British Heart Foundation

Submission to the Conservative Party Policy Renewal Programme – July 2025

About British Heart Foundation

British Heart Foundation (BHF) is the nation's heart charity, representing the 7.6m people living with heart and circulatory diseases in the UK.[i] BHF currently supports £430m of lifesaving research[ii] across the UK, as well as over 1,200 research staff.[iii] BHF also provides trusted health information to heart patients and their families across the UK; our Heart Helpline responds to up to 30,000 contacts each year, while our health information webpages receive millions of views every month.[iv] Since BHF was established in 1961, the annual number of deaths from heart and circulatory diseases in the UK has fallen by nearly half. [v] Nevertheless, cardiovascular disease (CVD) remains one of the UK's biggest killers, leading to around a quarter of all deaths.[vi] After decades of progress, premature deaths from CVD in this country are now rising. BHF analysis of official stats shows that in 2023, over 48,000 people in the UK died prematurely (before the age of 75) of cardiovascular conditions, which is an average of 940 people each week – and a 15-year high.[vi]

As challenging as this picture may seem, we have a vital opportunity to reverse more than a decade of lost progress and get heart care back on track. A sustained and strategic focus on reducing the impact of, and improving outcomes from, CVD can deliver economic growth and promote a healthy nation. BHF would welcome the opportunity to work with the Conservative Party to ensure better outcomes for people living with and affected by CVD, as part of your policy renewal programme.

The economic argument for tackling heart disease

Delivering game-changing health benefits by tackling cardiovascular disease will not only transform millions of lives and help contribute to an increase in healthy life expectancy, but it will also deliver a more prosperous nation. In fact, the cost of not acting is vast. Every year, the UK spends an estimated £12bn on cardiovascular disease healthcare costs, and the wider cost to the economy is £28bn.[vii]

A significant proportion of this is driven by cardiovascular disease-related economic inactivity. More working-age people are reporting long-term health conditions than ever before,[viii] with cardiovascular disease being the fifth most commonly reported condition among people economically inactive due to poor health in the UK. [ix] Those with long-term health conditions and their carers may be less productive due to these conditions, requiring more time off for treatment or recovery, meaning potential long periods of time out of work.

Analysis from the Institute for Public Policy Research (IPPR) shows that CVD increases risk of exiting employment most sharply compared to other health conditions.[x] In fact, IPPR found that heart disease is the single largest factor behind people leaving the workforce due to ill-health, and that 30% of people who are economically inactive have a cardiovascular condition.[xi]

A sustained and strategic focus on lessening the impact of CVD for good can deliver economic growth and a healthy nation.

CVD and inequality

People living in the most deprived communities in the UK are at the sharp end of the UK's CVD crisis. People living in these areas are more likely to live with, and die young from, CVD, and often have worse access to healthcare services that could help them manage and treat their condition. For example, CVD accounts for around a fifth of the life-expectancy gap between the most and least deprived communities in England.[xii]

Factors such as sex and ethnicity can also be linked to further inequalities in CVD prevalence and outcomes.[xiii]

Alongside targeted action to tackle inequalities in CVD, addressing broader population-level inequalities will be integral to unlocking progress on CVD, and building a healthier nation. We recommend that your health policy reflects a commitment to tackling the many barriers to good health, through prioritising prevention and improving care outcomes for communities across the country. As the risk factors for CVD also apply to many of the UK's biggest killers, tackling CVD has the potential to reduce inequalities in healthy life expectancy and support healthcare services more broadly.

Key Policy Priorities for CVD

Primary prevention to improve population health

Most cases of cardiovascular disease are preventable – 70% in the UK can be attributed to modifiable risk factors including obesity, tobacco and air pollution.[xiv]

As well as being the right thing to do for people's health and wellbeing, a focus on prevention would help the economy. Spending on disease prevention at a population level is cheaper than treating individuals when they become ill. It costs around £3,800 to give an additional year of good health to someone's life using public health measures, compared to around £13,500 using NHS interventions.[xv]

At a time when public finances are increasingly stretched, and the NHS in particular is at risk of dominating the entire economic picture, investing in prevention is fundamental to reducing the size of the healthcare burden, whilst boosting economic productivity and improving people's lives. Population-level interventions which aim to improve our environment and support people to live healthier lives are more likely to be effective and equitable, rather than relying on notions of personal responsibility, will also help to tackle health inequalities.

Our key policy recommendations for prioritising prevention and improving health at a population level include:

1. Maximising the potential of the Soft Drinks Industry Levy

The Soft Drinks Industry Levy (SDIL) has been highly effective, reducing sugar levels in soft drinks by 46% between 2015 and 2020,[xvi] and reducing daily consumption of free sugars by 4.8g in UK children and 10.9g in UK adults.[xvii] Furthermore, the SDIL raises an average £300 m each year[xviii] which has previously been used to fund a national breakfast programme, a holiday hunger programme and school PE premiums. We recognise the previous Conservative government's role in establishing this levy.

However, there are some limitations within the current structure of the SDIL that are stopping it from being even more effective. We therefore welcome the Government's consultation on strengthening the SDIL and support proposals to include milk and milk-alternative based drinks and strengthen the current thresholds. We note that this move has also been previously supported by George Osborne, who introduced the SDIL.[xix] Moreover, unlike tobacco and alcohol duties, the SDIL has never been uprated with inflation.

Alongside the existing consultation, we recommend that your policy reflect a commitment to uprate liability under the SDIL and consider how to build on its success elsewhere.

2. Expand measures to incentivise healthier food and drink production

Despite existing policies and programmes, average sugar and salt consumption in the UK is above recommended levels for both adults and children. Overconsumption of sugar is associated with the onset

of obesity, which costs the UK economy as much as £98bn each year,[xx] and is associated with an estimated 1 in 9 heart and circulatory disease deaths.[xxi]

Similarly, overconsumption of salt is a major driver of hypertension, or high blood pressure, which is linked to half of all heart attacks and strokes in the UK. BHF-funded modelling from 2022 found that, if all adults in the UK met the World Health Organization guidelines for salt consumption by 2030, we could avoid up to 1.4m cases of high blood pressure and save the UK economy up to £11.4bn by 2035.[xxii]

The SDIL has demonstrated that mandatory measures can shift industry practice where voluntary schemes have failed to deliver sufficient results, reducing sugar levels in soft drinks by 46% between 2015 and 2020.[xxiii] Comparatively, no category of the voluntary sugar reduction programme has yet met the 20% target, despite the original deadline of 2020. There was also only a 3.5% overall reduction in the average total sugar per 100g in products sold for in-home consumption and a 0.2% reduction in out-of-home products.[xxiv] There is an urgent need to build on this success and implement a broader mandatory measure, to reduce salt and sugar levels in products across the supply chain and create a level playing field across the food and drinks industry.

We therefore welcome the recently announced Healthy Food Standard. A new standard to make meals across the UK healthier is a huge step towards creating a food environment that supports better heart health. This move recognises the vital role that businesses can play in supporting everyone to have a healthier diet and one that has been championed and welcomed by retailers[xxv]. This standard should be robustly developed with health experts, swiftly implemented, and built upon with further commitments to create a healthy food environment.

As part of the Recipe for Change Coalition,[xxvi] BHF recommends looking to create some upfront incentives for manufacturers, which would help drive faster progress. We've seen how the SDIL has done this, by dramatically reducing sugar in drinks. Similar levies applying to levels of salt, sugar or calories across a much wider range of foods would not only accelerate action to make products healthier, but any revenues raised could also be used to support healthy eating programmes, such as fruit and vegetable subsidies for lower income families.

In addition to the Healthy Food Standard, we recommend that Conservative Party policy further accelerates progress by building on the success of the Soft Drinks Industry Levy (SDIL), introducing a similar manufacturer levy on unhealthy food products.

3. Develop a long-term tobacco control strategy

BHF fully supports the Government's Tobacco and Vapes Bill, and welcomes the Conservative Party's role in initiating this landmark, once-in-a-generation legislation. However, we are keen to see this Bill progress through Parliament as swiftly and robustly as possible, and are becoming concerned that Government is running out of time in the parliamentary timetable. Any efforts from the Conservative Party to hold Government to account on this legislation within the policy renewal programme will be greatly appreciated.

Alongside this, a comprehensive tobacco control strategy is also urgently needed to build on current steps to prevent uptake of smoking and support people to quit and make the Government's ambition of a Smokefree UK a reality.

The full cost of smoking to public finances in England is estimated at £16.5bn bn per year, more than double the £6.8bn raised from tobacco taxes.[xxvii] Given that the four biggest tobacco manufacturers each make on average £900m a year in the UK, with an average net operating profit margin of 50%,[xxviii] it is reasonable to expect such a harmful industry to pay for the damage its products cause through a levy on their profits.

BHF support a "polluter pays" levy on the tobacco industry. Also known as a Smokefree Fund, this policy could raise an estimated £700m per year,[xxix] which could be used to fund a strategic approach that will deliver vital tobacco control measures and stop smoking services, alongside supporting other public health programmes. If the Government does not accept the current proposed amendment to consult on a "polluter pays" levy as part of the Tobacco and Vapes Bill, we strongly suggest the Conservative Party considers committing to this as part of your policy renewal programme.

Secondary prevention and management of conditions, heart care and NHS workforce

Timely, specialist care is critical to prevent disability and premature death from CVD. However, high NHS waiting times, a lack of focus on identifying and treating cardiovascular disease risk factors, and an overstretched cardiac workforce are all putting lives at risk.

At the end of May 2025, there were 409,800 people waiting for routine cardiac care in England. Although this was a welcome drop on the previous two months, and the biggest drop we'd seen in 5 years, thousands of people are still waiting over 18 weeks for potentially lifesaving elective heart tests and treatment.

Such delays risk avoidable disability and can even cost lives. We believe that waiting lists are being driven by an increased need for care and are compounded by a struggling NHS, with the cardiac workforce facing burnout, shortages, and a lack of the infrastructure and equipment they need. While the recent 10 Year Health Plan aims to get the NHS back on its feet, getting to grips with the heart care crisis must be a priority if we are to reduce the physical and economic burden hampering it.

Our policy recommendations within health and care include:

1. Focus on secondary prevention and case-finding

Millions of people are living with risk factors for CVD like hypertension and high cholesterol, and diabetes; many of whom do not know it and are consequently not having their condition appropriately managed.[xxx] These people risk ending up on long waiting lists for elective care, or worse, experiencing a life-threatening emergency such as a heart attack or stroke.

The potential gains from increasing the number of people diagnosed with a risk factor and managing their condition appropriately are vast. UCL Partners estimate that if just 80% of people in England with diagnosed high blood pressure were on optimal treatment, around 16,000 heart attacks and strokes would be prevented in just three years with savings to the NHS of £180m.[xxxi]

There are examples of how CVD risk has been successfully prioritised in recent years: NHS England's Core20PLUS5 approach to inequalities includes hypertension and cholesterol as clinical priorities; the BP@Home remote management programme has shown promising improvements for some patients;[xxxii] the CVDPREVENT audit of primary care is supporting local systems to deliver targeted support to areas of unmet need;[xxxiii] and the Community Pharmacy Blood Pressure Checks service is enabling hypertension case-finding in community pharmacies, closer to the patients who need it, with estimates that this could prevent more than 1,350 heart attacks and strokes in the first year alone.[xxxiv]

However, these programmes are often locally implemented and limited by short-term funding cycles, an inability to scale more widely, a lack of public awareness around risk factors, and infrastructure and workforce challenges. Sustained funding for local systems is needed to enable them to tailor programmes for their area. Funding for CVD Prevention leadership must also be protected: these roles provide oversight and ensure that the delivery of the CVD plan within each Integrated Care System (ICS) is aligned with broader NHS priorities.

The focus on CVD in the new 'prevention accelerators' announced in the 10 Year Health Plan is welcome, but as outlined by the King's Fund in a recently-published long read, proactive identification, monitoring and treatment of high-risk individuals in primary care needs to be implemented much more consistently across England.[xxxv] To achieve this, GP practices need practical support from integrated care boards (ICBs) and others. ICSs must also take a whole-system approach to prevention, including working more closely with public health and local government. The King's Fund makes a number of additional recommendations in this long read which we encourage you to consider.

We recommend that your policy includes proposals for a sustainably-funded approach to the secondary prevention and identification of CVD. We know this has previously been a priority for the Conservative Party, having appointed Professor John Deanfield as the first ever Government Champion for Personalised Prevention. We suggest reviewing the evidence and recommendations in the King's Fund long read on CVD prevention, which BHF contributed funding towards, for further consideration.

2. Maximise capacity to reduce the cardiac elective backlog

Long waits for care are dangerous and can lead to permanent disability and even death. Many patients have told us that they are not being sufficiently supported while they wait for care. This can result in those waiting becoming more unwell and likely requiring additional and more complex care or leaving them out of work longer, potentially increasing the burden on the health system, and causing wider cost to the economy.

High cardiac waiting lists *and* waiting times are driven by complex and interconnected drivers, including an ageing population. The stubbornly high need for cardiac services is reflected in high referral rates and patients not moving efficiently through the pathway.[xxxvi] While we lack the granular data across the cardiac pathway to confidently identify specific pinch points in waiting lists, there are indications that diagnostic supply and demand is likely one driver behind delays to care.

The number of people waiting for an echocardiogram remains stubbornly high, and significantly higher than pre-pandemic. Whilst there has been some progress in reducing these numbers, in the last few months, progress appears to have reversed in England.[xxxvii]

Solutions that have been proposed to tackling waiting lists include increased use of private sector capacity, surgical hubs – which have been found to increase treatment volumes and shorten hospital stays[xxxviii] - and maximising staff and hospital theatre time through evening and weekend work. These are all welcome moves in the short term, but there are caveats to their use. With most of these interventions relying on the currently available pool of workforce, it's clear that sustainable NHS investment and the necessary workforce planning will be necessary.[xxxix]

Alongside this, local systems should be supported to build on pockets of innovation, such as use of remote monitoring to support patients while they wait,[xl] ensuring they are fit for treatment and avoiding unnecessary cancellations and delays.

3. Invest in the cardiovascular workforce

Research has shown that many cardiology services experience capacity issues across a variety of roles, and significant shortages in certain areas.[xli] In 2023, BHF ran a first-of-its-kind census of core roles within the specialist cardiac workforce in secondary care in England.[xlii]

Key areas of concern that emerged in cardiology include low staff numbers within specific cardiac subspecialties, demographic inequalities within the workforce and potential retirement hot spots. For example, 1 in 5 consultant cardiologists were aged 56 and over, with higher proportions in certain subspecialties, such as interventional cardiology. Fewer than 1 in 5 consultant cardiologists in our census were female, a lower proportion than many other medical specialists in the UK.[xliii] These are areas where

consultants may be more likely to retire within the next 5 to 10 years. Planning and appropriate funding are required to attract and train people in these areas to avoid an even more significant shortfall in the near future.

We are calling for sustainable, long-term funding to accompany the implementation of the forthcoming 10 Year Workforce Plan. We welcomed the 2023 NHS Long Term Workforce Plan, published by the last Conservative Government, which committed £2.4bn of funding for expansion of medical training, running to 2028/29. This was ambitious and much-needed plan that took positive steps towards lasting and beneficial change for CVD patients.

However, the 2023 funding commitment does not reflect the significant cost implications of an increase in NHS staff (i.e. wages, medical infrastructure, IT, medicines etc.), or the shift in delivery outlined in the 10 Year Health Plan. The composition of the workforce will need to change to meet the 10 Year Plan ambitions, requiring a strong pipeline to recruit and retain specialty talent and skills.

We encourage the Conservative Party to look at full costings of this implementation, including ongoing staff costs, training and recruitment costs, and the costs and underlying assumptions of necessary wider enablers such as technology and innovation, social care, shift to community care, and infrastructure.

We would also like to see a structured proposal to train, retain and develop the careers of staff across the entire cardiovascular workforce. Accessible, detailed information on both supply and demand is vital for workforce planning, and can help to illuminate shortages, potential retirement hotspots, inform the funding allocated for the Workforce Plan, and help us to design measures to train and retain an appropriate pipeline of clinicians.

We are very concerned about the decline in the clinical research workforce. For example, traditionally the medical specialty of cardiology (hospital heart specialists) has been seen as especially academic, but BHF's 2023 census of cardiology departments in England revealed that only 3% of cardiologists are clinical academics and 84% of cardiology consultants were reported as having no allocated research time.[xliv]

Evidence shows NHS staff involved in research have greater job satisfaction and staff turnover is lower in research active trusts.[xlv] Additionally, research-active hospitals make strong contributions to research and life sciences and deliver better patient care.[xlvi] Subsequently, we recommend your policy includes plans to bolster the clinical research workforce, and embed research into the NHS.

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