Tipping Point

Why heart care must be prioritised now

British Heart Foundation
In our Untold Heartbreak report published in 2021, we told the story of the pandemic’s devastating impact on the 7.6 million people living with heart and circulatory conditions across the UK. One year into the pandemic and we could already see the long-term challenges ahead for heart patients: a growing waiting list for lifesaving heart tests and surgeries, a steep drop in cardiac hospital admissions, and the fear and uncertainty that so many felt as they tried again and again to access support to manage their condition. We warned that unless decisive action was taken to prioritise heart health in the Covid recovery, we would all be left holding a ticking cardiovascular care time bomb.

When the Government announced the elective recovery plan last year, it pledged to carry out the ‘largest catch-up programme in the NHS’s history.’ But many of the heart patients who reach out to our helpline, attend our events, and take part in our research are telling us that they feel left behind. Despite the best efforts and commitment of NHS staff, millions have been unable to access routine care, record numbers continue to wait longer and longer for heart tests and procedures, ambulances are taking far too much time to reach heart attack patients, and there have been tens of thousands more deaths than expected involving cardiovascular diseases with no end in sight.

But the truth is that even before the pandemic, half a century of progress against death and disability from heart disease across the UK had been stalling. Heart care has now reached a critical tipping point. Returning to how things were before Covid will not be enough to bring us back from this brink and to a better future for the millions of people living with cardiovascular diseases and their families. And, with cardiovascular diseases costing the UK economy around £19 billion a year and further driving health inequalities, it also won’t bring more shared prosperity for our communities.

We must unite to push back against this heart disease crisis before it’s too late. That’s why the British Heart Foundation (BHF) is now calling for the UK Government to develop a new National Heart Strategy – one that puts heart care back on the front foot, stops the causes of poor heart health in their tracks, and supercharges research for the cures of the future.

As this paper outlines, the scale of the challenge for heart health is immense. But if we get this right, the opportunity to positively transform the life chances of millions of people and bolster our nation’s productivity is equally great. Every part of the system, from our research institutions to public health partners, NHS organisations and the voluntary sector will have an important role to play.

With one death every three minutes across the UK due to heart and circulatory disease, there isn’t a moment to lose.

Dr Charmaine Griffiths, Chief Executive
Tamsin, 45, from Essex, has been experiencing chest pain and breathlessness since May 2022, impacting her job as a dance teacher. She’s worried - heart disease runs through her family. Her late mother had her first heart attack when she was just 38 and her cousin died recently of a heart attack.

She found it difficult to get her symptoms taken seriously, and had trouble getting a GP appointment. Now, she’s been waiting nearly two months for an appointment at the Rapid Access Chest Pain Clinic, when she should have been seen urgently. All the while, her health is getting worse and she is struggling with stress and anxiety in light of her devastating family history.

“I’ve been experiencing worrying symptoms for about six months, and as a dance teacher, it’s very noticeable for me when I become unwell. After waiting a month for a GP appointment, I was seen at my local practice, but my symptoms were largely dismissed, and I was told I was fine.

“Since my symptoms persisted and they were impacting my quality of life, I saw the GP again in early September. A nurse ran an ECG and noticed some abnormalities in the report. A doctor reviewed the ECG and referred me to a Rapid Access Chest Pain Clinic. The clinic should have seen me urgently, but nearly two months on and I am still waiting. I’ve tried to communicate with the GP about the referral and to get some support while I wait, but I haven’t heard anything back.

Not only can I feel my health getting worse, but there is a huge psychological toll. My mother’s side of the family have all died due to heart disease. I know the realities of heart disease. I’ve lived it through my loved ones.

“I know the NHS is under huge pressure right now, but it feels like the opportunity to prevent any escalation of my symptoms might have been missed. I want to understand what these symptoms mean, but I’m stuck here waiting in limbo.”
Heart care is approaching a tipping point

Tamsin is just one of countless heart patients who feel stuck in limbo as they wait for vital heart care. Extremely long waits for a GP appointment, for the ambulance to arrive, for a heart test or procedure – these are all symptoms of a system on the edge of crisis. Based on BHF analysis of the latest NHS statistics in England and our work with patients and the cardiovascular healthcare workforce, this paper explores how the future of heart patients is hanging in the balance and the steps we can take now and over the longer term to get on a more sustainable footing.
Methodology – what evidence has informed this paper?

This paper draws together the following new evidence about the health and care system and patient experience in England:

Survey of heart and circulatory disease patients
Over July and August 2022, we asked polling experts YouGov to survey 3,000 people living with a heart or circulatory condition about their experiences of accessing care, their perceptions of the pandemic, what support they most needed, and where they wanted to see the NHS prioritise in the future. In this paper, we compare these results to a 2021 YouGov survey we conducted with a similar cohort of patients, which has allowed us to draw some conclusions on the impact of Covid over time. For more information about the survey respondents, see the Appendix.

Waiting list modelling
We have produced a waiting list model to provide a view of how the NHS cardiology waiting list in England could develop over the next six months. The model is based on several assumptions about the supply and demand expected on NHS services to form a view of what we believe is the most likely outcome for the cardiology waiting list. For further information about the assumptions in the model, see the Appendix.

Evidence review of the state of the cardiovascular workforce
To better understand what the workforce needs in order to deliver a step-change in services for heart patients, we drew together the most up-to-date information about the workforce from official NHSE statistics and published and unpublished research. We also conducted one-to-one semi-structured interviews with over thirty different professional organisations and workforce bodies, including most of the leading UK cardiovascular workforce associations. For a full list of organisations we spoke with, see the Appendix.

BHF data analysis
We analysed publicly available data about the health system in England, including datasets provided by the Office for Health Improvement and Disparities (OHID), NHS England, and NHS Digital.
01. Impact of this crisis on heart patients
Two and a half years on, people with heart and circulatory diseases continue to die on average at higher levels than expected.

Key findings

- From the beginning of the pandemic to August 2022, there have been just over 30,000 ‘excess’ deaths involving ischaemic heart disease (IHD) in England. IHD is the most common type of heart and circulatory disease. It is caused by narrowed arteries and can ultimately lead to a heart attack. In addition, there have been thousands more ‘excess’ deaths involving other heart or circulatory conditions, such as heart failure or cerebrovascular disease (stroke).

- Since the pandemic began, heart and circulatory diseases have consistently been a major driver of the overall excess mortality trend.

- This consistent level of excess mortality involving heart and circulatory diseases is unique and not in keeping with what we have seen with other condition-specific causes of death, such as dementia and cancer. This suggests that two and a half years following the start of the pandemic, the health system still has not recovered and adapted sufficiently to meet the needs of heart patients.

Background context

When the BHF was established in 1961, more than half of all deaths in England that year were attributed to cardiovascular disease (CVD) – the umbrella term for all diseases of heart and circulation, such as coronary heart disease, heart failure, or stroke. Since that time, the annual number of deaths from CVD in England has fallen by around a half.¹

Since 2011, however, this progress has started to stall. Over the past decade, heart and circulatory diseases have accounted for around 25% of all deaths in England annually and contribute up to a quarter of the gap in life expectancy between the most and least deprived communities in this country.¹

Heart and circulatory conditions contribute up to a quarter of the gap in life expectancy between the most and least deprived communities in this country.
Excess deaths

The Covid-19 pandemic changed the health profile of England in profound ways. Since its onset through August 2022, around 124,000 more people in total have died than we would have expected to see under ‘normal’ conditions over this length of time. CVD has been a major driver of this overall excess mortality trend.²

From March 2020 through to August 2022, there have been just over 30,000 excess deaths involving ischaemic heart disease (IHD) - the most common type of heart disease - in England. This is 14% higher than we would have expected to see pre-pandemic. Additionally, there have been thousands more excess deaths involving other heart or circulatory conditions, such as heart failure or cerebrovascular disease (stroke).³

Unlike other conditions, such as cancer and dementia, CVD has consistently been a major cause of overall excess mortality since the pandemic began. In fact, all-cause mortality actually declined during the first half of 2022, falling to its lowest levels since 2001⁴, but this was not the case for mortality involving cardiovascular diseases, which continued to report higher than expected levels.⁵

Covid-19 infection was likely a significant factor in excess CVD-related mortality during the first year of the pandemic, not least because research suggests that heart and circulatory disease risk factors, including obesity, hypertension, and diabetes, raise the risk of severe illness from the virus.⁶ Additionally, there is growing evidence that people with previous Covid infection have a higher risk of developing subsequent cardiovascular disease.⁷

However, Covid infection is no longer a driving force behind the excess CVD death rate. It is likely that external factors, such as sustained bottlenecks in access to and delivery of NHS services, are the main contributors to the number of extra heart and circulatory deaths we continue to sadly see. This suggests that services have still not sufficiently recovered or adapted to meet the specific needs of CVD patients.

The NHS Long Term Plan identified CVD as the ‘single biggest area where the NHS can save lives’ over the next decade and pledged to prevent 150,000 heart attacks, strokes, and dementia cases by 2029. Even before the pandemic, progress towards those ambitions was stalling. In its wake, the pandemic’s impact on the health system has contributed to a situation where 60 years of progress against death and disability from cardiovascular disease is now in danger of being reversed.

Figure 1 - Excess mortality in England by cause of death, 27 March 2021 to 26 March 2022
Any mention of the cause on the death certificate

![Figure 1](image-url)
What is contributing to these excess deaths?

1. 'Missing' patients & lost opportunities to manage risk factors for CVD

Key findings

• 43% of heart patients we recently surveyed who needed medical treatment for their heart condition over the past year have put off seeking NHS help due mostly to ongoing fears of catching Covid or burdening NHS services.

• 20% of heart patients reported that they have had an appointment for their heart condition cancelled over the last year. The most common types of appointment cancellations were for routine medication or condition reviews, reflecting continued disruption to this kind of vital care.

• There has been a particularly steep decline in hypertension management, with the proportion of patients with diagnosed hypertension who had their BP checked falling from 89% in March 2020 to 64% by March 2021. This has since partially recovered to 78% by March 2022 – good progress, but still not back to pre-pandemic levels.

• Analysis from NHSE shows that two million fewer people were recorded as having controlled hypertension in 2021 compared to the previous year.

• Modelling from NHSE shows that this reduction in blood pressure control could lead to an estimated 11,190 additional heart attacks and 16,702 additional strokes over a three-year period.
Background context

Too many people are living with undetected or unmanaged conditions such as high blood pressure, raised cholesterol, and atrial fibrillation. For example, an estimated 28% of adults in England have high blood pressure—that’s around 12 million people—and at least half of them are not receiving effective treatment. These common conditions can cause heart and circulatory diseases, increasing the risk of heart attack and stroke.

To turn the tide on mortality due to heart and circulatory diseases, we need to get better at the early detection and management of these high-risk conditions. Primary care services, particularly the NHS Health Check programme, have a leading role to play in this effort.

Pandemic impact

The UK entered the pandemic with primary care facing multiple challenges, including a lack of capacity to meet rising patient demand, and increasing caseload complexity. In the first year of the pandemic, there was seismic disruption to primary care activity, resulting in a steep decline in the management of risk factors for heart disease. This happened for several reasons.

Firstly, although primary care stayed open throughout the entire pandemic, the number of primary care appointments dropped sharply. While the decline in appointments was most obvious in the initial months of the pandemic (falling from 24 million in March 2020 to 16 million in April 2020), significant decline persisted for many months. This was due, in part, to changing behaviour, as patients heeded the ‘stay at home’ message and deferred seeking treatment.

An estimated 28% of adults in England have high blood pressure – that’s around 12 million people.
Even though the volume of General Practice appointments has returned to—and in some months now exceeds—pre-pandemic levels\(^{10}\), we know that a significant portion of heart patients continue to avoid seeking help. Our research has found that over the past year 43% of patients who needed medical care for their heart condition have put off seeking help primarily to avoid putting pressure on the NHS and because they were worried about catching Covid-19. We still do not know how many heart patients who deferred seeking treatment during this time will return or when.

Secondly, routine and preventive care suffered during the initial year of the pandemic as the NHS responded to acute Covid-related demand. Notably, the NHS Health Check Programme was suspended. As figure 2 shows, health check delivery plummeted to all but zero in the first quarter of 2020/21.\(^{11}\) While the proportion of eligible people receiving NHS health checks is recovering, rates are still not back to pre-pandemic level.

There was a particularly steep decline in blood pressure checks, with the proportion of patients with diagnosed hypertension who had their BP checked falling from 89% in March 2020 to 64% by March 2021. That has since partially recovered to 78% by March 2022, showing slow but clear progress.\(^{12}\)

Heart patients are still reporting challenges accessing routine care, with 20% of heart patients we surveyed reporting that they have had an appointment for their heart condition cancelled over the last year. The most common types of appointment cancellations were for routine medication or condition reviews, reflecting continued disruption to this kind of vital care.

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**Figure 2** - Proportion of eligible population aged 40-74 who have received an NHS health check

*England only*

43%

Our research has found that over the past year 43% of patients who needed medical care for their heart condition have put off seeking help primarily to avoid putting pressure on the NHS.

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Source: Office for Health Improvement and Disparities (2022) NHS Health Check Data
Third, to mitigate infection risk, services rapidly shifted to remote consultations where possible. This led to millions more appointments per month being conducted remotely compared to 2019 levels.\textsuperscript{13} This matters for CVD risk management because the remote delivery of care (which has benefits for some patients) reduces opportunistic blood pressure checking – amongst other impacts.

Like with NHS Health Checks, there has been some recovery of face-to-face appointments to pre-pandemic levels. Compared to the first year of the pandemic, more heart patients are telling us that they have been able to access face-to-face in person care (36\% in 2022 versus 22\% in 2021). However, according to the Royal College of General Practitioners (RCGP), this is still nowhere near pre-pandemic levels of face-to-face consulting access.\textsuperscript{14}

All of this has contributed to a situation where millions of people living with a heart or circulatory condition have not received the services they need from primary care to detect or manage their condition. Analysis from NHSE shows that two million fewer people were recorded in 2021 as having controlled hypertension compared to 2020. If these ‘missing’ patients are not found and appropriately treated and/or referred on to secondary care, NHSE modelling suggests that there will be an estimated 11,190 additional heart attacks and 16,702 additional strokes over a three-year period.\textsuperscript{15}

\textbf{20\% of heart patients we surveyed report that they have had an appointment for their heart condition cancelled over the last year.}
What we’re looking to see in the future

The recovery of services to manage high-risk conditions for heart and circulatory diseases must be at the heart of how we rebuild services. Rolling out innovative programmes, such as BP@Home, so they reach more people will be essential, but so too will be the recovery of tried and tested programmes, such as the NHS Health Check. However, primary care will never be able to deliver on this agenda without the right workforce in place. There has been no progress at all against the Government’s 2019 pledge to increase the number of GPs by 6,000 by 2024. In fact, the data show that since 2019 there has been a decline in fully qualified, permanent GPs working in England. There have also been declines in the community nursing and health visitor workforce over the past three years. These workforce shortages must be addressed as a matter of urgency.

What is being done to address this?

It is essential to get the routine management and detection of high-risk conditions for CVD back on track. The NHS has published a CVD Prevention Recovery Plan that has been trialling innovative ways to make this happen, including by:

Making it as easy as possible for people to have their blood pressure checked – this means scaling up innovative ways to meet people. For example, the BHF recently supported a programme that saw community pharmacy and other community partners mobilised to detect undiagnosed hypertension. In the first year of this programme the uptake has been fantastic, with the NHS estimating that over the next five years it could prevent over 5,000 heart attacks and over 8,000 strokes and save over 4,000 lives. The NHS now expects 5.5 million people to undergo checks over the next five years, of whom 10% are likely to need treatment.  

Empowering patients with hypertension to better self-manage their condition through, for example, innovations like BP@Home. BP@Home is an NHSE programme to improve blood pressure control in people with hypertension through home monitoring, by identifying who is at greatest risk from hypertension, recruiting patients to either buy their own BP monitor or have one supplied to them, and providing resources for guided self-management. Through this programme, 220,000 people who have been diagnosed with uncontrolled high blood pressure have received free blood pressure monitors. The roll out of BP@Home is still in its infancy, but promises to support improved health outcomes and provide patients with the confidence and peace of mind to help them manage their own health.
As part of the recovery effort, the NHS is also providing ring-fenced funding to create CVD leadership posts in each Integrated Care System (ICS) and local networks of clinical specialists to help join up care pathways and link with system partners. Currently, these posts are in their infancy and there is regional variation in their development. It’s vital that these posts are fully funded and supported over the long-term to ensure that ICSs prioritise cardiovascular care.

Looking to the future, it’s essential that ICSs develop cohesive regional plans to address the backlog of cardiac care, including across primary care, and to ensure progress against national delivery targets. To ensure transparency and local accountability, these plans must be co-developed with all system partners at every level and published externally and available to the public.
What is contributing to these excess deaths?

2. More patients are waiting longer for lifesaving heart tests and treatments

Key findings

• By the end of August 2022, there were a record 346,129 people on a cardiac waiting list in England. This is the 26th consecutive month where an increase has been seen and a 49% increase in the number of people waiting in February 2020.

• 7,467 people have been waiting over a year for a heart procedure – 267 times higher than before the pandemic.

• Modelling produced by the British Heart Foundation suggests that around 395,000 people in England could be on a waiting list for a heart test or procedure by April 2023 based on current trends and developments in the health system. This represents an increase of more than 76% compared to before the pandemic.

• Almost one in five patients (18%) we surveyed reported that their heart condition has deteriorated since the start of the pandemic. This is significantly higher than in 2021, showing the long-term impact of pandemic disruption for heart patients.

1/5

Nearly a fifth of patients are telling us that their heart condition has deteriorated since the start of the pandemic.
Background context

In the years leading up to the pandemic, NHS performance against key waiting times standards for elective care had been steadily declining. The statutory 92% elective care waiting time standard was last met in February 2016 and elective surgery was compromised every winter due to lack of system capacity. When it comes to heart care, the 2019 monthly cardiac waiting list averaged 224,262.

Pandemic impact on cardiac waiting lists

The pandemic has led to a drastic increase in waiting times for heart patients. By the end of August 2022, there were a record 346,000 people waiting for heart care. This was the 26th consecutive month where an increase has been seen and a 49% increase in the number of people waiting compared to early 2020. As figure 3 shows, thousands of these people have been waiting for over a year – an order of magnitude higher than before the pandemic began. Extremely long waiting times for a heart procedure can be stressful and anxiety-inducing for patients. Long waits can also have serious health implications for patients, as their heart health can deteriorate and they could then become inoperable or face worse long-term outcomes.

Worryingly, nearly a fifth of patients are telling us that their heart condition has deteriorated since the start of the pandemic - significantly higher than we found following the first year of the pandemic. We fear that this trend will continue unless decisive action is taken now.

7,467 people have been waiting over a year for a heart procedure – 267 times higher than before the pandemic.

Figure 3 - Number of patients waiting for heart procedures for over a year

Source: NHS England (2022) Consultant-led Referral to Treatment Waiting Times (number of incomplete pathways)
What do we think is going to happen to the cardiology waiting list?

Modelling produced by the British Heart Foundation suggests that around 395,000 people in England could be on a waiting list for a cardiology procedure by April 2023, based on current trends and developments in the health system. This represents an increase of more than 76% compared to before the pandemic.

Figure 4 - Projected cardiology waiting list in England

Source: NHS England (2022) Consultant-led Referral to Treatment Waiting Times (number of incomplete pathways); BHF projections

395,000 people in England could be on a waiting list for a heart test or procedure by April 2023.
What is being done to address this?

In February 2022, the Government and the NHS published their joint strategy for tackling the backlog of elective care. Recognising the unprecedented scale of the challenge ahead, the plan is clear that without targeted and bold action to increase NHS activity levels, the total elective care waiting list could increase from over six million to 14 million people over the next few years.

The plan sets out an ambitious target for the NHS to deliver 30% more activity, such as tests and surgeries, over the next three years compared to pre-pandemic levels. Several BHF-endorsed recommendations were also committed to in the plan, including the roll out of surgical hubs and community diagnostic centres, along with a pledge to provide personalised support to help patients as they wait for care.

If implemented fully, these changes should help cardiovascular care get back on track, and in the short-term can help provide critical information and support for patients waiting for vital care. The plan is notable, however, for failing to provide any meaningful new commitments on staffing levels – leaving in doubt how these ambitious aspirations will be met.

The plan also fails to prioritise the specific needs of heart patients, meaning the NHS has no clear national targets for clearing the heart backlog to work towards. With the government recognising that under this plan waiting lists will most likely not decline until 2024, we are looking at two very difficult years ahead for heart patients.

The elective recovery plan is clear that without targeted and bold action to increase NHS activity levels, the total elective care waiting list could increase to 14 million people over the next few years.
What is contributing to these excess deaths?

3. Heart patients are waiting too long for an ambulance and other emergency services

Key findings

• Urgent and emergency care services have been facing sustained pressure and a significant deterioration in performance standards since April 2021.

• While the target ambulance response time for a Category 2 call (which includes emergencies like suspected heart attacks or strokes) is 18 minutes, average ambulance waiting times in England have been consistently above 35 minutes since the start of 2022. They even breached one hour in March of this year.

• Extreme delays and overcrowding in emergency departments have led to over 4,500 excess deaths in 2020/21, according to the Royal College of Emergency Medicine.

Background context

In the years leading up to the pandemic, A&E was increasingly under pressure and had been missing key waiting time standards, such as the four-hour waiting time target. It was also not unusual for urgent and emergency care demand to disrupt elective activity during the winter months.

The performance target for ambulances to respond to a Category 2 call (those that are classed an emergency that may require rapid assessment or urgent on-scene intervention like suspected heart attacks and strokes) in 18 minutes on average had also never been met. Between April 2018 (when the target was introduced) and February 2020, the worst monthly average for Category 2 calls was 28 minutes.
Pandemic impact – first year

Overall cardiac hospital admissions dropped 26% in the first year of the pandemic compared to the previous year (343,000 admissions between March 2020 and February 2021, compared with 475,000).26

Even though attendances dropped, we know that heart attacks and strokes didn’t stop. We also know that heart patients in need of emergency services were not simply displaced from acute services to community care. For example, research shows that more people died in the community with heart failure in the first year of the pandemic than ever recorded (280 deaths over a four-month period) because they hadn’t been treated in an acute setting.27

Second year and on

By 2021, cardiac admissions to hospital started to recover, but were still below pre-pandemic levels. As referrals rose, and patient confidence to access services increased, ambulances began to come under increasing pressure not seen in the early stages of the pandemic.

Starting in the Spring of 2021, ambulance response times for Category 2 emergencies started to climb to unprecedented levels. As seen in figure 5, while the target response time for a Category 2 call is 18 minutes, average ambulance waiting times have consistently been around twice that all year— even breaching the one hour mark in March 2022.26

The national picture masks incredible regional variation. For example, in September 2022, the average ambulance response time for Category 2 calls overall was 48 minutes— with the best performing region of South Central (38 minutes on average) standing in sharp contrast to the worst performing region of East of England (74 minutes on average).29

These delays to ambulances getting to patients are mirrored in delays throughout the entire emergency care pathway and have had devastating consequences. The Royal College of Emergency

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**Figure 5 - Category 2 ambulance response times**

*These ambulance responses include calls for suspected heart attacks and strokes*

![Figure 5 - Category 2 ambulance response times](chart)

*Target of 90% of calls answered within 40 minutes on average

The Royal College of Emergency Medicine (RCEM) estimates that overcrowding and extreme delays in emergency services led to 4,519 excess deaths in England in 2020/21.30

Why is this happening?

Extreme delays and bottlenecks in this part of the pathway are a symptom of an entire health and care system that is in crisis. Ambulances can’t reach patients in their communities and homes because they aren’t able to handover patients at hospital, due primarily to a lack of beds. Hospital beds are full because of challenges managing patient flow across the whole system, particularly an inability to discharge medically fit patients into social care services, and a lack of workforce capacity.31 Backlogs in every part of the system have resulted in a vicious circle, with time critical heart and stroke care severely impacted.

What is being done about this?

The NHS has set out a number of steps to boost capacity and resilience, especially in emergency care, in its 2022 winter plan. These steps include measures to better support people in the community through a community-based falls response service and to maximise the use of virtual wards. The NHS is also developing a new Urgent and Emergency Care strategy, which is aimed in part at driving improvements in primary and community care to ease pressure on urgent and emergency care services. While we welcome these developments, we remain concerned that without additional significant investment, especially for social care services and primary care teams, they won’t be enough to allay this crisis.
02.

What needs to change?
What heart patients most want and need

Over July and August 2022, we asked polling experts YouGov to survey 3,000 people living with a heart or circulatory condition about their experiences of accessing care, their perceptions of the pandemic, what support they most needed, and where they wanted to see the NHS prioritise looking to the future. Here’s what they told us:

Heart patients want better information to help them manage their condition

Almost half (46%) of heart patients indicated that they needed more patient information and support beyond that which had been provided directly by their healthcare professional at various stages of their care. The top three stages when they needed further information were: while managing their condition (28%), right after diagnosis (24%), and while waiting for treatment (11%). As more and more patients have had to wait longer for vital heart tests and surgeries, it’s more important than ever that they are provided with the information and resources to self-manage appropriately.

Heart patients want to know the NHS has time to see them – otherwise they might continue to stay away

A significant amount of heart patients have put off accessing health services over this past year, with many saying that they were concerned about putting pressure on the NHS or catching Covid. It’s vital that these patients are supported to return to receive the care they need. When we asked patients what would make them more comfortable accessing NHS services, the clear majority (61%) said it was ‘knowing that the NHS has time to see them’ that would make the difference.

Heart patients need more mental health support

More than half of respondents agreed that over the last year the pandemic has had a negative impact on their mental health, equivalent to when we surveyed heart patients at the end of the first year of the pandemic. While most respondents were happy that Covid restrictions have ended, 30% said that the ending of restrictions has made them more stressed or anxious, with 7% saying they have felt unable to attend work or study since restrictions eased. Before the pandemic people with heart and circulatory diseases were already at risk of poor mental health; Covid continues to worryingly exacerbate this trend.

Looking to the future, heart patients want the NHS to prioritise access to GPs, making it easier to communicate with healthcare professionals, and increasing workforce numbers

We asked heart patients to tell us what the NHS should prioritise to improve care for their heart or circulatory condition. Reducing waiting times for a GP appointment, making it easier to contact their GP or specialist, and increasing the number of doctors were their top three priorities. This suggests that workforce shortages in both primary and secondary services are a key factor impacting heart patients’ perceptions of their care.

61% of patients said that knowing the NHS has time to see them would make them feel more comfortable using NHS services
To better understand what the workforce needs in order to deliver the step-change in services that heart patients need, we drew together the most up to date information about the workforce from official NHSE statistics, interviews with professional CVD workforce bodies, and published and unpublished research. This is what we found:

**What the cardiovascular workforce needs to meet the CVD challenges of today and the future**

Staff shortages are causing a crisis in heart care

All the stakeholders we spoke to from NHS services, professional societies, and voluntary sector organisations agree there is a crisis in cardiovascular care. They were unanimous that too few staff were being trained to keep up with demand. For instance, numerous studies have highlighted the need to significantly increase the number of cardiac physiology staff to meet current and future demand, particularly in echocardiography. One analysis found that 78% of departments offering physiological sciences services had difficulty recruiting qualified staff and that 8% of qualified staff posts were vacant. The 2021 Getting it Right First Time (GIRFT) report into cardiology estimates that 760 new cardiac physiology roles are needed over the next decade. We won’t tackle long waiting lists for heart tests if these shortages are not addressed.

The wider workforce, especially those involved in prevention and based in the community, are just as important as specialists for cardiovascular care

People with heart and circulatory conditions need support from a multidisciplinary team, working across the whole patient pathway, including local authority public health teams. Stakeholders believe that each heart team should have a community liaison coordinator and work closely with primary care teams. Stakeholders told us it was essential to consider workforce planning for all these roles in an integrated manner, rather than focusing in isolation on specific posts.
Any workforce plan must include measures to improve retention

In the 2021 NHS staff survey, 31% of staff said they often thought about leaving their organisation. Smaller surveys of cardiovascular staff show the same trends. Cardiovascular stakeholders suggested that it should be a priority to retain the current workforce and make best use of existing resources. The top reasons they were most likely to cite for poor retention in the CVD workforce were burnout and perceived unsupportive culture in the NHS, a lack of clear progression in some specialties, such as echocardiography, and more opportunities or higher rates of pay in the private sector and internationally. Any future workforce plan must take action to address those issues and improve retention rates.

The NHS needs a better process for collecting workforce data

Stakeholders we spoke to for this research felt strongly that there was a lack of accessible information about the cardiovascular workforce and no integrated approach to track changes and needs over time. For example, there is very little data about the number and type of hospital and community nurses providing cardiovascular care from NHS workforce statistics. Individual professional societies and some Royal Colleges have some good data about their own workforce specialty, but they and workforce planners do not think that this is all being drawn together and analysed to support policy and practice. Stakeholders highlight that the NHS needs a robust, integrated process for collecting and compiling data about the workforce to help calculate workforce need. Without this, good workforce planning is impossible.

31%

In the latest NHS staff survey, 31% of staff said they often thought about leaving their organisation.
03. Recommendations for future change
A National Heart Strategy

Heart care is at tipping point, with millions of lives hanging in the balance. This crisis can only be tackled with a renewed long-term vision and joined-up plan for how we prevent, detect, and treat heart and circulatory diseases, whether common or rare, and the commitment and resources to see it through.

That’s why we’re now calling on the new Prime Minister and his Government to put tackling cardiovascular disease at the heart of their new policy agenda. We need a National Heart Strategy—one that puts cardiovascular care back on the front foot, stops the causes of poor heart health in their tracks, and supercharges research for the cures of the future.

Led by Government, this new national effort will require all parts of our health and care system, research communities, and voluntary sector to play their part. It will also require widespread consultation with heart patients about the changes they most want to see. This will take time to get right and time to deliver. But in the immediate term, to set this effort up for success and bring services back from the brink, Government and health leaders must take the following first steps:
1. Putting heart care back on the front foot

The NHS Long Term Plan update must recommit to CVD aspirations, while also identifying priority areas for acceleration

In January 2022, NHS England and the Department for Health and Social Care committed to a ‘complete reset’ of the NHS’s strategy in England. It’s vital that the Long Term Plan update is published as soon as possible to give systems clarity on national priorities. The updated plan must recommit to all CVD aspirations, while also revising more granular delivery targets to reflect pandemic disruption and identifying priority areas for acceleration. We also need to see new commitments that build on pandemic innovations in CVD service delivery, for example the use of digital technology to aid patient self-management at home.

Transparent CVD leadership at all levels of the system is needed that can deliver specific plans in addressing the large backlog of cardiovascular care across the system

Delivering the Long-Term Plan and broader CVD recovery national ambitions requires transparent, clinically led CVD leadership at every part of the system. This will enable systems to work with all partners to co-develop specific plans that deliver on national objectives while still having regional buy-in, support, and accountability. We welcome the direction of travel for CVD prevention leads to be placed in every Integrated Care System (ICS), but also recognise that there is some variability in progress towards this goal and long-term funding for these posts remains in question. It’s vital both that CVD leadership at regional and local level is adequately resourced over the long-term and that regional CVD-specific plans are published to ensure progress towards better cardiovascular care.

We need a fully funded NHS workforce plan that address the key issues facing the cardiovascular workforce

The Government must follow through with previous commitments to publish an NHS workforce strategy and provide additional, ring-fenced funding for its delivery. As part of this, we need to see a fully costed plan for the future of the multidisciplinary heart team that address shortages in critical areas of CVD care, tackles retention barriers, modernises training and development, and prioritises staff health and wellbeing. The Government must also commit to developing a more robust process for the collection and analysis of NHS workforce data across all settings to help inform future workforce planning.
2. Stopping the causes of poor health in their tracks

The public health grant, which is used by local authorities to provide vital preventative services, has seen a real-terms cut of approximately 24% per-person since 2015/16.\(^{35}\) Services like stop smoking support and tobacco control have been most significantly affected, with a fall in spending of 41% in real-terms. Moreover, cuts have disproportionately affected more deprived local areas. These cuts have been compounded by inflation, and by the loss of the £400 million from the Contain Outbreak Management Fund (COMF) provided for local authorities to address the Covid-19 pandemic in 2021. Local authorities are now expected to do more with much tighter budgets. Local authority public health interventions represent excellent value for money, with each resulting healthy life year gained costing approximately three to four times less than healthy life years gained due to NHS interventions. The public health grant must be restored equitably and sustainably to allow local authorities to discharge their public health duties and reduce the risk of cardiovascular disease in their local populations.

The Government must commit to a strong prevention agenda to reduce population-level risk of cardiovascular diseases.

The most effective and equitable way to address drivers of ill-health is to implement policies that aim to change the environment we live in, rather than relying on personal responsibility, as they remove barriers to behaviour change that require substantial personal agency and resource.

Government must:

- Advance, without delay, key legislation from the 2020 obesity strategy, including planned restrictions on the advertising and promotion of foods high in fat, salt, and sugar (HFSS), as well as consider a mandatory measure to incentivise manufacturers to reformulate their products to make everyday food healthier.

- As part of a comprehensive tobacco control plan, consult on a ‘polluter pays’ tobacco levy to provide funding to support delivery of the Government’s ambitions of achieving a Smokefree 2030.

3. Supercharge research for the cures of the future

The Government must help to fill the funding gap in cardiovascular research

CVD and stroke research is significantly underfunded compared to the impact of these conditions on society: it receives only 9% of UK health R&D investment, considerably below the 19% that should be invested based on disease burden, as measured by disability adjusted life years. The IPPR has identified a £650 million gap in funding that currently exists for cardiovascular research in the UK. This Government previously committed to raise public spending on R&D to £22bn per year by 2026-27. This commitment should remain, with funding allocated in a way that addresses the current inequality in research funding between conditions. For example, the creation of a dedicated investment fund tasked with catalysing investment across ‘under-served conditions’ like CVD and stroke.
04. Appendix
Appendix

1. BHF commissioned YouGov poll

The BHF commissioned YouGov to run a 27-question survey with people living with a heart or circulatory condition or risk factor on their experiences of accessing care between June 2021 and June 2022. We received 3,019 responses over the period the survey was open (July – August 2022).

We targeted a broadly representative sample of respondents by location, ethnicity, and level of deprivation (using the Index of Multiple Deprivation; IMD). Details of the patient sample are given below.

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* A further 53 people elected not to answer the question on their ethnicity
** IMD 1-2 indicates the highest level of deprivation, IMD 9-10 indicates the lowest level of deprivation
*** Indicates how many respondents are living with a heart or circulatory condition, or a risk factor for a heart or circulatory condition
2. Waiting List modelling assumptions

Our waiting list modelling uses a ‘supply’ and ‘demand’ methodology, based on an approach used by the NHS itself, according to which changes in the overall size of the waiting list are driven by:

- **Supply**: the number of cardiology ‘pathways’ ending in first definitive treatment as defined by the RTT guidance, for example with an admission to hospital, treatment in an outpatient setting, or with a decision to refer back for management in primary care.

- **Demand**: the number of referrals from primary care to specialist cardiology services for first definitive treatment.

This relationship makes it possible to attempt to predict the size of the waiting list in future months based on the anticipated supply of, and demand for, cardiology appointments and inpatient treatments. The anticipated supply and demand for each month across the forecast window are based, in part, on the corresponding monthly values for the immediate 12-month period prior to the pandemic taking hold in England (March 2019 to February 2020). These baseline assumptions of ‘normal’ supply and demand are then combined with various assumptions about the impact of factors that evidence suggests are affecting, or are likely to affect, future supply and demand, including but not limited to:

- A return to more normal levels of demand for cardiology services as the intensity of the pandemic lessens.

- Developments in the health service that are constraining the supply of cardiology appointments.

- Impact of winter pressures.
3. Evidence review of the cardiovascular workforce: organisations we engaged with

The BHF spoke with 62 people from professional societies, voluntary sector organisations, arm’s length and NHS bodies. See below for the full list of organisations we engaged with for the evidence review.

- Age UK
- Arrhythmia Alliance patient group
- Association for Inherited Cardiac Conditions
- Blood Pressure UK
- British and Irish Hypertension Society
- British Association for Cardiovascular Prevention and Rehabilitation
- British Association for Nursing in Cardiovascular Care
- British Cardiovascular Intervention Society
- British Cardiovascular Society
- British Congenital Cardiac Association
- British Heart Rhythm Society
- British Medical Association
- British Society for Heart Failure
- British Society of Cardiovascular Imaging / of Cardiac Computed Tomography
- British Society of Cardiovascular Magnetic Resonance
- British Society of Echocardiography
- Cochrane Heart Group
- Health Education England (2 regional teams)
- Health and Social Care (Northern Ireland)
- Heart Research Institute UK
- Heart UK
- National Voices
- Nepalese Heart Foundation UK

- Northern Ireland Chest Heart and Stroke
- NHS Employers
- NHS England and NHS Improvement (national and 4 regions)
- NHS Health Scotland
- NHS Scotland
- NHS services including workforce planners, managers and HR teams in general practices, community trusts (rehabilitation), acute trusts (imaging, outpatient and ward teams) and centralised/regional teams. People took part from each of the four nations of the UK
- NHS Workforce Alliance
- Public health / local authority teams (3 in England)
- Primary Care Cardiovascular Society
- Royal College of Physicians
- Royal College of Surgeons
- Royal Society of Medicine
- Society for Cardiological Science and Technology
- Society for Cardiothoracic Surgery
- South Asian Health Action
- The King’s Fund
- The Health Foundation
- The Nuffield Trust
- Vascular Society
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