Health Innovation East

# Project Review Report

## The Innovation for Healthcare Inequalities Programme Wave 2 Project

### Whaddon Healthcare and Bedford Luton and Milton Keynes ICB: SGLT2 inhibitors for treating chronic heart failure with preserved or mildly reduced ejection fraction.

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## Executive summary

*This project, facilitated by Whaddon Healthcare Primary Care Network (PCN) with support from Bedford, Luton and Milton Keynes (BLMK) ICB, identified patients who had been diagnosed with chronic heart failure with preserved ejection fraction that could benefit from treatment optimisation using an SGLT2 inhibitor – Dapagliflozin. The project expanded an existing primary care Community Cardiology Clinic, scaling the tailored approach across 12 practices with under-served populations in areas of deprivation focusing on clinician education, case finding and engagement and clinical review and monitoring to ensure care was optimised for patients.*

## Background to InHIP Wave 1 and Wave 2 programmes

The Innovation for Healthcare Inequalities programme (InHIP) was a national collaboration between the Accelerated Access Collaborative (AAC), the National Healthcare Inequalities Improvement Programme and the Health Innovation Network delivered in partnership with Integrated Care Systems (ICS). The aim was to enable systems to generate evidence and pilot new approaches to accelerate access to NICE approved innovations.

The focus for the programme was the five clinical areas of maternity, mental health, respiratory, early cancer diagnosis, and cardiovascular disease contained within the Core20PLUS5 approach to reducing healthcare inequalities. Health inequalities are differences in health across the population that are systematic, unfair, and avoidable. They are caused by the conditions in which we are born, live, work, and grow. Reducing health inequalities is key to our strategy and underpins Health Innovation East's purpose – helping the best innovations in health and care reach the people, places, and problems where they bring most benefit.

To deliver InHIP, Health Innovation East (HIE) worked with system partners and key stakeholders across the East of England in two distinct phases: October 2023 to March 2024, Wave 1, and April 2024 to March 2026, Wave 2. Wave 1 projects included three cardiovascular projects with one cancer project. The Wave 2 projects covered three clinical areas including *cancer screening* (breast, bowel and cervical), *cardio-vascular disease* (heart failure with preserved ejection fraction and blood pressure optimisation with atrial fibrillation detection) and *respiratory disease* (interstitial lung disease (ILD) and diagnosis and treatment of asthma).

The specific innovations, technologies, and medicines supported across Wave 2 included:

- KardiaMobile for detecting atrial fibrillation in Hertfordshire and West Essex and Cambridge and Peterborough.
- FIT Testing for detecting bowel cancer in Norfolk and Waveney.
- FeNO for the diagnosis and management of asthma in Mid and South Essex and Suffolk and North Essex.
- Dapagliflozin to support heart failure with preserved ejection fraction in Milton Keynes.
- Nintedanib for treating progressive fibrosing ILD across the East of England.

By the 31 December 2025, Wave 2 programmes in the East of England had directly supported 2,707 people in underserved populations to enter health and care pathways with 981 directly starting treatments and or accessing a NICE recommended innovation as a result. We have used the learnings from Wave 1 to further adapt and scale our approach for Wave 2, increasing the number of projects from four to seven across a wider range of clinical and geographical areas including delivering a regional project alongside local projects and reducing the total investment by

50% yet delivering the same level of impact. This is based on our approach of building on local assets and partnerships, and through scaling activities we understand to be effective. All six projects Wave 2 projects are now complete with one project to be finalised by the summer 2026.

Our approach to evaluation has also developed over the lifespan of the programme. The four initial projects included formal impact evaluations, available from the ICS project teams with the National Health Innovation Network publishing an Impact Report in December 2024. Wave 2 has taken a proportionate approach to reviewing project learnings, outcomes, and impact, scaled to reflect the budget distributed and partner capacity. Each Project Review Report is drafted with delivery partners to focus on real world examples of how targeted interventions and innovations are improving healthcare access, experience, and outcomes for communities facing the greatest health inequalities.

## Background to scope of the project and partners

Nationally, cardiovascular disease continues to be a leading cause of hospital admissions and is generally associated with high morbidity and mortality rates[1]. Bedford, Luton and Milton Keynes (BLMK) ICS face considerable challenges in identifying and managing the growing burden of heart failure within its population.

Heart failure with preserved ejection fraction (HFpEF) accounts for approximately half of all heart failure cases nationally and is associated with substantial morbidity, frequent hospitalizations, and impaired quality of life. Despite its high prevalence, HFpEF has historically lacked disease-modifying therapies, leading to therapeutic nihilism and variability in care. Patients with HFpEF often have multiple comorbidities, further complicating management and contributing to poor outcomes.

Sodium–glucose cotransporter-2 (SGLT2) inhibitors have emerged as a landmark therapeutic advance in HFpEF. Large randomized controlled trials, including EMPEROR-Preserved and DELIVER, have demonstrated that SGLT2 inhibitors significantly reduce heart failure hospitalisations and improve patient-reported outcomes across a broad spectrum of ejection fractions, independent of diabetes status. As a result, contemporary international guidelines now recommend SGLT2 inhibitors as foundational therapy for patients with HFpEF.

Despite strong evidence and clear guideline endorsement, real-world uptake of SGLT2 inhibitors in HFpEF remains suboptimal in BLMK as shown by local prescribing data. Barriers include clinician unfamiliarity, concerns regarding renal function or adverse effects, fragmented care pathways, and uncertainty around prescribing responsibility. Addressing these gaps represents a critical opportunity to improve outcomes for patients with HFpEF.

Whaddon Healthcare PCN, based in Milton Keynes, was approached by BLMK ICS due to a high proportion of people registered in IMD 1&2 enabling them to test the approach with a Core20plus population. The project ran from November 2024 until October 2025 and focused on increasing the appropriate use of SGLT2 inhibitors in patients with HPpEF through targeted interventions designed to improve awareness, streamline prescribing processes and reduce implementation barriers. The project team specifically chose to focus on further integration of Dapagliflozin. Dapagliflozin has been recommended by NICE as part of the treatment regimen for heart failure with preserved or mildly reduced ejection fraction[2]. The project aligned with the recommendations of the Denny review[3] and strategic priorities of BLMK ICS as well as enhancing the heart failure care pathway by optimising treatment for identified patients.

By aligning clinical practice with current evidence and guidelines, this initiative seeks to enhance the quality of care and reduce the burden of HFpEF-related morbidity.

## Delivery and key findings

The project was delivered through collaboration between local health partners HealthWatch, primary care providers and specialist teams. Funding was provided by Health Innovation East alongside project management resource. Whaddon PCN facilitated the project with support from the BLMK innovation team and deputy medical director.

The aim was to assess 100 patients and identify patients with a confirmed (and coded) diagnosis of heart failure with preserved ejection fraction (HFpEF) in the five most deprived practices in Milton Keynes and optimise their treatment with Dapagliflozin or Empagliflozin. Other practices were then invited from Bedford and Luton to participate via email invitations from the practice manager. Twelve practices participated overall – ten signed up quickly and two joined nearer the end.

The project team gained temporary access to each GP practice via SystmOne so they could perform the patient searches. Patient notes were reviewed that had a diagnostic code of heart failure with preserved ejection fraction that were currently not prescribed an SGLT2 inhibitor. If appropriate patients were invited for further review with a GP either over the telephone or a face-to-face appointment at a community cardiology clinic. Patients were told about the benefits, risks and potential side effects of the medication so they could make an informed decision about whether they wanted to proceed. Out of the 52 patients that were reviewed, 35 received a prescription for an appropriate medication.

There was significant engagement from ICB partners to help overcome barriers with engagement from practices and with patient contact. Medicines optimisation teams and PCN pharmacists also helped to support discussions, and further support was gained from practice senior leadership or GP partners which helped boost recruitment of practices.

## Impact and benefits

Summary of the impact data:

Ten general practices across BLMK participated in the project. A total of **180** patient records were reviewed to identify individuals with HFpEF who may benefit from SGLT2 inhibitor therapy. From this cohort, **60** patients were invited for clinical review, resulting in **52** completed appointments, the majority conducted via telephone.

Following clinical assessment and shared decision-making, **35** patients agreed to initiate SGLT2 inhibitor therapy. On further clinical review, the vast majority have continued a SGLT2 inhibitor 6 months later. Patients who did not proceed included those with significant cognitive impairment, those who declined due to concerns about polypharmacy, and those who were found on review to have an incorrect or inappropriate diagnosis for treatment initiation.

The benefits from patients starting Dapagliflozin will hopefully be reflected in reduced hospitalisation and improved cardiovascular disease outcomes. In the DELIVER and DAPA-HF clinical trials, Dapagliflozin lowered the risk of worsening heart failure or death from cardiovascular events in patients with heart failure with a preserved ejection fraction[4].

## Reflection and learnings

Engagement from GP practices was variable, with two practices not able to help at the time despite positive discussion with the GP there. Our project aim was to target deep end practices. Deep End practices represent those who serve the

most deprived 20% of the population across the UK but there was variable engagement from these practices, and we had to widen our search to other practices. This is likely due to workload burdens in primary care. In some practices, there was reluctance from GPs to support key aspects of the pathway, including arranging baseline blood tests and issuing prescriptions, which created delays and additional workload for the project team.

Incomplete or insufficient information within referral letters and clinical notes further limited efficiency, often necessitating additional record review or clarification before patients could be assessed or treatment initiated. For example some patients on review were found to be already in the care of a Cardiovascular specialist at hospital. Others were living with multiple conditions including frailty and dementia which had progressed since the original diagnosis or was not recorded in the notes. These patients could not consent to care effectively, nor would it have been beneficial to add to current medication loads. For those patients that declined opportunity for review directly, it was due to polypharmacy and not wanting more medication to take. This highlighted the need for more accurate coding and data quality, as coding was a significant problem with large numbers of patients miscoded as HFpEF, usually incorrectly copied from an echo report.

We also found as the project expanded into other practices there was a difference in pathways for supporting clinical activities such as diagnostics, phlebotomy or BNP testing. The project team needed to redirect test requests back to the patients registered GP practice to fulfil or ask the patients to attend Whaddon for testing which was not always convenient due to travel. In future projects it would be better to encourage the patients registered GP to prescribe directly, enabling the patient to deal with their own familiar GP practice.

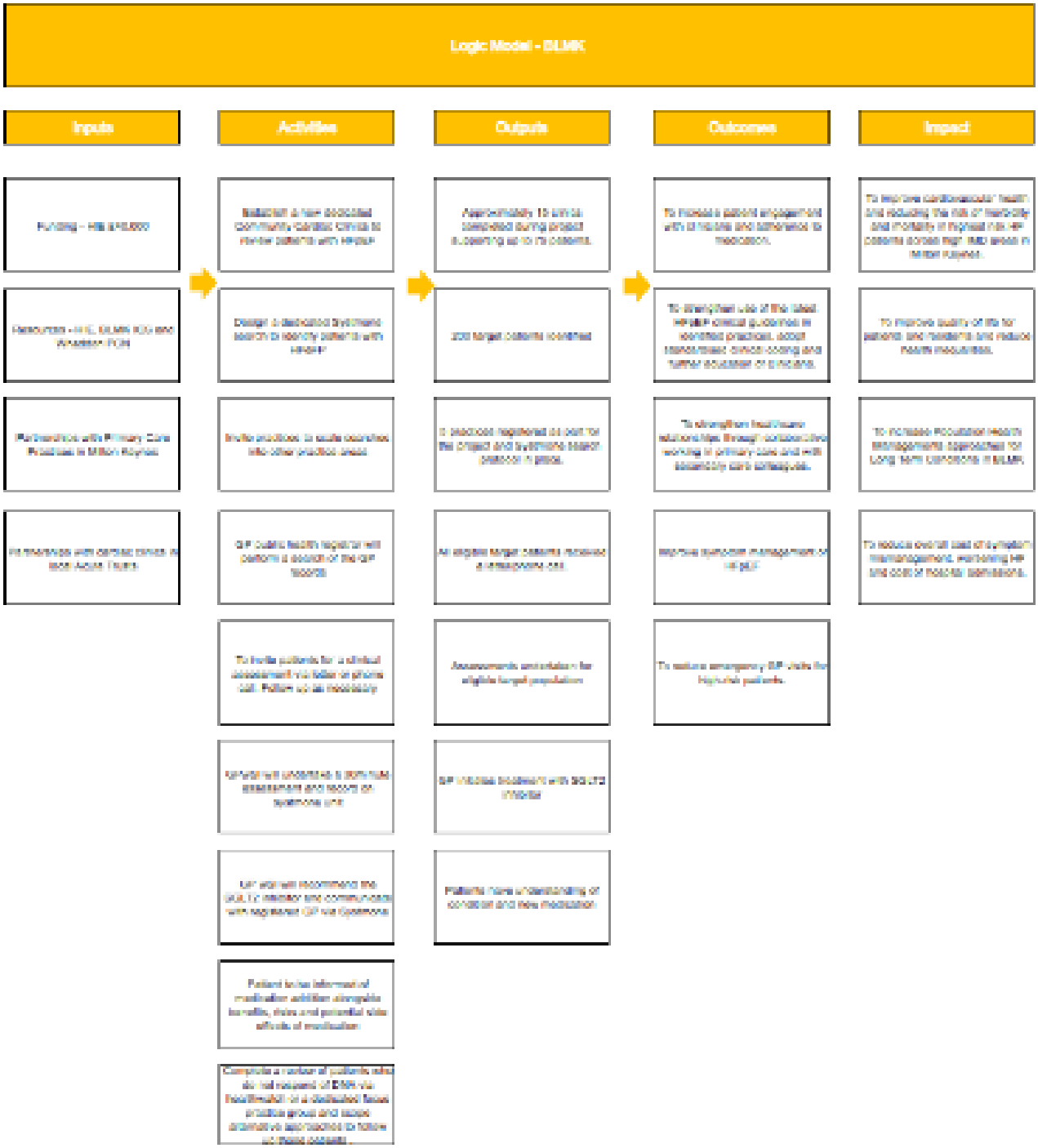
Future iterations of the project could be strengthened by enabling the project team to issue SGLT2 inhibitor prescriptions directly, reducing reliance on GP practices and minimising delays to treatment initiation. In addition, offering face-to-face appointments within local community settings may improve patient engagement, allow more comprehensive clinical assessment, and support shared decision-making, particularly for patients with complex needs or concerns about starting new medication.

## Conclusion

This project demonstrates that a targeted approach using a simple SystmOne search can effectively identify patients with HFpEF and increase the number of symptomatic individuals receiving appropriate medications. Implementing such searches in routine practice has the potential to improve patient care and optimise treatment for this population.

## References and Background

Appendix 1 - Logic Model and KPIs




Project KPIs: Baseline and **Achieved**

- Number of practices engaged in project: 5 practices planned with **12** recruited during the project.
- Number of patients case found in primary care: 200 patients planned with **180** patients reviewed.

- Number of patients engaged and attending assessment via a community heart clinic: 75 patients projected with **60** invited during the project with **52** attending clinic or a virtual clinic (telephone appointment.
- Number of patients receiving medicine because of activity: **35** patients had prescriptions initiated during the project. Baseline was not calculated as eligibility was based on clinical criteria.
- Number of patients participating in wider outreach activity - the project focussed on the model used for delivery patient outreach was limited to clinic reviews with initial input provided by Healthwatch BLMK.

## Appendix 3 – Acknowledgement and References


1. [1] Bellanca, L., Linden, S. and Farmer, R. (2023) 'Incidence and prevalence of heart failure in England: A descriptive analysis of linked primary and secondary care data The Pulse Study', *BMC Cardiovascular Disorders*, 23(1). doi:10.1186/s12872-023-03337-1.
2. [2]Solomon, S.D. *et al.* (2022) 'Dapagliflozin in heart failure with mildly reduced or preserved ejection fraction', *New England Journal of Medicine*, 387(12), pp. 1089–1098. doi:10.1056/nejmoa2206286.
3. [3]The Denny Review Available from https://blmkhealthandcarepartnership.org/denny-review/
4. [4]National Institute for Health and Care Excellence (NICE). Dapagliflozin for treating chronic heart failure with reduced ejection fraction [Internet]. 2021[cited 2024 Aug 27]. Available from: https://www.nice.org.uk/guidance/ta679