

Cardiovascular disease in England

Supporting leaders to take actions

Overview

- This work, sponsored by Daiichi Sankyo and Edwards Lifesciences, is informed by an analysis of published data on CVD; a literature review of current policy and evidence; and interviews and a workshop with key stakeholders working in health and care.
- Cardiovascular disease (CVD) causes 1 in 4 deaths in England, and is a leading cause of morbidity, disability and health inequalities. The Covid-19 pandemic has added to the urgency of tackling CVD because CVD significantly increases the risk of severe disease and death from Covid-19.
- CVD is largely preventable. The risk factors for CVD apply also to other major conditions such as cancer, dementia and diabetes. Preventing and managing CVD and its risk factors therefore has the potential to improve population health, reduce health inequalities and ease pressures on overstretched health and care systems by reducing demand for services.
- The current national CVD policy landscape is fragmented. National leaders need urgently to deliver coherent CVD and public health strategies that focus on preventing and managing CVD and its risk factors.
- Given its high prevalence and large contribution to health inequalities, tackling CVD will be a relevant priority in most local areas. Integrated care systems (ICSs) can tackle CVD in their local areas by establishing strong local leadership and partnerships on CVD and public health, focusing on preventing and managing CVD and its risk factors, raising awareness of CVD, using data, tools and technology effectively, and reducing clinical variation.

About this report

The work for this project was sponsored by Daiichi Sankyo and Edwards Lifesciences. This output was independently developed, researched and written by The King's Fund. The sponsors have not been involved in its development, research or creation and all views are the authors' own.

Why should cardiovascular disease (CVD) be a priority now?

Cardiovascular disease (CVD)¹ is a leading cause of morbidity, disability, mortality and health inequalities in England (see key CVD statistics below). The pandemic has added to the urgency of tackling CVD because CVD significantly increases the risk of severe disease and death from Covid-19.

CVD is largely preventable. The heavy disease, death and cost burden of CVD could be reduced substantially if readily available, cost-effective interventions for CVD prevention and treatment were more widely used. As the risk factors for CVD (eg, unhealthy diet, obesity, smoking) apply also to other major conditions such as cancer, dementia and diabetes, tackling CVD has the potential for reducing the overall burden of disease on individuals, services and the economy.

All sectors in the health and care system face pressing and competing demands on multiple fronts. While recognising the very real challenges that policy-makers and the newly formed ICSs face, and that staff working in health and care services are dealing with, this report outlines the case for policy-makers, ICSs and other national and local organisations to prioritise CVD in post-covid recovery plans. Reducing the prevalence of CVD and its risk factors can improve population health, reduce health inequalities and lower demand and cost pressures on the over-stretched health and care system.

¹ Cardiovascular disease (CVD) is a general term for conditions affecting the heart or blood vessels. Common comorbidities associated with CVD include, eg, high blood pressure, atrial fibrillation and diabetes.

Key CVD statistics

Morbidity

- 6.8 million people in England are living with CVD and even more with comorbidities or common, treatable risk factors that significantly increase the risk of developing CVD:
 - high blood pressure affects 1 in 4 adults, about 12.5 million adults, of whom half are undiagnosed or not receiving treatment
 - nearly half of adults have cholesterol above recommended guidelines
 - about 1.4 million people have atrial fibrillation and 270,000 people over 65 have undiagnosed atrial fibrillation.
- Almost 100,000 people have a stroke each year while two-thirds of the 1 million stroke survivors leave hospital with a disability.

Mortality

- CVD causes about 136,000 deaths annually, 1 in 4 of all deaths and premature deaths.
- People with CVD and related risk factors have a 3.9 times higher risk of getting severe Covid-19 and 2.7 times higher risk of dying from it.

Inequalities

- CVD is among the largest contributors to health inequalities, accounting for one-fifth of the life expectancy gap between most and least deprived communities; people from South Asian and Black groups have the highest risk of CVD.

Preventability

- Modifiable risk factors explain 90 per cent of CVD incidence and up to 80 per cent of premature deaths from CVD are preventable.
- The risk factors for CVD are risk factors also for other leading causes of morbidity and mortality, eg, diabetes, cancer, dementia and Alzheimer's disease, and Covid-19. CVD prevention and management therefore has significant potential for reducing the burden and costs to society of overall morbidity and mortality.

Potential for cost savings

- There were about 1 million hospital admissions for CVD in England in 2019/20, leading to 5.5 million bed days.
- CVD costs the health system an estimated £7.4 billion and the economy an estimated £15.8 billion a year.
- 1 in 6 people will have a stroke during their lifetime and social care costs to the UK economy for stroke survivors are estimated at £5.2 billion annually.

Where are we now on CVD?

Although progress in tackling CVD risk factors (notably smoking) and medical advances in its prevention and management have led to dramatic falls in CVD mortality since the 1990s, improvements stalled after 2010 and CVD remains a leading cause of morbidity, mortality and health inequalities.

Our analysis at The King's Fund of the extensive data on CVD and a literature review of current policy and evidence confirmed there is significant scope and need for reducing CVD and its adverse impacts on population health, health and care services and the economy.

We also held a workshop and interviews with a wide range of external stakeholders on what needs to be done nationally and locally to reduce the prevalence and impact of CVD. Despite the current pressures on the health and social care system, the stakeholders were optimistic about the prospects for addressing CVD and stressed that it was key not just to improving population health and reducing inequalities, but also for reducing demand and cost pressures on the over-stretched health and care system.

Opportunities for intervention exist across the whole CVD pathway including primary prevention, secondary prevention, acute, emergency and specialist care, and post-discharge and long-term care.

How can leaders accelerate progress on CVD?

This report aims to inform and support national and local leaders to take action to accelerate progress on tackling CVD.

National leaders

The current CVD policy landscape is fragmented and does not fully realise the potential that tackling CVD offers for improving population health, narrowing health inequalities and reducing NHS and social care workloads and costs.

The following should be priorities for the government, the Department of Health and Social Care, NHS England and other national bodies if the challenge of CVD is to be addressed.

- There is a strong case for greater co-ordination between national agencies and a comprehensive national CVD strategy which articulates this potential and describes how it can be achieved nationally and locally.
- Far more can be done at a national level on primary prevention of CVD. Bolder, evidence-based public health policies are needed to reduce risk factors such as smoking, poor diets and obesity, which would reduce prevalence also of other leading causes of morbidity and mortality such as cancer, dementia, diabetes and Covid-19.
- Primary care has a key role to play in timely detection and management of CVD and its risk factors earlier in the pathway, which would improve health outcomes and reduce pressures on acute and emergency services. Waiting times and delays in diagnosis and treatment can be life-threatening for many people with CVD, so action to address workforce shortages and deliver timely acute care is critical.
- The scale of and trends in post-pandemic health inequalities call for an ambitious, co-ordinated cross-government policy for reducing these inequalities. Tackling CVD needs to be at the heart of this policy as it is a leading contributor to health inequalities.

Local leaders

CVD exemplifies why local integrated care is so important. Everyone in a local public health, health and care system has a role to play in addressing CVD, both in terms of preventing it and because people with CVD are likely to interact with several parts of the system over the course of their lifetime. The advent of ICSs, with their partnerships across multiple local stakeholders, therefore, brings new opportunities to address CVD by developing locally relevant CVD strategies that can be implemented at scale and population level.

- Tackling CVD locally will require leadership at all levels of the system and strong partnerships to deliver a system-wide approach to the use of digital technologies and intelligence on population health and clinical care to plan and deliver services, engage communities and maximise community assets.
- The NHS, local authorities and public health services need to work jointly to address the wider determinants of health and inequalities, reduce behavioural risk factors and strengthen prevention and early detection of CVD.
- For those with long-term cardiovascular conditions, ensuring timely, co-ordinated, personalised care, and enabling people to self-manage their conditions, will be key to reducing the risk of recurrences and demands on services and improving outcomes.
- There is significant potential for reducing the large, unwarranted variations in the quality of clinical care for CVD.

The task of tackling CVD within the unprecedented systemic constraints that health and care services are currently facing can be facilitated by using data and tools, creating learning environments, enhancing capacity, and by using digitalisation and technology.

Conclusion

This report calls for urgent action by government, national and local leaders to tackle the large and unequal burden of disease and mortality associated with CVD, much of which is potentially preventable through bold public health policies to reduce CVD risk factors and timely, evidence-based health care for those who develop it or its risk factors. In particular, a stronger focus on primary and secondary prevention of CVD is called for, areas which had significant setbacks during the pandemic and also offer potential for significant health gain. Such measures can improve population health, reduce health inequalities and mitigate against escalating demand and costs leading to unsustainable pressures on the health and care system.

For long-term health gains and sustainability of the health and care system, there has to be a shift from repeated short-term fixes to alleviate pressures on services to a strong public health response with an emphasis on disease prevention. CVD can be an exemplar, given its leading contribution to the national burden of morbidity and mortality and the scope for prevention.

To view the full report visit:

www.kingsfund.org.uk/publications/cardiovascular-disease-england

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