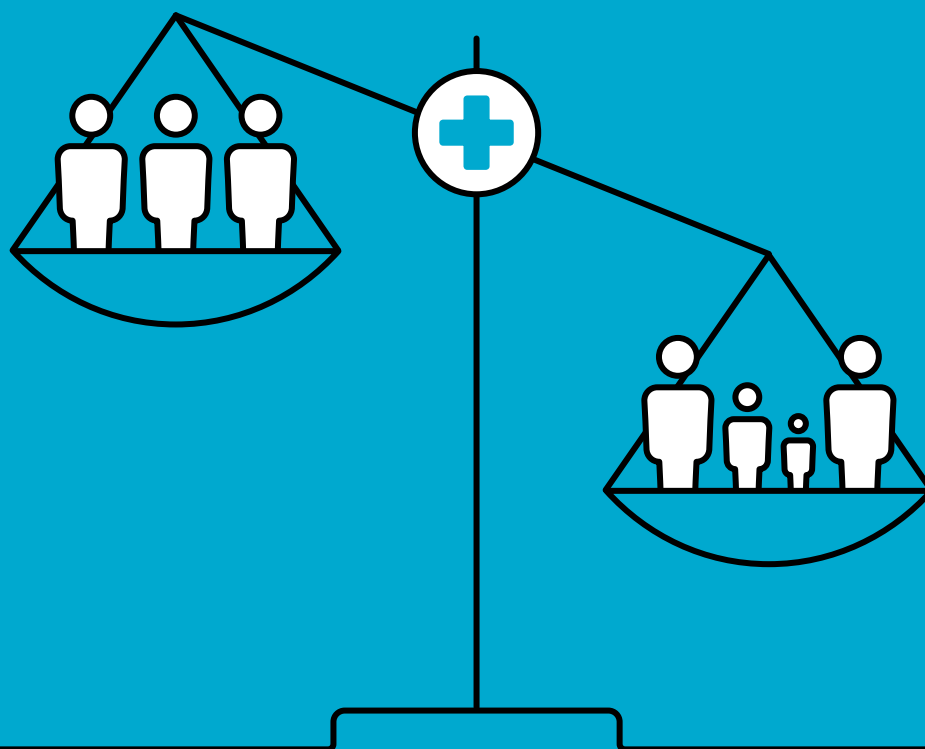


# Innovation for Healthcare Inequalities Programme

Impact and learning report



December 2024

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# Foreword



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The NHS Long Term Plan, published in 2019, placed tackling health inequalities as a key NHS priority for this decade. Crucial to the implementation of the Plan is the Core20PLUS5 approach which aims to deliver exceptional quality healthcare for all. The approach defines a target population – the ‘Core20PLUS’ – and identifies ‘5’ focus clinical areas as well as smoking cessation as a cross cutting theme requiring accelerated improvement.

However, we know that we can only meet the healthcare needs of our population through better engagement with those least likely to present at NHS services and by placing greater focus on local needs. This requires local insights and relevant data, and we need to include local, trusted voices when we design and deliver NHS services.

**...local teams built trust with underserved communities resulting in more timely access to the latest health technologies and medicines for those who are in greatest need.**

To put the Core20PLUS5 approach into practice, NHS England and the Health Innovation Network partnered to develop the Innovation for Healthcare Inequalities Programme (InHIP). The programme supported local teams to tackle healthcare inequalities by improving patient access to clinical pathways and proven innovations in underserved populations.

At the core of InHIP success was the requirement for an innovative, iterative design approach with local expertise. The project teams worked together with their communities to identify the most at need populations and to co-design approaches to improving pathway accessibility. As a result, local teams built trust with underserved communities resulting in more timely access to the latest health technologies and medicines for those who are in greatest need.

We are proud of the impact and learning that InHIP has generated in its first year, as well as the recognition that the programme has received locally, regionally, and nationally. These unique approaches to addressing healthcare inequalities are only the beginning. The projects implemented so far lay the foundations for further work needed in areas of high deprivation and with underserved populations.

We will continue to build on the rich learning and insights that have been gathered. We strongly encourage you and your colleagues to be part of this important approach. What can each of us – decision makers, innovators, clinical or non-clinical staff – do differently to address inequalities in healthcare? What barriers do we need to address and which opportunities can we harness? How can we better learn from and inspire each other? And most importantly, how can we better co-design and deliver services with underserved communities?

The examples in this report highlight the creativity shown in approaches to tackling healthcare inequalities. From bringing diagnostic services to where people are, to partnering with the community organisations, to optimising the use of existing and trusted relationships. Some InHIP teams focused on the wider social determinants of health, such as fuel poverty or smoking cessation. These examples may inspire approaches in your local area or guide you to solutions to challenges that you might be facing.

As we celebrate the first wave of this programme, we look forward to taking our learning and cementing it in our approaches to tackling healthcare inequalities in both InHIP Wave 2 and other key areas of work. It is essential to our healthcare ambitions that we use this opportunity to exchange our knowledge and learning about what works and what does not work. We need to be bold, we need to be innovative and we need to work with the communities most impacted by health inequalities.

The impactful work to date shows that if national and local teams, innovators, and community leaders work together, we can reduce barriers to access which will improve patient experience and health outcomes. Together we can achieve meaningful change to provide better healthcare for the population.

**As we celebrate the first wave of this programme, we look forward to taking our learning and cementing it in our approaches to tackling healthcare inequalities in both InHIP Wave 2 and other key areas of work.**



# What is InHIP?



# What is InHIP?

InHIP supports local teams to tackle healthcare inequalities by improving patient access to proven innovations in underserved populations across the Core20PLUS5 clinical areas of priority – maternity, mental health, respiratory, cancer diagnosis and cardiovascular disease as well as smoking cessation as a cross cutting theme.

InHIP began in 2022 as a unique collaboration between NHS England's Innovation, Research, Life Sciences and Strategy group (IRLSS)'s National Healthcare Inequalities Improvement Programme and the Health Innovation Network which is specialised in spreading innovation at pace and scale, delivered in partnership with integrated care systems (ICSs).

**The project teams developed and implemented innovative approaches to improve access for underserved populations, generating knowledge and key insights on what works best to address inequalities in healthcare.**

Funding was made available to ICSs to support eligible local projects across England.

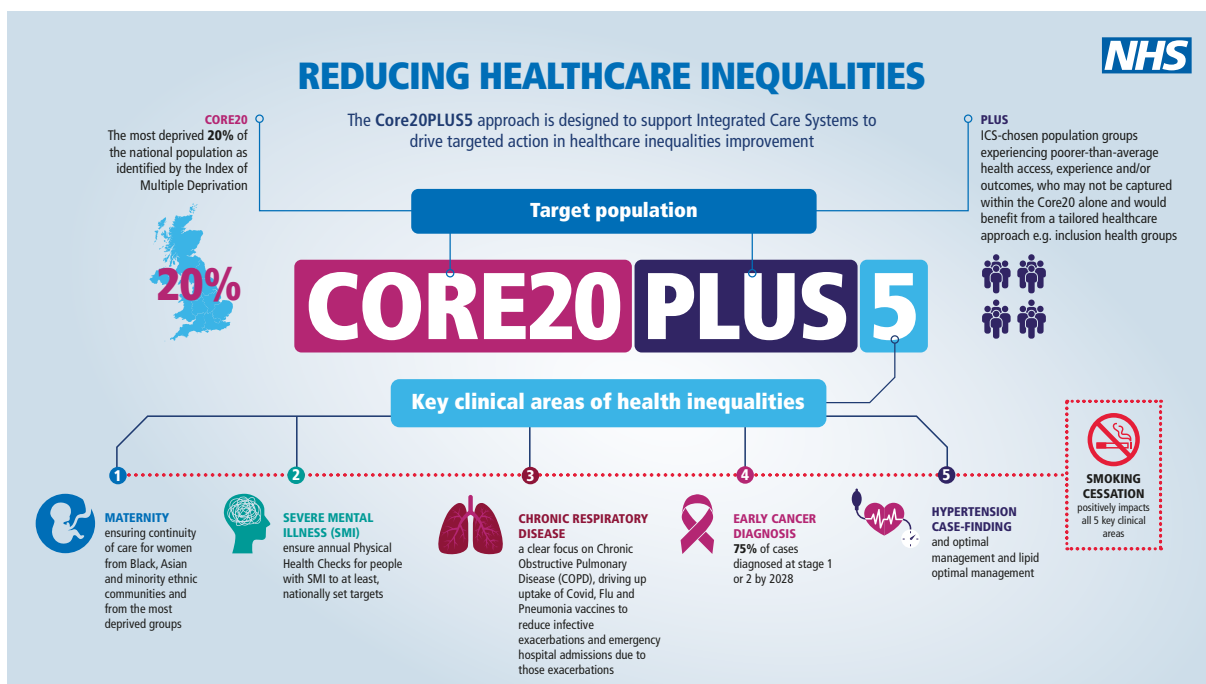
In total, projects were designed and implemented by 38 ICSs. The project teams developed and implemented innovative approaches to improve access for underserved populations, generating knowledge and key insights on what works best to address inequalities in healthcare. The

teams identified local partners, built new relationships, fostered trust, and worked across organisational boundaries to co-produce tailored interventions with local communities.

Using the Core20PLUS5 approach, teams across England were empowered to tailor their projects in line with the local needs of their communities. The local projects were supported by the national team, which provided delivery guidance, development of the national measurement plan and approach, health inequalities improvement educational content and community of practice coordination to facilitate shared learning across teams.

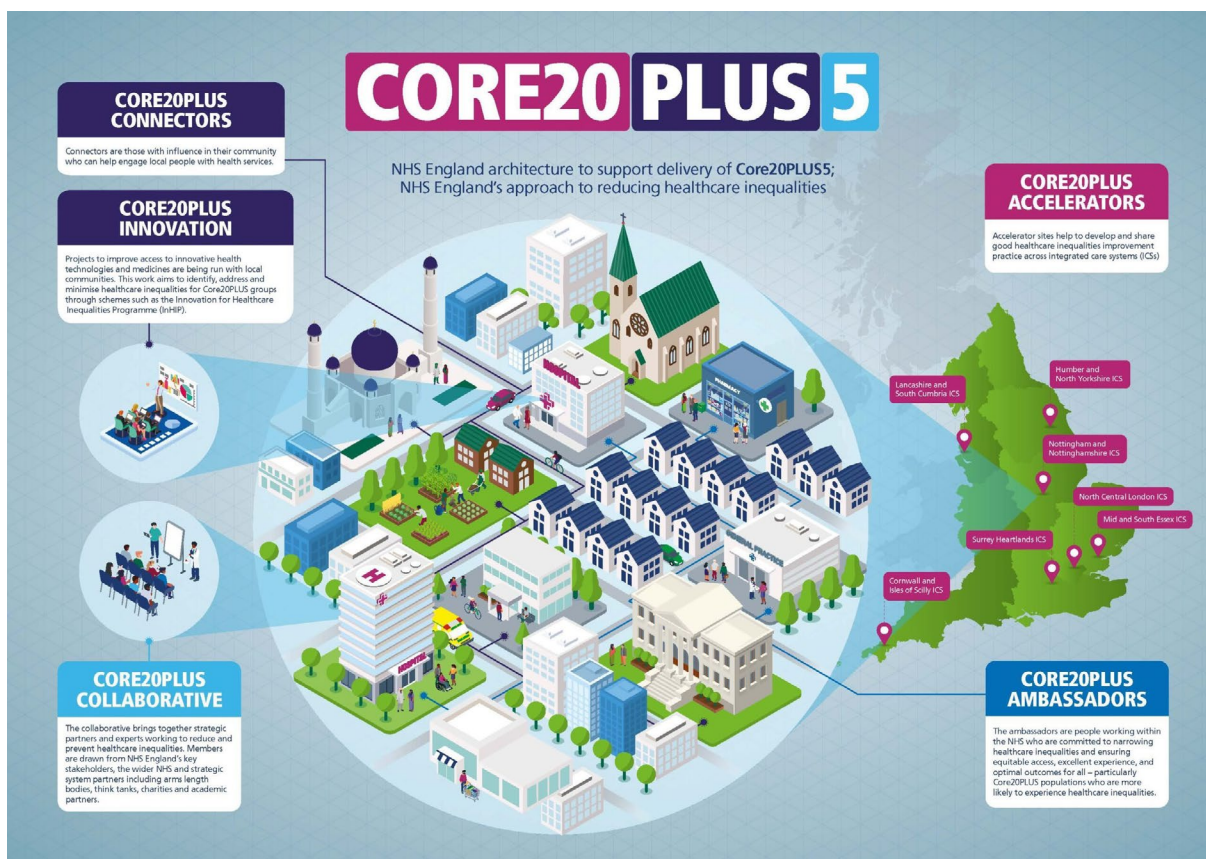
In addition to InHIP, the Core20PLUS5 approach is being delivered through a range of people and project led initiatives delivered by NHS England. [NHS England's National Healthcare Inequalities Improvement Programme](#) sets out the national strategic priorities for addressing healthcare inequalities in the NHS in England. This strategic approach provides clear priorities, creates a culture of continuous quality improvement and develops frameworks for accountability to improve healthcare inequalities in the NHS. This includes the development and deployment of [interventions](#) with partners, education programmes, capacity building and finance and assurance toolkits. As part of the Core20PLUS5 approach, ambassador and connectors programmes have been set up with people working in the NHS, partner organisations, community, faith, and social enterprise organisations to promote the reduction of health inequalities for all, particularly groups who are more likely to experience healthcare inequalities, such as communities living in deprived areas.

## The Core20PLUS5 approach



See [here](#) for larger version of infographic.

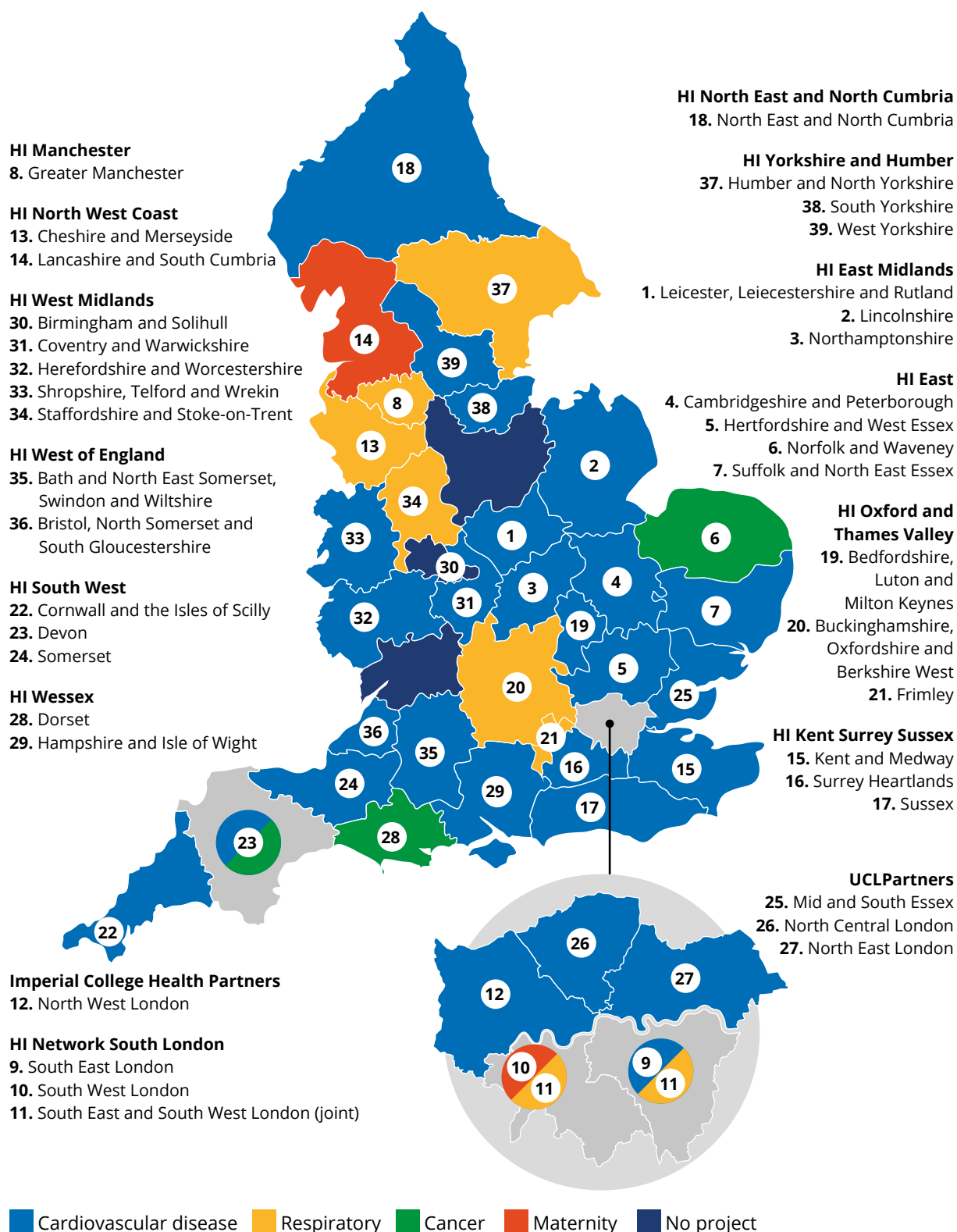
## The Core20PLUS5 ecosystem





38 out of 42 Integrated Care Systems delivered InHIP projects.<sup>1</sup>

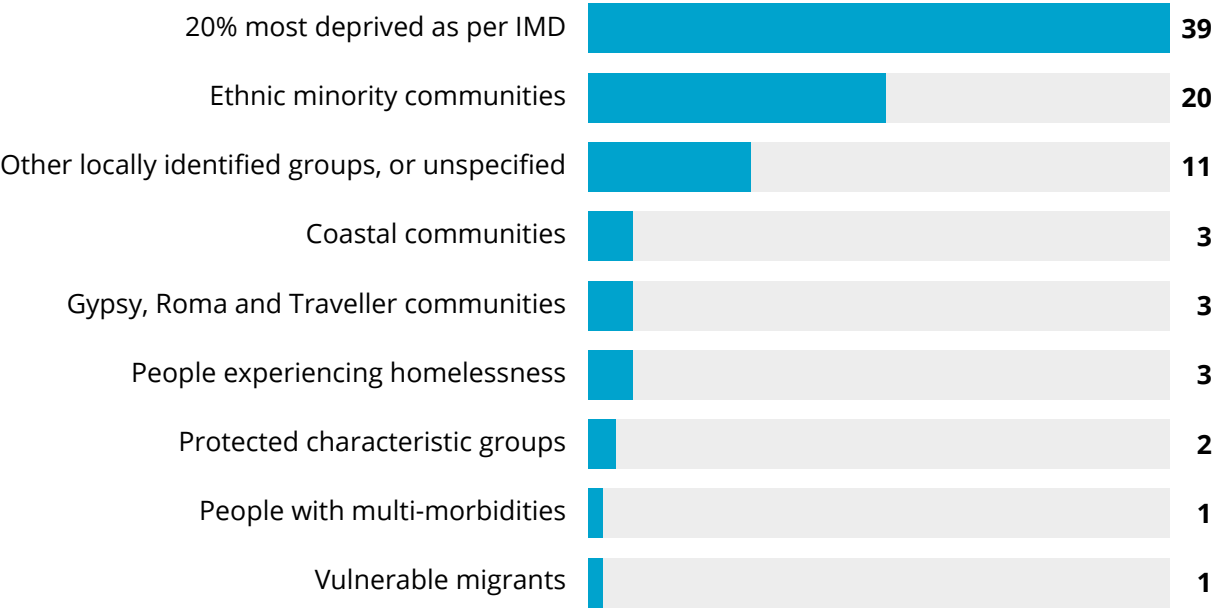
## Spread of projects by Health Innovation Network and ICB



Every project focused on the 20% most deprived populations and, in some cases at least one 'PLUS' minority group defined locally based on ICS population need.

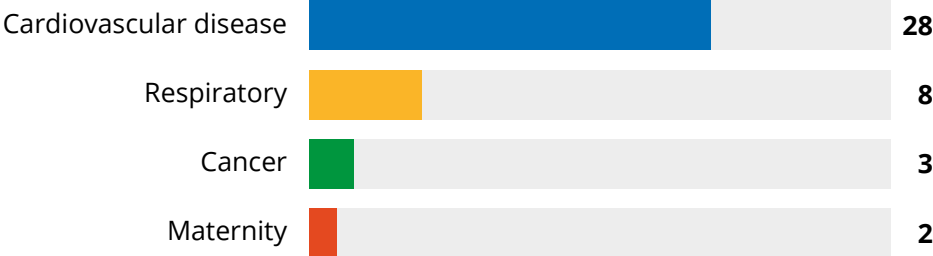
<sup>1</sup> Involvement in the InHIP programme was not mandated

### Count of projects by Core20PLUS group



A project may focus on one or two clinical areas and target multiple Core20PLUS groups. The majority of projects focused on cardiovascular disease. This reflects its impact on mortality and the number of NICE recommended innovations in this space.

### Count of projects by clinical priority area





# Impact and key learning

# Impact

Treatment pathways in the NHS use evidence-based innovative interventions, technologies and treatment. However, evidence shows that those living in the most deprived areas of England face the worst healthcare inequalities in relation to healthcare access, experience and outcomes.<sup>2</sup>

As the case studies in this report show, use of data, working with local non-NHS partners and building capacity all contribute to identifying, approaching, and caring for patients in ways that improve access to latest health technologies and medicines, minimising healthcare inequalities.

Over 34,000 people from underserved groups or deprived areas have benefitted from InHIP Wave 1 interventions with circa 8,000 patients gaining access to an innovative product on a treatment pathway.<sup>3</sup> The clinical pathways that were accessed the most through the programme were cardiovascular disease, followed by respiratory, cancer and maternity. Over 1,200 project sites were able to deliver a new pathway and / or innovation to patients. Almost 4,000 patients had broader health needs identified that resulted in them being referred on to additional services beyond the original core project focus.

95% of surveyed patients reported a positive experience of their care; highlighting the expertise of, and engagement with, staff, as well as the convenience of the services provided.

“ I was treated very efficiently and found the whole thing extremely helpful and worthwhile. A follow up blood test has been arranged for me and I attend my GP tomorrow. ”

“ I learnt more about atrial fibrillation. The GP explained everything very well and CDA staff were very nice. ”

“ The checks were extremely quick and convenient. It only took five minutes out of my busy schedule to check my blood pressure. ”

“ I would not have accessed the NHS health check if not for this service. ”

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<sup>2</sup> For more information on deprivation health, see the NHS England website, [Deprivation: what is deprivation health?](#)

<sup>3</sup> Data has been collected from individual project submissions in April 2024. Note some projects focus on multiple clinical areas and population groups.



## What project teams said

Project teams working on InHIP also benefitted from the programme, reported improved partnership working across sectors, the value of community outreach and applying the learning from InHIP to other projects.

“ Substantial strides have been made in fostering relationships. Sports integration into health programs targeting cardiovascular disease and mental health has begun and we have already established future projects. ”

“ The team have developed short, medium and long-term approaches for continuing the engagement with, and learning, from local communities. Learning from focus groups will also help inform other cancer programmes, particularly improving timely presentation from traditionally later diagnosed populations. ”

“ Staff found the outreach work rewarding. ”

“ It has just been a fantastic piece of work, I've never worked on a project or a programme that has been so well received. It really seems to have sparked everyone's imaginations. ”



# Key learning

The series of inspiring case studies in this report highlights what is possible when NHS teams and their communities work together. Addressing local inequalities in healthcare presents both challenges and opportunities.

Finding the target group for your project, encouraging that group to engage with their healthcare, understanding the barriers, and adapting services to support the building blocks for health were essential to project success.

We can learn valuable lessons from the approaches taken.

## Finding target groups

- **Access and analyse the data:** Gaining access to data can be an important enabler to identify target groups. For example, in North West London the team conducted in-depth data analysis to apply a clinical effectiveness approach to improve cardiovascular disease. Using de-identified data with links to over 400 providers in North West London combined with qualitative clinical engagement provided the insight needed to analyse health inequalities. This revealed significant atrial fibrillation (AF) inequalities. Levels of direct oral anticoagulants (DOAC) prescription appeared to increase with national Index of Multiple Deprivation (IMD) deprivation decile, indicating that those in more deprived areas of north west London (NWL) were less likely to be prescribed DOACs.

Experiences of many project teams revealed the importance of NHS organisations working together to enable data access, and the need for information governance processes to be effective and efficient. The time to set up these processes needs to be factored in when designing projects.

- **Get help from community organisations to reach out:** Community organisations proved to be key enablers for identifying target groups. The team in the East Midlands worked with Northamptonshire Black Communities Together (NBCT) and utilised their connections with community groups, a subset of which was identified and approached to work with the local team. This improved the team's chance to reach the target group and helped them to recruit community champions.

## Encourage engagement and understand barriers

- **Importance of co-design:** Teams built new partnerships with local system leaders, VCSE organisations, and community champions, who are trusted and have well developed relationships with local groups, to engage with the local community and better understand their needs. This proved key to success. For example, the team in Yorkshire & Humber partnered with England Boxing and the Football Foundation to run health checks in local sport facilities, leading to registrations with GPs, interest in further information and positive feedback from attendees.

Designing engagement opportunities with community leaders was key to success. For example, co-designing surveys and communication channels targeted at the specific cohort.

Removing language barriers, improving health literacy levels and the provision of gender appropriate services were important to enable target groups to engage.

Communication channels used by the target group can also help to reach the community. For example, the team in North East North Cumbria collaborated with a South Asian community radio station and used social media to encourage attendance to focus groups.

- **Make engagement activities work for your target group:** Community groups hold vital information on which timings and locations might work best for the target group. Offering sessions in an environment that community members feel familiar with and staff speaking the same language as the target group has proven to be important. For example, the team in the South West aimed to improve the uptake of faecal immunochemical tests, which is particularly low in deprived, rural, and coastal communities, and among those with severe mental illness and/or learning disabilities. The team offered bi-monthly GP-led drop-in sessions at a community centre. Trusted staff at the local venue helped people to feel comfortable and safe, which was particularly important for those patients who had previous negative experiences of healthcare environments. The sessions aimed to foster a feeling of acceptance and positivity, and included mental health services and support from housing, rehabilitation, and literacy services, enabling people to access support for multiple needs in one place. As a result, GPs had the opportunity to build trust with people who often had complex needs and may not have attended a traditional appointment.

## **Adapting services to support the building blocks of health**

- **Housing and finance:** Considering modifiable factors in a person's life where support may be available to effect change was important. For example, the team in Cheshire and Merseyside joined forces with voluntary and community organisations as well as local authority partners to support people with respiratory illnesses who are living in fuel poverty. The combined strengths of the stakeholders involved brought multiple services into one pathway which allowed resources to be proactively targeted at those in need. For example, clinicians are now asking respiratory patients routinely whether they have any damp or mould at home and if they are struggling to keep their homes warm. If required, patients are being signposted to relevant local services to receive further support.
- **Support for the wider family:** In the case of children and young people, a whole-household approach helps their families to understand how a change in their behaviour might help the patients to live healthier lives. For example, in Greater Manchester the team took a whole-household approach to asthma intervention which aimed to improve paediatric asthma management by supporting young people and/or their families to stop smoking. Fractional Exhaled Nitric Oxide (FeNO) testing was offered on wards and young people identified as smokers were referred to local stop smoking services. Adult smokers were referred to a Smoke Free app. Those who were unable to use an app were referred to the local stop smoking service. Continued support was offered in a community-based setting. Healthcare settings outside of wards were identified as more suitable for FeNo testing, and the local team concluded that all nursing and medical ward staff should be able to identify asthmatics and smokers and provide management support and smoking cessation advice. To allow staff beyond the project team to learn from the benefits of this approach, the team also engaged with paediatric asthma specialists to inform them about the benefits of a whole household approach.





# Recommendations and going forward

# Recommendations

An evaluation of InHIP wave 1 was conducted to understand the value from the programme and gather learning to inform future versions of the work. The recommendations below summarise this work and are relevant not only to InHIP but also to any team striving to improve healthcare inclusivity.

## **Use clinical and non-clinical expertise with a wide range of stakeholders to design the project**

- Multi-disciplinary project teams could include both clinical and non-clinical expertise (such as administrators, analysts, project management support and quality improvement skills). This needs to include expertise in healthcare inequality as well as community and voluntary, community and social enterprises (VCSE) organisations. Project delivery tasks need to be identified and team members could be assigned to these. Any skills gaps could be highlighted to system partners.
- Engagement activities with wider stakeholders such as clinical leads could begin at the design phase. This will secure buy-in, awareness and championship of interventions to reduce healthcare inequalities.

## **Enhance the use of data access and analysis**

- There are a number of useful tools and sources of data (publicly available for use via [NHS England](#)) to understand and support the reduction of health inequalities, which could be used by teams to underpin their projects.
- The [Healthcare Inequalities Improvement Dashboard](#) could also be used to provide insights to drive improvements in tackling healthcare inequalities. This dashboard provides key strategic indicators relating to healthcare inequalities all in one place.

## **Build relationships with partners**

- For related healthcare inequalities interventions, delivery teams could prioritise co-design and co-production, including people with lived experience and trusted and known community leaders. These relationships to be prioritised early, to ensure information reaches the right people at the right time.
- Delivery teams could account for the time taken to build relationships across delivery partners within project plans (particularly for meaningful engagement with Core20PLUS5 populations). They could also highlight the resource and time implications of these activities with commissioners and funders from the outset.

## **Foster trusted rather than more traditional settings for engagement**

- Project teams could aim to offer sessions in environments that community members feel familiar with and with staff speaking the same language as the target groups.
- Teams should understand and be sensitive to the beliefs of any given group and invest time to build trusted relationships in these settings. There should be a clear approach, but flexibility retained in order to adapt to the needs of the communities.

## **Incorporate health education and health checks**

- Engagement opportunities with local communities, when working to improve equity in healthcare, should aim to incorporate health education and health checks to maximise impact.

## **Ensure benefits are sustainable beyond the project lifecycle**

- Project delivery teams could reflect and share their learning about the local population and barriers to access more widely to improve understanding of healthcare inequalities across the ICS. This could be enabled by sharing through local clinical networks, communities of practice and peer learning sessions.
- Project teams could engage senior clinical leaders with healthcare inequalities interventions early. This will secure their buy-in, provide them with an opportunity to clinically champion and facilitate wider awareness of efforts to reduce healthcare inequalities.
- It is important that project teams work in an environment of continuous learning, ensuring their projects continue to measure, evaluate impact and continually evolving their approach to match.



# Going forward

In this first wave, the InHIP teams have learnt what works well when identifying, reaching out to, and engaging with their local populations. This is a significant step forward in addressing local healthcare inequalities.

The seeds have been sown and momentum has been created by the local project teams. This forms the basis for improved engagement with the Core20PLUS population across England.

Teams will further develop the relationship between the NHS and local communities to benefit from their local insights and expertise in reaching out to and engaging with underserved communities. Further co-designed programmes are being scoped and local champions will be

**Spreading the word about what works, building upon the initial success and making new ways of doing business as usual across England is the legacy of InHIP.**

involved in future work. Other teams continue to use newly introduced health technologies and medicines, set up community of practices sessions and influence commissioners to ensure their learning keeps having impact.

Local NHS teams across England can draw from these projects and assess whether these

approaches might work in their geographies. Spreading the word about what works, building upon the initial success and embedding these new ways of working across England will be the lasting legacy of InHIP. From the projects scoped to date, another 13,000 patients from underserved groups or deprived areas have already been identified to benefit from the next wave of the programme. This figure is expected to grow as more projects are confirmed and mobilised. In addition, a number of projects have secured new and additional funding which has been drawn from a range of sources including grants, ICB funds, and industry.



# Case studies

The following section provides case studies of 14 individual InHIP projects.

# Health Innovation East

## Increasing uptake of Bowel Cancer Screening (qFIT test) in the most deprived communities and other underserved populations

### The team's objective(s)

Deprived and underserved communities are known to have reduced uptake of cancer screening programmes, whilst deaths from cancer are responsible for circa 20% of the life expectancy gap. Increasing engagement with target groups through trusted community voices could improve understanding of cancer signs and symptoms, awareness, and access to bowel cancer screening with quantitative Faecal Immunochemical tests (qFIT) tests.

### What the team did and how

The Community Voices (CV) model in Norfolk and Waveney trains and utilises 'Trusted Communicators' (TC) who are already employed in the voluntary, community or social enterprise (VCSE) sector to have conversations with individuals from targeted cohorts accessing their service, venues, or activities. These conversations are in addition to the regular interactions that would take place as part of their work in the VCSE. TCs are uniquely placed to have these conversations as they have developed a relationship with these communities and are trusted and respected. In addition, these individuals are already approaching the organisations for support which can allow the discussion to take place. TCs were provided CV specific training alongside project specific training on the signs and symptoms of cancer, health screening services, bowel cancer screen, and the ordering of qFIT tests. The conversations were then summarised and uploaded as text onto the CV insight bank with all patient identifiable data removed. The conversations took place from July to November 2023. The targeted cohorts for this project were: Core20, refugees and migrants, and people experiencing homelessness. The team then uploaded qualitative data from conversations to the CV insight bank. In addition, the team obtained quantitative data of intent to order (individuals supplied with 0800 number or informed the TC that they would be ordering a qFIT kit) and number of conversations had by VCSE sector regarding cancer screening. The focus groups were also asked for qualitative data covering the appropriateness of the CV approach for sensitive conversation and perceived impacts of conversations. This allowed for further understanding on whether these conversations were well received and if the TCs felt that knowledge and uptake was positively impacted.

## Achievements

- 322 conversations were held in total across 10 VCSE organisations, with almost 30% of individuals intending to order a qFIT kit as a result of the conversation. Some of the barriers identified include a lack of trust in the service, difficulty in performing the test at home, fear of findings, mental health concerns, stigma, and lack of language specific guidance.
- An evaluation was completed by the Norfolk and Waveney ICS Evidence and Evaluation Advisor in February 2024, which draws together, analyses, and summarises the quantitative and qualitative data.

## Learning

- Following this project, it was determined that the CV model was appropriate to not only engage with these cohorts but also as an appropriate vehicle to discuss sensitive topics such as qFIT kits and bowel cancer. The model allows for much greater understanding of enablers and barriers to access.
- One of the primary challenges this project experienced was in navigating processes for data sharing between organisations and in working with systems that are not designed to record the impacts of innovation. Earlier meetings with key teams and a more clearly defined and communicated national approval process (e.g. Research, Innovation and Development Advisory Committee, RIDAC) have made the process easier.
- The short turnaround time of the project and time required to onboard trusted communicators have led the CV team to develop a central cohort of trained VCSE partners. This will allow the team to rapidly respond to future opportunities and empower communicators further via training and networking.
- The project identified that whilst a wealth of guidance on bowel screening is available, it is mainly online. This negatively impacts those without access to the internet or who have trouble accessing online services. In addition, printed resources cannot be ordered in bulk for non-NHS organisations aiming to support coverage of cancer screening.

## Going forward

- CV is an already established and highly regarded model with a strong evidence base.
- As a result of the project there are a number of TCs with the project knowledge to be able to continue to support their communities in accessing cancer screening services.
- There is currently work underway to determine how InHIP wave 2 can be incorporated into existing ICS priorities.

# Health Innovation South West

## Partnering with a local community hub to improve access to qFIT testing and wider healthcare

### The team's objective(s)

Uptake of faecal immunochemical test (qFIT), which can help detect cancer, is particularly low within deprived, rural and coastal communities, and those with severe mental illness and/or learning disabilities. This project aimed to increase access to health care and qFIT testing for these population groups in North Devon, a particularly deprived area.

### What the team did and how

The aim of this project was to improve healthcare access for those experiencing high levels of deprivation and who are underserved by traditional healthcare routes.

To provide additional support, Combe Coastal Practice in Ilfracombe, which is in the top 15% most deprived areas in the country, partnered with the local community hub, Belle's Place, to provide routine healthcare to underserved patients, including regular blood pressure monitoring as well as colorectal cancer screening using qFIT. This involved bi-monthly GP-led drop-in sessions at the community centre to reduce barriers in accessing healthcare at a venue where people felt safe.

The drop-ins used a holistic, person-centred approach in conjunction with mental health services and support from housing, rehabilitation and literacy services. Importantly, trusted staff at the outreach venue were vital in promoting uptake of the GP appointments. This model of care allowed GPs to spend more time building trust with people who often had complex needs, some of whom had previously had negative experiences with healthcare settings and may not have seen a GP for many years. In addition, an evaluation was carried out to understand efficacy of the service, patient engagement and staff experience.

### Achievements

- The evaluation involved qualitative interviews pre and post appointment with the community centre-based GPs, along with measuring patient attendance, hypertension, the number of qFIT tests carried out, and referrals to other services.
- In total, 84 appointments were arranged, with more than half of them receiving personalised healthcare from a GP. Most patients returned for follow-up sessions. The majority of those were male, white British, and over 50 years of age, representing a significant underserved population at risk in the South West.



## Learning

- This outreach model responded to the needs of the most vulnerable clients accessing Belle's Place, who often have multiple health conditions requiring a personalised approach and face multiple barriers to accessing healthcare.
- The community connector was instrumental in encouraging the patients to attend and start looking after themselves.
- Privacy forms a critical aspect of care when working with vulnerable service users. Therefore, early communication about how privacy is ensured and what that looks like in the outreach space are encouraged.
- The drop-in format and the unstructured appointments were critical to fostering feelings of acceptance and positive experiences among patients. As a result, it is recommended that this format should continue at Belle's Place.
- To enhance the overall healthcare experience for those most vulnerable, it is crucial to prioritise access to community spaces that mirror the positive attributes of settings such as Belle's Place and the outreach 'drop-in' clinic model. Creating environments that foster familiarity, build trust, promote acceptance, and provide space for patients to feel heard during their healthcare appointments can contribute to the wellbeing of individuals seeking healthcare. Implementing similar spaces or attributes within primary care for similar cohorts or expanding support for existing community initiatives can help address trust issues, reduce stigma, and mitigate feelings of shame that are barriers to routine care. By recognising and integrating these essential elements, healthcare providers can seek to create a more inclusive and supportive atmosphere, addressing the unique and often complex needs of the most vulnerable and underserved.

## Going forward

- It is the ambition of all partners to continue and expand the delivery of the GP outreach clinics at Belle's Place. The possibility of delivering this model of care as part of an ongoing health equity fellowship held by one of the GPs is currently being considered.

# Health Innovation Wessex

## Increasing faecal immunochemical test completion to improve outcomes for communities at risk of colorectal cancer

### The team's objective(s)

Colorectal cancer is the fourth most common cancer, with poorer outcomes affecting those living in communities with higher social deprivation. While the use of the NICE-recommended faecal immunochemical test (qFIT) is one way of supporting earlier detection, uptake remains low in some communities, particularly those in areas of deprivation.

### What the team did and how

Supported by Health Innovation Wessex (HIW), the Dorset Integrated Care System's Cancer Programme engaged with people across Dorset to understand their awareness and experiences of using qFIT. This included a Dorset-wide public survey and working with local community groups to engage with those that are less likely to complete a test. These are people experiencing homelessness, learning disability, fishermen, farmers, and construction workers. This allowed the team to obtain insight and identify interventions that would support people with suspected colorectal cancer to complete a test.

Instructional videos (the first intervention) were tested through a second Dorset survey and directly with the Core20PLUS5 groups to understand if these would meet the needs identified in the survey. Further work is underway to develop the second intervention which includes standardised patient information.

Alongside this, with support from Wessex Cancer Alliance, a GP champion and lead GPs for cancer in Dorset, the clinical decision support tool 'C the Signs,' was implemented across all Dorset Primary Care Networks to enable primary care teams to track and support qFIT uptake by their patients.

The outcomes of this work were independently evaluated by HIW.

## Achievements

- Engagement with over 900 members of the public in Dorset.
- The identification of at least two interventions that could support uptake of qFIT: instructional videos and standardised patient information.
- The implementation of C the Signs across all PCNs in Dorset and its use in all 69 practices.
- Commencing work with the provider of the packaging to change the transparency of the packaging for completed kits following patient feedback that it was embarrassing to return these in person. This work is anticipated to benefit patients across England.

## Learning

- A key challenge to the project was making meaningful links with people from underserved communities; relationships that were critical to learning from individual experiences. Therefore, the project connected with local community group leaders who helped champion the work and invited the team to join established community meetings to begin those relationships. The groups included a group of construction workers, a group identified as marginalised and vulnerable, a group of fishermen and farmers, and members from a learning disability group.
- These interactions highlighted that incentives within community members were intrinsic, driven by a desire to share their experiences and opinions on what improvements look like. This gave the project team confidence to build on these relationships. Working with Wessex Cancer Alliance, they have identified short, medium and long-term plans to increase public awareness and identify opportunities to test interventions with a 'You said, we did' approach.
- Similarly, the complexity of coordinating and engaging with multiple partners and stakeholders for the deployment of a primary care digital platform across an entire Integrated Care System (ICS) identified both expected and unexpected challenges, such as variations in systems used and team capacity to implement the platform. To address these challenges, a core group was identified comprising of an IT team from Dorset ICB, primary care, and ICS team members with a dedicated Primary Care Clinical Lead, who were willing and able to engage and understand the needs of clinical teams before, during and after the system was implemented.

## Going forward

- qFIT remains a national priority and the work started with the Dorset Core20PLUS5 communities will be used and evolved by the Dorset ICS Cancer Programme and Wessex Cancer Alliance. The team have developed short, medium and long-term approaches for continuing the engagement with, and learning, from local communities.
- Learning from focus groups will also help inform other cancer programmes, particularly improving timely presentation from traditionally later diagnosed populations.

# Health Innovation East Midlands

## Hosting events for opportunistic testing for atrial fibrillation and hypertension

### The team's objective(s)

The aim of this project was to identify un-diagnosed atrial fibrillation (AF) and hypertension (HTN) within African, Black Caribbean and South Asian communities in areas where high levels of deprivation exist. One of the goals was to encourage people who might not usually engage with the more traditional health service delivery venues and models, to get tested and learn about heart health.

### What the team did and how

The project supported a guided pathway to diagnosis, alongside some heart health and lifestyle education. Under-diagnosis and lack of treatment may lead to serious complications, such as stroke, heart failure and heart attack, particularly for people within these identified communities. The project has been codeveloped with the ICS Population Health team and Northamptonshire Black Communities Together (NBCT), Health innovation East Midlands, Northamptonshire Healthcare NHS Foundation Trust (NHFT), Public Health and social prescribing services, in collaboration with eight community partner organisations. Each organisation hosted opportunistic testing events where community champions facilitated the testing and the educational offer. Testing was conducted with a virtual monitoring, handheld device, called Docobo, which captures AF readings that are fed back to a clinical team for review, interpretation and possible onward referral to the GP for appropriate treatment, including direct oral anticoagulants (DOACs). The device was also able to store blood pressure (BP) monitoring data and participant personal and lifestyle data. The InHIP project is delivered by the community from within the community, supported by a clinical team.

## Achievements

- The team developed an outcome questionnaire which sat within the Docobo device, capturing patient information, GP details and lifestyle questions, alongside the AF and BP test results.
- An attitude questionnaire, accessed via a QR code, captured further lifestyle information, vaccination uptake (Flu/Covid), use of GP services and general health feedback.
- Testing took place across 13 community events = with 696 people attending and 424 people tested for AF and HTN. 5.2% of those tested were referred to their GP for suspected AF. Nearly 1 in 10 were offered additional clinical advice about cardiac issues that required follow up clinical care. 43% were identified with high blood pressure and either referred to urgent care or asked to monitor for seven days.
- Focus groups, organised by the University of Northampton, enabled participants from different communities to share their lived experiences of using health care services. Hundreds of people attended the events across several months. Almost two thirds were tested for AF and HTN and received further advice and blood pressure monitors. The local team also handed out goodie bags and related literature to people helping to prompt further discussion at home and within the communities.

## Learning

- Use of community champions ensured the effective conversations and engagement with communities and connection with clinical teams. 89% of those who attended events heard about the events from community champions or community leaders. As the champions delivered the testing at events that took place over an extended time period, a key learning was that more training would benefit them further to ensure their confidence could be built.
- Collaborative project teams ensured co-production with communities. This was important to build trust and confidence from the beginning of the project through to the evaluation. Working with clinical teams alongside NBCT supported the planning and delivery of the project, using their established relationships with local community groups, eight of which the local InHIP team chose to work together with. This improved the team's chance to reach the target group and helped them to recruit community champions.
- The team benefitted from using testing devices which are already used by local clinical teams and connected to local NHS systems. It also meant there were possibilities to add bespoke data requirements to devices for the needs of this project.
- Clinical input was invaluable in testing the use and appropriateness of remote technology, as well as the use of Community Champions. Their input enabled the learning from this project to be considered for wider testing opportunities. For example, support was available but community champions would have benefitted further with more clinical and device expertise direct at the events.



## Going forward

- The project has established access to relevant support information which will benefit future educational events led by community champions.
- Engaging community champions in future projects will ensure their knowledge is further developed, enabling them to contribute to the success of future endeavours. However, further funding will be required to sustain this model of community champions
- A [health inequalities video](#) has been produced which is being shared as a learning resource. The final evaluation report captures the learning and insights from the testing events and the attitude surveys and will be shared across the ICS to support future community approaches to interventions and delivery models.
- The project has enabled relationships to be formed with NBCT and local community teams, which will hopefully enable sustained future engagement with the ICS.

# Health Innovation Kent Surrey Sussex

## Lipid pathway optimisation for people from the Core20 most deprived, people from ethnic minorities and women aged 40-59

### The team's objective(s)

Given that CVD significantly affects life expectancy gaps, improving lipid management and familial hypercholesterolaemia (FH) treatment rates is crucial. The team's data highlighted that people from ethnic minorities, women aged 40-59, and those in the most deprived areas are more likely to not be treated to target. They engaged patients and communities to ensure equitable access to essential healthcare services with one of the voluntary provider partners.

### What the team did and how

The initiatives focused on lipid identification and therapy treatments in underserved groups. This involved mobilising lipid point-of-care testing in outreach settings targeting females aged 40-59 and ethnic minorities in known Core20 geographical areas, as defined by IMD.

The team worked with a community interest company that conducted engagement with women from minority backgrounds aged 40-59. The engagement consisted of focus groups and associated write ups. This helped the system understand lived experiences of women accessing health care services, identify at-risk individuals, easing primary care burdens and enhancing patient outcomes through specialised resources and tailored awareness campaigns for diverse communities. Health Innovation Kent Surrey Sussex facilitated developing the parameters for patient case finding, project development, risk mitigation, evaluation design and the delivery team qualitative feedback.

The local team identified Margate and Ramsgate PCN as meeting the project criteria as both serve people living in Core20 areas. According to CVDPrevent people in these geographies would benefit from additional resources to optimise lipid management. They collaborated with the Margate GP Practices to facilitate pharmacists in performing bespoke searches of GP records to identify patients who are from ethnic minority groups and women aged 40-59, invited them in for blood tests and health screening as appropriate, before optimising their lipid management medication. During the conversations with patients, referrals to wider supporting services were also completed, such as smoking cessation or weight management services.

## Achievements

- Improved access to lifestyle advice and local services e.g. ONE YOU
- Increased identification of people at risk of CVD (A, B, C)
- Increased GP awareness, knowledge, and confidence to support optimising patient management
- Improved patient and clinician experiences of the pathway
- Equitable access to detection and subsequent treatment using novel statin alternatives (Inclisiran, Bempedoic acid and Ezetimibe) for people in the 20% most deprived, ethnic minority groups
- Reduced number of inappropriate lipid management referrals to secondary care
- Improved health outcomes (reduced hypercholesterolemia, CVD, cardiovascular events, stroke) and resulting reduction in care demands/pressures
- Better understanding of GP practice populations in relation to CVD and IMD
- Awareness in primary care for barriers to access
- Improved understanding of barriers in community to accessing or receiving appropriate care

## Learning

- The key learning is the importance of meeting members of the community where it is most effective and working in partnership with multiple stakeholders who are not part of the traditional healthcare model.
- Patients receiving care through this project placed importance on longer appointments, allowing for a meaningful conversation that enabled true advocacy. Collaboration with stakeholders on venues suitable for people living in communities affiliated with the GP practice was proposed to streamline projects focused on similar areas.
- The team have also learnt how essential it is to ensure people do not feel overwhelmed by health and lifestyle advice, and being supported to realise that their thoughts are of equal importance, rather than healthcare providers driving their own priorities.
- Additionally, mitigating system pressures where possible and supporting scaling in a manageable way were paramount to our project's success. The use of data to define cohorts and ask questions of the project was helpful to bring partners on board and minimise scope creep.
- There was a clear ask to support administrative costs to start the project, and this is something they are incorporating into a business case, supported by evaluation findings, to consider within our local system. They are also exploring wider community events, networks, and leaders to onboard with this work to strengthen our existing partnerships and provide community-based outreach opportunities.

## Going forward

- To ensure sustainability, the team have drawn from the learnings of the work and are holding place level conversations to support delivery. This includes redesigned roles in the workforce, for example health coaches or specialist pharmacists. These would be supported by collaboration with the third sector to develop a bespoke outreach offering for people experiencing health inequalities.
- The project has also helped approaching patients as the team could offer information and flexibility. The team now issues information on cholesterol and its importance to all patients if not optimised. Moreover, teams suggest changes to medicines via online questionnaires/ texts allowing patients to respond with preferences. They can then agree (without an appt needed); decline; or request a call back. They can also call in if preferable to a questionnaire. This has helped to identify patients who would like more information/contact regarding health.

# Health Innovation North East and North Cumbria

## Improving access to CVD health checks by better understanding barriers for underserved communities

### The team's objective(s)

The lipid and familial hypercholesterolaemia (FH) pathway dictates that most at risk groups should be proactively identified, and risk assessed. However, the team's target audience of Black Africans, South Asians and underserved white British has historically had poor health check uptake. To understand barriers to uptake, the team hosted focus groups and conducted in-depth interviews with underserved communities.

### What the team did and how

The intervention was co-designed with community leaders from Black and minority ethnic (BME) groups, sport and wellness groups based on the themes that come out of the behavioural insights research which focused on understanding whether behaviours are easy, attractive, social and timely. The team and community leaders used the EAST (easy, attractive, social and timely) framework to co-design the intervention. This framework focusses on understanding whether behaviours are easy, attractive, social and timely. The focus groups took place in community hubs which allowed the team to seek views of the target group. The key theme that emerged from this research is the difficulty in accessing healthcare from the GP due to language barriers, health literacy levels and gender appropriate services. Through co-designing heart health checks that are easy, attractive, social and timely it can be ensured these communities take ownership for their health.

As a result, the project engaged commissioners from public health in Middlesbrough in the co-design of the delivery of healthy heart checks to ensure sustainability of outreach services once the project concludes. The public health commissioners are part of the Integrated Care Partnership within the ICB. The commissioners attended the focus groups with the community leaders and this helped to build new relationships between commissioners and community leaders.

For commissioners and providers, this research was done at the right time as the feedback provided helped commissioners to assess whether an outreach model for delivering heart health checks could be successful.



## Achievements

- Heart health checks were delivered to 500 people from underserved communities including Afro-Caribbean, African and South Asian communities. Over 60% of those tested had an abnormal result and were referred to their GP for a lipid medication review.

## Learning

- Identifying how to get access to the target audience took longer than expected. Through pre-existing relationships with local public health teams, the team have been provided with full access to all three target communities – Black Africans, South Asians and underserved white British groups. Moreover, the lead researcher has worked in the locality for years and has a good understanding of the demographics and the local authority landscape which helped the team to reach community leaders who are closer to the local population.
- Promoting the work via a local south Asian community radio station and Facebook also helped to engage with the target population.
- The current model of delivering health checks in GP surgeries does often not work for disadvantaged communities. They are not easy to access, attractive or social. However, deploying the heart health checks within local community hubs improves access to healthcare for these underserved groups.

## Going forward

- Public health commissioners in Middlesbrough have been core stakeholders throughout the lifecycle of the project. They are reviewing the model of delivery of heart health checks used within the project, including the use of community hubs and community leaders to drive engagement and uptake of heart health checks. Following this review, they will make a decision on commissioning this as a service.

# Health Innovation West Midlands

## Delivering vital health checks in community settings

### The team's objective(s)

The team focused their outreach community work within areas of high levels of deprivation across Warwickshire North. The aim was to identify and refer people at risk of cardiovascular events to ultimately prevent and reduce premature CVD mortality whilst increasing population awareness of the health risks posed by these conditions and risk factors.

### What the team did and how

In partnership with the outreach team at the local hospital, Primary Care Networks and clinical CVD Leads, the project established a community model by running a 'Community Healthy Heart Check Events' programme across Warwickshire North to deliver vital cardiovascular disease checks for individuals who do not usually access healthcare.

The events were supported by local organisations, including warm hubs, gyms, community centre groups, churches, and workplaces. The team targeted the events at the Core20 population and ensured that the events were accessible in areas identified as having a higher level of deprivation.

At the events in these community settings, the team offered blood pressure, heart rate, BMI and finger – prick cholesterol testing. The trained team also took the time to talk individuals through their results and what these mean for them.

In addition, the team worked with primary care to agree a referral pathway for individuals highlighted as requiring additional investigation. This includes the Docobo solution used to refer patients to their advised GP for further investigation.

## Achievements

- The project team commissioned the Docobo System to collect and process outcome data. The system is used as part of their Community Outreach Process and through this system they collect all patient outcomes, log experience, and refer as appropriate through to primary care.
- The team used the CVD Dashboard to monitor progress and numbers coming through to community clinics. This gave the team the ability to highlight any dips in patient engagement and alter approach for targeted groups.

## Learning

- NHS Information Governance Standards required for data sharing and processing had to be approved prior to going live. This took longer than expected and had an impact on processing patient outcomes, outlining referral pathways and information sharing with partners. Additional time, resource and full requirements should have been factored in during the project planning.
- Without in-depth local knowledge of groups/venues in the Core20 locations, it proved challenging to find relevant venues at the beginning of the project. In addition, the response to booking requests took longer than planned as a lot of community venues are volunteer or committee led. The project team utilised contacts through GEH Community Engagement Team and Outreach Team Booking Support to ensure targeted approach.
- It takes around 30 minutes to conduct one patient check which is longer than originally predicted and therefore limited the number of checks that could be done at one event. As a solution, the team increased the number of events booked per week and offered venues multiple dates to host outreach events giving the public improved access to the Healthy Heart Checks Service.
- With the evaluation of this project being conducted by third party, planning for this required additional input and resource. The project initially also struggled to commission a partner to deliver the evaluation. In response, the team utilised contacts at WN Place Level to agree a partnership with Warwickshire County Council Business Intelligence Team. The team also utilised Health Innovation resources. From an input and resource perspective, the project was supported by a Primary Care and CVD prevention Lead who outlined the design and provided data sets to aid the evaluation piece.

## Going forward

- Initial findings from this project suggest a change in processes at primary care level for the practices engaged with this resulting in better monitoring of their QOF populations and their processes for managing long term conditions through better use of practice staff and the ARRS roles. This change in practice will continue beyond the life of the project and hopefully spread organically to other GP practices in other parts of the county.
- The team are starting to take a whole system approach to CVD and the main findings from this project will inform how they commission and address CVD prevention in the long term as a system.

# Health Innovation Yorkshire and Humber

## The link between sports initiatives and health to improve access to services for underserved populations

### The team's objective(s)

This initiative aimed to address healthcare disparities among underserved population groups. Partnering with Yorkshire Sport and their Active Partners enabled the team to engage with individuals who typically do not access healthcare services. By integrating health services with sports, the team enhanced accessibility and approachability to health advice.

### What the team did and how

The team worked towards integrating health and physical activity through various initiatives across the region. Connecting health Core20PLUS5 initiatives with Yorkshire Sport and their numerous Active Partnerships means they could target specific geographies and population groups that require interventions the most. Via InHIP, the project team aligned these projects with the eventual uptake of NICE-recommended technologies.

In early 2024, the team collaborated with England Boxing to host events at a community center in South-East Leeds, offering health advice on cholesterol and heart health at the [Hamara Centre](#). In Barnsley, they partnered with the Football Foundation via the Active Partnership to involve the public health team and their ['How's Thi Ticker'](#) campaign in Walking Football and Sporting Memories events, targeting patients at high risk of cardiovascular disease. In South Yorkshire, the team arranged for the public health team to collaborate with Andy's Man Club and England Boxing, aiming to maximise impact and ensure every interaction counts.

### Achievements

- The outcomes of the Leeds boxing sessions demonstrated engagement primarily from Asian female participants across varied age groups. Health checks were conducted and feedback from attendees revealed positive outcomes, including registration with local GPs, interest in health information, and appreciation for access to healthcare services after the sessions.
- In Barnsley, advisors engaged with individuals across different sessions such as walking football, sporting memories, and Feel Good to Lose. While the numbers were modest, targeted population groups were reached, indicating potential for scalability. By leveraging these connections and understanding effective strategies, there is room for further development. Utilising sports facilities for future health events could further enhance outreach and impact, fostering continued collaboration between the sports and health sectors.

## Learning

- Navigating collaborations between the sports and health sectors proved complex yet rewarding. Clear correlations between physical activity and health outcomes drove the efforts. Challenges included time-consuming establishment of partnerships and some events being derailed due to system pressures. Clinical teams faced constraints, impacting outreach efforts. Ideally, joint community events combining sports and health would maximise benefits by engaging new population groups. However, it is important to agree in advance a timetable of events with all the partners involved. Drawing on their role as Health Innovation Yorkshire and Humber, the team could cultivate those partnerships and utilise their understanding of regional health priorities, to target areas requiring greater health outreach.

## Going forward

- The team are confident that the relationships they have cultivated will extend far beyond the scope of these projects. Substantial strides have been made in fostering relationships, with discussions underway across Yorkshire and Humber's Integrated Care Systems. Sports integration into health programs targeting cardiovascular disease and mental health has begun.
- The team have already established future projects with Doncaster Rovers including menopause, CVD and a Women's Health Boot Camp. Working with Fitmums and Friends and their 'Let's Get Going' programme in East Yorkshire, they are planning exercise and educational programmes aimed at perimenopausal and menopausal women. Work with Andy's Man Club and England Boxing is also being scoped in the South Yorkshire region. Through regional innovation hubs and strong connections with Integrated Care Systems, the project team aim to prioritise areas for intervention, potentially down to postcode levels, ensuring equitable health access for all.



# Imperial College Health Partners

## Conducting in-depth data analysis to improve the treatment of atrial fibrillation in deprived areas

### The team's objective(s)

The goal was to apply a clinical effectiveness approach to improve cardiovascular disease (CVD) outcomes in North West London (NWL). The team did so by utilising data to tackle health inequalities for those in NWL with CVD, specifically atrial fibrillation (AF). This was part of NWL's Integrated Care System's mission to optimise CVD care and treatment.

### What the team did and how

The team applied a structured methodology using a three-stage approach: Discover, Design and Delivery. Throughout, the team engaged with the NWL CVD clinical reference group and NWL AF working group. They conducted in-depth data analysis which identified local AF health inequalities, including the finding that patients living in areas of higher deprivation were less likely to be prescribed direct oral anticoagulants (DOACs) for their diagnosis of AF. This led them to focus on local populations living in areas of high deprivation. Afterwards, the team engaged local clinicians working in areas of NWL with high levels of deprivation, to explore their challenges in treating patients with AF, understand the drivers of inequalities from a patient perspective before identifying enablers to improve AF treatment. Finally, they facilitated targeted clinical review sessions to increase DOAC prescriptions, supported by development of bespoke data and insights packs as well as an education event including a dedicated AF case finding webinar.

### Achievements

- The DOAC review sessions resulted in an increase in DOAC prescriptions for patients living in deprived areas of NWL, as well as a positive impact on the local AF pathway and clinical teams. Of 218 patients reviewed, 6% patients were booked appointments to commence DOACs, with a further 26% being referred for further review.
- In the project evaluation, three of five PCNs involved indicated that they will continue to review their AF patients for DOAC eligibility as part of existing processes, and three of five PCNs involved stated their staff members involved felt more confident reviewing anti-coagulation following the sessions.

## Learning

- Data has enabled the project – the team utilised the strength of their local data asset Discover, a de-identified dataset, which links data from over 400 healthcare providers in NWL, to analyse health inequalities for both AF prevalence and DOAC prescriptions. This was combined with broad clinical engagement to add qualitative depth. We conducted nine interviews with clinicians from six of our target PCNs, exploring challenges with AF treatment from both a clinical and patient perspective, as well as potential enablers to increase prescriptions of DOACs. The key themes from these interviews were collated in a 'clinical insights' pack, that was shared with a wide range of stakeholders, including clinicians and the ICB.
- Another enabler has been collaborative engagement with a wide range of stakeholders. This included regular engagement with the NWL AF Working Group, which allowed them to share insights with a multidisciplinary team from across NWL, as well as review results, and test solutions against the day-to-day realities of primary care in NWL. In addition, the team worked in close partnership with the local Integrated Care Board CVD programme team to share insights and inform other programmes, request support, and receive healthy challenges.
- Within the resource constraints of the project, engaging with clinicians had to be prioritised.
- The main programme challenge was embedding work sustainably without adding significantly to local workload. Colleagues flagged that while they wanted to take part, they lacked time to be involved. The team mitigated this by ensuring that engagement and delivery activities remained flexible, e.g. providing additional resources. It is possible that this activity may result in lower demand on clinical services later on in the patient pathway, due to an increased number of patients being optimised. However, this is difficult to quantify. To help tackle this in the future, the team recommends that similar programmes of work should include evaluation of cost effectiveness to quantify the benefits of specific interventions.

## Going forward

- The programme has developed significant data-led insights into AF inequalities, as well as effective relationships with local staff members, that will both continue to demonstrate sustainable benefits through the NWL ICS's mission to optimise CVD care and treatment using research and innovation. The high level of quantitative and qualitative insight into local AF health inequalities generated have been vital in informing our approach to this mission.
- Relationships that have been built with local stakeholders will also be harnessed for the mission by recruiting Innovation Networks – communities of practice focused on utilising innovation to improve NWL CVD care and treatment.

# UCLPartners

## Offering health checks in places of congregation to address cardiovascular disease (CVD) diagnosis and treatment gaps

### The team's objective(s)

CVD is the primary cause of the life expectancy gap between the most and least deprived quintiles of Barking & Dagenham and Newham at 34% and 20% retrospectively, by cause of death in 2020/21. North East London has a high prevalence of CVD, deprivation and is ethnically diverse. The goal was to deliver a two-pronged approach to address health inequalities in primary and secondary CVD prevention.

### What the team did and how

The focus was to optimise hypertension and lipid management therapies, as a Core20PLUS5 priority in 2023. The geography to deliver this project was selected in areas identified with high rates of deprivation, using the SHAPE Atlas tool, overlaid with CVD burden, based on data from CVDPREVENT.

The InHIP programme is divided into 2 arms:

First, blood pressure (BP) checks were conducted in five places of congregation (places of worship, community centres and libraries), within ethnic minority communities. As regularly visited and trusted sites, places of congregation were chosen to ensure access to screening in underserved communities at scale. Connections with faith and community leaders were made via public health teams. Barts Health team offered free BP checks and arranged to go on a day where there would be the biggest impact, e.g. ladies day on a Monday. This led to an increase in awareness of BP checks, Know Your Numbers and other existing BP services within community pharmacy services.

Second, specialist cardiac pharmacists worked with primary care clinicians and teams over three months in six GP practices. This involved reviews of patients with CVD and consultations to optimise all lipid lowering therapy (LLT) across the pathway, including access to the innovative therapies. Complex cases were reviewed by a virtual lipid specialist multidisciplinary team once a week.

## Achievements

- A total of 201 people had blood pressure tested, of which 14% required onward referral to either a community pharmacy to confirm diagnosis or GP to optimise uncontrolled hypertension. Approximately 60% of people wanted to make lifestyle changes such as healthier eating and be more physically active. The advantage of screening at places of congregation was that it enabled access as well as creating a health dialogue in a community setting with peers.
- A total of 469 patients with CVD were reviewed. There was a 30% improvement in LLT uptake.

## Learning

- Collaboration is key for such programmes to be successful, particularly as service providers start to work locally in integrated neighbourhood teams as recommended by Fuller Stocktake report (2022).
- Working with key stakeholders, such as the public health teams, provided insight into the approach to take locally for screening programmes. Places of congregation were selected based on insights from the public team, from their work conducted on COVID-19 vaccination hesitancy programmes. Places of worship had the highest uptake rate with libraries being the lowest.
- Staff speaking the same language as the community was a key enabler.
- All screening venues welcomed the team back to do further health checks including cholesterol testing.
- Staff found the outreach work rewarding.
- There is reluctance in initiating innovative therapies in some care settings which is leading to longer waiting lists for acute trust lipid clinics.
- Patients seek advice from their local communities when making decisions to start on innovative therapies.
- Patient consultation between 9am to 5pm, leads to a proportion of patients not being available, therefore clinic times were extended to include evening hours.

## Going forward

- The relationships developed in this project will be maintained, whilst building on future projects in CVD prevention.

# Health Innovation Manchester

## Identifying and treating paediatric asthma and smoking

### The team's objective(s)

This project focused on asthmatic children and young people (and their families), living in IMD deciles 1 and 2 who are of the White British, Pakistani and Bangladeshi ethnicities. The work supports access to Fractional Exhaled Nitric Oxide (FeNO) testing in the ward and in the community as well as access to asthma biologics (if appropriate). The team also aimed to improve paediatric asthma management by supporting young people and/or their families to quit smoking.

### What the team did and how

The team offered patients FeNO testing on the ward to monitor inflammation of the lungs and offered advice and nicotine replacement therapy with support to be smoke-free and ultimately become healthier as a result.

The team took a whole-household approach to asthma intervention, working with Royal Oldham Hospital Children's and Paediatric Observation and Assessment Unit to help identify children and young people admitted to hospital with asthma or respiratory illnesses, who smoke or live in a household that smokes. Young people identified as smokers would be referred to the local stop smoking service, whilst adult household members identified as smokers were offered the Smoke Free app which entitled them to six months' free access to all premium features as well as up to 12 weeks' free nicotine interventions. Those that were unable to use an app were referred to the local stop smoking service. The adults were identified as part of the discussion on the child's admission to the ward. They were asked about their own smoking status as well as family members who lived in the same household as them.

Continued support has also been provided for patients, with a repeat test offered in a community-based setting as part of a follow-up asthma consultation.



## Achievements

- The team increased FeNO testing on the ward and in the community as all those attending a community appointment received a FeNO test.
- Around 95% of adults identified as smokers accepted a referral to the Smoke Free app or local stop smoking service provider. This helped to create smokefree homes (reported by the participants) and there is an anecdotal reduction in re-admissions and reduced length of stay.
- The local team also co-produced educational resources with trusted community groups, including local women, sport, and youth clubs as well as organisations supporting pensioners and people affected by homelessness. Moreover, the work of the team increased interest and focus from paediatric asthma specialists in other localities in taking a household approach to children and young people asthma management.

## Learning

- A need for educational resources to aid asthma management was identified. This stemmed from anecdotal evidence of a lack of understanding of parental smoking on their child's asthma, followed by a workshop, with key project partners, identifying a gap in educational resources helping young people self-manage their asthma. They then engaged with the community to gain insights into their understanding of asthma triggers and management for children and young people and confirmed their wants and needs for education outside of the healthcare setting.
- The local team also took onboard suggestions for what messages and resources would influence the target group to better manage their asthma or their child's asthma. This led to the co-production and co-design of a suite of resources including leaflets, animations and social media posts.
- Moreover, they identified healthcare settings outside of the ward that are more suitable for FeNO testing. This was due to the difficulty of gaining a reading on the ward due to the recent asthma exacerbation of the individual. Further, the team also learnt that FeNO testing should take place at the earliest opportunity either with a GP or in community follow ups. Importantly, all nursing and medical ward staff should be able to identify asthmatics and smokers and provide management support and smoking cessation advice. Finally, uptake of and continued engagement with stop smoking services may be improved with the use of incentives.

## Going forward

- The team have enabled continuous pathway development by developing a people and placed based toolkit, providing clear guidance and tools to successfully adapt and implement the pilot pathway as they plan to roll-out this project to interested sites within Greater Manchester.
- Further, the team have ensured continued, wide spread impact beyond the pilot and beyond the pilot-site by developing educational resources which are relatable and meaningful to people within all localities. The team were mindful of avoiding locality-specific branding to encourage uptake and spread of resources across Greater Manchester (GM). The resources are widely accessible via the GM Integrated Care Partnership website.

# Health Innovation North West Coast

## **A targeted approach to identifying and holistically reviewing patients with respiratory conditions, at risk of poor health outcomes due to fuel poverty**

### **The team's objective(s)**

Whilst winter is challenging for all those in fuel poverty, the cold temperatures are well-known to exacerbate respiratory conditions (asthma and chronic obstructive pulmonary disease). These patients are at a greater risk of admission to hospital over winter. The team knew that not all of the patients in Cheshire and Merseyside are medicines optimised for respiratory conditions and this project looked to address this.

### **What the team did and how**

The local team brought together NHS, voluntary and community sector and local authority partners to explore new ways of supporting people with respiratory illness who are living in fuel poverty.

Population health data was important to drive action. CIPHA (Combined Intelligence for Population Health Action) is a linked data platform which brings together health and social care data to understand and map population health data to support service design and improvement. The team used this platform to develop a fuel poverty dashboard, which identifies the population cohorts at greatest risk of harm.

Alongside this, a steering group brought together clinical and non-clinical experts across the NHS, local authorities, housing sector and voluntary and community. Together with their partners, the team defined and refined population cohorts and co-produced pathways of care. They also held workshops to understand and interrogate the local data. This resulted in several small "trailblazer" projects being established.

The package of clinical and non-clinical interventions offered to patients varied slightly between each site, but all included a clinical review and meds optimisation, referrals to pulmonary rehabilitation, referrals to local authority fuel poverty/ affordable warmth schemes, smoking cessation and community mental health/ anxiety support.

## Achievements

- The strength and value of this project is its approach of bringing multiple services and sectors together into one pathway and enabling available resources to be proactively targeted at those most in need.
- Clinicians are now asking respiratory patients routinely whether they have any damp/mould at home and if they are struggling to warm their home. If required, patients are being signposted.
- Over 300 patients identified and put on 'fuel poverty' pathway in St Helens, Knowsley and Warrington.
- The project facilitated £106,000 payments from St Helens local authority household support fund.
- Almost 300 referrals to local authority commissioned affordable warmth schemes.
- 160 referrals to wellbeing and social prescribing teams.
- Over 30 referrals to pulmonary rehabilitation.

## Learning

- Good quality data is key. CIPHA has been a critical tool to proactively identify people most at risk. By bringing together the data sets, the team were able to drill down and identify a target cohort.
- Start small and make sure to define a realistic number of people to support across each locality. Starting small helps to get work underway and means that learning can be used to grow the projects over time. This enabled local teams to adapt and improve their support offer more easily using a test-and-learn approach.
- Allow sufficient time for engagement as it takes time to gather all the relevant stakeholders needed. Planning for the support needed in winter should start in the summertime. The multidisciplinary workshops worked well as a space for stakeholders to come together.
- Connecting with existing services and projects that provide a broad range of health, wellbeing and financial support for people will create a holistic offer which makes best use of the resources available.
- Pre-appointment information, for example information leaflets that are shared with people before they have their appointment for the clinical review are now used to explain the background to the project, what will happen at the appointment and what the onwards referrals might include.
- Build Trust through consistent and open communication: the team have learnt that maintaining a single point of contact for the project has helped to build the relationship and trust between the care coordinator and patient.

## Going forward

- One of the key outputs from this work is the development of an implementation toolkit to help other areas to adopt this approach using resources developed by this project's trailblazer sites. The toolkit has been shared widely – locally and nationally. Recipients within Cheshire & Merseyside ICS received tailored packs, which contained data specific to each place.
- An event is being planned for summer 2024, to bring together Place Directors and senior stakeholders to deliver a coherent message about how to deliver a project and the best practice regarding leading clinical teams, methodology of engaging people, and the resources/assets needed.

# Health Innovation Network South London

## Respiratory diagnostic hubs for Core20 populations

### The team's objective(s)

There is a national crisis in the provision of objective respiratory diagnostic testing, with inequalities in access and inadequate local capacity. Recent expansions of services have not been evenly spread; areas able to meet requirements have developed faster, and this has often not been the case in more deprived areas. The aim of this project was to establish respiratory diagnostic testing in primary care-based hubs for deprived populations (IMD 1&2).

### What the team did and how

Bromley was chosen as the project location due to insufficient diagnostic provision and pockets of deprivation. The Primary Care Networks (PCN) identified target sites with prescribing data indicating uncontrolled asthma. The search tool SPECTRA was used to identify high risk cohorts. This was done by PCN administrators who were given responsibility for identifying clinically vulnerable patients.

In addition, a steering group was formed including the PCNs, the Health Innovation Network (HIN), respiratory team at Princess Royal University Hospital (PRUH) and One Bromley (OB) the Local Care Partnership which is a place-based team within the ICS.

The advantage of working at such a local level, with place-based local care partnership, was that the activity was highly focused in target areas of deprivation. The relatively small £50K funding pot acted as a catalyst for action and led to subsequent match-funding.

The steering group members agreed a two-arm delivery model, one delivered by physiologists from PRUH, the other conducted by primary care staff. The team engaged with under-represented groups through local charities and trusted clinicians embedded in the community, identifying actionable insights for the design of the hub; specifically the importance of care being available close to home and 'out of hours.' For example, the views of the Traveller community were sought via a trusted partner, a specialist public health nurse with close links to the community and the Asthma + Lung UK's support group – Breathe Easy – in Bromley. The key barriers identified were flexibility of appointment timings and locations – both of which were incorporated into the hub design (with out of hours appointments in proximal sites).

There was significant pressure on room availability in primary care, with appropriate rooms often not available where and when needed. The issue was resolved by representatives from all three PCNs in the most deprived areas, building relationship and buy-in, leading to the identification of workable space and a commitment to provision. The team then moved to a formal agreement through an MOU.



## Achievements

- The main achievement is that primary care-based testing for respiratory diagnostics is now available across Bromley, where previously testing was only available in secondary care.
- Through InHIP, five testing sites were directly established and are expected to test 15-20 people per week. One at PRUH, one in Penge PCN (13% of registered patients in IMD 1&2) and 3 in Crays PCN (31% of registered patients in IMD 1&2).
- Testing has successfully reached the most deprived populations; of the nearly 100 patients tested March to June 2024, a third were from IMD 1&2. The expected outcomes include increased accurate diagnosis and reduced time to access appropriate therapies, reducing exacerbations.

## Learning

- Timely identification of room availability requires a team effort involving all stakeholders.
- PCNs identifying the clinically vulnerable patients directly supported decision making and ensured the right patients received testing. Searches could have been run centrally, but this localised approach established ownership and upskilled the PCN workforce.
- One of the challenges faced was the dependency of the project on a small number of busy individual staff, presenting challenges to maintain tight timelines.

## Going forward

- The guiding principle for the project was to collaborate closely with PCNs, to engender ownership and ensure sustainability.
- One Bromley provided the PRUH with written assurance of future funding support, which enabled the service to recruit an additional physiologist and continue beyond the project timeline.
- The original ambition to build capacity within primary care and follow the model set out at the start of the project remains. Bromley Education and Training Hub (BETH) have agreed to fund training for staff to become fully accredited, however funding for testing is likely to remain a challenge.

# Health Innovation Oxford & Thames Valley

## Improving access to asthma biologics with pharmacist-led outreach clinics and hub-and-spoke service

### The team's objective(s)

In the region of the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System, deprivation significantly impacts health, driving variations in severe asthma care and biologics access. Data revealed that up to 80% of those eligible for asthma biologics were not receiving them, highlighting a pressing need for enhanced identification, diagnosis, and integrated care to address these health inequalities.

### What the team did and how

The Integrated Severe Asthma Care (ISAC) team worked with two District General Hospitals (DGH) and 14 Primary Care Networks (PCN) serving the most deprived and ethnically diverse populations across the system.

37 general practices were supported in improving the identification and management of poorly controlled, potentially severe asthma patients. DGH-based asthma teams were supported in building capacity to initiate advanced asthma therapies called biologics, improving access to them by reducing the need for patients' travel to Oxford.

ISAC consultant set up virtual multi-disciplinary teams (MDTs) between secondary and tertiary care to enable the DGHs to initiate asthma biologics and discuss complex cases. In addition, ISAC specialist pharmacists from Oxford's Severe Asthma Centre (SAC) proactively identified patients with suspected uncontrolled severe asthma and delivered outreach clinics in general practices. The ISAC specialists also designed and delivered educational sessions and resources to support primary care colleagues in all aspects of asthma care. Finally, each PCN was provided with a novel diagnostic device, FeNO machine, and associated training to improve asthma diagnosis and management.

## Achievements

- MDTs with both DGHs have been successfully established moving biologics initiation clinics closer to patients' homes.
- 115 patients have started asthma biologics, equating to an estimate of over £400,000 saved through reduction in acute healthcare utilisation.
- 214 patients received comprehensive medicines review. Of 165 who attended face-to-face clinics, 100% had medication adherence and inhaler technique checked, and bespoke asthma education provided.
- 42% of patients had their medications optimised and 28% had environmental inhaler switches, in line with the Net Zero NHS approach.
- 97% of survey respondents found pharmacist-led consultations helpful. 68% reported their asthma improved since.

## Learning

- Partnering with the ICBS's health inequalities lead proved to be instrumental in equipping the clinical team with appropriate knowledge and tools, resulting in improved engagement and reduced DNA rates among the vulnerable patients.
- Information governance processes take time to set up and might need to be re-negotiated throughout the project.
- Integrated healthcare records and simplified IG processes to enable NHS Trust teams to access primary care notes could help alleviate pressure on primary care and encourage greater engagement from general practice.
- Recruitment of specialist staff on fixed-term NHS contracts proved challenging due to uncertainty about future employment and lengthy HR processes.
- The SPECTRA patient prioritisation tool used in this project was useful for the identification of potentially uncontrolled asthma patients.
- The maintenance cost of FeNO machines can be reduced by changing to an alternative, cheaper brand and negotiating with the commissioner to subsidise FeNO costs in the second phase.

## Going forward

- Virtual MDTs between the SAC in Oxford and two District General Hospitals (one in Buckinghamshire and one in Berkshire West) continue monthly.
- Education, FeNO machines and training provided to the PCNs have left a sustainable legacy of skills which will continue being utilised by the primary care teams in improved diagnosis and management of asthma patients.
- ISAC pharmacists also improved access to novel asthma biologics and the transition to homecare at the OUH level. This enabled the sustained and timely initiation of these therapies, delivered directly to patients' homes, removing the need for regular travels to Oxford to collect them.

# Appendix

- [NHS England, National Healthcare Inequalities Improvement Programme](#)
- [NHS England, The Equality and Health Inequalities Hub, Case studies](#)
- [NHS England, What are healthcare inequalities?](#)
- [NHS Accelerated Access Collaborative](#)
- [NHS Accelerated Access Collaborative, Increasing diversity in research participation: A good practice guide for engaging with underrepresented groups](#)
- [Health Innovation Network](#)