

Health Innovation  
Kent Surrey Sussex



# Kent and Medway Innovation for Healthcare Inequalities Programme (InHIP)

Evaluation summary report

June 2024

# Contents

## 1. Introduction

1. Context
2. Kent and Medway InHIP programme
3. Evaluation questions

## 2. Methodology

1. Quantitative
  - Limitations
2. Qualitative
  - Limitations
3. Benefit forecast model
  - Assumptions and limitations

## 3. Results

1. Quantitative insights

## 2. Qualitative insights and thematic analysis

1. Staff surveys
3. Benefit forecast modelling

## 4. Summary of findings

1. How effective has the project been at reaching under-served groups (Core20PLUS)?
2. What effect has the project had on outputs or outcomes across the target groups?
3. What has been the monetary impact of the InHIP programme?
4. Is the approach a feasible option for future initiatives?

## 5. Conclusion

## 6. References

## 7. Appendices

# Executive summary

## Introduction

The Kent and Medway InHIP project's primary aim was to improve access to care, detection and effective management of hypercholesterolemia to reduce risk of CVD morbidity and mortality, with particular focus on improving access to screening and treatment in the Lower Super Output Areas (LSOAs) who are amongst the 20% most deprived in England, females aged 40 to 59 years old and ethnic minority groups (including Traveller communities).

This was achieved through primary care case finding and treatment intervention through lipid lowering therapies and NICE-recommended therapies.

The aim of this evaluation was to support local quality improvement efforts, contribute to the national AAC evaluation workstream, and inform future projects addressing inequalities by sharing valuable insights and learnings.

The following questions were identified for the purposes of the evaluation

1. How effective has the project been at reaching under-served groups (Core20PLUS)?
2. What effect has the project had on outputs or outcomes across the target groups?
3. What has been the monetary impact of the InHIP programme?
4. Is the approach a feasible option for future initiatives?

## Methodology

A mixed-methods evaluation was completed to evaluate the InHIP programme in Kent and Medway. This consisted of the below methodology:

### Quantitative insights

The data received comprised 845 individuals. Of this, 205 received a medication intervention, where 11 were NICE-recommended therapies. Health metrics included: Patient cholesterol and whether they were at threshold, patient blood pressure and whether they were hypertensive, and medication intervention received.

### Qualitative insights

Four interviews were conducted with key delivery members of the Kent and Medway InHIP project, lasting up to 45 minutes. Interviews were held over Microsoft Teams during January 2024 to February 2024. Participants were prompted on eight interview questions. Thematic analysis was conducted on the interview transcripts to organise the analysis by each theme. Staff surveys were also conducted, with responses analysed by the InHIP delivery team.

### Benefit forecast modelling insights

The number of patients in the total population sample was multiplied by the proportion of patients treated to threshold, associated risk reductions in adverse events and their associated costs to estimate total five-year savings to the health and social care system.

# Executive summary

## Results

### Access

- Core20 individuals comprised of 78% of the project sample.
  - Mocketts Wood Surgery had the highest share, at 87%.
- Females ages 40 to 59 years old comprised of 20% of the project sample.
  - The Limes Medical Centre had the highest share, at 29%.
- Ethnic minority groups comprised 2.5% of the project sample, compared to 4.8% of those with known CVD diagnoses in the wider ICB.
  - Due to data limitations, the true share of ethnic minority groups in the project sample could reasonably be expected to be larger.

### Impact

- 288\* individuals were treated to threshold.
  - 222 Core20 individuals (33.7% of group).
  - 59 females ages 40-69 (34.7% of group).
  - 9 individuals from ethnic minority groups (42.9% of group).

\*Due to double counting among the Core20 and Ethnic minority groups, individual group values may not sum to 288.

- 557 individuals were not treated to threshold.

### Five-year monetary benefits (2023/24 – 2027/28)

- £8,181 was forecasted to be saved in the project sample through escalation to lipid management.
- £154,274 was forecasted to be saved through escalation to lipid management in an ICB-wide rollout scenario.

## Summary of findings

### How effective has the project been at reaching under-served groups (Core20PLUS5)?

Every individual who was reviewed ( $n=845$ ) and who benefited as part of the project were from Core20PLUS. Of these, 220 individuals attended and received a blood test appointment, and 24% ( $n=205$ ) of the total sample received a medication intervention. Core20 individuals made up most of the sample (78%,  $n=659$ ). While those from an ethnic minority group only made up 3% ( $n=21$ ) of the sample, this is likely to be higher due to the way data was captured.

### What effect has the project had on outputs or outcomes across the target groups?

As a result of the programme case finding, 557 individuals amongst the total project sample were identified as not treated to threshold and in need of intervention, and 205 of the total sample received a medication intervention within the study period. Ultimately, the project successfully reached 160 individuals from the pre-defined health inequality groups that were not to threshold and escalated them to appropriate lipid lowering therapy. Moreover, within the study period there was an increase of 143 individuals who were treated to target within the practices involved. If not for this project, these service users may have been delayed in being identified and receiving an appropriate intervention.

### What has been the monetary impact of the InHIP programme?

The benefit forecast model indicates a potential £154k benefit to health and social care in the Kent and Medway ICB region over 5 years, reflecting measurable and monetisable project benefits. However, the project's total impact is expected to surpass these figures. The combination of these monetisable benefits alongside anticipated non-monetisable gains underscores the business case for further project investment and scaling. It is important, though, to conduct a thorough cost review before proceeding with any expansion.

### Is the approach a feasible option for future initiatives?

Interviews highlighted the support and challenges that the evolving InHIP project has faced, the importance of longer appointments and exploring different methods of communications to secure engagement and adherence to treatment. Despite this, concerns were raised on longer term sustainability, as the impacts on budgets and the complexities of reducing health inequalities across the system are apparent with wider system pressures and changes ongoing.



# Introduction



# Introduction

## Cardiovascular disease in Kent and Medway

Cardiovascular disease (CVD) affects around seven million people in the UK and is a significant cause of disability and death, with health and social care costs estimated at £7.8bn/year. Hypercholesterolemia is a recognised risk factor for CVD. Effective management of hypercholesterolemia can lead to a significant reduction in the risk of having a cardiovascular event, but low detection and limited awareness of risks and treatment options in primary care present barriers to effective management. Two thirds of those at risk of developing CVD are undertreated, with areas of deprivation experiencing a greater treatment gap.

## Innovation for Healthcare Inequalities Programme (InHIP)

NHS England's Innovation for Healthcare Inequalities Programme (InHIP) is a unique collaboration between the Accelerated Access Collaborative (AAC), NHS England's National Healthcare Inequalities Improvement Programme and the Health Innovation Network, formerly Academic Health Science Network (AHSN Network), and is delivered in partnership with Integrated Care Systems (ICSs). The primary aim was to address local healthcare inequalities experienced by deprived and other under-served populations through adoption of innovation. Project teams (comprising of clinical and non-clinical expertise) from across England worked together with local communities to identify, address, and minimise healthcare inequalities through projects to improve access to the latest health technologies and medicines. These technologies and medicines focused on five clinical areas of priority that closely align with the national Core20PLUS approach to reducing healthcare inequalities, which includes maternity, mental health, respiratory, cancer diagnosis, and cardiovascular disease. The programme supported ICSs to generate evidence in piloting new approaches to the spread and adoption of innovation to underserved and deprived communities.

# Introduction

## Project aims

The Kent and Medway InHIP project's primary aim was to improve access to care, detection and effective management of hypercholesterolemia to reduce risk of CVD morbidity and mortality, with particular focus on improving access to screening and treatment in the LSOAs who are amongst the 20% most deprived in England, females aged 40 to 59 years old and ethnic minority groups (including Traveller communities). This was achieved through community-based VCSE outreach work to test patients for hypertension and hypercholesterolemia in community venues closer to home, primary care case finding, and upskilling primary care, through virtual Multi-Disciplinary Teams (MDTs) with secondary care and bespoke training.

## Kent and Medway InHIP delivery team

The PCN's Digital Transformation Lead (DTL) Jessica Moreton, and one of the Clinical Pharmacists (CP) Ross McSavaney, led delivery. The DTL developed GP IT system reports to identify patients from the cohorts; administration teams then invited these patients for appropriate monitoring before review. The CP consulted patients via face-to-face and telephone appointments to offer therapies to help optimise lipids, including medication changes and lifestyle interventions. Patients received follow-up appointments and referrals into the wider multi-disciplinary team where necessary.

## HI KSS & Unity Insights

Health Innovation Kent Surrey and Sussex (HI KSS) commissioned Unity Insights on behalf of Kent and Medway to provide the quantitative and health economic element of an independent evaluation examining the established programme's effectiveness at reaching under-served populations. Specifically, focusing on populations from deprived areas (Core20), ethnic minorities groups, and females aged between 40 to 59 years old.

# Introduction

## Aims of the evaluation

The aim of the current evaluation was to support local quality improvement efforts, contribute to the national AAC evaluation workstream, and inform future projects addressing inequalities by sharing valuable insights and learnings. Findings from this evaluation aimed to support in improving access, experience, and outcomes to health care innovations for the targeted groups.

## Evaluation questions

The following evaluation questions were identified for the purposes of the current evaluation, with evidence generated from the quantitative analysis conducted by Unity Insights and qualitative analysis conducted by HI KSS:

1. How effective has the project been at reaching under-served groups (Core20PLUS)?
2. What effect has the project had on outputs or outcomes across the target groups?
3. What has been the monetary impact of the InHIP programme?
4. Is the approach a feasible option for future initiatives?



# REDUCING HEALTHCARE INEQUALITIES

The Core20PLUS5 approach is designed to support Integrated Care Systems to drive targeted action in healthcare inequalities improvement

**CORE20**  
The most deprived **20%** of the national population as identified by the Index of Multiple Deprivation



**PLUS**  
ICS-chosen population groups experiencing poorer-than-average health access, experience and/or outcomes, who may not be captured within the Core20 alone and would benefit from a tailored healthcare approach e.g. inclusion health groups



Target population

## CORE20 PLUS 5

Key clinical areas of health inequalities

1



**MATERNITY**  
ensuring continuity of care for **75%** of women from BAME communities and from the most deprived groups

2



**SEVERE MENTAL ILLNESS (SMI)**  
ensuring annual health checks for **60%** of those living with SMI (bringing SMI in line with the success seen in Learning Disabilities)

3



**CHRONIC RESPIRATORY DISEASE**  
a clear focus on Chronic Obstructive Pulmonary Disease (COPD), driving up uptake of Covid, Flu and Pneumonia vaccines to reduce infective exacerbations and emergency hospital admissions due to those exacerbations

4



**EARLY CANCER DIAGNOSIS**  
**75%** of cases diagnosed at stage 1 or 2 by 2028

5



**HYPERTENSION CASE-FINDING**  
and optimal management and lipid optimal management



**SMOKING CESSATION**  
positively impacts all 5 key clinical areas

# Introduction

## How InHIP supports the Core20PLUS5 aim

InHIP has two desired outcomes:

1. Increase NHS awareness of evidence-based innovations that can also reduce healthcare inequalities in the corresponding clinical areas.
2. Increase the adoption of these innovations. This could be by improving access, experience, or outcomes for Core20PLUS populations with associated conditions in the clinical areas.

Working closely with ICS partners, the HIN and the AAC have supported 39 different InHIP project pieces of work covering 38 ICS footprints since December 2022. Further, 25 projects aim to improve services focusing on cardiovascular disease prevention, 2 projects focus on maternity, 8 projects are in respiratory, and 3 projects cover cancer services.

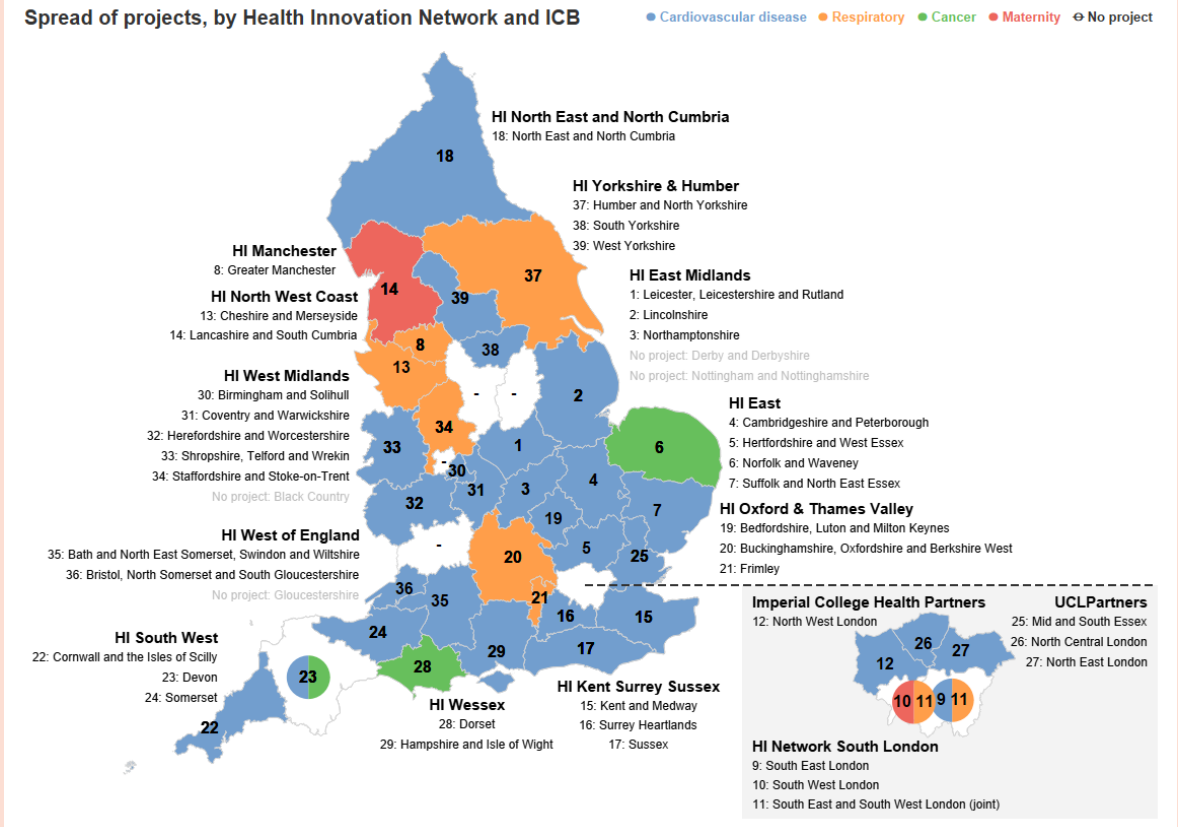


Figure 1: Map showing the spread of projects, by Health Innovation Network (HIN) and ICB



# Methodology



# Methodology summary

Provided by Unity Insights

## Quantitative methods

Datasets were shared by the Kent and Medway InHIP delivery team to Unity Insights, containing demographic and health metric data.

The data received comprised 845 individuals, including 205 who received a medication intervention (11 of which were NICE recommended therapies). Health metrics included: patient cholesterol and whether they were at threshold, patient blood pressure and whether they were hypertensive, and medication intervention received.

Provided by HI KSS

## Qualitative methods

There were four interviews with key delivery members of the Kent and Medway InHIP project in total, lasting up to 45 minutes.

Interviews were held over Microsoft Teams during January 2024 to February 2024. Participants were prompted on eight interview questions.

Thematic analysis was conducted on the interview transcripts to organise the analysis by each theme.

Staff surveys were also conducted via a Survey Monkey link and analysed by the project delivery team.

Provided by Unity Insights

## Benefit forecast modelling

Benefits were estimated for each patient based on the prevention of adverse events, using NICE resource impact estimates.

Benefit streams included prevention of adverse events such as stroke, transient ischaemic attack (TIA), and myocardial infarction (MI).

No costs were included in the analysis.

# Quantitative methodology

## Glossary

Table 1: Definitions of population groups.

### Definitions of population groups

<b>Core20PLUS</b>	Core20PLUS5 is a national NHS England and NHS Improvement approach to support the reduction of health inequalities at both national and system level. Core20PLUS populations in England suffer from poorer health outcomes, accentuated by the same patients suffering from inequitable access, experience and outcomes from health and care services and treatment pathways. The approach defines two target population groups – the ‘Core20 (nationally defined) PLUS (ICS defined) – and identifies ‘5’ focus clinical areas requiring accelerated improvement.
<b>Core20PLUS group(s)</b>	In the context of the current evaluation, these groups refer to the combination of all individuals who fall within the ‘Core20’ or any of the ‘PLUS’ groups defined for this project. It can, therefore, be interpreted as an aggregation of all of those who may be considered to suffer from health inequalities in the context of the project. For the purposes of the project, PLUS groups were defined to include females aged 40 to 59 years old and ethnic minorities.
<b>Ethnic minorities</b>	The Office of National Statistics (ONS) has highlighted that there is no true consensus on what defines an ethnic group, as identification to these is self-defined and subjectively meaningful to the individual. Ethnicity can include a variety of elements such as ancestry, culture, identity, religion, language, and physical appearance. Despite this, it is generally accepted that ethnicity includes all these aspects, and others, in combination. Under the Equality Act 2010, ethnicity includes colour, nationality and ethnic or national origins.
<b>Service users</b>	Any individual who is a user of services provided by health care organisations, in this case, the Kent and Medway InHIP project. A service user is a member of the project sample (see below).
<b>Project sample</b>	This refers to the population within this evaluation ( $n = 845$ ).
<b>General population</b>	This refers to the larger population outside the current project sample. In this context it is referring to the general Kent and Medway population.

# Quantitative methodology

## Data collection

Datasets were shared by the Kent and Medway InHIP delivery team to Unity Insights containing demographic and health outcome data. All individuals which were among the pre-defined health inequality groups were identified and invited to take part in the programme. An additional dataset was provided by the project team that contained aggregated cholesterol threshold data for the project period. The programme period varied slightly based on practice, but collectively ran from June 2023 to March 2024.

The five practices involved in the programme were Bethesda Medical Centre, Mocketts Wood Surgery, Northdown Surgery, Limes Medical Centre, and Dashwood Medical Centre.

## Data analysis

Evaluating the Kent and Medway InHIP programme's impact on addressing health inequalities involved a comprehensive analysis of datasets from the five practices provided by the Kent and Medway InHIP delivery team, as curated by Unity Insights. These datasets encompassed both demographic information and specific health metrics, facilitating a detailed examination of the groups pre-defined in the project plan.

The following Core20PLUS groups were included in the analysis:

- Core20
- Females aged 40 to 59 years old
- Ethnic minorities
- Total project sample (all identified Core20PLUS health inequality groups combined)

Where applicable, data from the Cardiovascular Disease Prevention Audit (CVDPREVENT), a national primary care audit, was used for comparison purposes.

## Exclusions

- Individuals that had missing data or “*No action – to target*” were excluded from the medication intervention analysis sample.

# Quantitative methodology

## Quantitative insights

### **Measurement of access**

Access was measured by analysing the following metrics:

#### Group demographics

Analysing patient access to the programme based on their Core20PLUS group provided insight to the distribution of each group among the five practices. Moreover, examining the distribution of age group and gender among the five practices demonstrates the case finding approach undertaken by each practice.

The proportion of patients that were identified as being part of the ethnic minorities group was compared with CVDPREVENT data of the wider Kent and Medway ICB to examine how representative the project sample was compared with the wider ICB.

#### Blood pressure

A patient was determined as having hypertension (stage 1) if they had a blood pressure result of 140/90 mmHg or higher when measured in a clinical setting (NICE, 2023). If a patient had their blood pressure taken and surpassed this threshold, it was assumed that they would enter the appropriate care pathway and thus benefited as part of the programme.

#### Blood test invites and attendance

The number and proportion of individuals from each group that were identified as needing a blood test appointment and subsequently invited was analysed to provide insight into the project teams' engagement as part of the case finding. The additional analysis of examining the proportion of each group that did not attend (or respond) to their blood test appointment was carried out to highlight potential barriers of certain groups not engaging with the programme.

# Quantitative methodology

## Measurement of treatment and impact

Impact was measured by analysing the following metrics:

### Non-HDL and LDL cholesterol

A patient was determined to be '*treated to threshold*' (TTT) if their non-HDL cholesterol was below the threshold of 2.5 mmol/L or their LDL cholesterol was below the threshold of 1.8 mmol/L in their most recent blood test. This criteria is intended to mirror that of CVDPREVENT indicator CVDP007CHOL (CVDPREVENT, 2024)

### Medication intervention

To further show impact of the programme, the proportion of patients either '*treated to threshold*' or '*not to threshold*' (NTT) that received some form of medication intervention (lipid lowering therapy) was explored. This exemplified how patients NTT were identified and appropriately received a first-time medication prescription or change in medication as part of the programme.

Please note: the evaluation dataset did not include data on whether each patient fell under primary or secondary prevention criteria. As a result, analysis of the two outcomes above were conducted on the entire dataset, with the limitation that percentages and rates are indicative and may be inaccurate due to the denominator (NICE 2023).



# Quantitative limitations

## Quantitative insights

Quantitative insights posed the following limitations:



Only the most recent result for each diagnostic test was available per individual, so it was not possible to measure if their cholesterol/blood pressure improved throughout the programme period. This made it difficult to determine whether outcomes were directly associated with programme activity.



The dataset had recorded each individual against one health inequality (HI), meaning it was not possible to know if someone had identified as being part of the ethnic minorities group AND were Core20. This does not mean the appropriate people were not reached through the programme, it just limits the identification of them within the data analysis.



The dataset contained many blank cells so not all metrics could be used as the sample size was too small. Example: Lifestyle advice, appointment type. This limited findings that could be made for certain metrics.



Due to many people contributing to the collection of data across practices, there were some inconsistencies in the data and the quality of the data recorded. Wherever possible, these were clarified with the project team or amended by Unity Insights where the intent was clear from context.

# Qualitative methodology

## Sample and data collection method:

- To gather lived experiences, deep reflection, and insights on the work, key delivery members of the local InHIP project were approached to ask if they could participate in a one-to-one interview via Microsoft Teams.
- The snowball sampling approach was then adopted to ensure wider members of the team were identified who would be willing to share their experiences and enable a rounded view of the project. A total of four people were interviewed, working across the InHIP delivery team.
- Interviews used open-ended questions to ensure participants were not led in their responses and could explore their thoughts and motivations in detail relating to the work, underpinned by using the same explanation script and questions to ensure all participants received the same information to minimise researcher bias.

# Qualitative methodology

## Qualitative insights

- The four interviews were conducted via Microsoft Teams meetings organised by HI KSS during working hours that met participants availability and lasted up to 45 minutes. Interviews were conducted during January 2024 to February 2024 to provide a complete experience of the entire project, as delivery concluded in December 2023.
- Interviews held over Microsoft Teams and recorded using a voice recorder to allow for the transcription to be checked for errors. Each interview was then individually analysed to identify the main themes for each question from that interview. If themes were identified in subsequent interviews that had not been identified previously, the previous transcript was rechecked to ensure there had been no human errors in missing words that could be linked to the newly identified theme.
- Every relevant quote from each interview was finally included in a master table to compare themes and the frequency at which each theme arose.

# Qualitative limitations

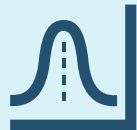
## Limitations

Quantitative insights posed the following limitations:



### Interviewer bias during data gathering and analysis

The interviewer was known to most participants, largely due to the relationships that had been formed during over the InHIP project duration between members of the InHIP team and HI KSS. It is known that interviewer presence can affect responses (Ross and Bibler Zaidi, 2018), but conversely this may have resulted in a more open discussion taking place due to the shared lived experience of the project.



### Lack of generalisability

The interviews were relevant to the specifics of the Kent and Medway InHIP project and the members of the team who were interviewed, so were unlikely to be replicable. Therefore, it is not possible to draw generalisations or statistically significant conclusions from the data presented (Miles and Huberman, 1984).



### Limited interpretations

The data often deviated from the original question, as they were designed to be open-ended and subject to the participants own interpretation with minimal interviewer interference. During analysis, the researcher could have introduced their own bias from knowledge of the programme and recollections of body language during the interviews, to place additional emphasis on quotes (Smith and Noble, 2014).

### Hindsight bias from respondents

The interviews took place when delivery of the project had finished, and there may be an element of bias from participants reviewing their experiences that occurred months prior to the interviews.



### Reporting error

There is the chance of human error being introduced when quality checking transcripts and transferring data between multiple platforms.



# Forecast Model Methodology

## Benefit forecast modelling

The evaluation used health economic techniques to generate benefit streams, where monetisable, in relation to the project. These were informed and estimated through quantitative analysis and were monetised using available unit costs or available information from literature. Only those benefits that can be measured and that are monetisable have been included in this analysis.

These benefits are likely to represent a reduction in health and social care activity, thus generating a non-cash releasing saving to the NHS or social care. Unit costs have been sourced from NICE resource impact reporting on lipids management (NICE, 2024). Unit benefits will be taken from the primary data, where available and where these are monetisable, but some degree of extrapolation based on literature is likely to be required to construct monetisable benefits.

The estimated benefits have also been presented as estimated benefits for five-year total savings. They are not adjusted for inflation or net present value (NPV). All benefits are associated with a reduction in the following events occurring as result of appropriate care escalation.

The analysis focused on the number of patients having their care escalated to meet threshold levels as the driver of the primary outcomes, following the methodology of the NICE (2024) resource impact template and as the main summary output of all of the project's activities, including the NICE recommended therapies.

The following benefit streams have been analysed:

- Stroke
- Transient ischaemic attack
- Myocardial infarction
- Unstable angina
- Coronary revascularisation
- Non coronary revascularisation

This analysis relates to all lipid lowering therapies and therefore is applicable for the two NICE recommended therapies (Bempedoic acid with Ezetimibe and Inclisiran).

# Forecast model methodology

## Benefit forecast modelling

### Scenario analysis:

Scenario analysis is used to understand the impact of the project if it were to be expanded further. As a result, two scenarios were modelled:

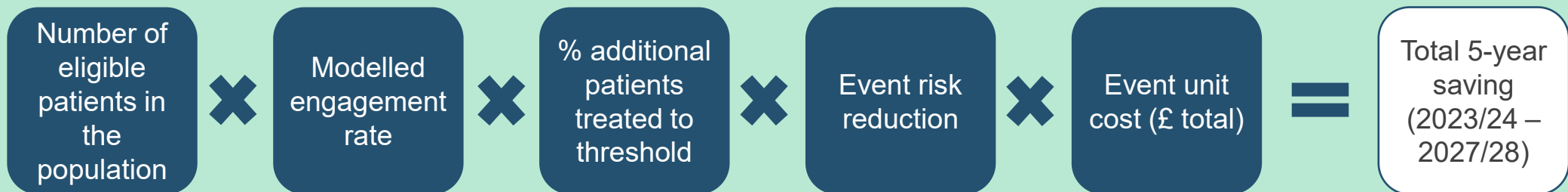
#### 1. Actual scenario

Analysis based on what occurred in the InHIP project to-date, based on all project data available.



#### 2. Expansion scenario

Forecast analysis based on what might occur if the InHIP project is replicated and expanded across a larger geography in Kent and Medway ICB.



\*This calculation will be repeated for each benefit stream

# Forecast Model Assumptions & Limitations

## Assumptions:

- 100% of patients that were escalated were assumed to be managed in accordance with NICE guidance.
- Adherence to treatment/medication post-escalation was expected to be 100%, as all patients identified as requiring intervention (via blood test) are expected to receive follow-up until they have achieved treatment targets.
- Inflation was estimated at 2.5% annually, in order to update unit costs to 2024 prices.

## Limitations:

- Costs were not included in the model, the analysis is benefits-only.
- The exact number of patients who were managed in accordance with NICE guidance and remained adherent is unknown.

## Unmodelled benefits:

The following benefits were either unable to be measured or monetised as part of the analysis:

- Benefits beyond a 5-year time horizon
- Improvements in quality of life for patients



# Results





# Quantitative insights: Access

## Demographic groups

All 100% of patients in the total project sample were from one or more of the targeted Core20PLUS groups. Figure 2 shows the break down in the sample by their respective demographic and registered practice ( $n=845$ ). Of the total project sample, Core20 individuals comprised 78.0% ( $n=659$ ), Females aged between 40-59 made up 20.1% ( $n=170$ ), and ethnic minority groups made up 2.5% ( $n=21$ ). Mocketts Wood Surgery had the highest proportion of Core20 individuals (87%,  $n=126$ ) Limes Medical Centre had the highest proportion of females aged 40-59 in their sample (29%,  $n=60$ ).

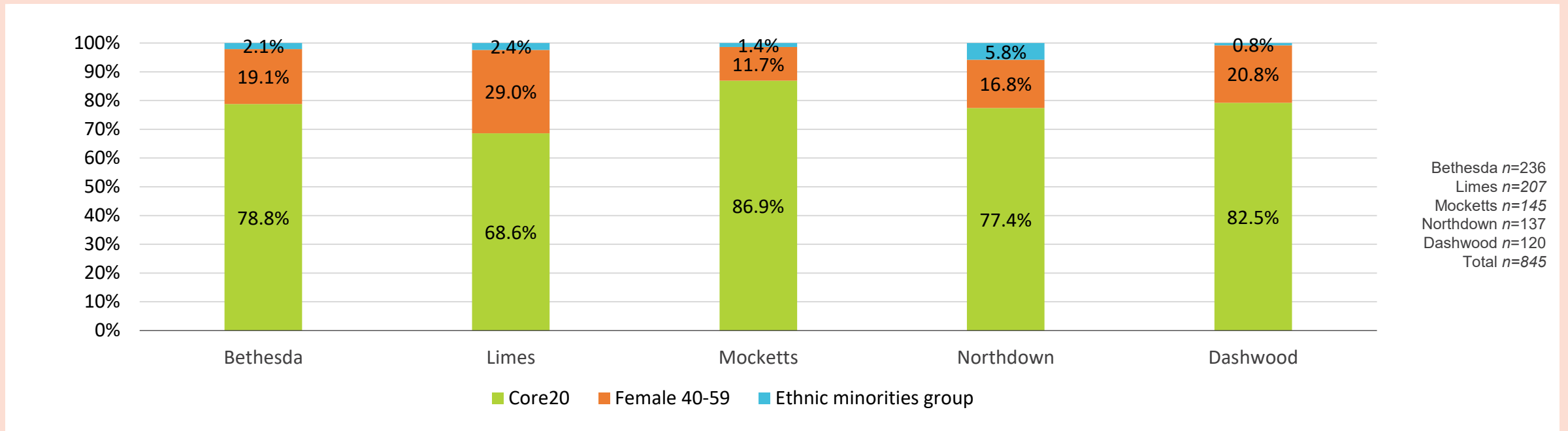


Figure 2: Project sample by group presented by practice

\* Total percentages may be >100% due to potential double counting across these groups (e.g., Core20 and Female 40-59)

# Quantitative insights: Access

## Ethnic minorities

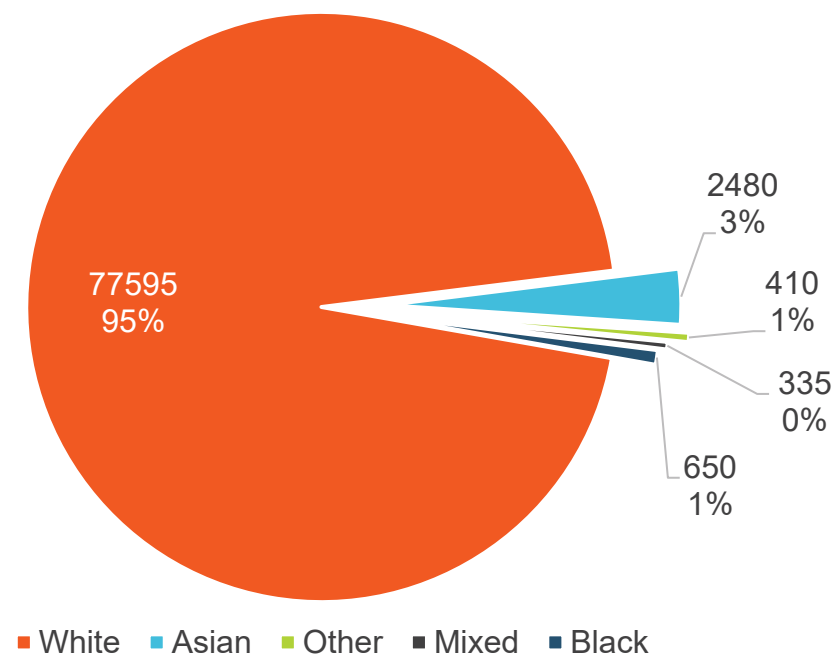
The analysis of CVDPREVENT data presents a useful comparative perspective on the results found in the datasets provided by the Kent and Medway InHIP delivery team. Figure 3 shows the Kent and Medway ICBs CVD population ethnicity breakdown.

Among the patients with a known diagnosis of CVD within the Kent and Medway ICB, individuals from ethnic minority groups represent 4.8% of the total, accounting for 3,875 out of the 81,470 cases (not including data classified as not-stated or missing; Figure 2). The Asian demographic comprises the majority within the ethnic minority population, making up 64.0% ( $n=2,480$ ), while the Black ethnic groups constitute a smaller fraction at 16.8% ( $n=650$ ) of the ethnic minorities with CVD in the Kent and Medway ICB.

In the project sample, ethnic minority groups make up 2.5% ( $n=215$ ). While the data does not provide granular detail on ethnicity breakdown, the proportion of service users identifying as part of an ethnic minority group in the intervention data is smaller than that of CVD patients in Kent and Medway ICB as a whole. Due to limitations in data availability (explored later), the true proportion of ethnic minority groups within the project sample could reasonably be assumed to be larger than is demonstrated within the data.

Source: CVDPREVENT, 2023. CVDPREVENT Data Extract [Website].  
URL: <https://www.cvdprevent.nhs.uk/data-extract>

Figure 3: Summary showing the actual general population split of ethnic groups within the Kent and Medway ICB population with CVD.



Total CVD population (excluding 'Not stated' and 'Missing'):  $n = 81,470$   
Total ethnic minority CVD population (excluding 'Not stated' and 'Missing'):  $n = 3,875$

# Quantitative insights: Access

## Age

Figure 4 shows the break down in the sample by respective age and registered practice ( $n=845$ ). Service users aged 60-69 made up 23.9% ( $n=202$ ) of the total population sample. Northdown practice had the highest proportion of service users aged 60-69 in their population sample (28%,  $n=38$ ).

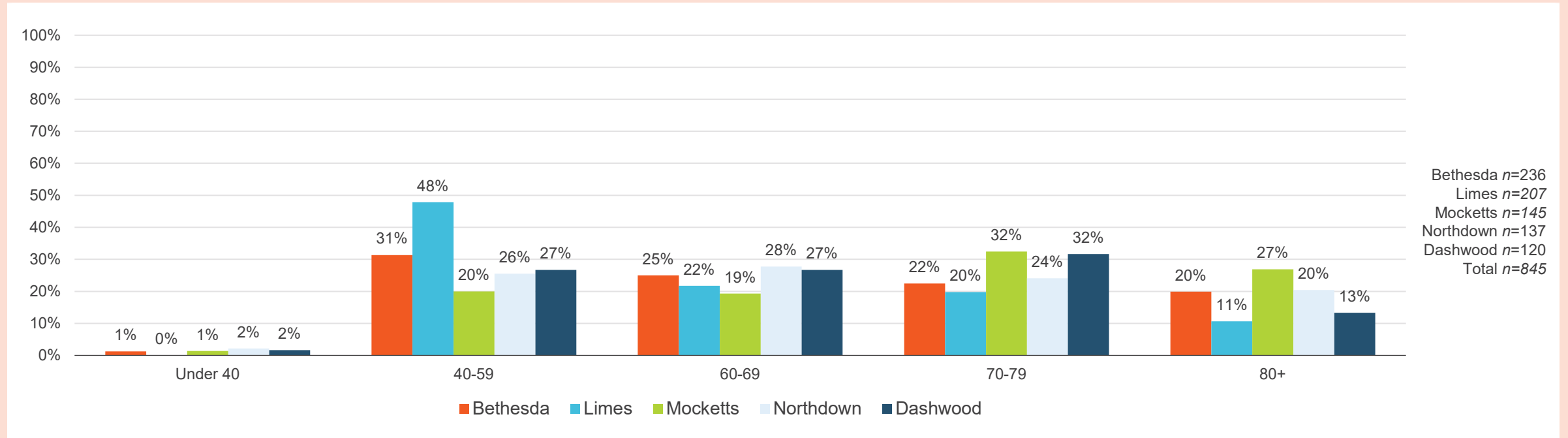


Figure 4: Project sample by age presented by practice

# Quantitative insights: Access

## Gender

Figure 5 shows the gender split for each practice involved in the programme. In the total sample, females made up 46% ( $n=387$ ) of those who benefitted from the project. Mocketts Wood Surgery had the highest proportion of females, 49% ( $n=71$ ). The average gender split for Kent and Medway ICB for CVD prevalence is 62% male and 38% female (CVDPREVENT, 2024). Thus, we can see a more targeted approach towards females within the five practices for this programme.

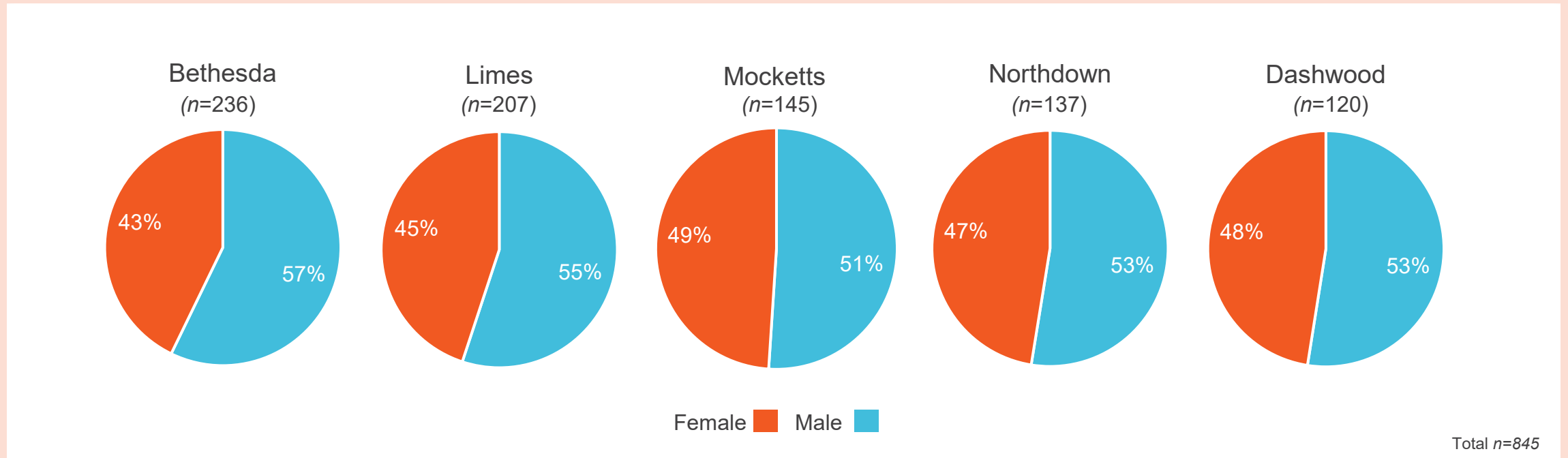
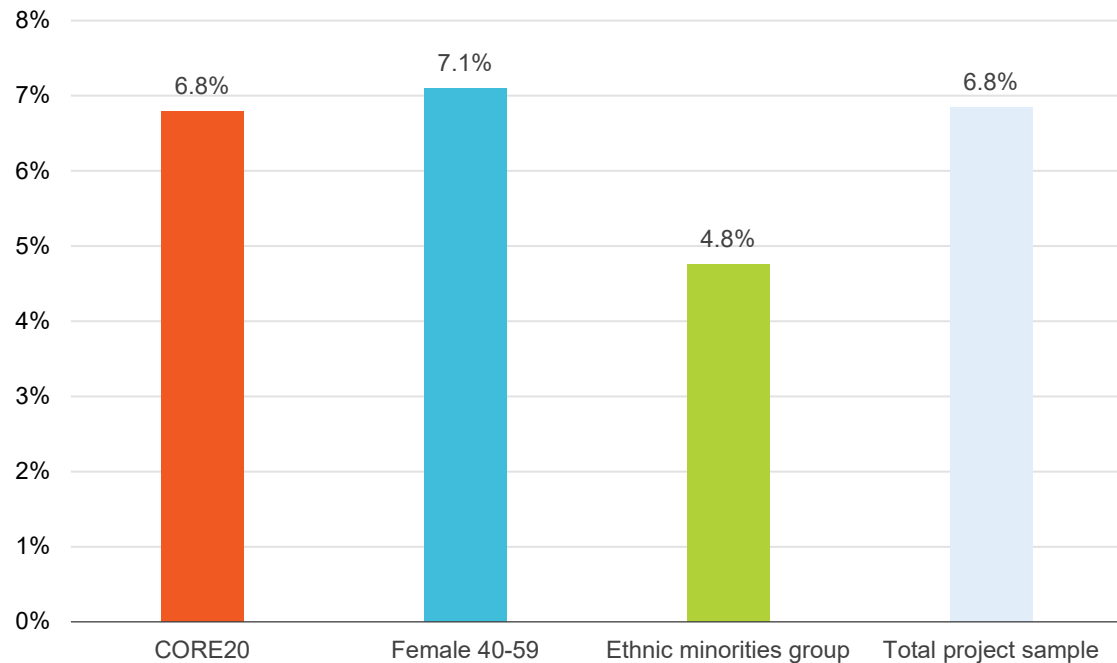


Figure 5: Project sample gender split by practice level.

# Quantitative insights: Access

## Hypertension



Sample sizes with blood pressure results: Core20 = 648, Females 40-59 = 169, Ethnic minorities = 21, Total project sample: 833

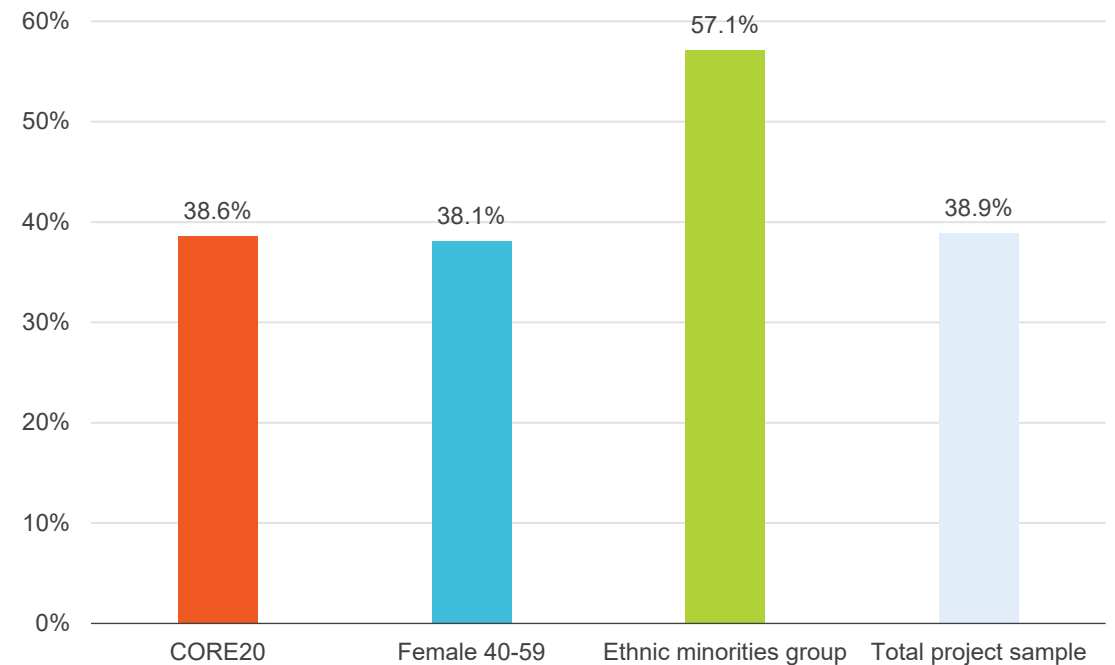
Figure 6: Proportion of each group identified as having stage 1 hypertension.

- High blood pressure places additional strain on the heart and blood vessels as they need to work harder to move blood around the body. As with cholesterol, early detection and management are the best measures to lower the risk of serious cardiovascular events. These findings (Figure 6) point to the identification of individuals with hypertension, who might otherwise have remained undetected.
- 833 of the 845 individuals among the total project sample had blood pressure results (98.6%). Of these, 6.8% ( $n=57$ ) were classed as having stage 1 hypertension blood pressure of  $>140/90$  mmHg).
- The ethnic minorities group had the lowest rate of hypertension at 4.8% ( $n=1$ ). Yet, it was difficult to draw conclusions on the ethnic minorities group due to the small sample size ( $n=21$ ).
- The females aged 40 to 59 years old group had the highest rate of hypertension at 7.1% ( $n=12$ ). The Core20 group had a similar rate of hypertension at 6.8% ( $n=44$ ).
- Due to the data having only one datapoint per patient, it was impossible to determine whether they were either previously or newly identified as having hypertension.

# Quantitative insights: Access

## Blood test appointment attendance

- There were 360 patients invited for a blood test among the total project sample. The majority were from the Core20 group ( $n=290$ ; 44.0%) followed by 63 (37.1%) that were among the females aged 40 to 59 years old group, and 7 (33.3%) that were from the ethnic minorities group (note: these percentages are percentages of the respective groups and not of those invited).
- There were 220 patients that attended and received a blood test appointment within the total project sample, 178 of these individuals were among the Core20 group (61.4%), 39 were females aged 40-59 (61.9%), and 3 were from the ethnic minorities group (42.9%).
- Figure 7 shows the percentage of each group that did **not** attend (DNA) their blood test appointment. Of the total project sample, 38.6% ( $n=112$ ) did not attend.
- Although a smaller sample size, the proportion of females aged 40 to 59 years old that didn't attend their appointment was similar to that of the Core20 group at 38.1% ( $n=24$ ).
- The ethnic minority group had the highest rate of DNA at 57.1% ( $n=4$ ); however, it's important to note that this percentage is skewed by the small sample size.



CORE20  $n=290$ , Female 40-59  $n=63$ , Ethnic minorities group  $n=7$ , Total project sample of available data  $n=360$

Figure 7: Percentage of the individuals identified as in need of a blood test that did not attend their appointment split by group.

# Quantitative insights: Case finding

## Cholesterol thresholds

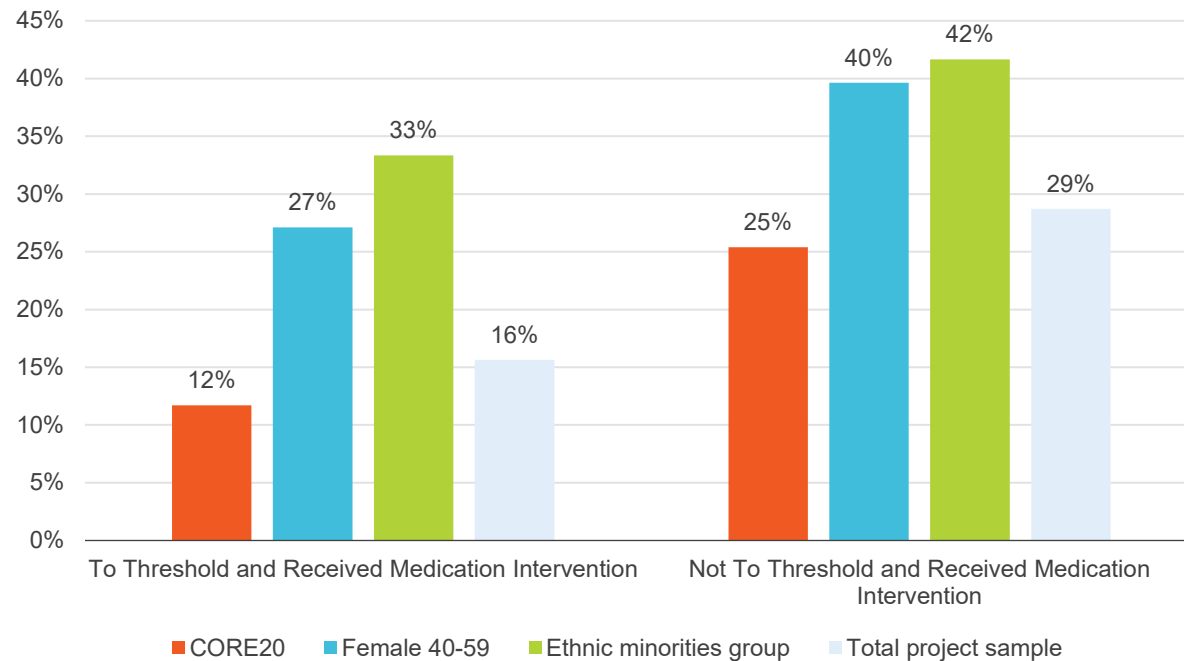
Table 1: Number of patients within each group and the total project sample that were either TTT or NTT.  
\* Numbers may not sum due to potential double counting across these groups (e.g., Core20 and Ethnic minority groups)

Group	Number of individuals treated to threshold (TTT)	Number of cases identified not at threshold (NTT)	Total
Core20	222	437	659
Female 40-59	59	111	170
Ethnic minorities group	9	12	21
Total project sample	288	557	845

- Elevated cholesterol levels can lead to hardening and narrowing of arteries putting people at increased risk of cardiac events such as heart attack and stroke. The best preventative measures are early detection and management of the condition. These findings highlight identification of individuals with Non-HDL and LDL cholesterol that was treated to threshold or not. Table 1 shows a summary of those TTT and NTT among each group.
- As a result of the programme's case finding, 557 individuals amongst the total project sample were identified as NTT and in need of intervention, either as part of historic blood test results or blood test results undertaken throughout the programme period.
- For the total project sample of 845 participants, a total of 288 (34.1%) individuals were treated to threshold in their most recent blood test.
- When examining the respective groups, the majority of these individuals belonged to the Core20 group ( $n=222$ ; 33.7%). The proportion of Females aged 40-59 had a similar proportion TTT at 34.7% ( $n=59$ ), whereas the ethnic minorities group had the highest proportion of patients TTT at 42.9% ( $n=9$ ) but it's important to note that they had the lowest sample size amongst each group at 21 individuals.

# Quantitative insights: Impact

## Medication intervention received



Sample sizes : Core20 = 137, Females 40-59 = 60, Ethnic minorities = 8, Total project sample: 205

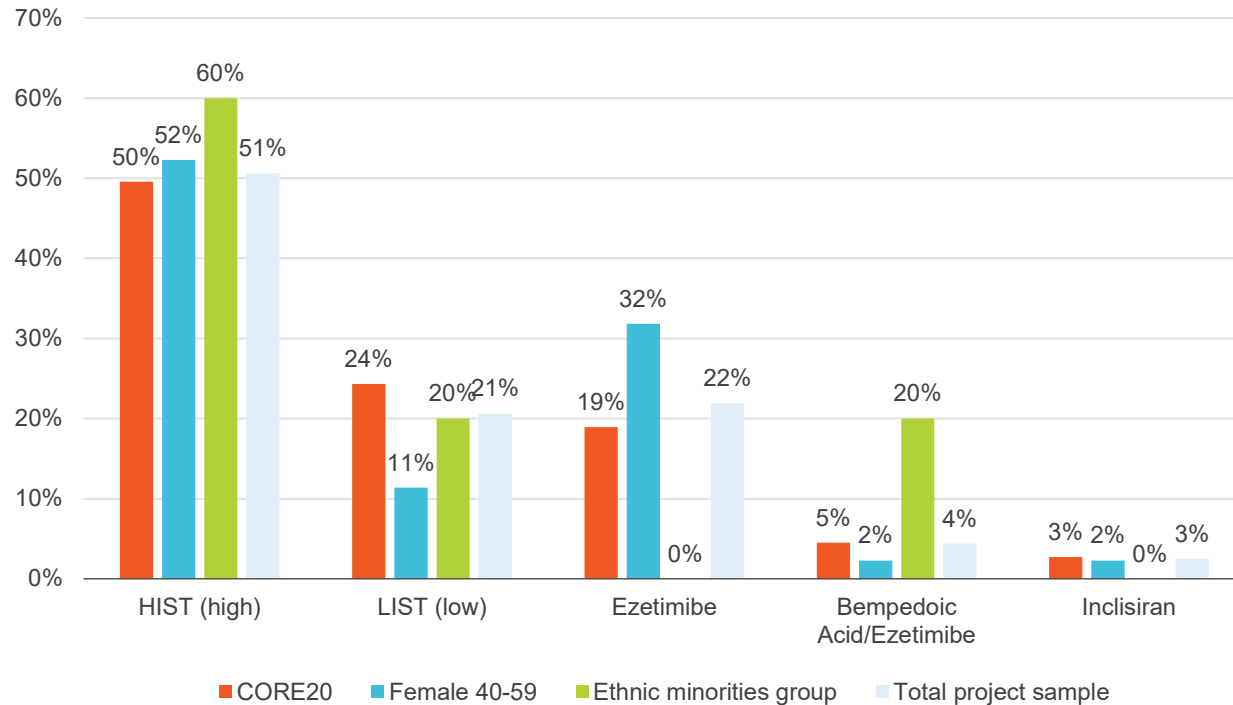
Figure 8: Percentage of patients that received a medication intervention based on whether they were TTT or NTT, split by group and total project sample. Note: this does not include missing data and individuals that required 'no action'.

- Figure 8 shows the proportion of patients that received a medication intervention. For the total project sample of 845 participants a total of 205 individuals received a medication intervention. Of those, 16% ( $n=45$ ) and 29% ( $n=160$ ) received a medication intervention for patients TTT and NTT, respectively.
- The percentage of patients receiving a medication intervention was highest amongst the ethnic minorities group, at 33% ( $n=3$ ) and 42% ( $n=5$ ) for to threshold and not to threshold, respectively. Although, this group had the smallest sample size at 21 individuals.
- Among the 170 females aged 40 to 59 years old, 27% ( $n=16$ ) were TTT and received a medication intervention, and 40% ( $n=44$ ) were NTT and received a medication intervention.
- Although the Core20 patients had the lowest proportion of individuals receiving a medication intervention for both the TTT and NTT groups, at 12% and 25%, respectively, they had the highest number of patients at 26 and 111.
- It is important to note that due to each individual having only one data point, it was impossible to determine whether the patient had been treated to target because of the programme. Yet, they have benefited as they received a medication review or change.



# Quantitative insights: Impact

## NTT medication intervention type



Sample sizes NTT receiving medication: Core20 = 111, Females 40-59 = 44, Ethnic minorities = 5, Total project sample: 160

Figure 9: Proportion of prescriptions given for each medication, broken down by group.

- For the total NTT sample group ( $n=557$ ), there were 160 patients (29%) that received a medication intervention (Figure 9).
- For the total project sample, HIST (51%;  $n=81$ ) and Ezetimibe (22%;  $n=35$ ) were the most prescribed lipid lowering therapies, closely followed by LIST (21%;  $n=33$ ).
- Although the Core20 group had the lowest proportion of HIST prescription intervention at 50%, they had the largest sample size, thus had the highest true prescription figure at 55 out of 111 total individuals from this group that received a medication intervention and were NTT.
- The ethnic minorities group had the lowest sample size of 5 individuals receiving medication intervention that were NTT. So, although they had the highest HIST prescription percentage of all the groups at 60%, this was from 3 individuals.
- Of the NRTs, there were a total of 11 prescriptions, all of which were for individuals NTT, with 7 for Bempedoic acid and 4 for Inclisiran. All groups had at least one individual that received an Inclisiran prescription.

# Quantitative insights: Impact

## Treated to target during project period

- An additional dataset was received from the project team that provided aggregated patient numbers for those treated to threshold in the baseline period and after the project had concluded. Across the project duration, 143 patients reached threshold (TTT), 343 had cholesterol data updates, and 217 were classified as not to threshold (NTT) needing lipid-lowering therapy. It should be noted that the identification of TTT patients during the project was not solely attributable to the project activities.
- Within the Core20 cohort, 105 patients were newly classified as TTT, 267 received cholesterol updates, and 180 were recognised as NTT. Among the females aged 40-59 and ethnic minorities groups, 38 were identified as TTT, 76 had their cholesterol levels updated, and 37 were categorised as NTT.
- For context, CVDPREVENT data showed that within the period of September 2022 to March 2023, there was a decrease of 15 patients that were treated to threshold within Margate PCN (which covers 4 of the 5 practices involved in the Kent and Medway InHIP programme). Comparing this with the increase of 133 patients that were treated to threshold in the following years programme period of September 2023 - March 2024 within the same PCN, it clearly demonstrates the improvement that accompanied the work involved in the InHIP programme.

Table 2: Change in number of patients that were among each cholesterol grouping between baseline and when the project had concluded, broken down by health inequalities group.

Cholesterol groupings	Change in the number of patients identified as TTT in fiscal year	Change in the number of patients that have updated cholesterol results within fiscal year	Change in the number of patients identified as NTT within fiscal year
Total project sample	<b>+143</b>	<b>+343</b>	<b>+217</b>
Core20	<b>+105</b>	<b>+267</b>	<b>+180</b>
Females aged 40-59 and ethnic minorities	<b>+38</b>	<b>+76</b>	<b>+37</b>

# Quantitative insights: Impact

## Impact summary

The table below shows a summary of impact as a result of the project.

Table 3: Impact summary breakdown by demographics

Group	Cases reviewed	Blood test attendance	Treated to threshold (TTT)	Additional patients TTT through the project period	Uptake of lipid lowering therapies (inc. NRTs)	Uptake of NICE recommended therapies (NRTs)*
Total project sample**	845	220	288	143	205	11
Female 40-59	170	39	59	38	60	2
Ethnic minorities	21	3	9		8	1
Core20	659	178	222	105	137	8

\* NICE recommended therapies are Inclisiran and Bempedoic acid with Ezetimibe

\*\* Total project sample figures will not be equal to the sum of the three Core20PLUS groups due to potential double counting across these groups

Note: the 'Additional patients TTT through the project period' were calculated from an aggregated dataset that had the ethnic minorities group and females 40-59 group combined.

# Qualitative insights

## Findings

The thematic analysis of the interview responses (four participants) provided a comprehensive overview and deep dive into the delivery of the InHIP project. Three overarching themes were identified, formed of nine sub-themes, defined below:

- **Infrastructure:** Participant perceptions on the project structure and interaction with other parts of the healthcare system.
  - **Data:** Anything data or measurement-related.
  - **Project:** Anything relating to activity locally or nationally.
  - **System:** Comments around national links or partnership working.
- **People:** Participant experiences on how the project related to people in the targeted communities, wider stakeholders, and associated conversations.
  - **Relationships:** Building trust with delivery people and communities.
  - **Dialogue:** Communication and conversations.
  - **Lived experience:** Anything relating to patients and communities.
- **Planning:** Participant's thoughts on how they would build on the existing project if they had the opportunity to be part of a similar project in the future, and the resources that would support delivery.
  - **Next steps:** Where they want to build on or improve.
  - **Resources:** Roles, reallocating work or redistributing professional boundaries.

# Qualitative insights

## Infrastructure: Data

The theme of infrastructure consisted of participants thoughts and views on the project structure and how the project interacted with other parts of the healthcare system. It was formed from the sub-themes of data, project and system.

### Data

The sub-theme of data was a result of anything data or measurement-related raised by participants. There are important points for consideration under this sub-theme, such as integration of data sets, the challenges in understanding the make-up of local populations and how individual organisations can have barriers to entering and sharing data.

Using data not only to define targeted groups, but also to drive conversations with partners to mobilise delivery was a key theme during the interviews:

*“Use the data...helps with the conversations, really target it to a certain group of people... help to bring people on board”*

*“We were a bit disappointed to hear that we were you know nationally near the bottom when it comes to...cholesterol control for...these groups. And so, we've...improved it. Obviously, it's a process...it's still going on, but we've...been able to make a real difference in terms of you know...cardiovascular prevention for these patients”*

The continued use of data to reflect on the success of the project was referenced, and how using data to define populations and minimise gaps had been a key learning for those involved:

*“We would kind of need to identify, is there a theme? Is there certain ethnic minority communities perhaps that aren't coming forward?”*

*“Success of actual engagement with that group of patients that have been specifically, proactively identified as people that need to kind of might need some help with their medication optimisation”*

# Qualitative insights

## Infrastructure: Project

These sub-themes were formed from participants referencing anything relating to activity locally or nationally. Findings included the speed of delivery due to existing relationships, the additional steps required to enable people to access the service, and learnings along the way.

The project was acknowledged to be time intensive, which may affect the scalability of the current model. Participants proposed to instead focus on how to use the project as an opportunity to become more effective and streamlined, to ensure the work can continue beyond the InHIP funds:

*"I don't think that's really sustainable as we've got a lot of patients on these registers and the amount of time that...we've spent on them. I don't think can be replicated in more widely. And so, it's just a case of can we change the way that...we work, make it more streamlined, make it more time effective and obviously more effective clinically as well."*

The importance of understanding wider work in the same clinical area across the Kent and Medway ICB footprint and the InHIP national programme was attributed to being helpful to securing engagement and providing reassurance, as well as having an invested PCN to support with scaling delivery:

*"We've had regular project meetings up until recently, I think that's also been helpful with the engagement of the team. For example, we've had colleague(s) from the ICB joining us and giving us some really good information again, Kent and Medway wide, rather than just this project."*

*"Listening to the webinars ...really interesting to hear that we're not alone with the problems. It's general."*

*"We've got a PCN on board, they've really embraced it. They have. They started off with 1 GP practice, and now that's rolled out to three more GP practices which is great."*

# Qualitative insights

## Infrastructure: System

The sub-theme of the system originated from participant comments around national links or partnership working within the existing healthcare system. Concerns about the wider system pressures featured heavily and, although not possible to be changed during the project, had considerable impact on patient outcomes.

The implications of delivery to the wider system pressures primary care experience were discussed by several participants as a risk that required mitigating during the early stages of the project. Suggestions as to how to overcome this included allowing enough time for partners to come on board, as well as allocating funds for initial set up:

*“Getting the PCNs on board we just have to take it very carefully...very mindful of the pressures that are in the system already.”*

*“Learning around capacity of providers to help with taking these types of innovative projects forward, really important that we start thinking about doing things differently...(the) reality (is)...very different in terms of allowing enough time (to)...bring those partners on board...(and) understanding their needs...do they need any sort of financial support to help them with set up or things like that”*

# Qualitative insights

## Infrastructure: Conclusion

Overall, the theme of infrastructure provided useful information reflecting the current state of the InHIP project, the support and challenges its delivery has encountered, and the opportunities for improvement for the future. The importance of mitigating system pressures where possible and supporting scaling in a manageable way were paramount to the project's success. The use of data to define groups and ask questions of the project was helpful to bring partners on board and minimise scope creep.



# Qualitative insights

## People: Dialogue

This theme was defined as participants thoughts and views on how the project related to people in the targeted communities, wider stakeholders, and the associated conversations that participants had with other staff or people from the communities. The theme of people was formed from the sub-themes of dialogue, relationships and lived experience.

### Dialogue

The sub-theme of dialogue was characterised by participants comments relating to the challenges of engaging with the targeted populations, and how traditional communication methods may not be appropriate when conducting targeted pieces of work. The findings show participants are keen to work with wider stakeholders who have strong existing relationships with communities to tailor approaches to promote engagement.

Tailoring communication methods for specific populations was discussed, along with additional support to secure engagement. Despite this, there was recognition the system should not assume what is most appropriate, and instead ask communities directly:

*“People that are classified within the Core20PLUS5 would possibly need an additional layer of support, communication and engagement to come forward because sending a text message asking somebody to potentially come and have a new blood test might not hit it for that population”*

*“It gives us a chance as part of that engagement piece that we’re going out in an outreach capacity. It gives us an opportunity to ask those populations questions about you know, what’s the best ways for us to engage with you guys.”*

*“We don’t have all of those answers at the moment. We don’t really know what’s the best way to engage with certain communities, but what we can do is work with our partners that do have access and are experienced of working with those communities.”*

# Qualitative insights

## People: Dialogue

The challenges of patients receiving disappointing news, or not receiving any follow up communication from healthcare settings, was suggested to have a wider impact on their adherence to treatment, which could be directly influenced by clinicians:

*“Our way of kind of reporting back what the impact has been to individuals, good, bad and ugly really, I think it's important. It's not always positive for people and I think it's important that we understand.”*

*“We've also looked at how we sort of reinforce behaviours as well. So, you know, if someone comes in for a blood test and it's been good... that's been well received as well.”*

Additional time during the screening appointments and the ability to receive external validation from clinicians was attributed to have supported patients not only to engage with the service, but feel involved with their care:

*“A real impact on certain patients...they're appreciating to have that time to go through their medication and have that time to talk it through.”*

*“Hopefully they'll find that the whole process is a bit more validating really and enjoyable...they're able to communicate with us and we're communicating with them... we're working a bit more closely with them rather than sort of remotely and we get in their side of the agenda as well. And...they're able to express themselves and get that validation as well.”*

# Qualitative insights

## People: Relationships

This theme linked to a sense of building trust with delivery people and communities, as well as members of the targeted groups. Participants discussed collaborative working, particularly around venues, as an enabler for project delivery, but cautioned about the realities of not individual's circumstances.

Consideration on how to work in partnerships with other stakeholders engaging with the same communities was proposed as a way to tailor outreach work during the remainder of the project:

*“Look to identify what outreach activities are going on in the next couple of months and is there an opportunity for us to kind of work in partnership”*

The importance of building trust and relationships with potential colleagues and the communities was discussed, with the potential to support raising awareness of the work and subsequent engagement:

*“It could just be something softer just to get to know someone, build rapport, whether it you know with with a clinician or just someone from the surgery to say that you know this is available or this is how to contact us.”*

Despite this, participants were conscious that timing is important for people to be able to prioritise their health, and personal circumstances may mean individuals choose not to engage:

*“But equally, we need to be understanding of their circumstances and sometimes these sorts of things just isn't something that they can really concentrate on at that point. But it's important that they know where to go when it is the right time for them as well”*

# Qualitative insights

## People: Lived experience

The sub-theme of lived experience consisted of participants relaying information relating to patients and the wider community. Participants placed significance on ensuring people do not feel scrutinised by health services, and clinicians considering the wider barriers that may impact someone accessing the service.

Several participants discussed other projects that are currently in train for the same or similar groups of people, and the impact this may have on individuals:

*“They're not being approached...for multiple different projects at different times. It's confusing to patients...might make them feel a little bit under...the radar and you might get a bit concerned if you're constantly being asked about things.”*

Whilst barriers to engaging with healthcare service were considered during the interviews, there was also discussion around once care is received and trust developed, the same goals are shared:

*“They're not against having these things done or talking about these things...maybe our appointment system is a bit daunting or waiting time for telephones is bit too long...patients were generally very interested in getting there, in achieving these goals as well.”*

*“Many reasons why that might have the wrong...might not have data on their phone, English might not be their first language and unfortunately sometimes you know people have really chaotic lives and it's not necessarily their priority to go and get a blood test done because there's other things that are going on for them, particularly at the moment with the cost of living”*

*“Once you're able to speak to patients, they generally have the same sort of goals as what you do. They want you know the best for themselves. Most of the time, and it's just creating that rapport with patients. That's the first step and quite often it's that that's the issue with trying to help these the groups of patients.”*

# Qualitative insights

## People: Conclusion

Overall, this theme provided powerful information about the importance of meeting members of the community at their level and working in partnership with multiple stakeholders who were not part of the traditional healthcare model. Participants placed significance on longer appointments, allowing for a meaningful conversation that enabled true advocacy. Collaboration with stakeholders on venues was proposed to streamline projects focused on similar areas. There was suggestion that this would help to mitigate people feeling overwhelmed and realise that their thoughts were of equal importance, rather than healthcare providers driving their own priorities.

# Qualitative insights

## Planning: Next steps

This theme captures participants thoughts and views on how they would build on the existing project if they had the opportunity to be part of a similar project in the future, and the resources that would support delivery. The planning theme consisted of the sub-themes of next steps and resources.

### Next steps

The sub-theme of next steps is characterised by where participants felt the project could be improved or built on. The findings show there are opportunities to amend the delivery model to support engagement, streamline existing projects and share the experiences of working in a new way.

As the interviews were held halfway through active delivery, there was significant discussion regarding how to implement outreach work and maximise the time people were engaging with the service:

*“Next stage of the project is to plan out what our outreach activity could be, and which potential communities or demographic area do we need to target and understand have we got any outreach activity going on there so that we can maybe get out and work with those people.”*

*“Any outreach events to to sort of encompass a lot more you know, it's not just about cholesterol if we're talking about cardiovascular disease on its own. We can be talking about blood pressure and diabetes and so on...especially with immunisations, we find that's another issue that we're... struggling with...with certain patient groups.”*

# Qualitative insights

## Planning: Next steps

Several participants referred to the learnings that had already come from the project, and how their own assumptions were being challenged to on how to demonstrate change:

*“When we don't hear from patients, we kind of assume that's not on their agenda...but for the majority of them I'll find it's something they want to work towards as well. we're learning a lot and I think there's always room for improvement. So, if we if we try something and it doesn't quite work right, then what have we done about it.”*

Sharing the learnings from the Third Sector and the project with the wider system was agreed to be a priority, not only to highlight the importance of patient education, but also to work collectively to improve health inequalities:

*“Learned a lot from the EK360 feedback which we can kind of hopefully help influence primary care in terms of the ways in which they approach their groups of patients and their can't really underestimate the education piece”*

*“There's work to be done across the HCP and links into the ICB...come together to address inequalities in terms of geographical patch.”*

# Qualitative insights

## Planning: Resources

The sub-theme of resources was defined as roles, reallocating work, or redistributing professional boundaries. The findings suggest there were considerations for the wider system when assigning roles to support delivery, and how to engage with communities. Despite this, available budgets could be a limiting factor.

*“(In an) ideal world, be even (more) brilliant if we could actually get the clinicians out, but I'm not sure whether that is going to be possible. But let's have a look and see because it would be great if we could do the blood test there and then, for example, and then we don't have to kind of revisit or expect the person to kind of proactively go”*

*“A big turnover in terms of those patients and we want to sort of reach out as soon as possible, as soon as they come to the area really, and try and whilst they're here to try and have a positive influence on them”*

The wider multi-disciplinary team and the creation of new roles were felt to have been a success during the project, with acknowledgement that the early stages of the project can involve more administrative work that could be challenging for primary care to fund alone:

*“Set up costs would be really good (to cover) because there's a lot of administration that's involved in it and you've also got your leads, I mean what's worked really well in our area has been the pharmacy lead which is (an) ARRS role which I think is a real positive for primary care.”*

*“Highlighted the importance of those community pharmacists... (the) health professionals that are in the wider system.”*



# Qualitative insights

## Planning: Conclusion

Overall, the theme of planning highlights important points for future project design and delivery. There are aspects of planning that would support project delivery, such as the use of redesigned roles in the workforce, supported by collaborating with the Third Sector to develop a bespoke outreach offering. Despite this, impacts on budgets and the complexities of reducing health inequalities across the system could pose a potential barrier to long term sustainability.

# Summary

## Staff survey findings

Three delivery team members responded to a staff survey via a Survey Monkey link in May 2024. This identified the following:



### What are the main learnings for you from this project?

The importance of pharmacy leadership was heralded as the main reason behind the overall project success. Emphasis on funding wider resources to support the initial administration costs not only helped minimise a knock-on effect to clinical delivery, but also resulted in sustainable change.

Open, informative, and flexible communication approaches, and ensuring patients can reply, helped with the success of patient attending appointments.



### What has this project taught you about tackling health inequalities?

Respondents highlighted the importance of trying different communication methods with individuals, and that personalisation is key. Additionally, demonstrating the evidence behind a successful initiative is essential to bring other stakeholders on board.



### Would you encourage other areas to adopt a similar project?

All respondents said yes.

### Are you considering other health inequalities projects for 2024/2025?

All respondents said yes.

# Benefit forecasting insights

## Actual scenario

The benefit forecast analysis shows that if the Kent and Medway InHIP project escalated a further 143 patients for lipid management, the project would save **£8,181**.

### Lipid management



# Benefit forecasting model insights

## Actual scenario

Table 4: Monetary savings after 5 years per benefit stream if 143 additional patients were escalated for lipid management.

Benefit stream	Number of people treated to threshold	* Event risk reduction *	Event unit costs (£ total)	= Total 5-year Savings (£)
Stroke	143	0.09%	£23,778	£3,178
Myocardial infarction		0.13%	£9,571	£1,826
Coronary revascularisation		0.13%	£8,555	£1,644
Non coronary revascularisation		0.08%	£9,263	£1,062
Unstable angina		0.05%	£3,523	£255
Transient ischaemic attack		0.05%	£2,961	£216
			<b>Total</b>	<b>£8,181</b>

# Benefit forecasting model insights

## Actual scenario

Figure 10 shows the monetary savings after 5 years from lipid management, totalling £8,181.

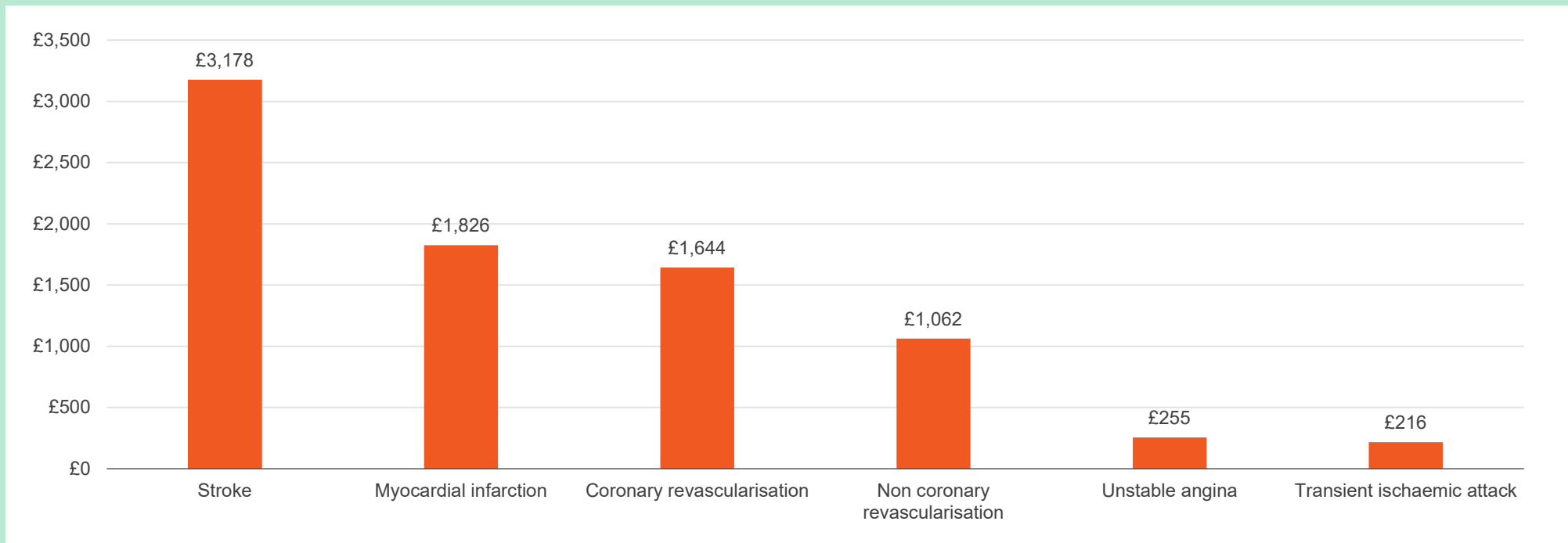


Figure 10: Monetary savings after 5 years if 143 additional patients are escalated for lipid management

# Benefit forecasting model insights

## Expansion scenario

The Benefit forecast analysis shows a total 5-year estimated saving from reducing adverse events, such as stroke, as a result of increased escalation to lipid management, to be **£154,274**.

### Lipid management

Total 5-year saving



# Benefit forecasting model insights

## Expansion scenario: 25% spread in Kent and Medway

Table 5: Forecasted monetary savings from escalation to lipid management after 5 years if the project is extended to a wider ICB geography implementation

Benefit stream	Number of people treated to threshold	* Event risk reduction *	Event unit costs (£ total)	= Total 5-year Savings (£)
Stroke	2,709	0.03%	£23,778	£59,924
Myocardial Infarction		0.02%	£9,571	£34,438
Unstable angina		0.01%	£8,555	£31,009
Heart failure		0.01%	£9,263	£20,032
Stable angina		0.04%	£3,523	£4,803
Transient Ischaemic Attack		0.01%	£2,961	£4,069
			<b>Total</b>	<b>£154,274</b>

# Benefit forecasting model insights

## Expansion scenario

Figure 11 shows the forecasted monetary savings after 5 years from lipid management if the project is extended to a wider ICB geography implementation. The estimated benefit from lipids management is £154,274.

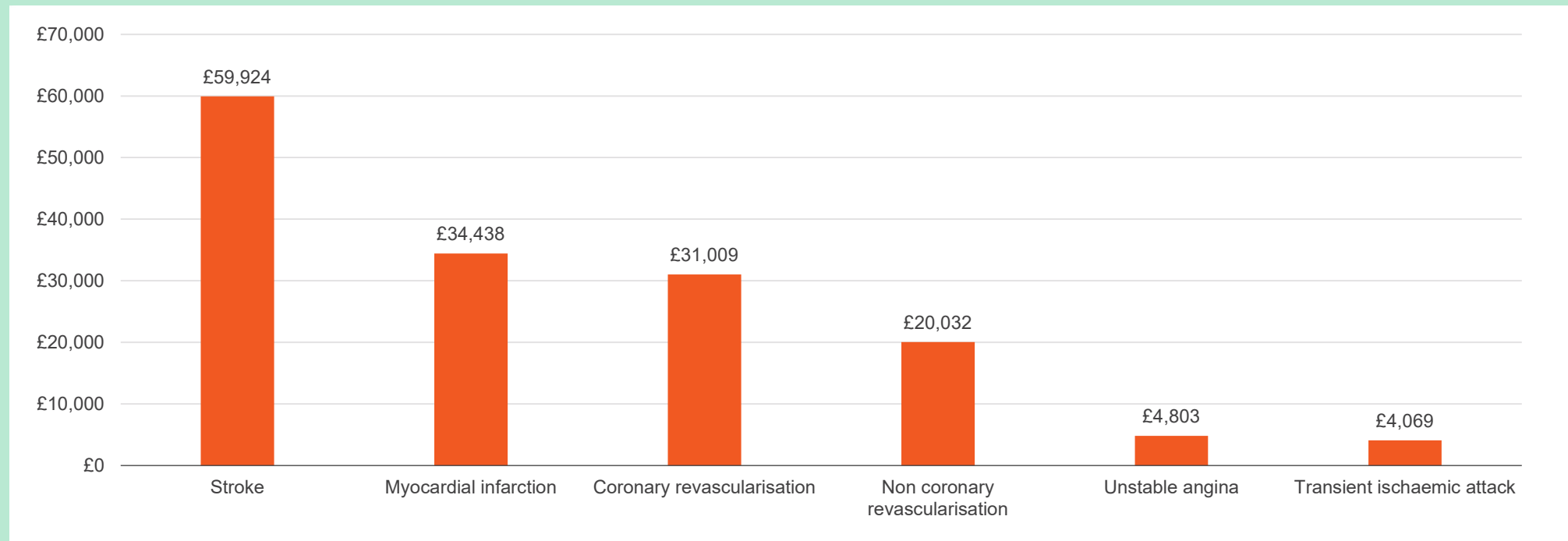


Figure 11: Forecasted monetary savings after 5 years from lipid management if the project is extended to a wider ICB geography implementation.





# Summary of findings



# Summary of findings

## How effective has the project been at reaching under-served groups (Core20PLUS)?

Every individual who was reviewed ( $n=845$ ) and who benefited as part of the project were from the Core20PLUS population. Of these, 220 individuals attended and received a blood test appointment, and 24% ( $n=205$ ) of the total sample received a medication intervention.



Of the total project sample ( $n=845$ ), Core20 individuals comprised 78% ( $n=659$ ), Females aged between 40 to 59 years old made up 20% ( $n=170$ ), and ethnic minority groups made up 2.5% ( $n=21$ ).



The proportion of service users identifying as part of an ethnic minority group in the intervention data is smaller than that of CVD patients in Kent and Medway ICB as a whole, however, due to limitations of the data collection, it is likely that this group is underrepresented in the data.



For the total project sample, 288 (34%) individuals were treated to threshold in their most recent blood test. When examining the respective groups, the majority of these individuals belonged to the Core20 group ( $n=222$ ; 34%). The proportion of Females aged 40-59 had a similar proportion TTT at 35% ( $n=59$ ), whereas the ethnic minorities group had the highest proportion of patients TTT at 43% ( $n=9$ ) but it's important to note that they had the lowest sample size amongst each group at 21 individuals

# Summary of findings

## What effect has the project had on outputs or outcomes across target groups?

As a result of the programme case finding, 557 individuals amongst the total project sample were identified as not to threshold and in need of intervention, and 205 of the total sample received a medication intervention. Importantly, 160 individuals from the pre-defined Core20PLUS health inequality groups that were not to threshold were identified and escalated for lipid lowering therapy. Further, within the study period there was an increase of 143 individuals who were treated to target within the practices involved. These service users may have been delayed in being identified and receiving an intervention if not for the project.



For the total project sample of 845 participants, a total of 288 (34%) individuals were treated to threshold in their most recent blood test. As a result of the programme case finding, 557 individuals amongst the total project sample were identified as not treated to threshold and in need of intervention, either as part of historic blood test results or blood test results undertaken throughout the programme period.



During the project, 205 individuals received a medication intervention. Findings revealed 160 patients who were NTT prior to the project received a medication intervention. A further 45 who were already TTT had their medicines adjusted.



HIST (51%;  $n=81$ ) and Ezetimibe (22%;  $n=35$ ) were the most prescribed lipid lowering therapies for the total project sample, closely followed by LIST (21%;  $n=33$ ). Of the NRTs, there were a total of 11 prescriptions, all of which were for individuals NTT, with 7 for Bempedoic acid with Ezetimibe and 4 for Inclisiran. All groups had at least one individual that received an Inclisiran prescription.

# Summary of findings

## What has been the monetary impact of the InHIP programme?

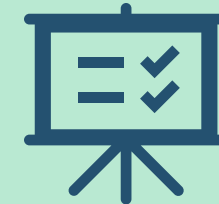
The results from the benefit forecast model encompass the broader scope and vision of the InHIP programme concerning lipid-lowering therapies across Core20 groups. They indicate a potential health and social care benefit of £154k over a 5-year period within the Kent and Medway ICB region.



The project's measurable and monetisable benefits illustrate its financial impact, though the broader implications are likely even more substantial. These non-monetised benefits encompass factors like enhanced quality of life and ongoing advantages extending beyond a five-year timeframe. The project's full impact is anticipated to unfold over decades rather than years.



The magnitude of the monetisable benefits, coupled with the projected scale of the non-monetisable gains, supports the rationale for ongoing investment and project expansion. Leveraging insights gained from current implementation is crucial for future scalability.



While the analysis does not currently include project costs, it is advisable to conduct a thorough cost review and implement cost-minimisation strategies before embarking on broader implementation. This approach ensures a positive return on investment.

# Summary of findings

## Is the approach a feasible option for future initiatives?

Interviews highlighted the support and challenges that the evolving InHIP project faced, the importance of longer appointments, and exploring different methods of communications to secure engagement and adherence to treatment. Despite this, concerns were raised on longer term sustainability, as the impacts on budgets and the complexities of reducing health inequalities across the system were apparent with wider system pressures and ongoing changes.



The evolving InHIP project challenges were noted to have been compounded by system pressures that, whilst outside of the immediate project control, should be mitigated where possible and was a key learning for team members. The use of data not only defined the eligible group within the target populations, but also brought wider partners on board. This is crucial and if this achieved, delivery is likely to be largely successful.



Participants expressed their pleasure in realising people want to engage with health education and look after themselves. This is validating to team members as they are delivering care in a new model, and therefore, would benefit from further confirmation by other data sources to provide a demonstrable link to patient outcomes.



Exploration into alternative venues and linking in with wider stakeholders to raise awareness of the service and engender trust in the communities was an important consideration for the project scaling. Further support could also be provided by a wider communications piece across the local area.



The significance of using ARRS roles to redesign service delivery and the workforce were discussed. Meaningful engagement can also be expedited by collaborating with the Third Sector and community leaders to develop a bespoke outreach offering. This is of significance, as despite being a new way of working, has seen positive result relatively quickly.



# Conclusion



# Conclusion

## 1. How effective has the project been at reaching under-served groups (Core20PLUS5)?

- Every individual who was reviewed ( $n=845$ ) and who benefited as part of the project were from Core20PLUS. Of these, 220 individuals attended and received a blood test appointment, and 24% ( $n=205$ ) of the total sample received a medication intervention. Core20 individuals made up most of the sample (78%;  $n=659$ ). While those from an ethnic minority group only made up 3% ( $n=21$ ) of the sample, this is likely to be higher due to the way data was captured.

## 2. What effect has the project had on outputs or outcomes across the target groups?

- As a result of the programme case finding, 557 individuals amongst the total project sample were identified as not to threshold and in need of intervention, and 205 of the total sample received a medication intervention within the study period. Ultimately, the project successfully reached 160 individuals from the pre-defined Core20PLUS health inequality groups that were not to threshold and escalated them to appropriate lipid lowering therapy. Moreover, within the study period there was an increase of 143 individuals who were treated to target within the practices involved. If not for this project, these service users may have been delayed in being identified and receiving an appropriate intervention.

## 3. What has been the monetary impact of the InHIP programme?

- The Benefit forecast model indicates a potential £154k benefit to health and social care in the Kent and Medway ICB region over 5 years, reflecting measurable and monetisable project benefits. However, the project's total impact is expected to surpass these figures. The combination of these monetisable benefits alongside anticipated non-monetisable gains underscores the business case for further project investment and scaling. It is important, though, to conduct a thorough cost review before proceeding with any expansion.

## 4. Is the approach a feasible option for future initiatives?

- Interviews highlighted the support and challenges that the evolving InHIP project has faced, the importance of longer appointments and exploring different methods of communications to secure engagement and adherence to treatment. Despite this, concerns were raised on longer term sustainability, as the impacts on budgets and the complexities of reducing health inequalities across the system are apparent with wider system pressures and changes ongoing.



# References





# References

- CVDPREVENT, 2023. CVDPREVENT Data Extract [Website]. URL: <https://www.cvdprevent.nhs.uk/data-extract>
- <https://www.cvdprevent.nhs.uk/insights?period=10&level=7&area=8041&group=0>
- Miles, M.B. and Huberman, A.M. *Qualitative Data Analysis: A Sourcebook of New Methods*, Sage Publications, Newbury Park, CA, 1984.
- NICE NG238 Resource Impact Template (Lipids) NICE (2024)
- NICE. (2023). *Lipid modification—CVD prevention | Health topics A to Z | CKS | NICE*. <https://cks.nice.org.uk/topics/lipid-modification-cvd-prevention/>
- OpenPrescribing (University of Oxford, 2024)
- Ross, P.T., Bibler Zaidi, N.L. Limited by our limitations. *Perspective Medicine Education*. 2019 Aug;8(4):261-264. doi: 10.1007/s40037-019-00530-x. PMID: 31347033; PMCID: PMC6684501.
- Scenario: Lipid therapy - primary prevention of CVD | Management | Lipid modification - CVD prevention | CKS | NICE
- Smith, J., and Noble, H. *Bias in research*. Evidence Based Nursing 2014;17:2–3. doi:10.1136/eb-2014-101946
- GOV.UK. (2019). English indices of deprivation 2019. GOV.UK. <https://www.gov.uk/government/statistics/english-indices-of-deprivation-2019>
- ONS. (2021). Postcode resident and household estimates, England and Wales: Census 2021—Nomis—Official Census and Labour Market Statistics. [https://www.nomisweb.co.uk/sources/census\\_2021\\_pc](https://www.nomisweb.co.uk/sources/census_2021_pc)