatory diseases

- We believe that it is critical for the UK to associate with the next Frameworks Programme, Horizon Europe, in the short-term, ensuring researchers continue to have access to traditional EU grant mechanisms while allowing the UK government to strategically develop alternate funding mechanisms that could thrive with the new opportunities presented.
- Current circumstances present a unique opportunity for the UK to aid the development of global clinical trial mechanisms that would allow for multinational clinical trials to be carried out in a coordinated fashion. This would facilitate industry investment in the UK, allowing the government to increase the UK’s investment in research and development (R&D) to 2.4% of GDP.
- Medical research charities contribute almost half of the total public investment in biomedical research. Despite the crucial role that medical research charities play in the UK’s R&D base, there are currently no direct Government levers that encourage charity investment in R&D. As new funding schemes and initiatives are developed, it is vital that they seek to harness the assets brought by the full breadth of the UK’s research funders, including the medical research charity sector.

With a combination of outstanding research institutions and universities, strong support for the life sciences industries and a health care system supported by the proper research infrastructure, the UK is uniquely well positioned to continue to lead globally. The UK has the most productive research base in the G7 in terms of papers and citations per unit of R&D expenditure and ranks within the top four of the Global Innovation Index<sup>3</sup>. Every £1 spent on public R&D delivers approximately £7 of net economic benefit to the UK and unlocks £1.40 of private R&D investment<sup>4</sup>. This includes investment from overseas helping to make the UK a

<sup>3</sup> Soumitra Dutta, Bruno Lanvin and Sacha Wunsch-Vincent, Global Innovation Index 2018: Energizing the World with Innovation (2018)

<sup>4</sup> Economic Insight, “What is the relationship between public and private investment in science, research and innovation?” (2015)

location of choice for businesses at the cutting edge of innovation and technology; the UK attracts more overseas investment in R&D than many other countries<sup>5</sup>.

Discovery science has a natural path into translation through the National Institute for Health Research (NIHR)'s infrastructure. The NIHR invests £300m a year in research infrastructure to support clinical research. According to Mat Cooper, NIHR's business development and marketing director, that £300m has a major financial return for the UK economy, estimated at £2.4bn. International research organisations and pharmaceutical and medical device companies currently want to conduct clinical trials in the UK<sup>6</sup>.

All of this demonstrates the vibrant research ecosystem already present across the research spectrum, nurtured by investment from the public, charity and industry sector working hand in hand with each other. The balance across all disciplines and from discovery science through translational into clinical research needs to be maintained at current levels.

### The UK must continue to associate with the next Frameworks Programme, Horizon Europe

In the near term, the government should focus on bolstering European collaboration to capitalise on existing networks and established ways of working. The UK must ensure association with Horizon Europe to allow UK-based researchers to continue to grow existing networks while alternative mechanisms are developed for international collaboration. Association with Horizon Europe would bring about certainty to the entire research ecosystem while enabling the UK to be deliberate and thoughtful in the development of new funding mechanisms. It would also reassure industry that UK-based scientists would not be disadvantaged in ways of working, ensuring continued private R&D investment and helping the government meet its goal of 2.4%.

The government has made welcome commitments in the second Life Sciences Sector Deal<sup>7</sup> and the NHS Long Term Plan<sup>8</sup> to ensuring that the UK remains a world leader in supporting clinical trials. These commitments must be upheld with investments in the proper infrastructure to deliver on these promises. While funding from UK Research and Innovation (UKRI) is key in delivering on the second Life Sciences Sector Deal, NIHR must also be properly resourced (both strategically and financially) to allow for an agile and innovative clinical trials system.

In the longer term, the UK government should nurture relationships/new funding arrangements with the US and Asia, looking beyond the EU to the best science available globally. As all science builds upon itself, the UK government must develop funding mechanisms that are not limited by place but instead focus on supporting the best people as well as the best science across the research spectrum.

As the UK considers future research funding mechanisms, it is critical that the UK government continues to maintain relationships with the vibrant and thriving medical charity sector and is deliberate in involving charities such as the BHF in strategic discussions.

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<sup>5</sup> [Eurostat Statistics Explained, R & D expenditure](#)

<sup>6</sup> [Getting results: why NHS clinical trials are the envy of the world](#)

<sup>7</sup> <https://www.gov.uk/government/publications/life-sciences-sector-deal/life-sciences-sector-deal-2-2018>

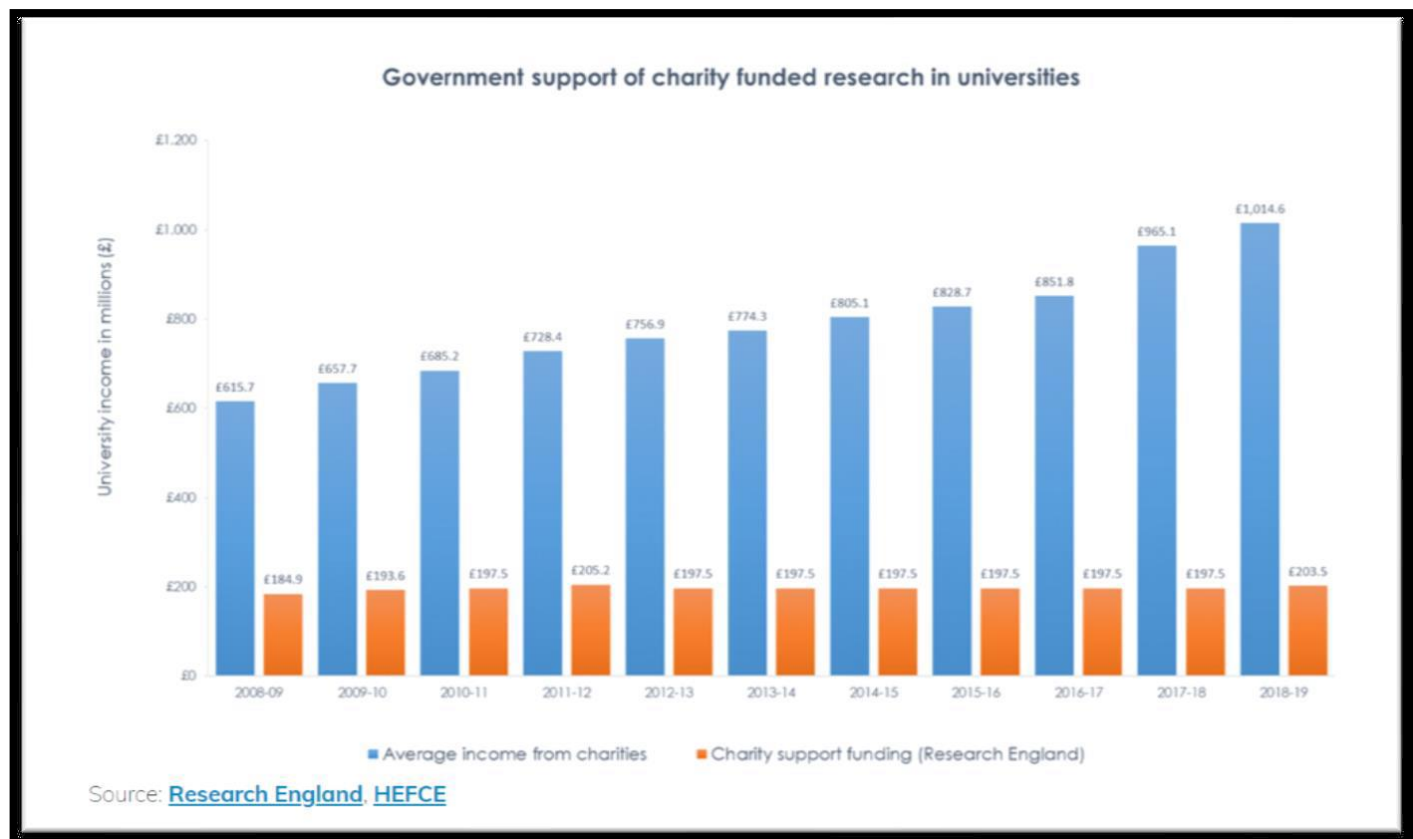
<sup>8</sup> <https://www.longtermplan.nhs.uk/wp-content/uploads/2019/01/nhs-long-term-plan.pdf>

## Increasing investment in the Charity Research Support Fund

The CRSF underpins charity investment in university research across England. The Fund is part of the quality-related research (QR) funding distributed through Research England, under UK Research and Innovation. Non-mainstream QR includes the CRSF which, in recognition of the unique position of charities, acts to top-up charity funding of university research so that it is at a comparable level to other funders. Universities that successfully win charity funding are awarded money through the CRSF to allow them to cover the indirect costs of research (such as heating and lighting) that charities cannot cover. Introduced in 2006 at £135.5 million, the Fund has supported significant charity funding of research within universities. However, it is now falling short.

Since 2010, the CRSF has been at a flat rate other than a small increase for 2018/19 which means the Fund is currently £204 million per year. The relative value for the Fund has been eroded by both inflation and an increase in charity funding. Its value has fallen from 28p of CRSF for every £1 received by universities from charity funders in 2010/11 to under 20p of CRSF per £1 in 2018/19.

These calls are echoed by the Association of Medical Research Charities (AMRC), a membership organisation of more than 140 leading medical and health charities that fund research in the UK, of which the BHF is a member.



The CRSF plays a vital role in the sustainability of BHF-funded research. If the fund did not exist and the BHF were required to pay in the same way as Research Councils, the charity could fund less than two thirds of the research it currently supports. The loss, reduction or continued freezing of the CRSF could have profound consequences for university research and the UK's ability to contribute to heart and circulatory disease research at a globally competitive level.

Universities are telling us it is increasingly difficult for them to cover the costs of doing charity-funded research and the sustainability of medical research charity investment in universities is at risk.

When new funding schemes and initiatives are developed, it is vital that they seek to harness the assets brought by the full breadth of the UK's research funders, including the medical research charity sector.

The Government must prioritise increasing the CRSF stream of QR funding to support universities to deliver the aims of the Industrial Strategy by leveraging investment from medical research charities.

Developing new levers to increase medical research charity investment in R&D would contribute to the Government's aim to increase UK R&D spend to 2.4% of GDP by 2027. Furthermore, medical research charities are also capable of leveraging significant funding from the private sector. Every £1 of public or charity investment in medical research is also associated with an additional £0.83-£1.07 of private sector R&D spend. This spillover effect leads to a real annual rate of return (RoR) on the investment of 15–18 %<sup>9</sup>.

Enhancing the CRSF, as recommended in the Life Sciences Industrial Strategy<sup>10</sup>, will strengthen the vital partnership between charities and Government that underpins charity investment in universities.

The Fund should be boosted in line with the current levels of charity investment to safeguard the unique attributes of charity-university partnerships and incentivize charity investment in academic research. To meet the target set for research funders to support 80% of the full economic costs of university research, the CRSF should be boosted to approximately £350 million per year (based on 2017/18 Transparent Approach to Costing figures).

## 2. Create healthier environments

Although there have been major improvements in population health in recent decades, millions of people remain at risk of heart and circulatory diseases, and there is still significant variation in risk factors between different geographical areas and groups. Two risk factors that have a large impact on heart and circulatory diseases are obesity and air pollution, both of which are influenced by the environments we live in. Even small reductions in these at the population-level could lead to major reductions in the prevalence of heart and circulatory diseases. Smoking is another cause of heart disease — an estimated 20,000 UK deaths each year from heart and circulatory disease can be attributed to smoking<sup>11</sup>. Yet despite this, more than one in seven adults smoke cigarettes in the UK, meaning it continues to represent a significant public health challenge. In order to tackle these challenges, we are calling on the Government to make the following financial commitments:

<sup>9</sup> <https://bmcmmedicine.biomedcentral.com/articles/10.1186/s12916-016-0564-z>

<sup>10</sup> Bell, J (2017). [Life Sciences Industrial Strategy – A report to the Government from the life sciences sector](#). p.23-24. [last accessed 5th February 2020]

<sup>11</sup> [BHF UK factsheet January 2020](#)

- Extend the soft drinks industry levy (SDIL) to include sugar-sweetened dairy drinks
- Provide adequate funding to local authorities so they can properly discharge their air quality duties, this includes financial support to install, maintain and operate PM<sub>2.5</sub> monitors as part of their air quality responsibilities.
- Provide financial support for Public Health England (PHE) to deliver a national campaign on air pollution as soon as possible.
- Support a 'polluter pays' approach to funding tobacco control, using legislative mechanisms set out in the Health Act 2006

## Obesity

In 2018, an estimated 29% of adults and 20% of Year 6 children in the UK had a weight defined as obese<sup>12</sup>, some of the highest rates in Western Europe. Children with obesity are five times more likely to become adults with obesity<sup>13</sup>, and setting healthy habits early in life is crucial to continued health in later years.

The rise in obesity is contributing to increasing rates of diabetes and placing many more people at risk of a heart attack or stroke, as well as heart failure<sup>14</sup>. Obesity is imposing an increasing demand on the NHS and our society. However, small changes could have far-reaching benefits: just a 1% year-on-year reduction in the number of people with an unhealthy weight and with obesity between 2015 and 2035 could avoid around 45,000 cases of Type 2 diabetes and 17,400 cases of coronary heart disease in the year 2035 alone.<sup>15</sup>

In addition to the health impact, obesity has a huge financial impact. It is estimated that the NHS spent £6.1 billion on overweight and obesity-related ill-health in 2014 to 2015. This figure is likely to be dwarfed by the indirect costs of obesity to employers and to society due to unemployment, early retirement and associated welfare benefits. In 2018, McKinsey estimated that obesity costs the UK 3% of GDP- around £60 billion in 2018- with large costs (around £5 billion) being borne by business due to sickness absence and reduced productivity<sup>16</sup>.

Excessive free sugar consumption is a significant driver behind these high rates of obesity and our children consume at least twice as much sugar than is recommended by Government guidelines, with sugary drinks being their number one source of sugar.

### Extending the Soft Drinks Industry Levy

Evidence suggests reducing the intake of sugar sweetened beverages can reduce individual rates of obesity<sup>17</sup>. Multiple modelling research studies demonstrate the efficacy of taxes in reducing consumption of

<sup>12</sup> NHS Digital. [Statistics on Obesity, Physical Activity and Diet, England, 2019](#).

<sup>13</sup> Simmonds M et al. (2016), [Predicting adult obesity from childhood obesity: a systematic review and metaanalysis](#). Obesity Reviews; 17(2):95—107

<sup>14</sup> British Heart Foundation (2018), [Growing diabetes epidemic could trigger 'sharp rise' in heart attacks and strokes by 2035](#).

<sup>15</sup> Cancer Research UK and UK Health Forum (2016). [Tipping the Scales: why preventing obesity makes economic sense](#)

<sup>16</sup> Annual Report of the Chief Medical Officer, Time to Solve Childhood Obesity, 2019, Annex B

<sup>17</sup> 6 Escobar, M., Veerman, J., Tollman, S., Bertram, M., and Hofman, K. (2013). 'Evidence that a tax on sugar sweetened beverages reduces the obesity rate: a meta-analysis'. BMC Public Health. 13: 1073.

sugary drinks, and in turn of reducing overweight prevalence<sup>18 19</sup>. Indeed, the Soft Drinks Industry Levy (SDIL), which came into effect in April 2018, has been highly effective in incentivising the drinks industry to reduce sugar from soft drinks. Data from Public Health England in September 2019 showed that 30,133 tonnes of sugar had been removed without reducing soft-drink sales<sup>20</sup>.

The soft drinks industry levy should be extended to include sugar-sweetened dairy drinks. To incentivise further reformulation the threshold should be lowered, and levy rate increased above inflation with revenue raised reinvested in measures to improve public health. The BHF is calling for this as a member of the Obesity Health Alliance (OHA), a coalition of over 40 organisations working together to reduce obesity.

The BHF recommends that a clear timeline should be set for sanctions for non-compliance with the current sugar and calorie reduction programmes, including consideration of fines and inclusion of categories into an industry levy. If Public Health England's (PHE) voluntary reformulation targets continue to be missed, the Government should consider introducing further fiscal measures in relation to foods high in fat, salt and sugar (HFSS), building on the success of the SDIL. Research has shown that fiscal and regulatory measures have been more effective at affecting behavior change and narrowing inequalities than voluntary measures<sup>21</sup>.

As a member of the Obesity Health Alliance, the BHF endorses their separate submission to this budget.

## Air pollution

Up to 36,000 deaths from all causes are attributable to outdoor pollution each year in the UK, and Public Health England (PHE) estimates that the cost to the NHS and social care will be around £2.8 billion between 2017 and 2025<sup>22</sup>.

BHF-funded research has shed light on how tiny toxic particles known as particulate matter harm the heart and circulatory system, contributing to the development of new health problems or putting people with existing conditions at increased risk of fatal events like a heart attack or stroke. We know that, each year in the UK, there up to 11,000 deaths from heart and circulatory diseases that can be attributed to particulate matter.

The BHF has estimated that, without bold action, heart and circulatory disease deaths attributable to particulate matter air pollution could exceed 160,000 over the next decade in the UK. However, small changes can make a big difference – a 1µg/m<sup>3</sup> reduction in PM2.5 concentrations in one year could prevent 50,000 new cases of coronary heart disease by 2035<sup>23</sup>.

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<sup>18</sup> Collins B, Capewell S, O'Flaherty M, Timpson H, Razzaq A, Cheater S, et al. (2015) Modelling the Health Impact of an English Sugary Drinks Duty at National and Local Levels. PLoS ONE 10(6): e0130770. doi:10.1371/journal.pone.0130770

<sup>19</sup> Briggs, A., et al. (2013). Overall and income specific effect on prevalence of overweight and obesity of 20% sugar sweetened drink tax in UK: econometric and comparative risk assessment modelling study. BMJ. 347:f6189

<sup>20</sup> [New report shows further sugar reduction progress by food industry](#)

<sup>21</sup> Capewell S, Capewell A. An effectiveness hierarchy of preventive interventions: neglected paradigm or self-evident truth? J Public Health (Oxf) 2018; 40(2): 350-8; Adams J, Mytton O, White M, Monsivais P. Why Are Some Population Interventions for Diet and Obesity More Equitable and Effective Than Others? The Role of Individual Agency. PLoS Med 2016; 13(4): e1001990

<sup>22</sup> Public Health England. [Estimation of costs to the NHS and social care due to the health impacts of air pollution](#), May 2018.

<sup>23</sup> Public Health England. [Estimation of costs to the NHS and social care due to the health impacts of air pollution](#), published in 2018

In the UK, we currently subscribe to European Union air quality limits, which set the maximum annual average concentration of fine particulate matter at 25 µg/m<sup>3</sup>. This is more than double the World Health Organization (WHO) guideline limit of 10 µg/m<sup>3</sup>, which they recommend in order to minimise the harm to health that we know exists.

There is no safe level of air pollution, but safer limits are vital to addressing this public health emergency. That is why we are calling for the adoption of the WHO's more stringent guideline limits for fine particulate matter into UK law, to be legally binding by 2030.

While some parts of the UK are within the WHO guideline limit, other parts are regularly in breach. Around 15 million people live in areas in England where average levels of PM<sub>2.5</sub> exceed WHO guidelines, meaning that almost a quarter of the population is likely to be exposed to dangerous levels of air pollution. The Government's 2019 Clean Air Strategy made important pledges to tackle five major air pollutants, including PM<sub>2.5</sub>. Importantly, this strategy presented air pollution as a health as well as an environmental issue, and pledged to improve our understanding of the problem, better communicate the health impacts of air pollution to the public and tackle the major pollution sources. While a step in the right direction, the Government's air quality plans must go further and faster to truly protect health. To support this, Government must ensure that appropriate investment is made across the following three areas.

### Tackling the sources of air pollution

The interventions with the greatest potential impact on people's health are those that directly tackle emissions at source<sup>24</sup>. The Clean Air Strategy outlined action to reduce air pollution emissions from transport, agriculture, domestic sources and industry, and emphasised the £3.5 billion being invested into tackling air pollution and improving public transport. However, the Strategy placed significant emphasis on the role of local authorities in this agenda. Local authorities need adequate funding to properly discharge their air quality duties.

### Monitoring, data and health evidence

Monitoring and modelling of air pollution levels is important in enabling us to fully understand people's exposure to air pollution, where to direct interventions and how these interventions are helping us to both meet ambitious targets and protect people's health. The Clean Air Strategy pledged £10 million investment in improving our modelling capabilities but did not mention any investment in air pollution monitoring. Only 82 monitors in Defra's nationwide Automatic Urban and Rural Monitoring Network measure PM<sub>2.5</sub><sup>25</sup>, which is used in national modelling. Government must ensure that their monitoring, as well as modelling capabilities are fit for purpose.

Moreover, while national government is required by EU law to monitor PM<sub>2.5</sub>, local authorities are not. Requiring this at the local level would improve granularity of our data and support the above aim but

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<sup>24</sup> Public Health England, [Review of interventions to improve outdoor air quality and public health](#), published 11<sup>th</sup> March 2019.

<sup>25</sup> Department for Environment, Food and Rural Affairs (Defra), [UK-Air, Air information resource](#). Last accessed 25 September 2019.

would place a huge financial burden on local authorities. Government must therefore provide financial support for local authorities to install, maintain and operate PM<sub>2.5</sub> monitors as part of their air quality responsibilities.

### Health information and public awareness

The Clean Air Strategy's focus on better public awareness of air pollution as a health issue is positive. Better information on air pollution is critical to both enabling people to protect their health and securing support for national action. The Prevention Green Paper, published in July 2019, provided more detail on the communication and awareness-raising work that Public Health England will undertake to support the Clean Air Strategy, including national-level awareness raising campaigns<sup>26</sup>. We urge Government to press forward with this work and provide financial support for PHE to deliver a national campaign on air pollution as soon as possible.

### **Smoking**

The BHF has been a key advocate for tobacco control and is a member of the Smokefree Action Coalition (SFAC). We were pleased to see the government's commitment to achieving a Smokefree England (a smoking prevalence of less than 5%) by 2030, which follows a commitment from Scotland to be Smokefree by 2034. It has been acknowledged that this is a challenging goal that requires bold action. Although smoking rates are falling overall, they remain stubbornly high in certain groups, meaning that these inequalities need to be tackled urgently.

Tobacco manufacturers are highly profitable and the principle of 'polluter pays' dictates that they should bear responsibility for paying for the cost of tobacco control<sup>27</sup>. To that end, we support the proposal for a 'polluter pays' approach to funding tobacco control, using legislative mechanisms set out in the Health Act 2006<sup>28</sup>. 72% of adults in England support the principle of making tobacco manufacturers pay a levy or licence fee to government to fund measures to help smokers quit and prevent young people from taking up smoking<sup>29</sup>.

Legislation would require tobacco manufacturers to fund the costs of tobacco control, while prohibiting their involvement in setting and implementing policy. This is essential to ensure that the UK meets its legal obligations as a party to the WHO Framework Convention on Tobacco Control. The 'Smokefree 2030 Fund' would be for DHSC to allocate, with help from an advisory committee including tobacco control experts from the academic, regulatory, voluntary sector and clinical community. The Smokefree Action Coalition Smokefree 2030 campaign sets out more detail on this proposal and a roadmap to achieving a Smokefree UK by 2030<sup>30</sup>.

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<sup>26</sup>Department of Health and Social Care & Cabinet Office, "Advancing our health: prevention in the 2020s," published 22<sup>nd</sup> July 2019

<sup>27</sup> Branston, J. R. and Gilmore, A. [The extreme profitability of the UK tobacco market and the rationale for a new tobacco levy](#). 2015, University of Bath.

<sup>28</sup> Health Act 2006. Annex 2: Scheme Powers of the Secretary of State Deriving from the NHS Act 2006.

<sup>29</sup> ASH Smokefree England survey 2019. Total sample size in 2019 for England was 10338 adults. Fieldwork was undertaken between 12th February 2019 and 10th March 2019. The surveys are carried out online. Figures have been weighted and are representative of all English adults (aged 18+).

<sup>30</sup> <http://smokefreeaction.org.uk/smokefree2030/>

As a member of the SFAC and a core funder of Action on Smoking and Health (ASH), the BHF supports the budget submission made by ASH and the UK Centre for Tobacco Control and Alcohol Studies (UKCTAS).

### Provide sustainable investment in the prevention of ill health

Since 2015/16 local authorities have sustained repeated funding cuts which have severely hampered their ability to provide the vital functions and services that prevent ill health. The public health grant has seen a £850 million real terms reduction between 2014/15 and 2019/20<sup>31</sup>. It is a matter of urgency for the Government to define and implement a long-term solution for the funding of local public health services. Proper funding of public health will be integral to identifying those at risk of heart and circulatory diseases in the community and signposting them to relevant services to prevent the risk from becoming a reality. The NHS long-term plan sets out several ambitions for public health, including smoking cessation programmes and support to prevent obesity, but coordinated approaches to prevention across sectors will be vital to drive improvements in the health of local populations.

## 3. Transform the detection and treatment of heart and circulatory diseases

A concerted drive to detect and treat the risk factors for heart and circulatory diseases as early as possible could prevent many more thousands of people suffering acute cardiovascular events such as a heart attack or stroke. Reducing variation in treatment and provision of high quality help with recovery is crucial to improving patients' quality of life and preventing future cardiovascular events. To achieve these outcomes the Government should:

- Provide sustainable investment in health and care services, including substantial investment in public health, workforce, education and training and capital.
- Increase funding for social care by £12.2bn

To improve outcomes for people with heart and circulatory diseases and deliver the ambitions of the long-term plan we need a sustainable investment in health and care services, including substantial investment in public health, workforce, education and training and capital. In England, the NHS long term plan is underpinned by a funding settlement up to 2023/24, with average annual increases of 3.3% a year. However, as things stand, the total health budget will increase by just 2.9% a year to 2023/24. Investing in and modernising the health service as set out in the NHS long term plan requires around 4.1% a year – a further £4bn above that figure<sup>32</sup>.

The NHS Long Term Plan rightly highlights the need to invest in the technology and expertise needed to detect the 'hidden killers' of inherited heart condition, such as Familial Hypercholesterolaemia (FH). Of the estimated 260,000 people living with FH in the UK, only around 6-7% currently know they have it. Without

<sup>31</sup> The Health Foundation and The King's Fund. [Press release: Health charities make urgent call for £1 billion a year to reverse cuts to public health funding.](#)

<sup>32</sup> Health Foundation (2019) [Health and social care funding: Priorities for the new government.](#)

the right treatment, 50% of men with FH will have a cardiovascular event by the age of 50, and 30% of women by the age of 60<sup>33</sup>.

Another priority highlighted in the Long term Plan is heart failure which is a debilitating condition that affects more than 920,000 people in the UK. All too often people with this condition end up in hospital due to a lack of available support in the community. Currently eight in ten cases of heart failure are diagnosed in hospital, despite patients having symptoms that could have been picked up in primary care, Heart Failure places a significant burden on the NHS, costing 2% of its total budget<sup>34</sup> and comprising 5% of emergency admissions<sup>35</sup>. Investing to improve access to diagnostics and treatment in the community could prevent up to 230,000 hospital admissions and 30,000 deaths from heart and circulatory diseases over the next decade in England, relieving some of this burden<sup>36</sup>.

High quality cardiac rehabilitation services are vital for allowing people with heart and circulatory diseases to adjust to a new normal, increasing their quality of life and reducing the chances of future recurrence of disease. Achieving an uptake rate for cardiac rehabilitation of 85% in England could lead to nearly 20,000 fewer deaths and nearly 50,000 fewer hospital admissions over the next ten years, as well as saving tens of millions of pounds in future care costs<sup>37</sup>. But to do this we need a new offer, re-designing services around the person and not the institution. Support services also need to address the wider needs of patients, providing psychological and emotional support, as well as supporting their physical health. But to do this, systems need the time and resources to think differently about how they deliver services, both within the NHS and across the health and care sector.

It is vital that the NHS receives sustainable funding to ensure that the long term plan is a success and can transform the lives of people living with or at risk of heart and circulatory diseases.

Another significant challenge faced by the health and care system is the lack of sustainable funding for social care. Funding for social care has not kept pace with demand, falling in real terms for most of this decade. Restoring access to 2010/11 levels of service, and investing to stabilise the social care workforce, would require an increase of £12.2bn compared to estimates of funding available in 2023/24 for councils to spend on social care<sup>18</sup>. With health and care systems working together as part of integrated care systems, sustainable funding across the system will be critical to transforming outcomes for people with heart and circulatory disease.

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<sup>33</sup> Marks D, Thorogood M, Neil HA and Humphries SE, A review on the diagnosis, natural history, and treatment of familial hypercholesterolaemia, 2003.

<sup>34</sup> APPG on Heart Disease and British Heart Foundation (2016) Focus on Heart Failure: 10 Recommendations to improve care and transform lives

<sup>35</sup> Clark A. L. and Brown R. Reducing the cost of heart failure while improving quality of life. British Journal of Cardiology 2013;(20):45–6.

<sup>36</sup> Mortality and hospital admissions estimates based on Bottle A et al. Routes to diagnosis of heart failure: observational data using linked data in England. Heart 2018; 104: 600-605

<sup>37</sup> Hinde, S., Bojke, L., Harrison, A., and Doherty, P. (2018) Improving Cardiac Rehabilitation Uptake: Potential health gains by socioeconomic status.