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Executive summary

The One Vision Charity Health Improvement Project delivered community-based cardiovascular screening and education across Hertfordshire, identifying undiagnosed hypertension and optimising management in high-risk ethnically diverse populations. The project demonstrated strong clinical, economic and social value, supporting NHS priorities to reduce cardiovascular inequalities.

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:

Hypertension is a leading modifiable risk factor for cardiovascular morbidity and mortality. NICE (2023) emphasises that the proactive detection and effective management of hypertension represent some of the most cost-effective interventions in public health (2).

One Vision is a Hertfordshire based charity, serving a wide range of ethnically diverse and faith-based communities across the county. With £20,000 of funding from Health Innovation East, One Vision delivered a cardiovascular health improvement project aligned with InHIP objectives and the priorities of the NHS Long Term Plan.

The project ran from March 2025 to September 2025 and focused on identifying undiagnosed hypertension and atrial fibrillation (AF) including optimising the management of existing cardiovascular conditions. Delivery took place through bespoke community engagement events hosted in trusted community and faith settings. These locations were selected to overcome barriers to access experienced by populations less likely to engage with traditional healthcare services.

The primary population groups included Black British, Black Other, Asian British and Asian Other communities—groups known to experience higher prevalence of hypertension and poorer cardiovascular outcomes. The project directly addressed health inequalities by improving access to screening, health education, and GP follow-up, supporting Core20PLUS5 and local ICS prevention priorities.

Delivery and key findings:

The project was delivered using a community-based outreach model centred on trust, cultural competence, and accessibility. One Vision worked with local faith leaders, community champions, and volunteers who were trained to support blood pressure screening, health education, and signposting to NHS services.

Delivery was supported by a multidisciplinary approach including community volunteers, project management support from One Vision, and strategic oversight from Health Innovation East. 46 volunteers from within the communities were trained to perform AF checks using NICE recommended KardiaMobile and blood pressure checks using blood pressure monitor cuffs. Training sessions were held prior to the project launch, and further training sessions took place throughout delivery as more volunteers were onboarded. The project progressed to schedule and met its engagement event target, exceeding the screening targets of 500 within the agreed timeframe.

A total of 15 community engagement events were delivered across Hertfordshire, benefitting 803 individuals who received blood pressure and cardiovascular risk checks. Community venues were selected to maximise reach among selected populations less likely to attend GP surgeries for preventative care. The events incorporated culturally appropriate messaging, informal health discussions, and one-to-one engagement.

Individuals identified with elevated blood pressure, potential AF or known cardiovascular conditions were signposted to their GP for follow-up. Consent was sought from the participants for evaluation and follow-up after three months, 177 participants agreed to be contacted and 117 reported subsequent clinical outcomes.

The screening figures are shown in the below table:

Stage	Number of People	% of Total Screened (N=803)	Comment
Total Screened	803	100	BP and Cardiovascular Risk Check completed
Signposted to Healthcare	322	40	Individuals identified and signposted to GP
Consented to follow up	177	22	Agreed to contact and follow up Evaluation
Reported Clinical Outcomes	117	15	Patient reported outcome following contact with GP or Consultant Follow up

Two key participant groups emerged:

a. Group 1 – Newly Screened (no prior hypertension diagnosis):

- 53 individuals attended their GP following screening
- 23 (43%) were diagnosed with hypertension and commenced medication
- 30 (57%) were advised on lifestyle modification and proactive monitoring

b. Group 2 – Known Hypertension or Cardiac Condition:

- 64 individuals followed up with healthcare providers
- 18 (28%) had medication adjustments and initiated home blood pressure monitoring
- 8 (13%) were referred for specialist review
- 38 (59%) continued existing treatment with lifestyle and dietary changes

Lifestyle modification was promoted among the 30 participants who did not require medication, and among the 38 patients who maintained their current therapy but adopted healthier habits. Among the 64 patients with pre-existing cardiovascular conditions, 18 had medication changes and home monitoring introduced, ensuring better blood pressure control. According to Law et al. (2009) (3), appropriate medication titration can reduce cardiovascular events by up to 25%. Meanwhile, the eight specialist referrals, though associated with modest short-term costs, represent appropriate escalation of care to prevent acute admissions—an approach consistent with NHS Long Term Plan priorities (NHS England, 2019) (8).

Encouraging home blood pressure monitoring empowers patients to take an active role in managing their health. Public Health England (2017) found that home monitoring reduces unnecessary GP consultations by up to 30% while improving adherence to therapy. This shift from reactive to proactive management contributes to sustainable healthcare resource use and improved long-term outcomes (1).

Impact and benefits:

The project delivered a range of significant impacts and benefits, including measurable clinical, socio-economic value, economic benefits, greater inclusion, improved connections between healthcare systems and communities, and stronger relationships built on trust.

Clinically, the identification of 23 new hypertension cases enabled early intervention, reducing future risk of stroke, myocardial infarction, and chronic kidney disease. Medication optimisation and home monitoring among those with existing conditions supported improved blood pressure control and self-management.

Evidence from Roux et al. (2008) (10) and Public Health England (2018) (9) suggests that community-based lifestyle interventions—such as improving diet, physical activity, and weight management—can reduce lifetime healthcare

costs by 10–30% per individual at risk. Such interventions also improve health-related quality of life, generating measurable quality-adjusted life year (QALY) gains at low cost.

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An independent social value assessment using the Our Social Value (OSV) platform (11) which applies established wellbeing valuation and cost–benefit methodologies to quantify the economic value of non-financial outcomes (Our Social Value, 2025). This was estimated total social value generation of £274,305.40. This equated to approximately £342 of social value per participant and a highly favourable social return on investment. Key drivers included improved wellbeing, increased health awareness, and greater engagement with primary care.

The economic value of this project stems from its capacity to reduce future expenditure on high-cost events such as stroke, myocardial infarction, and chronic kidney disease. As Luengo-Fernandez et al. (2009) (5) demonstrated, preventing one stroke can save the UK health system between £20,000 and £45,000 in acute and long-term care costs. Given the low annual cost of antihypertensive therapy (approximately £100–£200 per patient per year; PSSRU, 2023) (6), early detection and management of hypertension provide a highly favourable cost–benefit ratio.

From a system perspective, the average cost per person screened was £25, with an estimated net annual system saving of £60,300. The return on investment was estimated at £4 saved for every £1 invested, based on avoided acute events, improved disease control, and reduced demand on urgent care.

Reflection and learnings:

Key learnings from the project highlighted the importance of trusted community delivery models in addressing health inequalities. Engagement was significantly enhanced by delivering services in familiar settings and using culturally competent facilitators and trusted members of the community. Delivery being supported by existing faith and community networks, which could further strengthen the systems narrative, particularly around sustainability and scalability. Community-led, culturally competent delivery models are highly effective in reaching underserved populations and generating significant clinical, economic, and social value. Embedding such models within ICS prevention strategies offers a scalable approach to reducing cardiovascular health inequalities.

Participation voice - individuals attending the events reported positive experiences and provided feedback reflecting trust, accessibility and behaviour change:

“This screening gave me the awareness and support I didn’t know I needed. I’ve always been health-conscious and never expected this. Please bring this to more community events.”

- Tamil woman, age 39 (diagnosed with hypertension during an event)

“I don’t usually attend health checks, but because this was in our community and explained in a way I understood, I felt comfortable. I followed up with my GP for the first time in years.”

- Male participant, Black British community, age 52

“Having the checks at our place of worship made a big difference. It felt safe, respectful, and not rushed. I now check my blood pressure at home and feel more in control.”

— Asian woman, age 45, with existing hypertension

These participant quotes support the reinforcement of the importance of trusted settings, cultural competence, and empowerment, which are key themes of the project. The project demonstrated that relatively small investments in

community-led prevention can generate substantial clinical and social returns. Embedding similar models within ICS prevention strategies could further strengthen sustainability and scale.

One Vision, the partner commissioned to deliver this project also shared learnings from their extensive experience in faith-based community outreach activity. They have described their key conditions for success below.

- Depth of trust built over time, rather than transactional engagement
- Culturally fluent leadership rooted in lived experience, faith, and community life
- Networked reach across multiple communities, not single-group engagement
- A distributed leadership model involving faith leaders, volunteers, and champions, not just staff
- The ability to translate between statutory systems and community realities
- Safe, non-clinical spaces that reduce fear, stigma, and power imbalance

For One Vision these are translated into enabling values, inbuilt into the organisation's leadership style and approach – which fundamentally underpin the delivery of volunteer engagement, driving the success and uptake by the community in the activities which result in organisational impact.

Challenges more broadly experienced included variability in GP follow-up times and reliance on self-reported outcomes for evaluation. Future projects could benefit from earlier engagement with primary care networks to streamline referral and feedback pathways.

Conclusion:

The One Vision Health Improvement Project successfully demonstrated the value of community-based cardiovascular prevention in reducing health inequalities. By improving early detection, optimising management, and empowering individuals through education and self-monitoring, the project aligned strongly with NHS Long Term Plan and InHIP objectives.

The outcomes provide a compelling case for continued investment in community-led cardiovascular screening and prevention initiatives. Future sustainability could be achieved through integration with primary care networks, public health teams, and ongoing ICS prevention programmes.

References and Background

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