Health Innovation Wessex

Hampshire and Isle of Wight Integrated Care System Innovation for Healthcare Inequalities Programme (InHIP) wave 2: Follow on independent evaluation

Lead Author:
Dr Rebecca Player

Date of Report:
December 2024

Part of the Health Innovation Network

Evaluation Team

Emily Hunter, Senior Programme Manager
Dr Amanda Lees, Evaluation Programme Manager
Dr Rebecca Player, Evaluation Programme Coordinator

Correspondence

Dr Rebecca Player, rebecca.player@hiwessex.net.
Health Innovation Wessex,
Innovation Centre, 2 Venture Road, Southampton Science Park, SO16 7NP.

Disclaimer

This report presents the findings of a small scale, independent evaluation of the Hampshire and Isle of Wight Integrated Care System Innovation for Healthcare Inequalities Programme (InHIP) wave 2, which followed on from a larger scale evaluation of wave 1 InHIP. Its primary objective was to gather insights and feedback from the participating PCNs, and it highlights reflections from both waves. The findings of this independent evaluation are those of the author and do not necessarily represent the views of Hampshire and Isle of Wight Integrated Care System (HIOW ICS). This report presents findings from a follow-on evaluation of InHIP wave 1 and as such we recommend reading this wave 2 evaluation alongside the wave 1 report[1].

Declaration of Interest Statement

Health Innovation Wessex (HIW) supports innovators to bring their innovations to the NHS as well as provide an evaluation service more broadly to our members and others. On occasion, we evaluate innovations that we have also supported. Whilst these evaluations are independent, for transparency we disclose our dual role where applicable. The HIW Innovation Adoption team supported the delivery of the programme for HIOW ICS, while the HIW Insight team conducted the evaluation.

Acknowledgements

We would like to thank all stakeholders and primary care networks (PCNs) for their participation in this evaluation.

The interviews and analysis were undertaken by Dr Rebecca Player.

[1] Insight library-InHIP

Health Innovation Wessex

Table of Contents

Executive Summary

Background

Hampshire and Isle of Wight Integrated Care System (HIOW ICS) identified hypertension (HTN) and atrial fibrillation (AF) as clinical priorities. Building on the first wave of the Innovation for Healthcare Inequalities Programme (InHIP), wave 2 aimed to improve cardiovascular disease (CVD) testing and diagnosis in PCNs serving socio-economically deprived communities. The programme's objective was to increase access to HTN and AF screening for individuals aged 45 and over who had not had their blood pressure checked in the past five years, aligning with NICE guidelines[2].

Evaluation design and methods

The evaluation focused on understanding from the perspective of staff involved, each PCN's implementation strategies, perceived impacts on under-served groups, and sustainability of blood pressure (BP) awareness and testing. Data was collected via key informant interviews and documentary analysis to examine approaches, challenges and outcomes to the each PCN's project, and the extent to which lessons from InHIP wave 1 were integrated into wave 2.

Key findings

1. Approaches to each PCN's project:

- Tailored strategies included community outreach and clinic-based testing to engage under-served groups.
- Use of data-driven methods, such as Quality Outcomes Framework (QOF) data and Accurx[3] invitations, to identify target cohorts.

2. Challenges:

- Difficulties persist in engaging people in the most deprived neighbourhoods due to socio-economic barriers.
- Limited feedback mechanisms to monitor and ensure patient follow-up.
- Staffing capacity during busy periods.

3. Outcomes:

- A total of 364 BP recordings across the PCNs demonstrate engagement with under-served populations while also uncovering previously undiagnosed health conditions (e.g. pre-diabetic, AF).
- Participants subjectively reported increased awareness of health risks and the importance of regular monitoring.
- Collaboration between healthcare and community organisations fostered trust and accessibility.

[2] Hypertension | Health topics A to Z | CKS | NICE
[3] Accurx | The simple way to communicate about patient care

4. Success stories:

- Bitterne PCN's whole-person approach with community events reportedly improved trust and participation among the public
- Isle of Wight's One Wight Health employed a targeted clinical approach to systematically and efficiently identify individuals.
- Island City PCN's systematic follow-ups and use of technology for text invitations enabled a personalised and targeted approach.

Lessons learnt

- Direct patient engagement through community settings or similar and personalised invitations, such as tailored messages, were crucial for encouraging participation.
- Establishing clear communication channels between clinicians and project organisers enhanced alignment and efficiency.
- Sustained buy-in from practices required early engagement and alignment with existing workflows.

Recommendations for sustainability

- Incorporate a proactive, continuous monitoring system of BP checks to address health issues early and consistently.
- Leverage technological solutions, such as direct messages to patients (e.g. Accurx) for scalable and efficient patient engagement.
- Support staff training to provide 'one-stop' care[4] and expand service accessibility through low-cost venues like libraries.

Conclusion

InHIP wave 2 was perceived by staff to have increased public engagement, recording a total of 364 BP readings and facilitated early identification of high BP (a total of 106 high BP readings) or other health risks in under-served groups at participating PCNs, laying a foundation for sustainable CVD prevention and management strategies. Continued focus on proactive care, collaboration, and innovative delivery models is needed for long-term, sustained impact.

[4] To provide multiple services in one appointment (e.g. BP recording and further blood tests)

1. Background

Hampshire and Isle of Wight Integrated Care System (HIOW ICS) identified hypertension (HTN) and atrial fibrillation (AF) as clinical priorities. The 2022/2023 Quality Outcomes Framework (QOF) data shows that HIOW have improved their screening and registration for HTN, decreasing their projected unidentified HTN population from 125,065 to 103,340. This remains, however, well below the national average[5].

Building from the wave 1 Innovation for Healthcare Inequalities Programme (InHIP) and the evaluation reported by Health Innovation Wessex in 2023/2024[6], the 2024/2025 InHIP programme[7] maintained a focus on providing HTN and AF clinical checks in primary care networks (PCNs) serving socio-economically deprived communities.

The InHIP wave 2 programme objective was to increase access to CVD services through outreach and engagement of local at-risk populations and to target those who are more socio-economically deprived and traditionally under-served. In line with the NICE guidelines[8], the programme sought to uncover unidentified health issues in asymptomatic patients by increasing awareness of HTN and delivering HTN check-ups in patients aged 45 and over who have not had their blood pressure checked in the last five years.

The activities were clinic or community led and were built on pre-existing outreach groups or existing clinics to co-deliver and collaborate between community, health, and social care. The more socio-economically deprived areas included in this programme were Isle of Wight (IOW) (One Wight Health GP practices and public health), Bitterne PCN in Southampton, and Island City PCN in Portsmouth. All three PCNs used data-driven approaches to identify their target cohort, dependent on their population needs.

library/141/independent-evaluation-of-hampshire-and-isle-of-wight-integrated-care-system-innovation-for-healthcare-inequalities-programme-inhip
HIOW Integrated Care Board (ICB) commissioned Health Innovation Wessex (HIW) Insight team to undertake this follow-on, small scale evaluation to understand how the wave 2 projects had built on InHIP Wave 1. As agreed with HIOW ICB, this evaluation was tight in scope (reflecting available resourcing). This short report sets out the evaluation objectives, methods, key findings from

[5] NHS digital Quality and Outcomes Framework. https://digital.nhs.uk/data-and-information/publications/statistical/quality-and-outcomes-framework-achievement-prevalence-and-exceptions-data/2022-23
[6] InHIP Hampshire and Isle of Wight Final Evaluation Report.pdf
[7] Programme refers to ICB level, project refers to local PCN level.
[8] Diagnosis | Diagnosis | Hypertension | CKS | NICE

data sources available to the evaluators, and lessons learnt. We recommend that it is read in conjunction with the wave 1 evaluation report.

2. Evaluation objectives, questions, and methods

The following section outlines the evaluation objectives, questions and methods that were developed at the start of the evaluation in collaboration with HIOW ICB.

2.1. Evaluation objectives

HIOW ICB wished to understand the following:

- Each PCN's project aims and objectives.
- Each PCN's project activities and the various steps involved in completing the project.
- The impact on under-served groups, as perceived by members of staff from participating PCNs.

2.2. Evaluation questions

The evaluation questions were as follows:

1. How has each PCN implemented projects to engage under-served groups to increase HTN and AF testing and awareness?
2. To what extent have these projects built on lessons learned from InHIP wave 1?
3. What was the experience of staff of working in a different way with under-served groups? What were the barriers and facilitators/pre-requisites?
4. In what ways, if any, have each PCN's projects affected under-served groups' understanding of HTN, AF and the need for testing?
5. What effects, if any, have the InHIP projects had on access (and equity of access) to CVD testing, HTN and AF diagnosis (and associated health-related outcomes)?
6. What steps can the PCN take to ensure the sustainability of BP testing and recording in usual practice?

2.3. Evaluation methods

Two methods were deployed to address the evaluation questions primarily drawing on interview data, alongside any pre-existing data provided by HIOW ICB. Insight selected the evaluation methodologies to reflect a) the resources available for evaluation, b) HIOW ICB's requirement to build on the findings

from InHIP phase 1 (reported in March 2024)[9]. Data was collated retrospectively.

2.3.1. Key informant interviews

HIW Insight team interviewed two individuals from each funded PCN (a total of six individuals). These short interviews (e.g. c. 30 to 45 minutes) involved individuals who were closely engaged in their projects, including clinical, operational, community, or strategic staff members. The purpose of the interviews was to gain detailed insights into each project's processes, approaches, barriers, challenges, and reflections. Information was gathered about each PCN's strategies for reaching their targeted cohort, approaches used to address health inequalities, and the perceived impact on participants' awareness of blood pressure testing and HTN.

- Rapid qualitative analysis (RQA) is a method to organise information systematically, accurately and efficiently to inform practice. RQA was used to manage and interpret the interview transcripts.

2.3.2. Documentary analysis from secondary data sources

Basic outcome measures for each PCN were provided by HIOW ICB and analysed. These outcome measures, alongside the interview findings, are presented in the following section.

3. Descriptions of each project

This section describes each PCN's project to provide insights into the approach taken, the targeted cohort, and the methods and levels of engagement. These descriptions were provided during the evaluation interviews and the project plans. Data provided by the PCNs from the events are included within each section as part of their description.

3.1. Bitterne PCN

Bitterne PCN delivered additional clinics and community-led events to maximise attendance and awareness of CVD testing. The PCN took a whole-person approach to identify individuals who did not have a blood pressure reading recorded in their patient record. The PCN aimed to encourage engagement from people who typically do not visit the GP surgery, particularly

[9] Independent Evaluation of Hampshire and Isle of Wight Integrated Care System Innovation for Healthcare Inequalities Programme (InHIP), Health Innovation Wessex Report Finder

those who are socially isolated. This was done by identifying patients through QOF and contacting them via text (using the Accurx system) or phone call.

Also, Bitterne PCN collaborated with a local church group with an open invitation that was advertised in church bulletins and the GP surgery to provide community BP testing for those underserved individuals. A social prescriber and healthcare professional attended the church's outreach group monthly to offer BP readings alongside conversations about any other needs like housing or food banks.

The two interview participants reported the collaboration between community and the PCN worked well for the events, with the community leaders reportedly keen to continue working with health and social care. The project has been ongoing for two years and the team plan to continue this approach until their next review.

Table 1 Bitterne PCN number of events, blood pressure check and atrial fibrillation identified

Description	Number
Number of clinics or community events	5
Total number of attendees	89
Total number of patients with high BP readings	24
Total number of patients with atrial fibrillation identified	*

*numbers between 1-7 are not reported as per NHS Digital suppression rules

3.2. Isle of Wight One Wight Health

The Isle of Wight One Wight Health took a clinic-based approach to their project. Prior to their project starting, they had numerous discussions about the best way forward and considered community approaches such as setting up a stand at a supermarket for BP checks. However, it was assumed and determined that this approach would likely attract individuals who regularly visit their GP practices, and who are already proactive about their health. Therefore, they decided to provide additional clinics for BP testing for the communities served by their three PCNs.

They employed a systematic approach to reach their targeted cohort. First, they reviewed data from all GP practices and QOF records to identify individuals needing BP checks. By noting each patient's age and postcode, they cross-referenced this information with the Index of Multiple Deprivation (IMD) to pinpoint the areas requiring focus. After filtering the data by age, they discovered a significant number of working-age individuals in more deprived areas who had not had their BP checked, particularly those 45-68 years old.

Their method of engagement involved sending out invitations via SMS to the targeted cohort of patients. This approach aimed to improve engagement by inviting patients to their familiar local practice, reducing potential anxiety. Appointments were scheduled at various times, including weekends and late afternoons or early evenings, to accommodate different schedules and increase accessibility. Patients received text message invitations through the Accurx system, enabling them to book appointments conveniently. This strategy aimed to ensure better attendance and engagement. The invitation process reportedly proved to be effective, with practices running the clinics using a standard QOF report. Their approach was consistency: standard clinics, standard locations, and standard workforce. This uniformity was established to ensure smooth and efficient operation of BP testing.

Overall, the PCN reported the project as positive, particularly emphasising the effectiveness of their approach in identifying and targeting patients.

Table 2 One Wight Health number of events, blood pressure check and atrial fibrillation identified

Description	Number
Number of clinics or community events	9
Total number of attendees	172
Total number of patients with high BP readings Total number of patients with really high BP readings	51 *
Total number of patients with atrial fibrillation identified	Not recorded

*numbers between 1-7 are not reported as per NHS Digital suppression rules
IOW identified high BP as over 140/90, really high BP as over 180/120.

3.3. Island City PCN

Island City PCN offered additional clinics at four main sites within their PCN to engage and provide CVD testing. The PCN took a clinic-based approach, meaning they provided the clinics at their practices. The focus was on inviting patients for blood pressure checks, specifically targeting those who had not had a BP check in the last five years. Reports from SystmOne were used to identify patients needing checks and based on birth month (aged 45 and over) to streamline the process. Invites via Accurx were primarily used to reach these patients, and these were generated two to three weeks in advance. Some practices did call some patients if there had been no response to encourage engagement. The additional clinics were held mid-week in the afternoon to accommodate staff availability.

The uptake varied across the sites, but the approach ensured that patients most in need of BP checks were identified and invited. For those with high BP, an appropriate follow-up was organised. It was found that when identifying hypertension, sending a patient home with a BP machine to self-monitor tended to eradicate white coat syndrome[10] and was reportedly proven useful. Additionally, extra-large BP cuffs were available for patients. The PCN had some difficulties retrieving all BP machines loaned to patients.

Overall, the PCN reported their project as a success, noting an increase in BP checks.

Table 3 Island City PCN number of events, blood pressure check and atrial fibrillation identified

Description	Number
Number of clinics or community events	4
Total number of attendees	103
Total number of patients with high BP readings	27
Total number of patients with atrial fibrillation identified	Not recorded

4. Reflections on findings

This section outlines what worked well and the areas for improvement identified across all projects, based on responses to specific questions posed during the interviews. It also examines relevant themes from InHIP wave 1, comparing them with the developments and progress achieved in wave 2 to understand what has been built upon from the first wave and where there are differences.

4.1. What worked well

Each PCN customised their approach to best suit their specific area and population needs. Some adopted a hybrid strategy, combining community outreach events with clinical appointments. This approach aimed to engage individuals who might not typically visit a GP practice, while also offering a 'one-stop shop' with clinical appointments for further testing and care if needed. Other PCNs opted for a direct clinical approach, which was time-efficient and fostered familiarity for both patients and staff. This method also proved to be efficient in terms of data entry and management. By tailoring

[10] White coat syndrome is a temporary rise in blood pressure caused by anxiety during medical visits.

their strategies, each PCN delivered a project that effectively addressed the unique needs of their communities and improved CVD testing rates:

- Tailored approaches for patient comfort and convenience: Each project adjusted their approach to suit different patient needs, whether by holding events in community settings or offering alternative times at GP surgeries. This flexibility made it easier for patients to access care and ensured a comfortable environment for engagement. As one participant explained,

  "I've learned that people are able to engage more than they feel that they are, and I have learned that actually the community involvement does make a big difference to people." (Participant 2).

  Offering clinics at varied times, such as weekends and late afternoons, also helped increase patient access:

  "We did kind of try to target a bit of a range of different times. So weekends as well as I think we did some late afternoon early evenings as well, just hoping to catch people possibly on their way home from work." (Participant 4).

- One-stop clinics for streamlined care: Some PCNs found success in combining multiple services, such as blood pressure checks and blood tests, during a single visit. This one-stop approach improved efficiency and patient care. As one participant shared,

  "On the Saturday clinics, we did like one-stop clinics where they had a clinician who could do the blood pressure, but we also had a healthcare assistant at the same time that could take their bloods and do the full workup at that actual one point." (Participant 1).

  Others expressed interest in providing similar services, such as same-day blood tests and ECG appointments, though logistical challenges sometimes arose:

  "If their blood pressure is really high, we get them into the next available slot." (Participant 6).

- Healthcare, social care, and community collaboration, a whole-person approach: Integrating healthcare professionals with social care workers during community events enhanced patient engagement, particularly with under-served groups. One participant noted,

  "We send our social prescriber and a clinician so we can then help anyone who needs assistance. It was a really good way of engaging...

they get to meet people on a one-to-one basis in a kind of safe environment." (Participant 1).

Additionally, collaborations with community organisations, such as local churches, were beneficial for building rapport with the public, with one vicar even requesting more frequent visits and future collaborations. A holistic approach addressing both physical and social needs was found to improve patient outcomes.

"We did adopt a whole-person's approach with physical and social needs... It just helps support the patient and it just led to a better outcome." (Participant 1).

This approach highlighted the potential to bridge gaps in health inequalities.

- Targeted digital communications and booking system in primary care: Tools like Accurx were used effectively with all projects to send messages to targeted patients with a reminder to get their BP checked. Messaging patients allowed for multiple appointment links, giving patients greater flexibility on booking their appointments but also helping operational efficiency. One participant noted,

  "It was great because patients can just book it at the time when they want to and it really did work... It relieves staff and improves operational efficiency." (Participant 4).

  One PCN took the initiative to prompt patients by calling them when deemed necessary. As one participant explained,

  "There were some people invited by telephone. So, if we spotted someone who might need a bit of encouragement, the reception team would phone a few people and get them booked in where we had spaces." (Participant 6)

- Data-driven approaches for targeted engagement: Using data, such as QOF data, helped identify the target cohort for engagement for all projects. One participant described the process,

  "We had a look at the data for all the practices and looking at the QOF data... so we knew where they were, in the right area, and the areas of deprivation." (Participant 3).

  "We looked at our QOF to see who was obviously due to have the invitation" (Participant 1).

Another PCN used their reports from SystmOne to identify appropriate patients,

> *"Mainly reports we have reports available on SystmOne. Yeah, that gives a readily available report of anyone who's not had a blood pressure check within the last five years."* (Participant 5)

- The implementation of structured protocols, or standard operating procedures (SOPs), played a necessary role in guiding the CVD pathway across all projects. These protocols ensured staff had clarity on procedures and patient follow-ups, as highlighted by one participant who stated,

> *"We've got a protocol in place."* (Participant 6).

Staff satisfaction emerged as a positive outcome of the projects. Many staff members found their involvement rewarding and valued the opportunity to engage in meaningful work. One participant shared that clinicians enjoyed the clinics, describing the work as fulfilling,

> *"All the clinicians really liked all these clinics and doing this kind of work, I think it was quite rewarding for them."* (Participant 1).

The additional financial incentive for weekend work contributed to their satisfaction, as another participant remarked,

> *"It was great to be given the opportunity... we're able to earn a little bit more money than we might normally."* (Participant 4).

- PCNs reported that their projects had an impact on patient awareness of their health. Participants thought patients may be more motivated to engage in healthier behaviours, such as weight management and addressing other risk factors. One participant noted,

> *"It has made a difference. People wanting to go into weight management... different things."* (Participant 2).

Furthermore, the projects provided an opportunity to educate patients on the broader implications of high BP, as explained by another participant,

> *"We try to educate people... high blood pressure can lead to other problems like kidney issues or diabetes."* (Participant 6).

- Engaging under-served groups required a tailored and personable approach. According to Participant 2, being approachable and breaking down barriers, rather than relying solely on formal skills or qualifications, is important to make patients feel comfortable, being a *"person's person"*. At

Bitterne PCN, social prescribers played a central role in reaching under-served patients, creating a bridge between patients and healthcare.

4.2. Areas for improvement

- Engaging other practices: Effective engagement with practices at the start of the project was identified as an area for improvement. One PCN, despite overall success, acknowledged that clearer initial communication could have facilitated greater participation from other practices in their area. As one participant observed,

  "...it's been hard enough as it is to engage with practices, but when they've done it I think they found out actually it was quite straightforward." (Participant 3).

- Enhancing communication between the ICB and clinicians: Participants highlighted the opportunity to increase communication between the ICB and clinicians involved in patient care to enable a shared understanding of the project objectives. One participant suggested,

  "It would have been helpful if the ICB could touch base with at least one clinician involved in the day-to-day patient interactions, ensuring that the objectives of the project were crystal clear from the start." (Participant 5).

- Improving patient engagement, particularly among the most deprived/ under-served groups: Patient engagement, especially with the most deprived populations, remains a challenge. Participants shared that patients often hesitated to participate due to health concerns or financial barriers. For example, Participant 2 reported,

  "I don't want to get in trouble if my diabetes is not controlled,"

  highlighting the need for reassurance and education. Additionally, financial constraints, such as the inability to afford prescriptions, were a barrier to participation. Clear communication about the benefits of testing and building rapport were suggested as key strategies to address these issues.

- Tailoring approaches for deprived areas: Proactive strategies to engage patients in severely deprived areas were suggested. One participant highlighted the need for a more proactive approach, such as making personal phone calls, to improve engagement in such regions. They stated,

"We would change our approach. It might be we have to be a bit more insistent with certain patient groups, especially for example [location] is really deprived. So that might actually need like a physical phone call." (Participant 5).

Tailored engagement methods were seen as essential to addressing the unique challenges faced by specific populations.

- Staff capacity: Some PCNs recognised the need to expand the workforce to meet growing demand. One participant mentioned that, although the events were well-attended, there were times when they did not have enough staff to manage the volume of patients.

"I think the only thing we did is probably thinking about maybe more hands because it's so well attended now, sometimes they don't have enough. You know we're sending two, but they're seeing quite a lot of patients in that period in that couple of hours. So I think it's more about if we're able to expand the workforce to actually send to those events now." (Participant 1).

Expanding the workforce to meet demand would ensure that these events could be more effectively managed. Moreover, focusing on preventative care was highlighted as a long-term solution to alleviate the pressure on health services, with one participant noting that early diagnosis of conditions like atrial fibrillation could prevent costly future health issues, such as strokes. They explained,

"I think she ended up finding they had atrial fibrillation. So they ended up being escalated to cardiology in the end and they ended up on a statin. Yeah. Yeah. So I mean that person, it could have big implications for further down the road like... Like the diagnosis of atrial fibrillation being picked up, you could avoid them having a stroke in the future, which would be cost tens of thousands of pounds if they ended up in hospital." (Participant 6)

4.3. Lessons learnt

Key lessons learnt across all PCNs were:

- Engagement from under-served groups relies on adaptability and persistence; direct engagement with the public fosters trust and participation (e.g., Bitterne PCN engagement approaches at community events).
- Direct communication methods like text messages were highly effective, with multi-channel strategies (texts and phone calls) adding value despite being resource intensive.

- Systematically utilising diverse data sources enables precise patient targeting, enhances engagement, and ensures alignment with project objectives.
- Clear, timely communication and direct contact between project and programme leads and clinicians were recommended to prevent confusion and inefficiencies.
- Training clinicians to perform additional tasks, like blood tests, during visits would enhance efficiency and improve patient experience with faster results.
- Sustained buy-in from practices required early engagement and alignment with existing workflows.

4.4. Sustainability: suggestions and approaches

During the interviews, participants were asked to share their ideas for sustaining their approaches. The suggestions they provided are outlined below.

- One important approach to sustainability is maintaining a proactive and continuous monitoring system. Participants reported that it is vital to prioritise ongoing care rather than delaying action, as proactive management helps prevent potential health issues from arising or escalating. This continuous approach ensures that long-term conditions are consistently monitored and managed, reducing the risk of complications.
- Technological resources have also played a significant role in enhancing care management. The use of technologies has streamlined patient care processes, making it easier to track, monitor, and manage efficiently. In addition to these technological solutions, financial considerations were mentioned to be critical to the sustainability of local health services.
- Training staff was another key aspect of sustainability. By enhancing the skillsets of healthcare providers, they can offer a broader range of services and operate more effectively, providing patients with a more comprehensive "one-stop shop" for care. In addition to improving staff capabilities, innovative solutions such as offering BP checks in public spaces like libraries may also be an effective, low-cost strategy. This would not only increase the accessibility of health checks but also foster greater public engagement within community spaces, benefiting both health outcomes and local organisations.

Sustainability was also a key focus for InHIP wave 1. For example, those delivering projects aimed to create long-term models, such as the surgery pod at the Horizon Wellbeing Hub (Strawberry Health) and continued BP testing at the Thornhill Wellbeing Café. However, organisers of larger, one-off events faced challenges in guaranteeing sustainability due to the resources required, noting that ongoing collaboration with other agencies and community groups, and using data driven approaches to identify individuals, could help alleviate some of these challenges and increase long-term impact.

5. InHIP wave 1 and 2: similarities and differences

Reflecting on InHIP wave 1 provides valuable insights into the different approaches adopted by each PCN across both waves, particularly in addressing BP testing for under-served groups. The table below compares findings from InHIP wave 1 and wave 2 to highlight key similarities and differences.

Table 4 Themes from InHIP wave 1, wave 2, and comparison

Themes from InHIP 1	InHIP wave 1	InHIP wave 2	Comparison
Accessibility and inclusivity	Attendees and organisers overwhelmingly praised community BP testing events for their accessibility and inclusivity, highlighting the collaboration between practices and community volunteers as a key factor in making wellbeing assessment and care accessible and fostering a sense of community. The use of social prescribers in addition to healthcare professionals in a community setting was found to be key to accessibility.	After establishing rapport and trust within the community, staff members at Bitterne PCN observed that patients became less hesitant to seek health advice or assistance at their community events. Participants noted that their hybrid approach of clinic and community events improved accessibility for target population. However, one staff member emphasised the importance of setting clear boundaries to manage patient contact effectively, ensuring patients understand the appropriate methods and times to reach out.	Both reports highlight the benefits of a community-led approach in improving patient accessibility. By involving health, social, and community leaders, awareness and participation in BP testing increased. In Wave 2, greater emphasis was placed on understanding and managing patient boundaries (interaction parameters on the professional relationship between a healthcare professional and a patient), recognising this as a factor for maintaining effective and sustainable engagement.
Reaching people who would not otherwise have had a BP reading in a long time	Several attendees explained that if they had not attended a community event, they would have not had their BP tested. This was also acknowledged by event organisers, suggesting that an effect of these events was reaching those who would not	By sending messages to patients and offering more flexible times for blood pressure checks, either in the community or through additional clinics, PCNs were able to reach patients who would not normally get their BP checked.	Using technology like Accurx to contact people is an effective method for engaging patients who have not had their blood pressure checked. Although it was used in both waves, wave 2 reported a more systematic and methodical approach to targeting patients and utilising technology to do so.

	otherwise have come forward for BP testing (and those who had not had a reading recently).		
Early identification and intervention	Some of the attendees who were interviewed explained that their BP reading had been raised, and that they would not expect to have found this out without having attended the event, indicating that attendance had resulted in earlier identification of a possible issue.	Staff members agreed that preventive care is essential and noted that BP checks were crucial for some patients, as it helped identify potential issues that could be further investigated.	Both patients (wave 1) and staff (wave 2) recognised the importance of continuous monitoring, early identification, and preventive care. On both waves, it was reported that some patients, who would not have usually had their BP checked, found earlier identification of possible issues.

Table 5 highlights key topics from InHIP waves 1 and 2, focusing on accessibility, patient engagement, and collaboration. Both waves emphasise the importance of making BP checks accessible through community events or additional clinics, with the aim of making patients feel more comfortable in each setting. Key strategies included using text invitations and flexible scheduling to reach people who would not otherwise seek care. Both waves noted the value of bridging primary care with community health initiatives (in some PCNs), improving awareness and encouraging proactive health behaviours. The projects' events were recognised for their ability to reach some underserved populations, identify health issues early, and foster interagency collaboration. Although not formalised, wave 2 demonstrated a more systematic and methodical approach to understanding target cohorts. All projects in this wave utilised data-driven methods, including the use of Accurx, to identify their target populations. In contrast, not all PCNs in wave 1 relied on data-driven approaches for cohort identification.

In summary, while there were challenges, both waves reported positive outcomes, including increased awareness of BP monitoring, patient follow-up, and improved collaboration among health, social care and, for some PCNs, community leaders too.

Table 6 sets out each project's main characteristics, benefits, and challenges. The table brings together information from InHIP wave 1 with details of wave 2 projects, organised by delivery model.
This demonstrates the approaches used and identifies commonalities in the models.

Table 5 PCN delivery model, features, benefits and challenges – wave 1 and wave 2

Model	PCNs	Features	Benefits	Challenges
Clinically focused	Portsdown Practice Group, Woolston and Townhill (wave 1) One Wight Health (wave 2) Island City (wave 2)	• Detailed SOPs entailing clinician responsibilities for follow up. • On-the-day input of readings into patients' clinical records. • Agreed process for sharing results and actions with partner surgeries. • Events within/around surgery setting • Large scale, one-off events (use of text messaging, extensive advertising) • Clinician-led events. • Data-driven invitations	• Large attendance (only Portsdown) • High numbers of BPs taken at events • Likely to ensure that results are entered into patient records and that relevant surgeries are notified. • Facilitates monitoring of the patient journey and follow-up. • Possibility to target attendance via data driven invitation	• May not be able to record readings from patients of surgeries outside of the participating PCN. • Resource intensive (diverting from normal service delivery if during surgery hours) (only Portsdown) • Less sustainable (only Portsdown). • May not be an accessible location for most under-served groups. • Additional/out of hours clinics may be difficult to staff.
Hybrid (a mixture of approaches- clinical and community)	Strawberry Health (wave 1) Bitterne (wave 2)	• Detailed SOPs entailing clinician responsibilities for follow-up. • On-the-day input of readings into patients'	• For the clinics, sustainable as available daily during opening hours	• Financial outlay for surgery pod and resource to support people to use it (only Strawberry Health).

		clinical records (via the surgery pod for Strawberry Health and for the additional clinics for Bitterne - not for the community events). • Agreed process for sharing results and actions with partner surgeries. • Some events within surgery setting • Within pre-existing community events/groups • Community events may be led by social prescribers with healthcare staff present • A mixture of data-driven invitations and open invite.	• Immediate input into patient records and sharing with partner surgeries (clinic events only) • Facilitates monitoring of patient journey and follow-up. • Support from existing staff in surgeries and community and social staff at community events. • Possibility to target attendance via data driven invitation • Potential for broadening community approach for other initiatives.	• May not be an accessible location for most under-served groups (clinical settings) • Harder to monitor patient journey and follow up at community events • May not be able to directly input patient readings at community events.
Social model	Living Well (wave 1)	• Within pre-existing community events • On the day recording of readings but input into patient notes afterwards • Events may be led by Social	• Lower attendance but sustainable via ongoing events. • Use of existing events' volunteers, infrastructure etc.	• Not easy/possible to target attendance via data-driven invitation – reliant on existing attendance at events • Harder to monitor patient journey and ensure follow-up.

		Prescribers/Wellbeing team	• Well-placed to reach the most under-served communities.	• Results may not all be entered into patient records.

6. Conclusions

InHIP wave 2 had several positive impacts, including increased engagement with the public, particularly among patients who may prefer alternative venues to primary care for BP checks. It highlighted the importance of proactive preventative care and data driven approaches to identify specific cohorts, all PCNs identified important health issues such as AF and pre-diabetes in some patients. Although some staff recognised that engaging people in self-management can take time, the projects were reported to increase patient awareness of HTN, which may lead to positive changes in health behaviours for some patients.

While wave 2 reported positive outcomes, impact, and awareness, sustainability remains a key consideration for the future. Maintaining a proactive and continuous monitoring system of BP awareness and testing is crucial, as it ensures HTN testing is consistently managed and reduces the burden on the NHS. Additionally, using advanced technologies, increasing staff training, implementing innovative solutions, along with collaboration between health system partners, could improve the sustainability and effectiveness of initiatives to address inequalities in testing and diagnosis of cardiovascular disease in under-served communities.

Version Control

Version	Status	Key Changes	Authorised by
V1	live		