

The British Heart Foundation's written submission to the Public Accounts Committee inquiry on NHS backlogs and waiting times

About the British Heart Foundation and heart and circulatory disease

The British Heart Foundation (BHF) is the largest independent funder of medical research into heart and circulatory diseases in the UK and research we fund has helped halve the number of people dying from these conditions since the 1960s. Our vision is a world free from the fear of heart and circulatory disease, and we work to transform the detection and treatment of heart and circulatory diseases and provide trusted information for people affected by these conditions.

Today, there are more than 7 million people living with cardiovascular disease (CVD) in the UK – more than twice as many people as cancer and Alzheimer's combined. CVD causes around a quarter of all UK deaths annually, on average one death every three minutes. The NHS Long Term Plan identified CVD as the single biggest area where the NHS can save lives over the next ten years. Healthcare costs relating to heart and circulatory diseases are estimated at £9bn each year.

About our representation

We welcome the opportunity to respond to this important inquiry on NHS backlogs and waiting times. Our response will focus on waiting times for cardiovascular care across the entire health system. Our analysis of waiting time data is limited to patients in England only and our policy recommendations are for the NHS in England. Should you require any further information about anything in this response, please contact Lisa Plotkin, BHF Policy Manager (Health and Care) at plotkinl@bhf.org.uk

Executive summary

- Despite the unwavering efforts of NHS staff, there has been a seismic disruption to every aspect of cardiovascular care during the pandemic, with devastating consequences for patients and their families. This disruption has been felt along the entire pathway, from community services to primary care, across elective procedures, and in emergency services.
- The pandemic has caused a step change in waiting times for heart patients. Prior to the pandemic, in 2019, monthly waiting lists for heart tests and treatments averaged 224,262 people and on average 88 per cent of patients had met the 18-week waiting time standard. The latest NHSE statistics show that at the end of September 2021, there were over 275,000 people waiting for heart tests and treatments – the highest number since records began. On average, from January to September 2021, the number of patients that had met the 18-week waiting time standard fell to 77 per cent.
- The situation for heart diagnostics is particularly concerning. In the decade leading up to the pandemic, monthly waiting lists for heart ultrasounds (known as echocardiograms) averaged around 55,000 at month-end, with on average 97 per cent of patients waiting less than the six-week target. Since the pandemic began in March 2020, the echocardiography waiting list has averaged around 199,000 at month-end, with on average 58 per cent of patients waiting less than the six-week target.

- There is also a primary care backlog for patients, with analysis by the Health Foundation showing significant drops in primary care consultations over the course of the pandemic. This disruption – combined with changes to how services are delivered and other factors – has contributed to a decline in the detection of high-risk conditions like hypertension. If these ‘missing patients’ do not commence treatment, the Institute for Public Policy Research (IPPR) suggests that an additional 12,000 heart attacks and strokes will occur over the next five years.
- Emergency services have also been hit, with cardiac hospital admissions dropping 28 per cent in the first year of the pandemic compared to previous 12-month period. At the end of October 2021, the average response rate for Category 2 (emergency or potentially serious) ambulance calls for conditions like heart attack or stroke were three times higher than the 18-minute target time. The BHF believes this is directly putting lives at risk.
- While we welcome commitments by the Government to recover services, especially the creation of 100 new community diagnostic centres, we do not believe the Government’s ambitious aspirations to return the backlog to pre-pandemic levels within three years will be achievable without greater prioritisation of cardiovascular care and a long-term strategy for the NHS workforce.
- The BHF is calling for the imminent Elective Recovery Plan to comprise of a specific plan for restoring cardiovascular disease services, including for getting people diagnosed with and treated for CVD. This must outline clear steps on how to grow the NHS workforce to expand cardiovascular care services and properly resource the new diagnostic centres.

Impact of Covid-19 on waiting lists for heart tests and treatments

1. The pandemic has caused a step-change in waiting times for heart patients. The latest NHSE statistics show that at the end of September 2021 there were over 275,000 people waiting for heart tests and treatment, including invasive heart procedures and surgeries – the highest number since records began. Of those, 69,995 had been waiting over the target 18 weeks – more than double the number compared to pre-pandemic average monthly levels. This means that around a quarter of all heart patients currently on the waiting list are what are referred to as ‘long waiters.’ⁱ
2. At the end of September 2021, the number of people waiting over a year for heart tests and treatments was 3,575 – this is 128 times higher than before the pandemic began (when just 28 people had been waiting this long). For the first time over 100 people have now waited over 100 weeks for heart care.
3. The situation for heart diagnostics is particularly concerning. Most recent figures show that at the end of September 2021, there were 149,050 people waiting for a heart ultrasound (known as echocardiograms) – this is the highest number on record and stands in stark contrast to the pre-pandemic average of 55,000 people.
4. At the end of September 2021, 64,962 people had waited more than six weeks for an echocardiogram, meaning that only 58 per cent of patients waiting for heart tests had met the six-week target waiting time at month-end. In fact, while patients waiting for an echocardiogram comprise 11 per cent of the total diagnostic waiting list, they make up 18 per cent of the patients who are waiting longer than six weeks and 43 per cent of the patients who are waiting longer than 13 weeks. This suggests that any recovery

plan that focuses on tackling 'long waits' must prioritise the delivery of heart diagnostics.

5. Between September 2020 and September 2021, the test with the largest increase in the proportion of patients waiting six weeks or longer was echocardiography. Every other key diagnostic test, apart from MRIs, has shown improvement year on year as the NHS has sought to recover services to pre-pandemic levels.
6. Elective heart procedures are far from 'routine.' Long waits for diagnosis and treatment of conditions like coronary heart disease or heart failure are emotionally distressing and increase the risk of someone becoming more unwell or even dying while they wait for care. There were 5,800 'excess deaths' from heart and circulatory conditions in the first year of the pandemic, and the significant delays in care may have contributed to this.ⁱⁱ
7. Long waits for tests and treatments also put pressure on an already over-stretched health system, as patients may turn to other parts of the system for support while they wait, including primary care and A&E. Modelling from the BHF suggests that in a 'worse case scenario' it could take up to five years for cardiac waiting lists to recover to pre-pandemic levels, peaking at over half a million people in January 2024, if the NHS does not receive sustained, long-term investment and continues to face Covid-related or winter pressures.ⁱⁱⁱ
8. We welcome the Government's 2021 Spending Review settlement for the NHS, including the over £8 billion ring-fenced to tackle the elective backlog over the next three years. We would like to stress, however, that the 'largest catch-up programme in the NHS's history' risks leaving heart patients behind if CVD care is not prioritised. We outline our policy solutions to this in the last section of this response.

Impact of Covid-19 on primary care and community services

9. Waiting lists for diagnostics and hospital treatment do not reveal the full extent of pent-up demand across the health system. Over the course of the entire pandemic, there were 7.42 million fewer referrals for elective care than would normally have been expected. These are people who have not yet come forward for care, who have not yet been detected, or who cannot access services.^{iv} It remains unclear how many of these 'missing' patients are living with or at risk of CVD or how many will present for care and when they might do so.
10. Covid-19 has also impacted how patients with or at risk of CVD interact with primary care. There were five million fewer face to face GP appointments in 2020 and 2021 compared to 2019.^v While many patients welcome the flexibility and safety that remote consultations can provide, it does mean that some opportunities for healthcare professionals to collect information usually gained through physical clinical examination (such as blood pressure measurement) have been lost.^{vi} This may result in missed or delayed diagnoses of high-risk conditions, like hypertension.
11. The impact of missed or delayed detection of high-risk conditions may not be immediately obvious, but it could have long-term devastating consequences. Analysis by the Institute for Public Policy Research (IPPR) found that the NHS issued 470,000 fewer prescriptions for preventative cardiovascular drugs (such as statins) between March and October 2020 compared to the previous year.^{vii} If these 'missing' patients with a high-risk cardiovascular condition do not commence treatment, the IPPR forecast that an additional 12,000 heart attacks and strokes will occur in the next

five years.^{viii} This is inimical to NHS Long Term Plan aspirations to prevent 150,000 heart attacks, strokes and dementia cases by 2028.

12. The pandemic has fostered innovative ways of working across the system that many patients and healthcare professionals think are valuable, and the rise of remote consultations is an important part of that. The challenge now is for GP practices to work out the optimal balance of face to face and remote appointments where it is clinically appropriate to do so and in line with patient preferences. We support the Government's commitments outlined in the 'blueprint for improving access to GP appointments' to not only increase GP numbers, but also to expand the number of other primary care professionals, including pharmacists and other allied health professionals, to meet this challenge.^{ix}
13. At the other end of the treatment spectrum, patients recovering from a heart attack or heart surgery also face challenges accessing recovery and support services, such as cardiac rehabilitation. Cardiac rehabilitation is a NICE-recommended intervention which can save lives, improve quality of life, and prevent unplanned hospital readmissions. Even before the pandemic, access to and uptake of cardiac rehabilitation services was low – only 52 per cent of eligible patients took it up.^x This low uptake was due to a variety of factors, including an outdated and sometimes rigid delivery model and a lack of prioritisation at a national and local level.
14. The NHS Long Term Plan recognised that scaling up and improving access to cardiac rehabilitation to be amongst the best in Europe would prevent up to 23,000 premature deaths and 50,000 acute hospital admissions over 10 years. It set a target of 85 per cent of eligible patients accessing cardiac rehab by 2028. The pandemic has completely derailed progress towards that goal. From February 2020 to July 2020, the rate of uptake for cardiac rehab declined by 36 per cent, due in large part to staff redeployment to the Covid-19 frontline. People with Asian and Black, African, or Caribbean ethnic backgrounds experienced disproportionately dramatic declines in participation compared to white populations, with their participation rates falling by 45 and 44 per cent respectively.^{xi} Services continue to face widespread Covid-related disruption due to staff redeployment.
15. As services are restored, and public confidence in accessing NHS services increases, healthcare professionals have told us that they are seeing large numbers of patients who have experienced significant physical deconditioning over the past 18 months, including many with progressively worsening heart disease. This may increase the burden on the health service in the longer term as well as lead to potentially worse health outcomes for the individual, such as heart failure.

Impact of Covid-19 on emergency services for CVD patients

16. During the early months of the pandemic, there were significant reductions in attendances for urgent and emergency care for heart attacks and strokes. During the first peak of the pandemic in Spring 2020, there was a 50 per cent reduction in the number of people presenting to A&E with the symptoms of a heart attack.^{xii} There was also a 22 per cent decline between January and September 2020 in heart failure hospital admissions compared to the same period in 2019. Studies suggest that these patients were not all treated elsewhere in the system. For example, we know that more people died in the community from heart failure during the pandemic than ever recorded (280 deaths over a four-month period) because they hadn't been treated in

an acute setting.^{xiii} Overall, cardiac hospital admissions dropped 26 per cent in the first year of the pandemic compared to the previous year (353,000 admissions compared to 475,000).^{xiv}

17. Even though attendances dropped, we know that heart attacks and strokes didn't stop. A BHF survey of cardiologists during the first wave suggested that the drop in A&E attendances for CVD was due in part because patients were fearful of catching coronavirus.^{xv} We worked closely with the NHS to encourage people experiencing symptoms of a heart attack to call 999 and presentations have now largely returned to expected levels.
18. As services across the NHS have begun recovering and patient confidence in accessing services has increased, there are now worrying signs that ambulance services are under a level of unsustainable pressures not seen during the initial stages of the pandemic. NHS Access Standards introduced in 2018 stipulate that all ambulance trusts should respond to Category 2 (emergency or potentially serious calls for conditions like heart attack or stroke) in 18 minutes on average and to 90 per cent of calls in 40 minutes. From the introduction of these targets to the beginning of the pandemic, both the average and 90th percentile response time targets were never met. However, as Category 2 calls declined in the first wave of the pandemic, the 90th centile target was first met in April 2020 and the average target was first met in May 2020.^{xvi}
19. As the first wave of the pandemic receded, Category 2 incidents began to increase and response times worsened. By October 2020, the average response time had increased to 25 minutes and 21 seconds and the 90th centiles averaged 52 minutes and 6 seconds.^{xvii} By October 2021, the average response time had increased to 53 minutes and 54 seconds – triple the 18-minute target time – and the 90th centile was 1 hour and 56 minutes.^{xviii}
20. If treatment for conditions like heart attack is delayed, this increases the likelihood of poor outcomes, including the development of heart failure or death. The BHF is increasingly concerned with reports that patients are dying of heart-related conditions due to what the College of Paramedics has called 'unacceptable long waits' for ambulances.^{xix} We would like clarity from the Government about steps that are being taken to address this, particularly in the context of the emergence of the Omicron variant and potential further wave of infections.

Workforce pressures

21. Like many areas of the NHS, cardiology services entered the pandemic with significant staff vacancies. Health Education England (HEE) analysis from 2021 shows widespread capacity issues across a variety of cardiac roles and significant shortages in certain areas like cardiac physiology (the workforce responsible for delivering many cardiac diagnostic tests).^{xx}
22. The Getting It Right the First Time (GIRFT) programme estimates that an additional 760 new cardiac physiology roles are needed to meet demand over the next decade, with 460 of those roles needed for echocardiography alone.^{xxi} It's important to note that this GIRFT report was delivered before the full impact of Covid-19 on NHS waiting list had become apparent and before the Government announcement of 100 new community diagnostic centres. The additional staffing requirements of these new

facilities further underscores the need to invest in the training and retention of the cardiac physiology workforce.

23. There are also vacancies across the wider workforce involved in delivering and planning cardiac care, including advanced clinical practitioners (ACPs), specialist nurses and cardiac network leaders. These shortages compromise the Covid-19 recovery and also wider system aspirations for CVD outlined in the NHS Long Term Plan.
24. As Public Accounts Committee members heard during your recent inquiry into lessons from Covid-19, the demands of delivering care during the pandemic on the entire health and care workforce have been considerable.^{xxii} Polling in May 2021 by YouGov of over 1,000 NHS staff at all levels found that one in eleven are considering leaving the sector due to Covid-related pressures at a time when the system can least afford it.^{xxiii} Strong data on how this will specifically affect CVD services is not readily available, but insight from healthcare professionals suggests that many are considering moving organisations or retiring within the next five years. If these projections are borne out, this could lead to even larger backlogs in cardiovascular care and increased pressure on remaining staff to deliver the step-change that the Covid recovery requires.
25. We understand that growing, training, developing, retaining, and supporting NHS staff to meet the challenges of today and the future will be a constant and long-term effort. As a first step to getting this right, we support this Committee's recent recommendation that the Government should provide an update on a substantive long-term workforce plan to ensure the future resilience of the health and social care workforce.^{xxiv} We supported Jeremy Hunt's amendment to the Health and Care Bill, which would place a duty on the Secretary of State to publish independent assessments of current and future workforce numbers every two years. Although the amendment was not adopted by Government during the Common's Stages in November, we continue to support on-going efforts to amend the Bill in the Lords.
26. We were also very concerned to see that the 2021 Spending Review settlement provided no uplift or clarity on HEE's budget. With the recent announcement that HEE is to be absorbed into NHSE^{xxv} (pending legislation) we urgently need clarification about whether NHS workforce training and development costs will need to be met from NHSE operational budgets or whether additional, ring-fenced funding for this purpose will be forthcoming.

A brighter future for cardiovascular disease services – our recommendations

27. Heart and circulatory diseases did not stop for the pandemic. With thousands waiting and potentially millions more undiagnosed or undertreated, the Government must take decisive action to reduce the backlog of heart care now. Specifically, this includes:
 - a. Prioritising the recovery of cardiovascular services within the forthcoming elective recovery plan. This must be supported by a national strategy for cardiovascular recovery across the system.
 - b. Strengthening workforce planning by adopting the health sector's amendment to the Health and Care Bill that would place a duty on the Secretary of State to

publish independent assessments of current and future numbers of staff needed across the NHS, social care, and public health every two years.

- c. Embedding cardiovascular leadership at all levels of the NHS via the ongoing review of health and care leadership, led by Sir Gordon Messenger.

28. Further recommendations on how to address the backlog of cardiovascular care and support the future transformation of services, as outlined in the BHF's Untold Heartbreak report, include^{xxvi}:

a. Developing clear cardiovascular leadership roles across the system

- Robust leadership for CVD should be present at all levels of the health and care system, including in integrated care systems (ICSs) and primary care networks (PCNs)
- Cardiac networks, which hold the potential for playing a key role in helping to address the cardiovascular care backlog, should be resourced and held accountable for driving improvements and outcomes for CVD patients and reducing unwarranted variation in care across regions
- ICSs must urgently develop strategies to improve the detection and management rates of risk factors for CVD, including hypertension, atrial fibrillation, and high cholesterol in their local population

b. Ensuring a robust cardiovascular workforce

- The Department of Health and Social Care (DHSC) should work with HEE – and then its successor function within NHSE pending legislative reforms – to develop a national plan to expand and address gaps in the cardiovascular health and care workforce.
- NHSE should work with HEE – and then its successor function within NHSE pending legislative reforms – to ensure staff are able to access the necessary professional development and training to expand their roles and skills.
- NHSE should invest in support services for NHS staff facing burnout and requiring psychological support as they recover from the pandemic, as well as allowing the workforce to work more flexibly to improve rates of staff retention and satisfaction.
- ICSs and cardiac networks should work together to allow staff to work across a number of settings in their area, allowing for pooling of workforce and waiting lists where appropriate to reduce unwarranted variations in care and make efficient use of workforce and resources.
- ICSs and PCNs should make use of additional roles in primary care to best support the needs of patients with long-term conditions, such as heart failure.

c. Evaluating and sharing good practice

- DHSC and the NHSE's new digital directorates (pending legislative reforms) should work with the National Institute for Cardiovascular Outcomes Research (NICOR) to join up CVD data across settings to fully understand the impact of the pandemic on people living with heart and circulatory diseases.
- Cardiac networks and ICSs should be resourced for rapid-cycle evaluation of innovative approaches to care that have been developed throughout the pandemic.
- Measures of success will need to focus on outcomes, not only activity, with an increased focus on what matters to patients including measures of patient experience and quality of life.

d. Supporting patients as partners in their care

- NHSE should be appropriately resourced to support patients to self-manage and improve their wellbeing while they wait for treatment. This will need to include regular points of contact to inform patients about delays, support them with self-management, and signpost to relevant services.
- NHSE should be appropriately resourced to identify and manage those at risk of CVD through opportunistic detection of conditions such as hypertension and AF during routine NHS contacts.
- Cardiac networks, ICSs, and PCNs need representation from patients with lived experience of CVD in their local area to ensure that the needs of patients are at the heart of changes to the health and care system.
- PCNs should be resourced to identify and support patients in their local area who will be able to self-manage their condition remotely, providing the necessary equipment and support. This will not only empower patients to play a more active role in their care but will also free up time for healthcare professionals to support patients with more complex needs.

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ⁱ Waiting times data referred to this in this response are from the NHSE Consultant-led Referral to Treatment (RTT) Waiting Time data for September 2021: [Statistics » Consultant-led Referral to Treatment Waiting Times \(england.nhs.uk\)](https://statistics.nhs.uk/articles-and-commentary/consultant-led-referral-to-treatment-waiting-times)

ⁱⁱ Public Health England analysis of ONS death registration data.

ⁱⁱⁱ BHF, [The Untold Heartbreak](#), 2021

^{iv} NHS Confederation, [Building Back Inclusively](#), 2021

^v Caroline Fraser and Rebecca Fisher, [How has the Covid-19 pandemic impacted primary care?](#) Health Foundation, 2021

^{vi} BHF, [The Untold Heartbreak](#), 2021

^{vii} PPR, [State of health and care: the NHS Long Term Plan after Covid-19](#), 2021

^{viii} Ibid.

^{ix} NHS England and Improvement, [Our Plan for Improving Access to Patients and Supporting General Practice](#), 2021

^x BHF, [National Audit of Cardiac Rehabilitation \(NACR\) Quality and Outcomes Report 2019](#), 2019

^{xi} BHF, [National Audit of Cardiac Rehabilitation \(NACR\) Quality and Outcomes Report 2020, 2020](#)

^{xii} BHF analysis. We are happy to provide more information if requested.

^{xiii} Shoaib et al (2021) Substantial decline in hospital admissions for heart failure accompanied by increased community mortality during COVID-19 pandemic, *European Heart Journal - Quality of Care and Clinical Outcomes*, 2021

^{xiv} NHS Digital, Hospital Episode Statistics for Admitted Patient Care and Outpatient Data: [Hospital Episode Statistics for Admitted Patient Care and Outpatient Data - NHS Digital](#)

^{xv} BHF analysis. We are happy to provide more information if requested.

^{xvi} The Nuffield Trust, [Ambulance response times](#), 2021.

^{xvii} National Statistics and NHSE, [Statistical Note: Ambulance Quality Indicators](#), 2020

^{xviii} National Statistics and NHSE, [Statistical Note: Ambulance Quality Indicators](#), 2021

^{xix} [Increased Ambulance Handover Delays Threatening Patient Safety, RCEM and College of Paramedics Warn](#)

^{xx} NHS, [Getting it Right First Time: Cardiology](#), 2021

^{xxi} Ibid.

^{xxii} House of Commons, Committee of Public Accounts, *Initial lessons from the government's response to the COVID-19 pandemic*, 19 July 2021 [Initial lessons from the government's response to the COVID-19 pandemic \(parliament.uk\)](#)

^{xxiii} Connor Ibbetson, [One in eleven NHS workers plan to leave healthcare sector after pandemic](#), YouGov, 2021

^{xxiv} House of Commons, Committee of Public Accounts, *Initial lessons from the government's response to the COVID-19 pandemic*, 19 July 2021 [Initial lessons from the government's response to the COVID-19 pandemic \(parliament.uk\)](#)

^{xxv} <https://www.gov.uk/government/news/major-reforms-to-nhs-workforce-planning-and-tech-agenda>

^{xxvi} BHF, [The Untold Heartbreak](#), 2021