

**The British Heart Foundation's written submission to the Health and Social Care Select Committee**  
**inquiry: Delivering Core NHS and Care Services during the Pandemic and Beyond**

**Executive Summary**

There are more than seven million people living with heart and circulatory diseases in the UK today. Many millions more have risk factors for these conditions such as high blood pressure, raised cholesterol, and type 2 diabetes. People with heart and circulatory diseases are at increased risk of complications and death when infected with Covid-19. A recent study revealed the most common comorbidities with the virus are chronic cardiac disease (29%) and uncomplicated diabetes (19%). Data from the Office for National Statistics (ONS) have also shown that heart and circulatory disease is the most commonly cited pre-existing condition on the death certificates of people dying as a result of Covid-19. However, heart and circulatory diseases do not stop for a pandemic, and even in the context of Covid-19 the leading causes of death persist unabated - dementia (including vascular dementia) and heart disease.

**We welcome the opportunity to share our insight and priorities for health and care services, and feel that due to the significant and wide ranging impact of Covid-19 on heart and circulatory disease patients, the committee should commit to an oral evidence session to explore these issues in more detail.**

**The major impacts of Covid-19 on heart and circulatory disease services and the people who need them are:**

- **Access to urgent and emergency care** – The number of people attending emergency departments in England with symptoms of a possible heart attack halved from an average of around 200 per day at the beginning of March to around 100 per day by the end of March<sup>i</sup>. There continues to be a decrease of 40% on expected attendances, translating to thousands of missed presentations every month.
- **Deferral of diagnostics procedures and therapeutic interventions** – Early data suggests that tens of thousands of elective procedures for heart and circulatory diseases have been deferred as part of the response to Covid-19. As lockdown continues and such services remain unavailable, the urgency of these procedures for individual patients is increasing, creating a significant cohort of patients who will need treatment urgently.
- **Reduced access to specialist care in the community** – Access to specialist services in the community has been depleted due to redeployment of staff for the Covid-19 response. While this has affected a wide range of specialist heart and circulatory services across primary, secondary and community care, BHF insight has confirmed a significant impact on services in the community needed to support the 920,000 people living with heart failure in the UK.
- **Impact on recovery and support services** – Cardiac rehabilitation services have been severely impacted by Covid-19, with many teams being redeployed, and face-to-face care stopped for the foreseeable future due to social distancing measures. Cardiac rehabilitation services reduce risk of death from a cardiovascular disease by 26% while decreasing hospital admissions rates by 18%.<sup>ii</sup> As such they have a significant role to play in providing support and reducing pressure on secondary care.
- **Identification and management of risk factors for heart and circulatory diseases** – Services to identify and support those with risk factors for heart and circulatory diseases have been impacted by redeployment and social distancing measures. An estimated five million people in the UK have undiagnosed hypertension and more than 200,000 people have undiagnosed atrial fibrillation. These groups, when left unsupported, are at an increased risk of heart attacks and strokes.

**To tackle these issues and improve outcomes for people with heart and circulatory diseases both now and in the future, we recommend:**

- **Consistent minimum standards of care must be achieved both now, and in the future –** Relevant clinical bodies such as condition specific societies and royal colleges should work with NHSE/I across primary, secondary and community services to define minimum standards of care across the range of heart and circulatory diseases across the lifespan. These standards should then be used to inform local systems while prioritising changes to, and reintroduction of, services.
- **Access to urgent and emergency care must be improved** - The NHS and the Government should do more to ensure patients understand that emergency services are available, and measures are in place to protect them from Covid-19. Patients should not delay seeking help as this will negatively impact their outcomes and increase their chance of long-term disability if they survive.
- **Access to specialist care in the community must be improved –** System leaders should prioritise increasing capacity to support people with chronic conditions such as heart failure, whether this is through returning support in the community, outreach from secondary care or through increasing support for primary care services to manage these patients. This will play a crucial role in improving outcomes for patients, as well as providing the support needed to keep patients out of hospital.
- **Access to recovery and support services must be improved –** In areas still experiencing high levels of staff redeployment, digital options should be used to ensure patients are still able to access support, with face-to-face services returning as an option as soon as possible as capacity issues and safety concerns surrounding Covid-19 infection are resolved.
- **New models of identifying and supporting those at risk of heart and circulatory diseases should be explored –** including technological solutions for identification and management of at-risk groups and maximising opportunities across the health and care system to opportunistically detect and manage risk factors for heart and circulatory diseases.
- **Innovative good practice developed as a result of the Covid-19 pandemic should be maintained –** including moves towards ambulatory care models and supported self-management, and increasingly joint ways of working across the health and care sector. These should be maintained to improve long-term continuity of care. The Government should expedite changes to the Health and Social Care Act 2012 to allow these ways of working to continue and further develop.

### **About the British Heart Foundation**

1. The British Heart Foundation (BHF) is the largest independent funder of medical research into heart and circulatory diseases in the UK, and our research has helped halve the number of people dying from these conditions since the 1960s. Today, there are more than 7 million people living with heart and circulatory diseases in the UK and these diseases still cause more than a quarter of all UK deaths. Our ambition is to beat heartbreak forever, and we work to transform the detection and treatment of, and support for people with, heart and circulatory diseases.

### **Evidence used in this submission**

2. This submission is based on up to date scientific literature and analysis of available health and care data. We have also used insight gathered from our helpline, which has received 6307 calls and 2414

emails between the 16<sup>th</sup> March and 3<sup>rd</sup> May. This has helped us to understand the issues affecting people with heart and circulatory diseases during the Covid-19 pandemic.

3. Intelligence has also been gathered through our strong relationships with local health and care services, and the healthcare professionals working within them. Our Health Service Engagement Team cover the whole of the UK. From the start of the crisis, they have been recording the information shared with them by professionals in the health and care system. This insight, by its nature does not give a perfect picture, as it depends on the availability of teams during the pandemic. However, we are confident in the reliability of the information due to a high level of consistency across all nine of our regional teams and the high proportion of it that has come from either clinicians or from senior strategic leads or bodies. The insight collected also largely aligns with what is being reported across the sector and represents the impact of Covid-19 on a range of services that are not currently well represented by available datasets.
4. This diverse range of quantitative and qualitative data has allowed us to build a strong understanding of the impact that Covid-19 has had on heart and circulatory disease services and the people who access them.

### **Covid-19 and heart and circulatory disease**

5. There are more than seven million people living with heart and circulatory diseases in the UK today. Many millions more have risk factors for these conditions such as high blood pressure, raised cholesterol, and type 2 diabetes. Prior to the Covid-19 pandemic, these conditions caused a quarter of all deaths and made up the single biggest driver of health inequalities. Together, they cost the NHS in England at least £7.4 billion a year and form the single biggest area where the NHS can save lives over the next 10 years.
6. **The impact of Covid-19 has not only set back ambitions to improve outcomes for people with heart and circulatory diseases, but also had a profound impact on the way that they access care, with implications for peoples' short-term risk of mortality and longer-term health.** Heart and circulatory diseases do not stop for a pandemic, and even in the context of Covid-19 the leading causes of death persist unabated - dementia (including vascular dementia) and heart disease<sup>iii</sup>. The response to Covid-19 has led to significant delays to people's care, leading to a parallel increase in people dying from heart and circulatory diseases due to an inability or unwillingness to access care. Further to this, limits on resources mean many people have received reduced levels of care and support for their condition, and this has contributed to a growing population of people suffering from ill health beyond those needing support for Covid-19 itself.
7. **People with heart and circulatory diseases are at increased risk of complications when infected with Covid-19.** A recent study of approximately 16,700 severe Covid-19 cases across the UK revealed the most common comorbidities with the virus are chronic cardiac disease (29%) and uncomplicated diabetes (19%)<sup>iv</sup>. ONS data looking at Covid-19 related deaths have also shown that heart and circulatory disease is the most common pre-existing condition for Covid-19 fatalities<sup>v</sup>, with 14% of patients dying from the disease also having coronary heart disease mentioned on their death certificate. These data have also revealed an increase in deaths in England and Wales that are not all currently attributable to Covid-19, and are likely part driven by changes in peoples' help seeking behaviours and ability to access care during the lockdown<sup>vi</sup>.
8. **The impact of Covid-19 is also being felt disproportionately by people from Black, Asian or Minority Ethnic (BAME) backgrounds.** Prior to Covid-19, these groups already suffered an increased burden of heart and circulatory diseases and its risk factors, and it is likely that these underlying conditions, are contributing to the disproportionate effect that the pandemic is having on them<sup>vii</sup>. Thirty-four per cent of confirmed cases of Covid-19 and 32% of deaths in intensive care occurred

amongst people from Black, Asian or Minority Ethnic (BAME) backgrounds<sup>viii</sup>. This compares with 14.5% of the total population who are of BAME origin.<sup>ix</sup> Even when taking into account factors such as age, geography, socioeconomic status, health and disability, the risk of death related to Covid-19 is still significantly higher than those of white backgrounds and almost double (1.9 times higher) for men and women of black ethnic backgrounds<sup>x</sup>.

9. **According to ONS data, people living in more socioeconomically deprived areas have also experienced Covid-19 mortality rates more than double of those living in less deprived areas.** General mortality rates are normally higher in more deprived areas, but so far Covid-19 appears to be taking them higher still<sup>xi</sup>. While the reasons for the disproportionate impact of the virus on these groups is complex and multifaceted, it is in part driven by the increased burden of heart and circulatory diseases and its risk factors such as hypertension and diabetes, highlighting a need to address these inequalities as part of the response to Covid-19.
10. **Given the wide ranging and severe impact that Covid-19 has had on people with heart and circulatory diseases, we believe the committee should focus on this topic at a future oral evidence session to better explore how these impacts can be mitigated going forward.**

#### **The impact of Covid-19 on heart and circulatory disease services and the people that use them**

11. Health and care services have adapted rapidly to cope with the surge in demand caused by Covid-19. Innovations that would typically take months or years have been achieved in weeks and days, such as implementation of virtual consultations and the development of online options for rehabilitation and management of long-term conditions. As the infection rate slows and we consider how we return to a “new normal”, we welcome the opportunity to set out our priorities for the immediate and long-term future of heart and circulatory disease services during and beyond the pandemic. Some key issues and impacts for heart and circulatory disease services have included:
  - a) **Access to urgent and emergency care**
12. **Since the beginning of lockdown, attendance at A&E with symptoms of heart attacks and strokes has dropped significantly.** The number of people attending emergency departments in England with symptoms of a possible heart attack halved from an average of around 200 per day at the beginning of March to around 100 per day by the end of March<sup>xii</sup>. While this has now slightly improved, there continues to be a decrease of 40% on expected attendances, translating to thousands of missed presentations every month. The number of emergency attendances for stroke are also expected to have decreased and, in both instances, those who are presenting at hospital are waiting longer to do so and presenting with more severe symptoms.
13. A BHF survey of cardiologists from across the UK largely attributed this decrease to people avoiding hospital due to fear of infection with Covid-19 or out of a desire not to burden the NHS<sup>xiii</sup>. This failure to attend and late presentation at A&E is a common theme across countries dealing with significant rates of Covid-19 infection. It has implications not only for immediate mortality but also for peoples’ long-term outcomes and the likelihood they will develop further issues such as heart failure that require continued support. This in turn contributes to an increased burden on NHS services in the longer term.
14. While the drop in A&E attendances for heart attacks is well documented, we know from local health and care teams and through calls to the BHF Heart Helpline, that a number of other patient cohorts have been avoiding accessing, or unable to access healthcare, including those with chronic, life-limiting conditions such as heart failure whether acquired congenital or inherited . **More needs to be done to understand this trend and the impact it is having on the immediate and longer-term health of people with heart and circulatory diseases as a matter of urgency.**

## **b) Deferral of diagnostic procedures and therapeutic interventions**

15. Throughout the pandemic, some procedures for heart and circulatory disease patients have been rightly deferred where possible to reduce the risk to patients of infection and free up capacity in intensive treatment units (ITU) for Covid-19 patients. As lockdown continues and services remain unavailable, the urgency of these procedures for individual patients is increasing, creating a significant cohort of patients who will need treatment urgently.
16. **Early data suggests that tens of thousands of elective procedures for heart and circulatory diseases have been deferred as part of the response to Covid-19**, leaving a backlog of patients requiring treatment and support, which will only increase as the lockdown continues until services are fully restored. As the rate of coronavirus infection subsides, addressing this backlog will continue to stretch the capacity of the NHS both in terms of completing procedures, but also providing the relevant recovery and support services for patients prior to and after their treatment.
17. **Vital cardiac screening investigations for adults and children with congenital heart disease have also been halted in response to the Covid-19 pandemic.** These patients often require significant interventions before symptoms appear, based on routine screening (e.g. MRI and echocardiography) that cannot be delivered virtually. Most of the guidance released during Covid-19 has prioritised patients based on whether they are symptomatic as a measure of need, which is not suited for this patient population and puts them at significant risk of being overlooked for current and future prioritisation of care.
18. For example, paediatric and congenital heart disease cardiology is only delivered in 11 surgical centres and there is currently insufficient capacity, including in paediatric intensive treatment units, to deliver the care that these patients need. In some instances, capacity in these centres has been used for adult Covid-19 patients. Some children with congenital heart disease need immediate surgery, whilst others can and have been temporarily postponed. However, these patients often have time critical lesions such that if the operation is performed too late it has implications for life expectancy and long-term quality of life.

## **c) Reduced access to specialist care in the community**

19. **Access to specialist services in the community has been depleted due to redeployment of staff for the Covid-19 response, particularly specialist nurses.** While this redeployment has affected a wide range of such specialist heart and circulatory services across primary, secondary and community care, BHF insight has confirmed a significant impact on services needed to support those with heart failure in the community.
20. People with heart failure represent a significant cohort of patients with complex care needs. There are estimated to be 920,000 people living with heart failure in the UK<sup>xiv</sup> and there are 102,000 admissions each year where heart failure is the primary diagnosis<sup>xv</sup>. More broadly, there are 1.1 million hospital episodes in England a year (5.5%;2018/19) that include a heart failure diagnosis as the cause or contributing factor<sup>xvi</sup>. Around 80% of inpatients in England and Wales are classed as either NYHA stage III or IV, where their condition is significantly or extremely life-limiting<sup>xvii</sup>, and when admitted, most heart failure patients experience a length of stay twice as long as the average (10 vs 5 days)<sup>xviii</sup>. Ninety-eight percent of heart failure patients are also living with at least one other long-term/chronic condition<sup>xix</sup>, meaning their care needs are often complex.
21. **Prior to the Covid-19 pandemic, heart failure services exhibited significant variation across the UK. Covid-19 has exacerbated this variation due to inconsistent reduction in services for heart failure patients, due to redeployment of staff.** Insight about changes to heart failure services were the

most frequently collected by our Health Service Engagement team (more than half of 172 discrete pieces of insight) and nearly two thirds of this insight described a loss of or decrease in services<sup>xx</sup>. This impact has been confirmed by the increase in calls to our helpline from patients who are struggling to access support in the usual way.

22. **Such services are not only vital for the health and wellbeing of heart and circulatory disease patients but are also key to relieving pressure on the broader health system by keeping people out of hospital.** Heart failure patients who need a diagnosis, as well as the current managed population, or those requiring support following discharge are all put at risk of exacerbations that require hospitalisation when support is not available to them in the community or primary care. Much of this care requires face to face services, particularly for diagnosis.
23. **Unfortunately, the scale of change and the impact this has had on patients has been largely invisible to the system due to a lack of community-based data and a lack of system leadership across the whole heart failure pathway.** As a result, many heart failure patients have struggled to access services and get the wider support that they need. The lack of data has also made it challenging to provide the necessary guidance to enable local teams to risk-stratify their patients and prioritise work in a consistent way during the pandemic<sup>xxi</sup>.

#### **d) Impact on recovery and support services**

24. **Cardiac rehabilitation services have been severely impacted by Covid-19, with many teams being redeployed and face-to-face care stopped for the foreseeable future due to social distancing measures.** More than half of our insight collected from cardiac rehab teams in this time has described a decrease in services, with some implementing virtual-only options and others losing their services altogether<sup>xxii</sup>. This reduction has not been uniform across the country, exacerbating existing variation in services.
25. Guidance from NHS England and NHS Improvement (NHSE/I), published early in the outbreak, recommended against inpatient assessments for cardiac rehabilitation following percutaneous coronary intervention (PCI)<sup>xxiii</sup>, which means a significant number of patients who normally would have been able to access cardiac rehabilitation may have left hospital with limited support. This includes the loss of one-to-one consultations and group-based support, as well as support to self-manage and optimise medications. Importantly, services have lost the ability to clinically assess patients in person, meaning that requirements for psychological support and ongoing cardiac issues are less likely to be identified and managed. This is likely to have implications for readmission rates and the subsequent burden on the system.
26. The combination of people presenting late with the symptoms of heart attacks, the build-up of patients with postponed secondary care appointments for cardiac investigations (such as cardiovascular magnetic resonance imaging), deferred procedures (such as, valve implantations and treatment of congenital heart disease, electrophysiology study and ablation, cardioversion, device implantation and cardiac surgery) combined with a lack of rehabilitation services is likely creating a perfect storm of patients, with much worse outcomes for those who are more likely to develop chronic diseases such as heart failure, requiring life-long support.

#### **e) Identification and management of risk factors for heart and circulatory diseases**

27. Identifying and treating people with risk factors such as hypertension and atrial fibrillation is important for reducing the burden of heart and circulatory diseases. **It is estimated that as many as five million people in the UK have undiagnosed hypertension, which is associated with 50% of heart attacks and strokes. There are also more than 200,000 people estimated to be living with undiagnosed AF in the UK, increasing their risk of a stroke by five times.** Malignant hypertension

and atrial fibrillation in particular are associated with a significant clinical risk if not treated quickly. Though it is not currently clear how Covid-19 has affected these patient groups specifically, patients continue to need support in order to manage their condition, including optimisation of medications.

28. Prior to Covid-19, many of these risk factors would have typically been picked up by opportunistic interactions with health and care professionals and through the NHS health check programme. Social distancing and redeployment of services mean many of these opportunities have now been lost without alternatives in place. **Our insight from local health and care systems has revealed a widespread and variable decrease in services that would previously have been used to identify and manage these patients, with 60% of that insight describing a reduction or loss of service.**
29. As well as failing to identify and manage those with pre-existing high-risk conditions, the circumstances of the lockdown and the accompanying negative lifestyle changes, such as reduced physical activity, may also be adding to people's risk of heart and circulatory diseases.

**Achieving an appropriate balance between Covid-19 and core health and care services in the face of growing demand**

30. **There must be a clear plan for supporting heart and circulatory disease patients both alongside the Covid-19 pandemic and as we move beyond it.** As Covid-19 infection rates subside, but appropriately postponed cardiac care becomes more urgent, well-defined guidance and support must be communicated to the health and care system on how to reopen services and how to prioritise patient populations in a new, redefined 'normal'. **This plan must be widely communicated to all aspects of the health and care systems as well as to patients to help them navigate how to access the appropriate services at the appropriate time.**
31. Current demand on health and care systems will remain high in some areas due to Covid-19. Equally, the health and care system must be appropriately resourced to address a potential second surge of Covid-19 infections as the country emerges out of lockdown. There will be a continuous tension between the continued direct response to the Covid-19 pandemic and ensuring that new heart and circulatory patients, and the backlog of deferred patients, are addressed in time to avoid suboptimal outcomes. This will include planning for a surge in heart and circulatory disease patients who were unable to access care due to resource restrictions at the peak of the pandemic, and an increase in demand from those who need support with managing long term conditions.
32. Future service provision must be planned across all these horizons, including consideration for addressing psychological as well as physical health to ensure systems can address the needs of their populations as we move through the pandemic.
- a) Consistent minimum standards of care must be achieved both now and for the future**
33. Covid-19 has exacerbated existing variation in health and care across the country, and clear guidance will be necessary to ensure minimum standards of care are maintained throughout the pandemic and as we move into a new normal.
34. **Relevant clinical bodies, such as condition specific societies and royal colleges should work with NHSE/I clinical leads (including health and care professionals across primary, secondary and community care) to define minimum standards of care across the range of heart and circulatory diseases across the lifespan.** These standards should then be used to inform local systems while prioritising changes to, and reintroduction of, services. These standards should:
- Define the minimum standards of service expected across a range of scenarios based on current and future levels of service capacity due to Covid-19 (including a second wave) and the backlog of care and support for heart and circulatory conditions. This should include



routine care as well as the reintroduction of elective procedures based on local capacity and need.

- Account for the care needs of shielded populations and those adhering to stringent social distancing due to their increased risk, who may continue to self-isolate as the lock down is gradually lifted. Government should ensure that guidance for these populations is clear and well communicated to avoid confusion and to support informed patient decisions.
- Support decisions to prioritise patients based on their level of need rather than length of wait or an ability to treat them quickly to reduce the backlog of patients. This should be balanced with their risk of future complications while waiting for procedures.
- Support prioritisation of patients based on more than symptom burden, ensuring asymptomatic patients with complex needs, such as those with congenital heart disease are also able to access care, including access to specialist centres.
- Build on improvements from rapid innovations in services achieved in response to Covid-19.

**35. Developing clear standards with strong clinical leadership will allow local teams to build services around the needs of their patients, while ensuring consistent standards of care across the country.**

Several organisations have already done this for heart and circulatory diseases, and BHF has worked with The British Society for Heart Failure to define and disseminate these standards for healthcare professionals and heart failure patients<sup>xxiv</sup>. These standards are now being used by services across the UK to ensure vital heart failure services are protected during the pandemic.

**b) Access to urgent and emergency care must be improved**

36. We continue to work in parallel to the NHS to inform patients that they should continue to access emergency and urgent care appropriately, calling 999 with heart attack or stroke symptoms and contacting 111 or their GP for worsening heart conditions such as increasingly symptomatic heart failure.

37. **However, patients need reassurance that the risk of getting Covid-19 by attending hospital when requested is mitigated by systems in place to separate those needing care for Covid-19 from those that need care for something else. The NHS and the government must to do more to ensure this message is clear.** Patients should not put off care for fear of being a burden to the NHS, as delays could mean worse outcomes for patients, including a greater chance of long-term disability if they survive. This will only increase the future burden on health and care services.

**c) Access to specialist care in the community must be improved**

38. **System leaders should prioritise increasing capacity to support people with chronic conditions such as heart failure, whether this is through returning support in the community, outreach from secondary care or through increasing support for primary care services to manage these patients.** This will play a crucial role in improving outcomes for patients, as well as providing the support needed to keep patients out of hospital. Where possible these services should be delivered remotely, but where face to face interaction is needed, systems should be in place to separate patients needing Covid-19 care from those that do not, to decrease the risk of Covid-19 transmission and increase patients' confidence in safely accessing care. Such services will help mitigate a surge in demand on secondary care from patients who have been unwilling or unable to access care for their condition during lockdown.

39. A multidisciplinary team approach should be used for delivering community services to patients to help them manage their condition and seek help where appropriate. This approach delivers a broad range of support for patients and increases the flexibility of teams to provide support in times of redeployment as they are not solely reliant on individual specialist nurses.



#### **d) Access to recovery and support services must be improved**

40. Cardiac rehabilitation reduces your risk of death from a cardiovascular disease by 26% while decreasing hospital admissions rates by 18%.<sup>xxv</sup>. It is also a cost-effective intervention for supporting people with heart and circulatory diseases to live well for longer. **In areas still experiencing high levels of redeployment, digital options should be used to ensure patients are still able to access support, with face-to-face services returning as an option as early as possible, as capacity issues and safety concerns surrounding Covid-19 infection are resolved.** Where clinically appropriate, services should continue to explore the possibility of delivering rehabilitation across a range of conditions, allowing for maximal use of rehabilitation services to meet the needs of patients.
41. Rehabilitation services should also use local resources to ensure that patients are still able to access the support they need for the longer-term. Social prescribing link workers should ensure that patients are able to access any services that are still available to help patients address any needs they may have beyond the scope of the programme, including peer support and continued support with physical activity.
42. Rehabilitation services have been very fast to respond to the outbreak, with many initiating online services to maintain support for some patients. The BHF is working alongside partners such as the British Association for Cardiovascular Prevention and Rehabilitation (BACPR) and have initiated a solution for patients and clinicians to ensure patients are still able to access support in these challenging times<sup>xxvi</sup>. These resources will continue to develop in the future expanding the reach of innovative in home, in community solutions for all patients with heart or circulatory conditions that could benefit. The BHF will also continue to build on this advice with prevention messaging around diet and exercise, to reduce the future burden of heart and circulatory diseases.
43. Prior to Covid-19, uptake to cardiac rehabilitation programmes was poor (~50%), and this was particularly pronounced amongst certain groups including women, those with a BAME background and socioeconomically deprived groups<sup>xxvii</sup>. In the future, as the infection risk of Covid-19 decreases further, clinical bodies should work with BACPR to define when group-based sessions can safely resume, and these should be brought back as early as possible to complement digital offerings. **In the long-term it will be important to maintain digital offerings alongside face to face forms of rehabilitation to improve choice for patients and help increase uptake of services, particularly among poorly represented groups.**

#### **e) New models of identifying and supporting those at risk of heart and circulatory diseases should be explored**

44. As the impacts of Covid-19 on society become increasingly long-term, including prolonged social distancing and a digital-first approach to delivering services, developing new models for identifying and managing risk factors for heart and circulatory disease will be important for reducing the burden of heart and circulatory disease in the UK.
45. The BHF is working with NHSE to pilot a scheme to prescribe blood pressure monitors to high risk groups, to support them to self-manage at home. As part of this we are donating 500 monitors. Initiatives like this are important to ensure that high risk patients are well managed, and if successful should be rolled out more widely. Technological solutions should also be explored and evaluated for identifying those at risk of Atrial Fibrillation at home, allowing services to better target support to those who need it most. The Government should also accelerate its review of the NHS health check programme, to see how the programme can be adapted to identify and support those at risk of heart and circulatory diseases while social distancing is still enforced.

46. **Those with hypertension and atrial fibrillation at greatest risk of complications should be able to receive the support they need in a setting segregated from Covid-19 treatment.** Data from the CVDprevent audit and AF demonstrator programme developed as part of the NHS long-term plan should be used to identify high risk individuals and target them early to ensure that opportunities are not lost. Approaches such as this will also play an important role in tackling health inequalities.
47. As people are better able to access care, healthcare professionals should maximise opportunities to check patients for risk factors of heart and circulatory diseases as part of other episodes of care, allowing asymptomatic but high-risk patients to be identified and supported quickly. Where services are still available or are reinstated early, we would support the broadening of services to accept patients from a wider geographical area to ensure that opportunities to identify those at risk are not lost where staff have been redeployed.
48. **The Government and health and care services should seek to prioritise prevention messaging that seeks to reduce the burden of heart and circulatory diseases, including providing advice about eating and living well and resources to ensure people are remaining physically active.** Initiatives to tackle smoking and obesity should also be bolstered in this time. This should consider the higher burden on deprived communities and those from BAME backgrounds.

#### **Meeting extra demand for psychological support services**

49. **People with heart and circulatory diseases are 2 to 3 times more likely to be diagnosed with a mental health condition<sup>xxviii</sup>, and those suffering with conditions such as depression have been shown to have significantly higher rates of mortality<sup>xxix</sup>.** Despite this, we know that psychological support remains a significant unmet need. Prior to the Covid-19 pandemic, a survey commissioned by the BHF revealed that approximately a quarter of heart and circulatory disease patients and their carers suffered with feelings of depression and anxiety with 44% and 37% of those people respectively not receiving any support<sup>xxx</sup>. Recently released ONS data has also shown significant increases in anxiety amongst the general population, with four in five people reporting they are worried about the impact of Covid-19 and more than half of people saying it is affecting their wellbeing<sup>xxxi</sup>.
50. **Services must integrate around the needs of patients, ensuring that they are able to access the resources they need to support both their physical and psychological health.** Primary care networks are an increasingly important structure for delivering joined up personalised care and should play a major role in integrating the physical and psychological care needs of patients as we move through the Covid-19 pandemic. New roles entering primary care through the Additional Role Reimbursement Scheme, such as social prescribing link workers and health coaches should be utilised to ensure patients can access the resources they need.
51. We welcome the funding from Government for organisations such as Mind to address the increase in mental health need during this time<sup>xxxii</sup>, and would welcome ring fenced funding to ensure that psychological support services for people with long-term conditions are available going forward.

#### **Meeting the needs of discharged hospital patients with complex needs**

52. **To ensure patients with complex needs receive the support they need, the Government must ensure that local systems are not using legislation in the Coronavirus bill to relax aspects of the Care Act unless it is absolutely necessary for dealing with demand related to Covid-19.**
53. Discharge guidance must be regularly updated as we move through the pandemic, to ensure that these patients are able to access suitable support for their individual needs. This will be supported

by bolstering of specialist care in the community and recovery and support services as outlined above.

**Ensuring that positive changes that have taken place in health and social care as a result of the pandemic are not lost**

54. **While services have been severely impacted by Covid-19, it is important to acknowledge that significant innovation has occurred as a result of adapting to adversity during the pandemic.** It is encouraging to see that the NHS has advised Trusts to embed positive changes for the longer-term<sup>xxxiii</sup>. Innovation will continue at pace, and **patient safety must be at the centre of decisions about what should be retained in the future.**
55. Key changes for heart and circulatory disease services have included an increasing movement towards ambulatory care models and supported self-management using technology. These changes have been vital for delivering rehabilitation services, and methods for remote monitoring of people with heart failure and risk factors for heart and circulatory diseases. While this has been vital for maintaining care in the crisis, it also offers an opportunity for us to better deliver person centred care closer to home in the future. A recent example is the “Our Hearts, Our Minds” cardiac rehabilitation programme being made available remotely. The programme includes individual, partner and group sessions as well as cardiologist review and guidance from cardiac rehabilitation nurse specialists. This programme, supported by the BHF, has previously helped significantly improve uptake rates for cardiac rehabilitation in the space of a year in the Western Health Trust (Northern Ireland).
56. **In order to ensure that positive innovation is maintained, and negative changes are removed, we now need to assess the wider impacts of innovation on patients’ outcomes and experience.** Charities have a significant role to play in this, not only due to their strong links with services, but also their history in designing and implementing innovations in healthcare and helping embed them for the longer-term. For instance, prior to the Covid-19 pandemic, the BHF in Scotland alongside NHS 24’s Scottish Centre for Telehealth and Telecare, and the Scottish Government’s Technology Enabled Care Programme worked together to integrate remote monitoring of blood pressure using a digital health solution. This has led to a significant increase in uptake of remote monitoring in the region, increasing identification of hypertension in the community and supporting them to self-manage.
57. **Innovations established during Covid-19 must be used to complement care and improve patient choice where appropriate, rather than simply replacing services as part of cost saving measures.** All innovations should also be evaluated for their effect on health inequalities, that are likely to have increased during this time as services rapidly moved online. This is particularly important in the context of rehabilitation services where the move to digital platforms has been welcomed, but the need for a range of options will remain crucial to improve uptake in the future.
58. Rapid responses requiring sectors to work together quickly to implement services have accelerated the ambitions of joined up working across health and care systems at all levels, highlighting the benefits of local areas being able to share budgets and resources to meet the needs of their populations. **The government should expedite the changes needed to the Health and Social Care Act (2012) to allow systems to work together more freely in the future, as well as during the current pandemic.**
59. Lastly, relationships formed across care settings during Covid-19 and the breakdown of silos has the potential to improve patient care in the future, allowing for more efficient transfer of care and the ability for patients and healthcare professionals to better access the specialist input they need. **Where strong relationships and new ways of working have been developed across primary**

**secondary and community care boundaries, these should be maintained to help improve long-term continuity of care.**

**60. For further information please contact: Dr Samuel Dick, Policy Manager (Health and Care Systems), British Heart Foundation ([dicksa@bhf.org.uk](mailto:dicksa@bhf.org.uk)).**

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<sup>i</sup> [PHE Emergency Department Syndromic Surveillance data to 29<sup>th</sup> March 2020](#)

<sup>ii</sup> Anderson L, Thompson DR, Oldridge N, Zwisler A, Rees K, Martin N, Taylor RS. Exercise-based cardiac rehabilitation for coronary heart disease. Cochrane Database of Systematic Reviews 2016, Issue 1. Art. No.: CD001800.

<sup>iii</sup> Office for National Statistics - Deaths involving COVID-19, England and Wales: March 2020

<sup>iv</sup> Docherty et al (2019) Features of 16,749 hospitalised UK patients with COVID-19 using the ISARIC WHO Clinical Characterisation Protocol (pre-print)

<sup>v</sup> Office for National Statistics - Deaths involving COVID-19, England and Wales: March 2020

<sup>vi</sup> Ibid

<sup>vii</sup> [Institute of Health Equity \(2020\) Marmot review 10 years on](#)

<sup>viii</sup> Statistics from Intensive Care National Audit and Research Centre, covering England, Wales and Northern Ireland

<sup>ix</sup> Percentages based on ONS 2016 population estimates

<sup>x</sup> Office for National Statistics - Coronavirus-related deaths by ethnic group, England and Wales: 2 March 2020 to 10 April 2020

<sup>xi</sup> Office for National Statistics - Deaths involving Covid-19 by local area and socioeconomic deprivation: deaths occurring between 1 March and 17 April 2020

<sup>xii</sup> [PHE Emergency Department Syndromic Surveillance data to 29<sup>th</sup> March 2020](#)

<sup>xiii</sup> BHF Heart Matters Magazine - [Why are thousands fewer people being treated for a heart attack? April 2020](#)

<sup>xiv</sup> [Conrad, N; Judge, A, Tran, J et al. Temporal trends and patterns in heart failure incidence: a population-based study of 4 million individuals, The Lancet, 2018; 391, 10120](#)

<sup>xv</sup> UK hospital admission statistics, 2018-19; NHS Digital/ISD Scotland/NHS Wales/DH Northern Ireland

<sup>xvi</sup> Hospital admission statistics, England 2019-19; NHS Digital

<sup>xvii</sup> Heart Failure Audit 2017/18; NICOR

<sup>xviii</sup> Hospital admission statistics, England 2019-19; NHS Digital

<sup>xix</sup> BHF analysis of UK heart failure prevalence data, 2018; The Health Improvement Network (THIN/IQVIA/Cegedim)

<sup>xx</sup> BHF insight from Health Service Engagement (17<sup>th</sup> March – 4<sup>th</sup> May).

<sup>xxi</sup> [NHSE/I Guidance: COVID-19 prioritisation within community health services](#)

<sup>xxii</sup> BHF insight from Health Service Engagement (17<sup>th</sup> March – 4<sup>th</sup> May).

<sup>xxiii</sup> NHSE/I Guidance: Clinical guide for the management of cardiology patients during the coronavirus pandemic

<sup>xxiv</sup> [British Society for Heart Failure: Retention of Essential Heart Failure Services during COVID-19 Pandemic](#)

<sup>xxv</sup> Anderson L, Thompson DR, Oldridge N, Zwisler A, Rees K, Martin N, Taylor RS. Exercise-based cardiac rehabilitation for coronary heart disease. Cochrane Database of Systematic Reviews 2016, Issue 1. Art. No.: CD001800.

<sup>xxvi</sup> [BHF - Cardiac Rehabilitation at Home](#)

<sup>xxvii</sup> BHF - [National Audit of Cardiac Rehabilitation \(NACR\) Quality and Outcomes Report 2019](#)

<sup>xxviii</sup> [Arthritis Research UK et al. Twice as likely: Putting long term conditions and depression on the agenda](#)

<sup>xxix</sup> [The King's Fund, Long-term conditions and mental health](#)

<sup>xxx</sup> BHF and Picker – Unmet needs amongst people with cardiovascular disease (check title)

<sup>xxxi</sup> Office for National Statistics - Coronavirus and the social impacts on Great Britain: 16 April 2020

<sup>xxxii</sup> <https://www.gov.uk/government/news/new-advice-to-support-mental-health-during-coronavirus-outbreak>

<sup>xxxiii</sup> [Letter from Simon Steven and Amanda Pritchard on the second phase of the Covid-19 response for the NHS](#)