BHF response to the Health and Social Care Committee's inquiry on clearing the backlog caused by the pandemic

Despite the great strides that have been made over the past several decades, cardiovascular disease (CVD) remains a major cause of morbidity and mortality in the UK, accounting for 1 in 4 deaths. Heart and circulatory diseases are the major cause of avoidable premature illness and death in men, and the second most common cause in women. Additionally, we know CVD causes an enormous socioeconomic burden and personal suffering, and continues to be a significant driver of inequality and the growing life expectancy gap between different parts of the UK.

Since March 2020, when the pandemic hit, this reality has only worsened for heart patients. Despite the heroic efforts of everyone across the health and care system to respond to the needs of patients, millions of people have not been able to access the care they need. There were 5,800 "excess" deaths from heart and circulatory conditions in the first year of the pandemic in England, and the significant delays to care have likely contributed to this figure.

1. The impact of the Covid-19 pandemic on waiting lists for heart tests and treatments

Despite the unwavering efforts of NHS staff, there has been seismic disruption to cardiovascular care during the Covid-19 pandemic, with devastating consequences for the 7.6 million people who live with heart and circulatory diseases in the UK.

Even before the pandemic began, around 233,000 people in England were on waiting lists for heart diagnosis or treatment. The backlog of heart care caused by the pandemic is vast, and it continues to grow, exacerbating existing strains on the health and care system.

The latest NHSE statistics published in mid-August reveal that at the end of June 2021 in England, 252,354 people were waiting for heart tests and treatment, including invasive heart procedures and heart surgery – the highest number on record. The number of people waiting over a year decreased in June 2021 to 3,806 from a peak of 5,248 in March 2021, however, the figure is still 136 times higher than before the pandemic began in February 2020, when just 28 people had been waiting this long. As of the end of June 2021, there were 39 people in England who had been waiting over two years for a heart procedure or surgery.

2. 'Hidden patients' who may emerge in the coming months or years

Waiting lists do not give the full picture. There are potentially a large number of people who may not yet know they are at risk of becoming more unwell without any treatment, or

who have existing conditions or symptoms but who have not yet come forward for diagnosis or treatment.

a. People yet to be 'detected'

Finding people early and supporting them to manage cardiovascular risk factors such as atrial fibrillation (AF), high blood pressure and raised cholesterol is vital for preventing the onset of disease and can help people live longer, healthier lives. But too many people are still living with undiagnosed 'high risk conditions' that significantly increase their risk of developing heart disease, stroke, or vascular dementia.

- Around 15 million adults in the UK have high blood pressure and at least half of them are either undiagnosed or are not receiving effective treatment.[i]
- It is estimated that nearly half of adults in the UK are living with total cholesterol levels above national guidelines.[ii]
- It is estimated that at least 270,000 people over 65 have undiagnosed AF in the UK.[iii]

Efforts to detect these high risk conditions have been severely disrupted during the pandemic for a number of reasons, including changes in peoples' help-seeking behaviour, reduced availability of CVD services, the suspension of important detection programmes like the NHS Health Check, and the sharp decrease in face-to-face appointments.

Analysis by the Health Foundation shows that 31 million fewer primary care appointments were booked between April 2020 and March 2021 in England compared to the previous 12 months – a fall from 310 million to 279 million.[iv] Importantly, this number includes nearly 5 million fewer face-to-face appointments in 2020 and 2021 when compared to 2019. This sharp decrease in face-to-face appointments, and the rise of remote models of care, created significant challenges for the detection of high risk conditions. Healthcare professionals often detect high risk conditions opportunistically by, for example, taking a patient's pulse to check for AF or measuring their blood pressure during another routine appointment. This is much more difficult to do when care is delivered remotely.

System leaders and health and care professionals are telling us that, because of the issues outlined above, the detection gap may have increased and that ongoing limited capacity in primary care will compound the problem unless opportunities are taken to work differently.

The impact of missed or delayed detection of high risk conditions may not be immediately obvious, as conditions like high blood pressure are not always accompanied by noticeable symptoms. But this disruption could have devastating long-term effects. In England, analysis by the Institute for Public Policy Research (IPPR) found that 470,000 fewer new prescriptions of preventative cardiovascular drugs (including anti-hypertensives, statins, anti-coagulants, and oral antidiabetics) were issued between March and October 2020 compared to the previous year.[v] If these 'missing' patients with high risk conditions are not

found, diagnosed, and commenced on treatment the IPPR forecast that an additional 12,000 heart attacks and strokes will occur in England in the next five years.[vi] This will not only cause unnecessary harm and distress to those affected, but also stretch NHS resources further in the medium and longer-term. This could jeopardise the ambitions of the NHS Long Term Plan, which aims to prevent up to 150,000 heart attacks, strokes, and dementia cases to 2029, and turn back the clock on 60 years of progress on heart and circulatory diseases in the UK.[vii]

Efforts to detect undiagnosed high risk conditions within the community will be important as the immediate threat of Covid-19 recedes. The BHF has welcomed the recently announced nationwide rollout of blood pressure checks in high street pharmacies, which has the potential to prevent 3,700 strokes and 2,500 heart attacks, according to NHS estimates.[viii]

b. People yet to be diagnosed

An early and accurate diagnosis is vital for improving outcomes from cardiovascular diseases. For example, heart failure has a worse five-year survival rate than many cancers and early diagnosis is the key to better outcomes.

There were longstanding issues with the capacity for cardiac diagnostic services pre-pandemic – with patchy access to blood tests like NTproBNP (which is used to diagnose heart failure) and gaps in diagnostic cardiology imaging workforce and heart imaging capacity. These have only been exacerbated by the pandemic.

One indicator of fewer diagnoses is shown in the rate of referrals by GPs to consultant-led outpatient appointments. In April 2020, these were 75% lower than in the same period in the previous year. In February 2021, these were still 25% lower than in February 2020.[ix]

At the same time, we have seen fewer diagnostic heart tests, such as echocardiograms, being carried out in England. Over the year to February 2021, the number of echocardiograms fell by 29% on the previous year, pointing to significant delays in diagnosis and treatment.[x] A recent study by the IPPR estimates this has led to 23,000 missed diagnoses of heart failure in England during the pandemic.[xi]

The amount of time that people are waiting for echocardiograms has also increased drastically, with 37% of people in England waiting over six weeks at the end of April 2021, compared to just 4% in February 2020.[xii]

Emerging NHS structures, like community diagnostic hubs, have great potential to alleviate the backlog of diagnostic care, if properly supported and resourced. Assessment and diagnosis of CVD should be at the heart of any plans for diagnostic hubs, with clear measures and accountability for reducing the time to diagnosis. In the short term, diagnostic hubs should be given clear guidance from relevant healthcare professionals

on how to prioritise patients based on need, to minimise the number of excess deaths and poor outcomes driven by delayed diagnosis of diseases like heart failure.

Healthcare professionals and system leaders told us that, from as early as April 2021, they were already seeing an increase in the number of patients attempting to access primary care and community services. Many of these patients have more severe symptoms of existing conditions, as well as symptoms and signs leading to new diagnoses of heart and circulatory diseases.

3. Reduced access to treatments

Whilst every effort has been made to continue emergency surgery through the pandemic, there has been a sharp increase in people waiting for low-priority high-volume procedures[1], as well as people who have not had a referral.[xiii] There are now significant waiting lists for procedures and surgeries for a range of conditions, including CVD. The BHF has noticed a number of concerning trends across the care pathway.

- ### Urgent and emergency care

  There were significant reductions in attendances for urgent and emergency care for heart attacks and strokes across the UK during the early months of the Covid-19 pandemic. During the first peak in 2020, the BHF observed a 50% reduction in the number of people presenting to Accident and Emergency (A&E) in England with the symptoms of a heart attack.

  BHF is not aware of any publicly available evaluations of the NHS 111 call-first pilot, but we are concerned that encouraging people to seek help via NHS 111 rather than directly at A&E may lead to delays in people accessing care for urgent conditions, like heart attack and stroke. This is especially concerning as we know that response times for Category 2 (emergency) ambulance calls (for conditions like heart attack and stroke) are currently above the 18 minute target time, and patients are also experiencing significant delays once they reach A&E.[xiv] If treatment for conditions like heart attack is delayed this increases the likelihood of poor outcomes, including the development of heart failure.

- ### Routine and elective care

  There has been a sharp decrease in the number of 'routine'[2] heart procedures and operations. In the first year of the pandemic, there were 133,000 less than in the previous year in England.[xv]

[1] These include priority 3 and priority 4 procedures (those that can be delayed by up to or longer than three months) for conditions ranging from bone and joint conditions to ophthalmology.
[2] Please note that, when it comes to heart disease, non-emergency and elective care is far from 'routine', though this is the language commonly used in the health system. Long waits for routine and elective care put lives at risk. Please see the BHF's recent Untold Heartbreak report for more information.

Patients are also waiting longer for heart treatment. For example, in June 2021 there were 136 times more people waiting more than a year for heart procedures, including surgery, in England than there were in February 2020. Although down from 170 times more people waiting at the end of April 2021, this still shows a significant increase in people waiting over a year.

- Primary and community care
  Patients have experienced reduced access to routine primary and community care through redeployment and reductions in face-to-face care. Access to care has been unequal, and particularly limited for people who have been unable to access virtual options.

Given the size of the backlog, supporting patients while they wait for care will be more important than ever to help ensure they can stay well between episodes of care and reduce the impact of stress, anxiety, and the prospect of worse long-term health outcomes.

4. Disruption to cardiac rehabilitation

Cardiac rehabilitation services offer a range of support to patients, including exercise to improve cardiac function, advice on diet and exercise, and psychological and peer support. It can help save lives, improve quality of life and, critically, reduce hospital readmissions. Cardiac rehabilitation services have, however, been historically under-resourced and there has been wide variability in the type of service that is offered. The Community Rehabilitation Alliance, of which the BHF is a member, is calling for a broad review of rehabilitation services so the healthcare system can understand what is available, and what will be needed to expand and modernise rehabilitation services to meet the scale of need both for Covid-19 (including long Covid) and other health conditions.

Even before the pandemic, access to and uptake of cardiac rehabilitation services was historically limited to just over half of eligible patients.[xvi] The Covid-19 pandemic amplified this trend. It resulted in a significant drop in people attending cardiac rehabilitation – a result of a combination of fewer referrals (as a result of fewer heart attack patients presenting to A&E and surgeries being postponed) and significant disruption due to staff redeployment. People with Asian and Asian British ethnic backgrounds experienced the largest drop in participation when compared to White populations between February and July 2020, falling 45% overall. Similarly, people with Black, African, Caribbean and Black British ethnic backgrounds experienced an overall 44% drop in participation.[xvii] Before the Covid-19 pandemic people with minority ethnic backgrounds already had lower rates of participation in cardiac rehabilitation, so these trends amplified pre-existing inequities in access.

Novel approaches to providing rehabilitation and wider recovery and support services during the pandemic have included use of apps and livestreamed exercise classes, and outdoor options such as walking groups, but there has been significant variability from

service to service. Patients have also told us that, while online services have worked well during lockdowns and periods of shielding, they feel that vital components of cardiac rehabilitation (for example psychological and peer support) work best when delivered face-to-face.

5. The considerable toll on the workforce

Prior to the pandemic, cardiology services already had significant staff vacancies across the UK. In England, prior to the pandemic there was one cardiologist per 41,335 of the population, with significant regional variation in access to cardiologist-led care.[xviii]

There were also vacancies across the wider workforce, with suboptimal numbers of both advanced clinical practitioners (ACPs) and specialist nurses in England. ACPs and specialist nurses play a vital role in delivering care, with many fulfilling extended roles that are not only vital to delivering quality care to patients, but also in delivering the ambitions of the NHS Long Term Plan in England. Current estimates are that between three and four heart failure specialist nurses or ACPs are needed per 100,000 population to deliver the requirements of the Long Term Plan, as opposed to the one per 100,000 previously recommended.[xix]

Prior to the pandemic there was also a very significant shortfall in the cardiac physiologist workforce. The NHS Getting It Right First Time (GIRFT) Cardiology report estimates that around 760 new cardiac physiologists will be needed to meet demand over the next ten years.[xx]

These widespread staff vacancies meant the health and care system was already working at reduced capacity in the years prior to the pandemic. This meant that health and care services across the UK entered the Covid-19 pandemic with an already overworked and exhausted workforce.

The pressures of delivering care during a pandemic compounded pre-existing workforce pressures, and has resulted in a concerning rise in work-related stress and burnout. For example, a survey by the British Medical Association (BMA) found that 32% of respondents said that they or clinical colleagues in their department had been on sick leave due to anxiety, stress, depression, or post-traumatic stress disorder caused by the pandemic.[xxi] Healthcare professionals and system leaders across the UK indicate that these broader trends are reflected in the workforce that supports people with heart and circulatory conditions.

There is now a real concern that the NHS could be facing a workforce exodus in the coming years because of the intense pressures and stress brought about by the pandemic. Given the challenges that lie ahead in terms of recovering NHS services in the medium and long term, it is expected that some staff may decide to leave the NHS, compounding existing workforce shortages. Polling in May 2021 by YouGov of 1,009 NHS workers in

England across all roles found that 1 in 11 (9%) are considering leaving the healthcare sector.[xxii]

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 from the service in the next five years, with a significant minority suggesting they are less likely to work for the NHS in the future. This is a serious concern given the significant pre-existing vacancy rates across cardiology services.[xxiii] If expected staff retention trends are borne out, this could lead to even greater staff shortages in cardiology, compounding existing issues with waiting times and increasing pressure on remaining staff. Worryingly, conversations with system leaders have also revealed widespread concerns about people later in their careers considering earlier retirement, which could have significant implications for the future of clinical leadership at a crucial period for health and care systems across the UK.

As the immediate coronavirus crisis begins to recede, space and time for staff to reflect on and learn from the difficulties experienced during the pandemic will be needed. It will be important for systems to introduce formalised support networks and safe spaces, like Balint groups, which provide a supportive forum for healthcare staff from all backgrounds to discuss and reflect on the emotional and social challenges of caring for patients.[xxiv] Action to support the mental and emotional health of the NHS workforce must also address longstanding structural and resourcing shortfalls. A long-term and sustainable strategy that prioritises recruitment, training, and retention of skilled NHS workers is urgently needed.

6. Modelling future demand for cardiovascular services

Even before the pandemic began, there were over 230,000 people waiting for heart care and diagnosis in England. System leaders told us that maintaining waiting lists at the levels seen prior to the pandemic had required steadily increasing activity from staff, with little room in the system for any future increase in demand.

The BHF's modelling of waiting lists for cardiology treatment in England shows three scenarios for the impact of the pandemic on cardiac services. In all three scenarios, it is estimated that it will take years for the heart care backlog to recover to pre-pandemic levels in England.

Even in the 'best case' out of the three modelling scenarios produced by the BHF – where already-planned Government investment in the health service helps NHS England (NHSE) to tackle the backlog more quickly – it is predicted that it may take until around May 2024 for cardiology waiting lists to return to pre-pandemic levels.[xxv]

In the 'worst case' scenario, we estimate that it could take up to five years for the heart care backlog to recover to pre-pandemic levels. In this scenario, the number of people waiting for heart care and diagnosis could peak at 550,385 in January 2024 if NHSE does

not get enough investment and is under increased pressure from Covid-19 or a bad winter. At the same time, people specifically waiting for heart surgery could almost double by February 2022 compared to pre-pandemic levels, with numbers peaking at 15,384.[xxvi]

Without immediate Government intervention to reduce the backlog of heart care, there is a risk that thousands more people could die from heart and circulatory diseases, despite the NHS going above and beyond during the pandemic.

A brighter future for cardiovascular disease services

The Government must take decisive action to reduce the backlog of heart care now. This must include a clear plan for cardiovascular services and rapid investment to build more capacity into NHSE and relieve pressure on the workforce, as well as better support for heart patients while they wait for treatment.

Ensuring appropriate funding and resources

- Substantial and long-term increased investment in the health and care system is needed to address the backlog and support transformation of services, including for social care and public health.
- At the minimum, the health service will need an increase in funding of 4% a year on average for the next ten years to bring health spending in the UK in line with other G7 countries, as advised by the recent Lancet commission.[xxvii]
- Equitable and sustainable restoration of the public health grant is needed, to allow local authorities to provide vital stop smoking services and weight management support. This has seen real term cuts of 24% since initial allocations were made in 2015/16. £1 billion is the minimum amount required to stabilise the Public Health Grant and restore funding to 2015 levels, as advised by the Health Foundation.[xxviii]
- Funding allocations at the regional and local level should have a strong focus on the reduction of health inequalities associated with CVD, exacerbated by Covid-19.

Developing clear cardiovascular leadership roles across the system

- Robust leadership for CVD services should be present at all levels of the health and care system, including in emerging 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 in outcomes for CVD patients and reducing variation in care across England.
- ICSs must urgently develop strategies to improve the detection and management rates of risk factors for CVD, including hypertension, AF and high cholesterol in their local population.

Ensuring a robust cardiovascular workforce

- The Department of Health and Social Care (DHSC) should work with Health Education England (HEE) and NHSE to develop a national plan for England to expand and address gaps in the cardiovascular health and care workforce.
- NHSE should work with HEE to ensure that staff are able to access the training needed to expand their roles and skills to support in delivering improvements set out in the NHS Long Term Plan.
- 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 staff retention.
- 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.

Evaluating and sharing good practice

- NHSX should work with DHSC, NHS Digital, and 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.

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.

Conclusion

A substantial long-term investment is needed to not only address the backlog of care, but to deliver the ambitions of strategies like the NHS Long Term Plan. If we fail to act now, we risk turning back the clock on 60 years of progress on heart and circulatory diseases in the UK. To do so would be failing not only our health and care system, but also the 7.6 million people currently living with heart and circulatory diseases across the UK and the many millions who will develop CVD in the coming years.

Endnotes

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