

Health Innovation South West

Lipid Service Redesign Toolkit



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We would like to thank the Somerset Lipids Project Team for their commitment and dedication to improving patient care and lipid management in Somerset. As an organisation we are privileged to have been able to be part of the team and capture their unique journey so far.

We would also like to thank Imperial College Health Partners and Health Innovation Oxford colleagues who have supported the review of this document.

A. About the toolkit

1. Context

Cardiovascular disease (CVD) causes a quarter of all deaths in England and is the leading cause of premature mortality in deprived areas (Raleigh, et al., 2022). Heart attacks and strokes can be prevented, and the NHS has made CVD prevention a priority, committing to preventing 150,000 heart attacks and strokes in the next 10 years (Ahmad, et al., 2022).

It is estimated that 20 million people in England have elevated cholesterol levels, and the national prevalence of familial hypercholesterolaemia (FH) is approximately 1 in 250 (BHF, 2022).^a Cholesterol levels can be lowered through lifestyle changes, and medicines initiation and optimisation. There is a need to ensure those at risk are identified and offered effective treatment, and clinicians are supported in identifying and managing patients.

CVD-related events are consistently higher in the South West (SW) than the national average (Quality and Outcomes Framework (QOF) data). For example, CVDPREVENT data for Devon ICB 2023 showed that 20% of patients with CVD diagnosis did not receive lipid-lowering medication, and only 24.2% of these achieve the non-HDL cholesterol 2.5mmol/l target. Furthermore, socio-economically deprived groups (IMD) and coastal communities are recognised as having a higher burden of disease.

In March 2023, through the National Implementation Agreement, Health Innovation North East and North Cumbria, NHS England, and Novartis (The Tripartite) funded successful applicants to build on approaches to delivering lipid management optimisation established through the Lipid Management and FH Programme delivered by the Academic Health Science Networks (AHSNs) between 2021-2023. The national programme aimed to improve FH detection and lipid management optimisation, improve access to appropriate medicines for lipid treatment using NICE-endorsed summaries, and enable resources and education provision to healthcare professionals. (The AHSN Network, 2022).

Health Innovation South West (formerly South West AHSN) secured funding through the Collaborative Lipids Fund (CLF) to deliver a project focused on improving and building a service model in Somerset, implementing best practice and developing cross-organisational working in both Somerset and Devon since April 2023. This toolkit was a key deliverable of this project designed to capture key tools, resources and processes generated throughout Somerset Lipids Project to spread learning and best practice across the Peninsula.

The key insights from this project so far have been captured in the [Collaborative Lipids Fund Early Insights: Somerset Lipids Project Evaluation Report](#). The insights report is from the mixed methods process evaluation that we conducted to understand implementation insights and the short-term outcomes of the project from April 2023 – February 2024. Both the report and the toolkit are key project deliverables, with the latter presenting the practical tools and resources that have been generated as part of this project.

The development of the Insights report and the creation of this toolkit has been jointly funded by the tripartite group (see above).

^a Familial hypercholesterolaemia (FH) is a condition caused by a defective gene that causes high levels of cholesterol in the blood. Commonly inherited from one parent but in rare instances can be more serious and inherited from both parents.

2. What is the toolkit?

This toolkit has been designed through the documentation and capturing of key tools, resources and processes that were core to the project and redesign work that evolved for Somerset Lipids Project and the subsequent Service redesign as part of the CLF phase of work from April 2023 to the end of February 2024.^b It can be used as a practical tool alongside the more detailed Insights Report. The toolkit focuses on the following areas:

- securing funding;
- creating a service redesign team;
- developing a common vision;
- defining the service needs;
- establishing a robust evaluation and learning framework;
- developing an education and engagement programme; and
- ensuring service sustainability and durability.

The Insights report and associated toolkit have been reviewed by the Somerset Lipids Project Steering Group and colleagues from Imperial College Health Partners and Health Innovation Oxford have reviewed the toolkit content, usability and usefulness. Their feedback is included in the document annex, focusing on areas for future work, development and improvement.

3. How to use the toolkit

This toolkit is designed to be read alongside the Collaborative Lipids Fund Early Insights: Somerset Lipids Project Evaluation Report to understand the details and context behind the project. It can be read in its entirety, or the reader can go to the most relevant sections to understand and use specific tools and resources associated with targeting a specific element of a service redesign.

The toolkit is designed to benefit audiences across the health system, from system leaders, clinicians, practice level staff and operations teams wanting to improve their services, to programme managers supporting change projects through Health Innovation Networks and similar organisations.

Are you part of a system which is experiencing challenges with lipid optimisation at all levels?

- Secondary care lipid services with long waiting lists. Example resource: data collection tool to manage demand and waiting times (under development)
- Primary care patient lipid optimisation and meeting QOF targets. Example resource: [primary care lipid practitioner contact and evaluation tool](#)

^b The Collaborative Lipids Funding (CLF) initiative, part of the Accelerated Access Collaborative (AAC)/Health Innovation Network National Lipids Programme, aimed to enhance lipid management optimisation across regions. In partnership with Health Innovation Networks and stakeholders, CLF supported the implementation of best practices and innovative delivery models for cardiovascular disease prevention and recovery in high-risk populations. This initiative, funded by Novartis Pharmaceuticals UK, built upon previous successes by targeting resources where they would have the greatest impact. Health Innovation Network South West were successful in receiving funding to support proposals submitted by Somerset and Devon.

Are you part of a system in the process of setting up a lipid service and need some tools to evaluate your improvement?

- Methodology and tools needed to show impact and capture learning. Example resource: [Evaluation and learning framework](#)

Are you part of a system undertaking a re-design for another service? Many of these tools and templates are transferrable to other services.

- Service redesign pathway work by all key stakeholders. Example resource: [Lipid Service Re-design Workshop Report template](#)

Are you undertaking system improvement work in areas of the country with similar demographics and challenges? (Rural and coastal i.e., demographics/access issues)

- Insights into service redesign and delivery in a rural and coastal area. Example resource: [nearest neighbour tool](#)

The tools and resources used throughout the redesign can be found individually at the end of each section or collectively at the end of the document in section 5. They are also accessible on the Health Innovation South West webpage.

These resources have been generated by the Somerset Lipids Project Team for use in Somerset. If these tools and resources are used by other systems/organizations, they will need to be adapted and the Somerset Lipids Project team cited.^c

The Health Innovation South West Lipid Service Redesign Toolkit IS:		The Health Innovation South West Lipid Service Redesign Toolkit IS NOT:	
✓ 	An overview of and access to practical tools, resources and process insights, generated from the Somerset Lipid Service redesign project between April 23 and Jan 24.	✗ 	Prescriptive – it is an example of what has worked well in one county, and there are other examples both nationally and in other areas of the country which have used different service redesign models and developed alternative tools and resources. Providing clinical guidance outside of Somerset.

^c If the Somerset lipid resources and tools are used, please cite the Somerset Lipids team as follows: 'This has been adapted from resources created by the Somerset Lipid Project Team as part of their Lipid Service Re-design work undertaken between April 2023 and March 2024'

B. The Toolkit: Key elements of a service redesign

1. Define the problem, go where the energy is, secure funding

Identifying the problem is central to starting a change project. At the heart of the problem in Somerset was the challenge of growing waiting lists in the lipid clinic. A system approach to understanding and defining the problem is important and core questions that delve into the various aspects of the system are useful to ask early in the process.

How is the system currently operating?	• What are the existing processes and workflows across the system? What are the constraints? How is information about patients, treatments, and outcomes communicated within the lipid service? • What are the patient experiences?
What are the past lessons?	• What can we learn from others who have addressed similar challenges? What are their models?
Why does it matter?	• What is the significance of addressing these problems? What are the long-term consequences if left unaddressed?
What are the symptoms?	• What observable issues or challenges are currently affecting the system?
Who is affected?	• Which stakeholders are impacted by the problems and how?
What are the root causes?	• What factors contribute to the emergence and persistence of these problems? • How do external factors, such as regulatory changes, technological advancements, or patient demographics, influence the lipid service?

Figure 1. Created by Health Innovation South West. System thinking approaches can be accessed online, including the Office for Science “Guidance - An introductory systems thinking toolkit for civil servants”.^d

^d Government Office for Science. 2023. An introductory systems thinking toolkit for civil servants. Available at: <https://www.gov.uk/government/publications/systems-thinking-for-civil-servants/toolkit>

Whilst projects such as this are often set up due to clinicians wanting to improve patient care, ultimately there is a need to secure funding to create a well-resourced, functioning, sustainable service. There is also the need to bring a team together to ensure input from across the system.

The problem definition work in Somerset was immersive and unfolding in the early stages – building on the keen energy from the service lead and different groups in the system and on the opportunities emerging through wider CVD work. The problem was defined through bringing in local knowledge and experiences about the challenges, building strong collaboration with multiple stakeholders across the system, and developing examples of different models. This early phase gave the foundations for an initial business case created by the lipid service lead, and led to the formation of a steering group which collectively planned, delivered and evaluated the project with the support of Health Innovation South West and CLF funding.

2. Creating a team

In late 2021, The Health Innovation South West CVD Clinical Lead led the formation of a multi-organisational steering group, driven to reduce the high lipid service waiting lists in the county and overseen by the Lipid Service lead to:

- secure funding for the lipid service design and delivery;
- build and solidify the foundations for a sustainable service, including defining and recruiting into key roles;
- deliver primary care education in lipid management to improve detection and treatment of hyperlipidaemia, including the development of key resources for Health Care Professionals (HCPs) and people with or at risk of CVD;
- help develop a primary/secondary care integrated and regional lipid pathway by working alongside the lead clinician and primary care and the commissioners; and
- develop pharmacist and GP led lipid clinics, with oversight from the lead clinician.

The team consisted of the South West Genomic Medicine Service Alliance (SWGMSA), Somerset CCG (now Somerset Integrated Care System), The Somerset Training Hub, Yeovil District Hospital (YDH), Public Health Somerset and lipid service colleagues from University Hospitals Bristol (UHB) including the following:

- strong leadership skills and vision (lipid service lead);
- an ability to identify and secure funding for the service (ICS);
- those who were working on parallel workstreams in their organisation and wanted to join forces (SWGMSA);
- those representing the needs of primary care particularly in the areas of education and training and PCN CVD champions; and
- those involved in protecting and improving public health in the area of CVD.

The role of the Health Innovation South West was fundamental to the success of the project and the organisation provided advice and expertise in the following areas:

- clinical knowledge and expertise in Familial Hypercholesterolaemia (FH);

- bringing organisations together to understand the needs of the local population and enable the co-creation of innovative solutions;
- evaluation and learning expertise to support the team to articulate their problems and goals, define the changes they aim to achieve, and identify the actions necessary to implement and achieve those changes, and evaluate them; and
- stakeholder coordination and programme management for the service design.

Since then, the team has evolved and expanded to include additional partners from other organisations and departments of Somerset Foundation Trust working collaboratively with the lipid service and a patient representative. This includes the new ICS CVD lead, Diabetes, Endocrinology, Rheumatology and Nephrology and Dietetics, in order to optimise coordination and maximise the opportunities to improve lipid management at all system levels.

The steering group has met virtually on a monthly basis and once face to face in the Lipid Service Re-design Workshop (see next section for more detail). In addition, task and finish groups were set up where necessary to focus on the establishment of the education and training programme, Patient Involvement and Evaluation and Learning. The ability to bring the team together virtually enabled full team representation, effective and inclusive decision making and information sharing.

Quote from insights:^e

“I look around the team that we have, I sort of think ‘who are we missing from this conversation? Who would bring a different perspective that we don't have?’ I think team working, for instance, should bring diversity with it and all sorts of diversity. But typically, that leads to different experiences and that different knowledge will bring in diversity of thought.”

The key elements of creating this high functioning team have been:

- clear leadership and partnership across the team;
- good representation and diversity of skills;
- adaptability and learning culture that has been built in;
- good communication processes;
- networks with regular action focused meetings and sharing;
- clarity of vision and motivation to improve patient health outcomes;
- a clear view of where this work fits into the wider CVD and Long Term Conditions work; and
- the programme management and coordination support of the group and team, which has been a core component of successful design and implementation and keeping up delivery momentum.

^e The quotes referenced in the toolkit are drawn from the evaluation which included semi-structured interviews and surveys with the core steering and project delivery team members (n8). The participants consented to their responses being included in the analysis and write up anonymously. The quotes represent a diversity of voices from the team such as the lead consultant, lead programme manager, clinical pharmacist, FH specialist Nurse, programme manager for the Genomic Medical Service Alliance, and Somerset CVD Clinical Champion.

Quotes from insights:

“This group can hold the uncertainty well. The teams that thrive are those that have that permission to try and permission to fail. It's that shared responsibility that we're in this together, stronger together kind of approach.”

“Effective collaboration between participants from many different spheres (primary care, secondary care, Health Innovation South West & Public Health, GMSA etc.). Drawing on individual expertise relevant to each aspect of the implementation.”

“Good collaboration between primary and secondary care with patient outcomes and benefit at its heart.”

Resources:

Resource name	Location
Somerset Lipids Project Steering Group TOR v6	Health Innovation South West Website
Somerset Lipids Project Governance Structure	Health Innovation South West Website

3. Refining the problem, creating a vision

Health Innovation South West brought the lipid service redesign project team together in a face-to-face workshop to collectively:

- **explore the context** in which the lipid service operates, including the needs of the local population;
- **review what worked** in the existing service, including key areas for improvement; and
- **create a high-level vision** to steer the work in terms of ‘in an ideal world what would this service look like’.

This forum enabled in-person collaboration for the first time, facilitating the review and planning of future work, while significantly enhancing crucial relationships, ultimately benefitting all aspects of project delivery.

The tools used at the workshop to support the collective understanding of the patient’s journey through the lipid service (including primary and secondary care) were vision creation and process mapping. Using the [NHS England and Improvement tool – Creating a Vision](#), the team were led through a process of visualising and defining what they were hoping to achieve, to look more closely at the people and organisations involved in the service and how this would look different in the future, tapping into the inspirational creativity of the team (figure 2).^f

^f ACT Academy, NHS Improvement. 2021. Creating a vision for your change. Available at: <https://www.england.nhs.uk/wp-content/uploads/2021/06/01-NHS104-Phase-2-Creating-a-vision-for-your-change-210817-A.pdf>

Following the vision setting, pathway mapping was used to support the project team to form a collective understanding of how the patient moves through the service, in terms of contact points, when the clinical pathway is used, clinical decision-making points, testing points and when advice and guidance is given (figure 3). The pathway mapping also enabled the team to identify what worked well at the time and areas where improvement was needed. This design approach enabled the team to design their logic model and strategy and focus for implementation.

Quotes from insights:

“The stage [the team were involved at] made us start thinking about ‘actually what could be a better model’, and so that turned into all the work that we've done. So it turned into that initial pathway meeting that we had to look and see ‘well, what is the pathway and what we need’... that eventually evolved into the model that we now have, along with all of the work with the logic model... and it's actually a really good way of visualising and driving the thing forward so that we know what we want to achieve, and how we can measure that in the long term.”

Resources:

Somerset resource name	Location
Somerset Lipids Project Vision	In document
Somerset Lipids Service Patient Journey Process Map	In document
Somerset Lipids Service Redesign Workshop report	Health Innovation South West Website
Somerset Lipids Service Redesign Workshop slides	Health Innovation South West Website
Tool/resource template	Location
NHS England and Improvement tool – Creating a Vision	See link opposite

OUR VISION

A high quality, patient centred, accessible and equitable service for all.

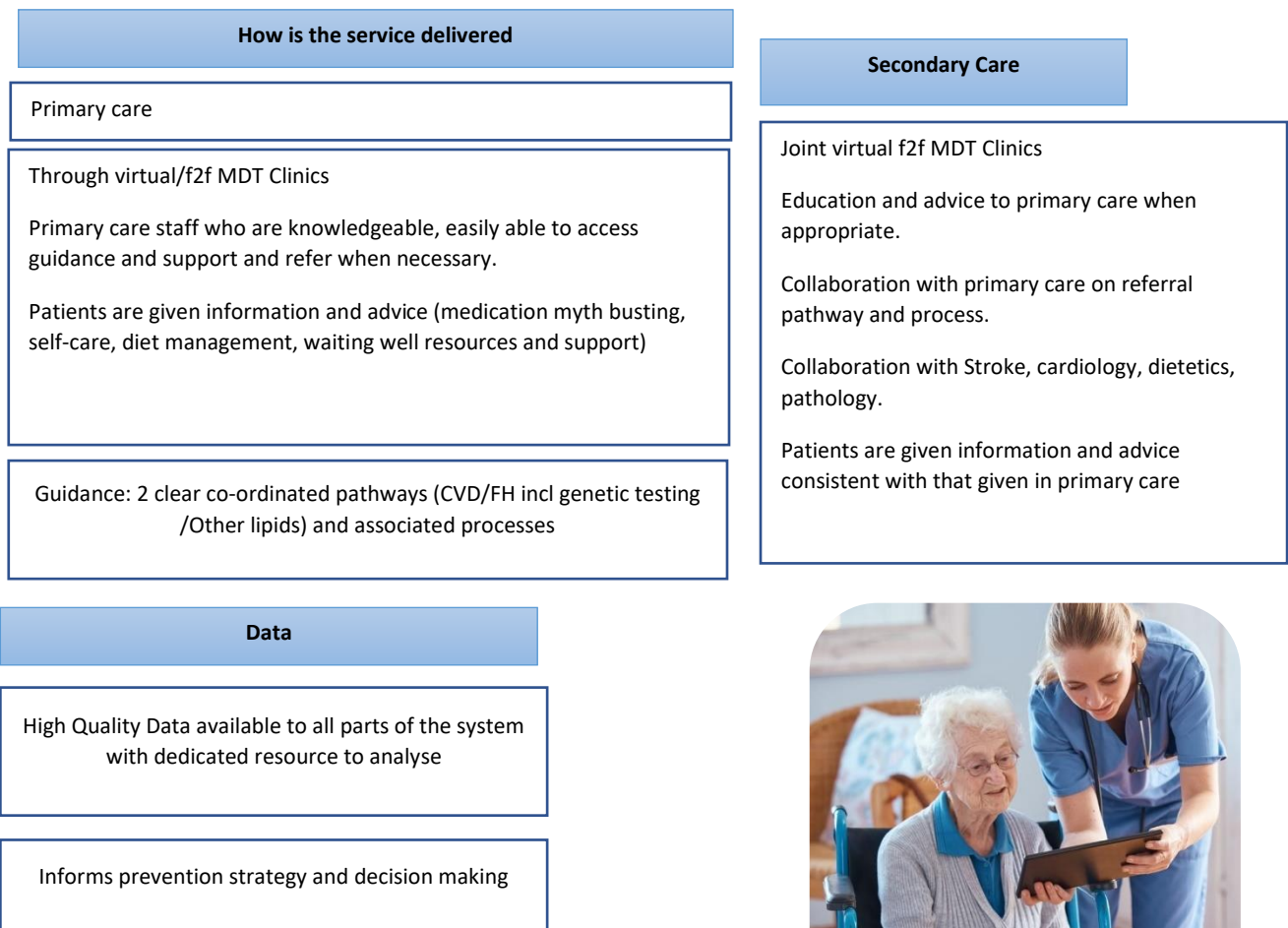
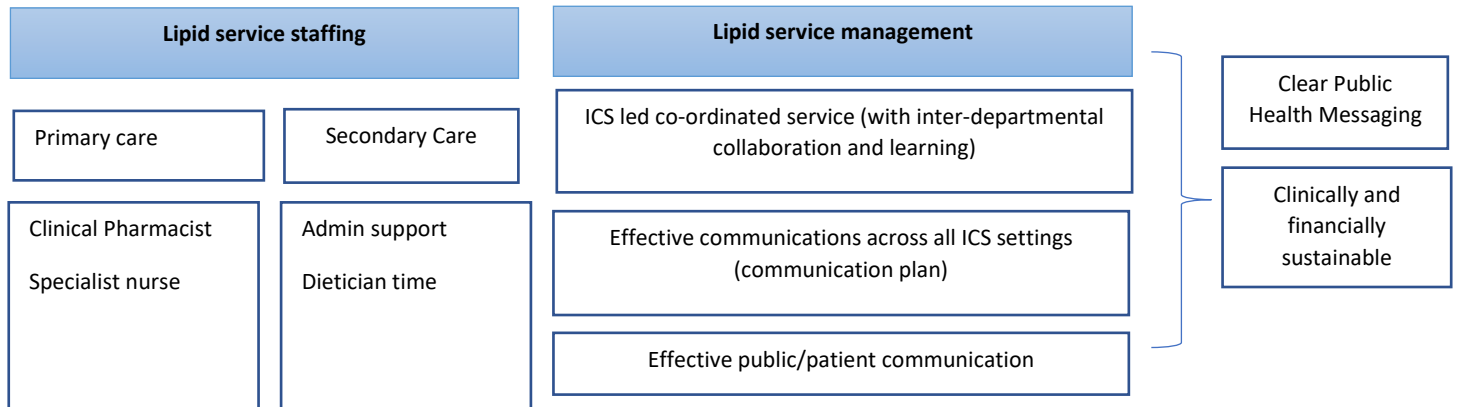


Figure 2. Somerset Lipid Service Vision Workshop

Process map of the patient journey through the Somerset Lipid Service (January 2023)

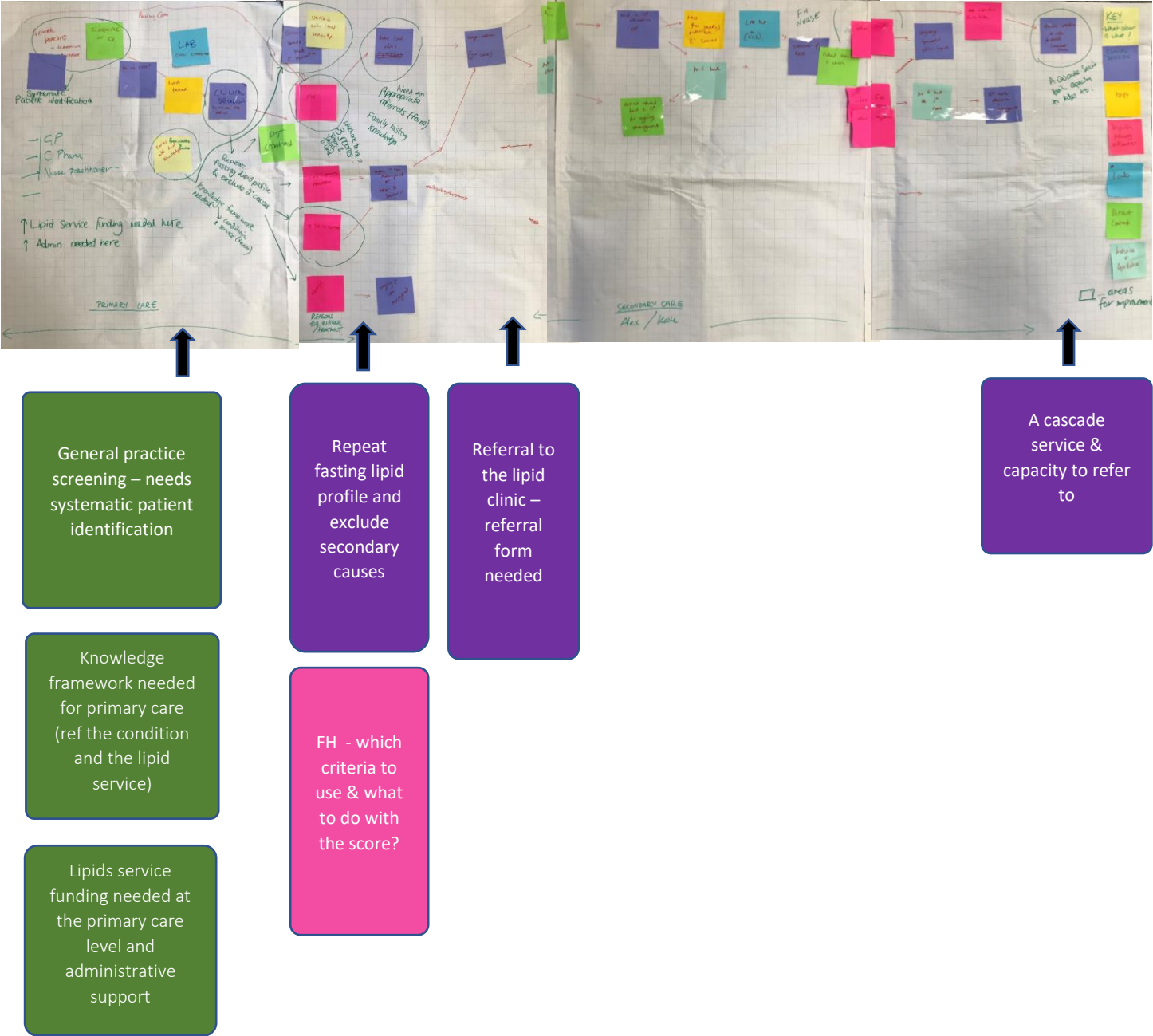


Figure 3. Somerset Lipid Service Patient Journey Workshop

4. Putting in place a robust evaluation



Using tools and approaches such as the pathway mapping and logic modelling at the start of the design process will enable you to identify key areas to be developed and delivered as part of your programme.

The section below explains how to put in place a robust evaluation and learning framework to support the team to evaluate multiple aspects of the project and understand if, how and why it is working, and its value, effectiveness, or quality.

Evaluation aims to provide insights that can be used for improvement, decision-making, and building knowledge. Evaluation is a core part of quality improvement and, when done well, can help teams learn and understand how best to improve health care.

This section of the toolkit provides a snapshot of the phases and elements to consider when putting an evaluation in place. The four phases of an evaluation are shown in Figure 4 below.

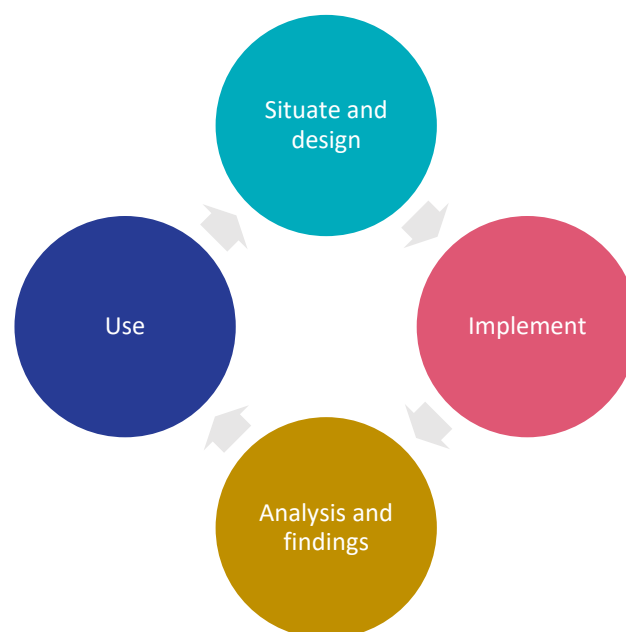


Figure 4. Phases of an evaluation



Evaluative thinking and tools help programmes and organisations articulate their problem and goals, define the changes they aim to achieve, and identify the action necessary to achieve those changes. Bringing evaluation into the programme and redesign work from the beginning provides the foundations for monitoring, evaluation and learning, and supports the development of the strategy and programme design.

Stakeholder Engagement

Evaluation involves working closely with stakeholders from across the programme, such as programme managers, clinical leads, steering group and project group members, and representatives from the system and target population. Working closely with the team from the

start of a project and programme design enables you to be clear what the evaluation aims are and help foster a supportive environment to conduct the evaluation.

Develop a logic model

If your team is beginning a project or redesigning a service, developing a logic model is a valuable process in getting agreement from stakeholders on the problem being addressed, and the key purpose of the project and what is needed to achieve it.

What is a logic model?

The logic model is essentially a road map that outlines the steps required to achieve the desired outcome of a program or intervention. It provides a clear understanding of how the program is expected to work, what activities and resources are required, and how the intended outcomes will be achieved from those activities.

Logic models are usually developed in facilitated workshops with a diverse group of stakeholders during the inception phase of the programme design. The logic modelling process helps:

- navigate the complexity of change with critical thinking and diversity of views. It facilitates a shared consensus;
- break down a complex process into manageable steps for clinicians and teams;
- show pathways of change and focus attention on plausibility of causal relationships;
- articulate the assumptions underlying the change theory of a programme. The model can additionally incorporate thinking about contextual influences surrounding the programme, the current barriers, and enablers, and the unintended consequences of the new programme; and
- communicate your programme and change idea in a quick and easy way to others.

The core components of a logic model are seen in Figure 5, and the example logic model from Somerset Lipids Projects is attached in the toolkit resources and insights report.

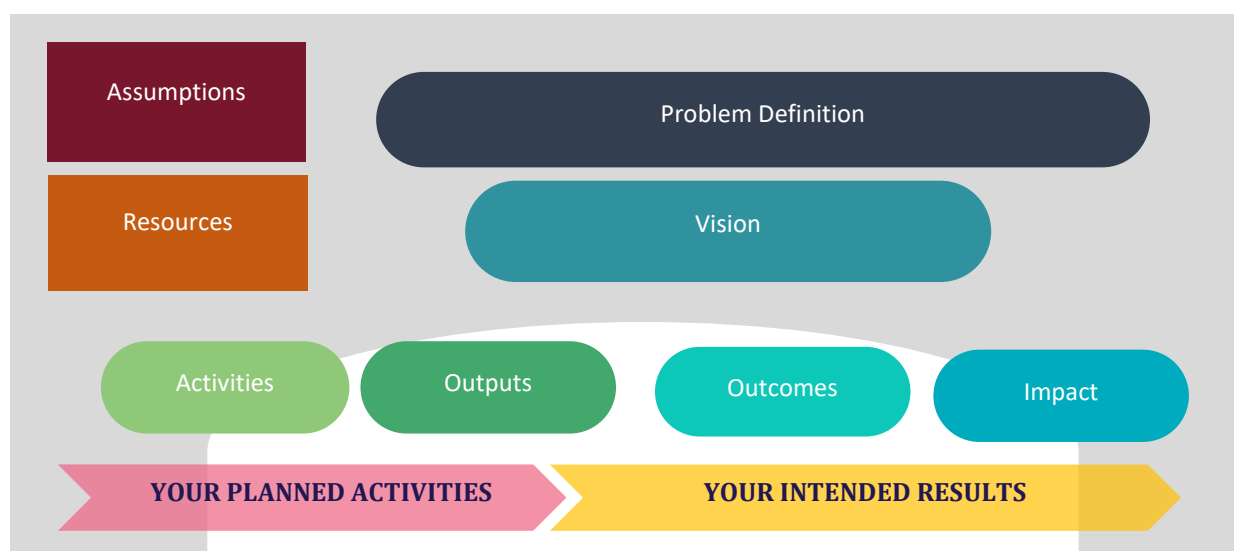


Figure 5. Logic model components

How to use it?

Once the logic model is developed, it can be used to guide your measurement and evaluation approach as well as support project planning and communication about your programme with stakeholders, funders and commissioners. Additionally, it can be used to capture lessons on implementation based on how you thought your change would happen and the adaptations or revisions needed as the project progresses.

Develop a measurement plan and an evaluation approach

A measurement framework provides a roadmap for collecting, analysing and interpreting the data you collect, ultimately enabling you to make informed judgments about the success or impact of your project.

What is a measurement framework?

A measurement framework describes each of the outcomes and impacts you have specified in your logic model in more detail, in terms of operationalising the concept, identifying specific measures and how measurement will take place. A measurement framework is a table that details how you will answer your evaluation questions. It specifies the measures you plan to use, the data source, timeline for data capture and the person(s) responsible.

How to use the framework

The measurement framework template should be completed one row at a time, considering each of the following columns: output/outcome/impact, evaluation question, measure (qualitative and or quantitative), baseline, data source, timeline including when you will capture baseline data and responsibility for collection (table 1).

OUTCOME / IMPACT	EVALUATION QUESTION	MEASURE	BASELINE	DATA SOURCE	TIMEFRAME	RESPONSIBLE
EXAMPLE: Increased levels of knowledge, skills or confidence in managing their COPD	EXAMPLE: Does the intervention (I) lead to people with COPD (P) having increased knowledge, skills or confidence in managing their COPD (O) from pre to post intervention (C)?	EXAMPLE: Validated Patient Activation Measure (PAM) questionnaire	EXAMPLE: Not yet available	EXAMPLE: Administered by mentor during initial and exit telephone call	EXAMPLE: Baseline (immediately pre intervention) and 12 weeks post intervention	EXAMPLE: Innovator

Table 1. Health Innovation South West Evaluation Team Measurement Framework example.

What will you measure?

Any evaluation you undertake will have limits in terms of timelines and resourcing. It is important to consider which of the outputs, outcomes or impacts in your logic model are measured within your evaluation. Thinking about what type of evaluation you want to use can help determine your focus. Examples include formative, process, outcome summative, rapid cycle, and developmental evaluation. Deciding on the approach and what can be measured depends on:

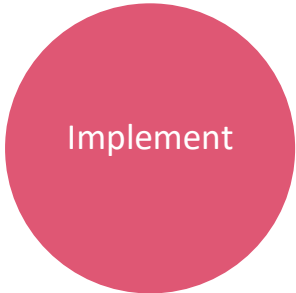
- the stage your programme is in (conceptualisation, implementation, mature stage);
- the requirements and expectations of various stakeholders involved. What decisions do you and the commissioners want to be able to make at the end of the project;
- the timeframe available for conducting the evaluation;
- whether the outcome or impact can change because of your innovation within your timeframe; and
- the budget for the evaluation.

Understanding the type of evaluation you are conducting and the questions you are seeking to answer is beneficial to guide what measures are useful and feasible to collect and why. If you have a clear, considered, and concise logic model, then evaluation questions should be easy to establish. These should be:

- clear, specific, and well-defined;
- focused on the change idea or innovation you are implementing;
- measurable; and
- aligned with your logic model.

Note: Having data from a ‘comparator group’ can be a more robust way of establishing whether your change idea is more effective than an alternative (such as the usual care pathway or another intervention). It can often be difficult to identify an appropriate comparator group and collect data from them. One way to overcome this is to compare groups on routinely collected data only, if it is accessible. Some evaluations do not have a ‘comparator group’ and will compare data before and after an intervention has been implemented. Evaluators need to be aware how this limits their ability to claim that the innovation caused a change in the outcome.

Now that you have your measurement framework in place, you are ready to begin implementing your change idea and the accompanying evaluation. The following is a brief overview of steps that need to be undertaken to implement the evaluation.



Implement

Data collection tools and informed consent

Information sheets, consent forms, and interview or focus group questions will be developed during this phase, for qualitative work with patients or staff and project teams, and data collection queries or templates for quantitative data collection. Obtaining informed consent is an important consideration for the evaluation. Before you begin collecting the data for your evaluation, you must seek the consent of people who will be involved. Not everyone will want their data used for evaluation

purposes, and if patients are participating in the evaluation for quantitative or qualitative work, it is important to let them know that they are still able to receive the service even if they do not participate in the evaluation.

Data collection

Once you have specified the measures in the measurement framework, you can begin collecting baseline data. To obtain the best quality data, ensure these measures are undertaken prior to the patient being involved in any part of the change idea. If you are external to the organisation that you are collecting data from, a data sharing agreement will need to be in place or considered.

Your measurement framework will have specified when you plan to collect any follow-up data, and collection timelines should be clearly communicated to staff. Some data will not be 'baselined' but will only be collected towards the end of the project, or after the intervention has finished; this could include qualitative data. It is important to be clear on who is responsible for each part of the process, and a plan put in place. It is important to collect data early, or collect test data, so you can user-test it and troubleshoot, before the analysis and write up phase.

When collecting data from individuals at various time points, such as a baseline and follow-up measure, use a unique identifier or key that links the data from each time point to the same individual. This identifier should be a random or pseudonymous code that is not linked to the individual's identity, to protect their privacy when sharing and storing data. Ensure data security and compliance with relevant privacy regulations to protect participants' information.

At the end of the project, you will have a range of data sources to analyse and synthesise, to understand what effect (if any) your project has had, and to what extent you have achieved your goal. You might have chosen to analyse the data at more than one timepoint. For instance, mid-way through the implementation to support learning and adaptation, and at the end of the project to understand how your project was delivered and if the intended outcomes were achieved.

Quantitative data can be analysed by looking at:



Analysis and findings

- changes over time from baseline – measures you have collected before and after the change idea was implemented;
- changes over time from a period before and after implementation – looking at routinely collected data to understand what might have changed for your patient group; or
- comparison with a comparator group – if you have access to routinely collected data, you can compare changes in your intervention with that of a comparator group.

There are a range of ways of analysing this data, depending on the type of data it is, the frequency of data collection, the type of comparator data you have, the number of participants and the amount of missing data you have. To conduct a robust and meaningful analysis, it may be more appropriate to conduct descriptive rather than inferential statistics. We advise you to obtain advice from someone with an expertise in data analytics or statistical analysis to support you to identify the most appropriate methods. To access this type of expertise, contact your local Health Innovation Network, ICS data analytics team or university.

Qualitative data can be analysed in several ways.

The most commonly used methods in evaluations are thematic and framework analyses. Thematic analysis allows the themes to emerge from the data, whilst framework analysis imposes a pre-existing framework on the data. Both approaches are valid, but what you choose will depend on your research question.



Discover,
share, apply

You should have identified and agreed the purpose of the evaluation at the start of the project.

This should include how you intend to use the findings. If you have chosen a rapid-cycle approach you may generate findings at key points in the programme to support learning and decision-making early. If you are producing an end of project evaluation report, it should be agreed what audience it should be disseminated to for decision-making, for learning, for information, and for wider audience knowledge sharing.

It can be useful to bring your stakeholders back together to discuss and interpret the results before you write up your findings. Early sharing will support you to discuss what the findings might mean in relation to your change idea and goal.

It is recommended that you structure your final report around the evaluation questions, answering each one in turn using the data you have collected. Where there are gaps in data, it is useful to identify why the gaps have occurred and what learning has been gained from this. Ensure that participant confidentiality and privacy are maintained in any reports you produce.

Resources:

Somerset resource name	Location
Somerset Lipids Project Logic Model	Health Innovation South West Website
Service User Feedback Survey flier	
Tool/resource template	
Patient experience: resources on measures and information sheet & consent form template	
Example data collection tool – primary care lipid practitioners	
Logic model and measurement framework template	

5. Implementation: Agreeing and Developing Key Elements

Once the Somerset team defined the problem and set a vision for the programme, they were able to further detail the pathway and changes through a pathway map and develop a detailed logic model and an evaluation approach. Following the foundational design phase, key areas within the model were ready to be developed with the team – going from idea to development and implementation. In order to move forward with implementation, each activity area in the logic model was focused on, and a delivery plan was put in place.

Two core activity areas for the Somerset Lipids Project were developed which focused on: lipid management education and engagement (including resource development), and building capacity in primary and secondary care which required the development of a workforce model and the recruitment of staff. These areas will be looked at in turn in sections 5.1 and 5.2 below to help readers who may implement and deliver similar activities.

5.1 Implementing an education and engagement plan for primary and secondary care

One strand of the service redesign work in the South West has been to work with the primary and secondary care workforce to improve their understanding and confidence to optimise lipid management.

Our programme therefore had a strong focus on education and engagement across the workforce. This section provides the learning and tools to implement an education and engagement plan for lipid management.

In order to establish the needs of primary care, the lipid service lead and the ICB CVD lead engaged both with PCN clinical directors and Local Medical Committee leads (LMC) early on in the project to ensure that their input and feedback regarding their priority needs in lipid management were captured both at the start and throughout project delivery.

Following this, system level guidance and resources were developed by the project team with input from key stakeholders such as PCN leads, to support lipid management in Somerset to complement existing national guidance. These resources are housed on the Somerset Lipid Service page on TeamNet. TeamNet is an online platform that supports knowledge sharing and collaboration in primary care. The resources were launched online at the start of August 2023 and 64 practices in Somerset now have access to lipid management resources and guidance. Alongside the downloadable resources about lipids pathways and management, the materials on TeamNet include guidance on who to refer to, what to do before referral, and how to refer. The resources can be viewed through Cardiology, Endocrinology, and Stroke/TIA sections in TeamNet. Development of the new lipid service page on TeamNet continues, with feedback from primary care and a new enhanced topics page.

Between August 2023 and February 2024, the TeamNet Lipid Service page had been viewed 137 times by 29 practices.

In addition to these resources being developed and housed on a primary care platform, a communication was sent out to all PCNs and practices in Somerset to highlight the changes to the

lipid service, new resources available on TeamNet, and the various job roles which have been/are being recruited to. The plan is to repeat this information dissemination again in February/March 2024.

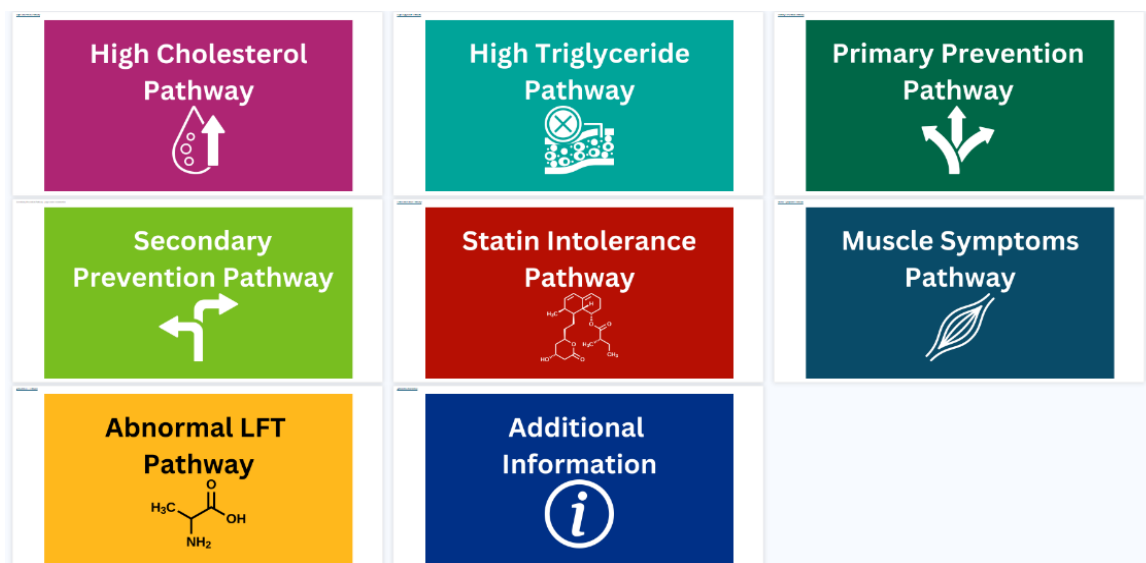


Figure 6. Somerset Lipid Service Topics page

The resources below have been created by the Somerset Lipids Project Team:

Somerset resource name	Location
Somerset Lipid Management Clinical Guidelines	Health Innovation South West Website
Communication to primary care new service page and resources	
Somerset Lipid Service TeamNet Link, NHS Somerset Foundation Trust	See link opposite
Practice level cholesterol management searches: practicalities, approaches, lessons [§]	See footnote

A core part of the programme has been supporting primary and secondary care staff with the knowledge and tools to understand and manage FH and lipids patients with the delivery of content led by the Somerset Consultant in Diabetes, Endocrinology and Lipids, or another expert member of the team. An education programme was established using a multi-pronged approach of engagement through three avenues:

1. interested Primary Care staff contacting the lipid service lead requesting education session for practices/PCNS;

[§] For more information contact Harriet Matthews: harriet.matthews@healthinnovationsouthwest.com / Alex Bickerton: Alex.Bickerton@SomersetFT.nhs.uk

2. education sessions being provided through [the Somerset GP Education Trust \(SGPET\);^h](#) and
3. working with Daiichi Sankyo to deliver lipid management pathway education across a wide audience.

In terms of secondary care, engagement was done through clinician to clinician conversations covering cardiology, stroke and dietetics, with the lipid consultant highlighting the importance of lipid management and sharing lipid management resources. This was further reinforced through the provision of targeted education sessions to junior doctors, registrars, stroke nurses and diabetes nurses in the community.

The use of multiple methods of engagement and delivery has meant that a total of 537 health care professionals have engaged and completed training with high impact results. The post-session survey feedback from n114 respondents highlighted:

- 99% of survey respondents strongly agreed or agreed that the session had improved their understanding of lipid management;
- 98% of survey respondents strongly agreed or agreed that they felt that they had more confidence to manage patients with lipid disorders, including FH; and
- 96% of survey respondents strongly agreed or agreed that they felt better able to implement or support the implementation of the lipid pathway within their role.

Resources

Somerset resource name	Location
Somerset Lipid Project Primary care education and engagement survey flier	Health Innovation South West Website
Lipid Management Presentation primary care	
Tool/resource template	
Education Session log tool example	
Evaluating training programmes: resources 1. Kirkpatrick's Four-Level Training Evaluation Model.^{ij} 2. Centers for Disease Control and Prevention. Recommended Training Effectiveness Questions For Post course Evaluations User Guide.^k	See links

^h Somerset GP Education Trust. 2023. somersetgpeducationtrust.co.uk

ⁱ Kirkpatrick, J.D. and Kirkpatrick, W.K. 2016. Kirkpatrick's four levels of training evaluation. ATD Press

^j For an overview of the four-level training evaluation model, see MindTools. Kirkpatrick's Four-Level Training Evaluation Model. Available at: <https://www.mindtools.com/ak1yhhs/kirkpatrick-s-four-level-training-evaluation-model>

^k Centers for Disease Control and Prevention. *Recommended Training Effectiveness Questions For Post course Evaluations User Guide* Atlanta, GA: CDC, 2019.

5.2 Workforce model and recruitment

The Somerset Lipid Service model and workforce has been built over time, with early problem definition work in Somerset in 2022 – building on the keen energy from the service lead and different groups in the system and funding opportunities emerging through wider CVD work.

The problem was defined through bringing in local knowledge and experiences about the challenges, building strong collaboration with multiple stakeholders across the system, and developing examples of different models, including the workforce needed. This early phase gave the foundations that allowed the lipid service lead to develop a business case.

As a result of the foundational work and business case, the Somerset Lipid service was able to create a workforce model that has a multidisciplinary team approach and enables primary and secondary care to work more closely together to support each other and patients (figure 7). For more in-depth information about the workforce model please see the Somerset Lipids Project Evaluation Report.

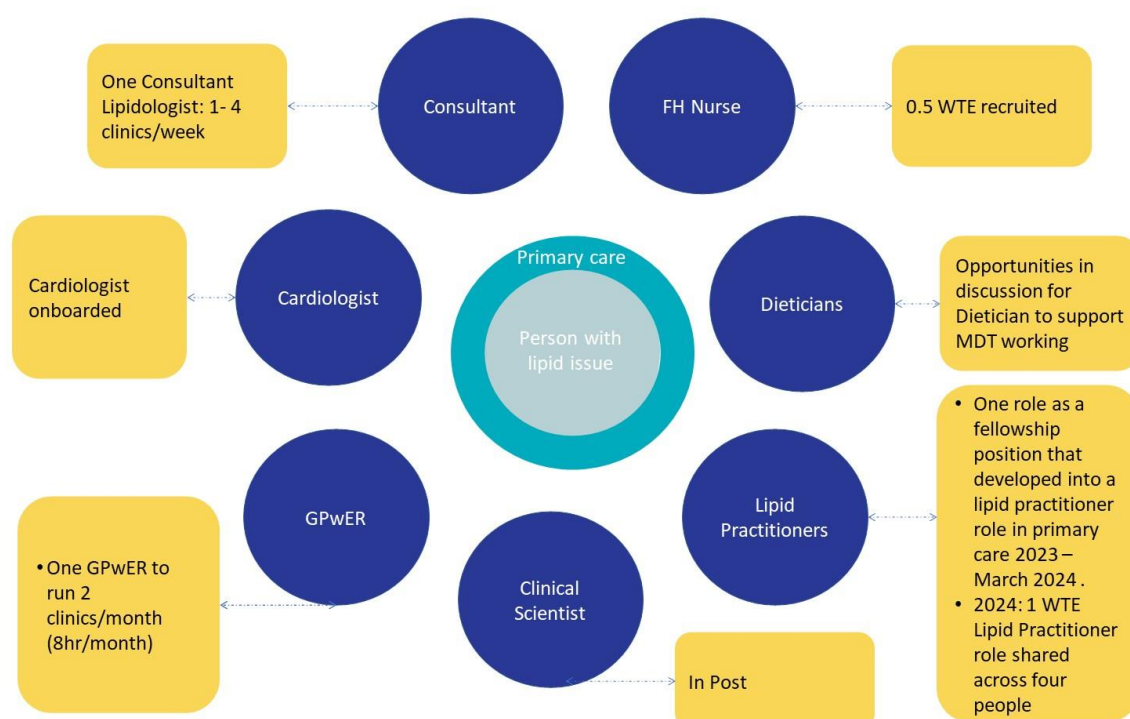


Figure 7. Workforce Model

Resources

Somerset resource name	Location
Somerset Lipids Project GPwER job description	Health Innovation South West Website
Somerset Lipids Project Specialist Lipid Practitioner job description draft	
Somerset Lipids Project FH Clinical Nurse Specialist Job description	
Project Co-ordinator Role overview	

6. Embedding sustainability

It is crucial to think about how your project and change is developed and how it can be successful beyond the early design and delivery stages. Sustainability should be considered at the beginning of an improvement project to understand where the project strengths and gaps are and what can be done to enhance the chances of sustainability. However, as sustainability can mean different things, the [NHS Institute for Innovation and Improvement](https://www.england.nhs.uk/improvement-hub/wp-content/uploads/sites/44/2017/11/ILG-1.7-Sustainability-and-its-Relationship-with-Spread-and-Adoption.pdf) provides a useful definition below.^l

“Sustainability: new ways of working and improved outcomes become the norm. Not only have the process and outcome changed, but also the thinking and attitudes behind them are fundamentally altered and the systems surrounding them are transformed in support. As a result, when one looks at the process or outcome one year from now or longer, one concludes at minimum that it has not reverted to the old way or old level of performance. Further, it has been able to withstand challenge and variation; it has co-evolved with other changes in the context.”

- NHS Modernisation Agency and from the NHS Sustainability Model and Guide©
- NHS Modernisation Agency and from the NHS Sustainability Model and Guide©

Thinking about sustainability means considering the structures and elements surrounding and enabling a project and how they are working and maturing. It is important to consider the micro, meso and macro levels of the change, and how work within those levels influences implementation, spread and sustainability.^m For instance, you can consider the following aspects when thinking about what influences implementation and spread at micro, meso and macro levels (see resource table for NAAS and CFIR frameworks):

- the innovation and intervention evidence, complexity and design;
- the problem definition, vision and purpose of the change;
- individuals and behavioural changes;
- the internal dynamics within teams and organisations;
- the culture within which teams work and implement change; and
- the wider context, systems and processes in how work is shaped.

^l NHS Institute for Innovation and Improvement. Sustainability and its relationship with spread and adoption. Available at: <https://www.england.nhs.uk/improvement-hub/wp-content/uploads/sites/44/2017/11/ILG-1.7-Sustainability-and-its-Relationship-with-Spread-and-Adoption.pdf>.

^m Micro in this instance would be considering the individuals and small groups, their interactions, actions, behaviours, needs, perceptions, and such. The Macro level of change would be considering the medium system level such as organisational level, inter-organisational level, organisational culture. The macro level in this context is the wider social, political, and economic context and factors, such as the National CVD agenda and additional cholesterol QOF areas.

In the case of Somerset, the project design evolved over time, with the core development and implementation of the service redesign occurring in 2023. Once the team collectively created a vision and clear implementation plan, and early delivery of the model had begun, it was possible to reflect in a structured way about the elements of the project and outcomes to be sustained.

To achieve this, with support from Health Innovation South West, the team used the [NHS Sustainability Model](#).ⁿ A summary of the findings is captured in Figure 8, which shows that the project scored 76 out of 100, with the highest factor scores for Staff and Process. However, the lower score for 'Organisation' showed that more work was needed in this area.

6.1 Summary Sustainability Findings (Somerset example)

PROCESS

- What has gone well?
 - Change has a wide variety of benefits beyond helping the patients.
- What would be even better if?
 - Benefits of the change which are supported by evidence and believed by stakeholders are communicated more widely.
 - The improved process can be adapted to support wider organisational change, even if specific individuals or groups leave the project.
 - Evidence of impact and monitoring progress is communicated more widely than the core project team, and the measurement system is set up to continue beyond the formal life of the project.

STAFF

- What has gone well?
 - Staff have been involved from the beginning of the change process and have helped to identify skill gaps.
 - Staff are able to share their ideas regularly, and some of them have been taken on board during the project. They believe that the change is a better way of doing things and have been empowered to run small scale test cycles (Plan, Do, Study, Act).
 - Organisational leaders are highly involved and visible in their support of the change process. They use their influence to communicate the impact of the work and to break down any barriers. Staff regularly share information with, and actively seek advice from leaders.

ⁿ NHS sustainability-model. 2010.pdf. Available at: <https://www.england.nhs.uk/improvement-hub/wp-content/uploads/sites/44/2017/11/NHS-Sustainability-Model-2010.pdf>.

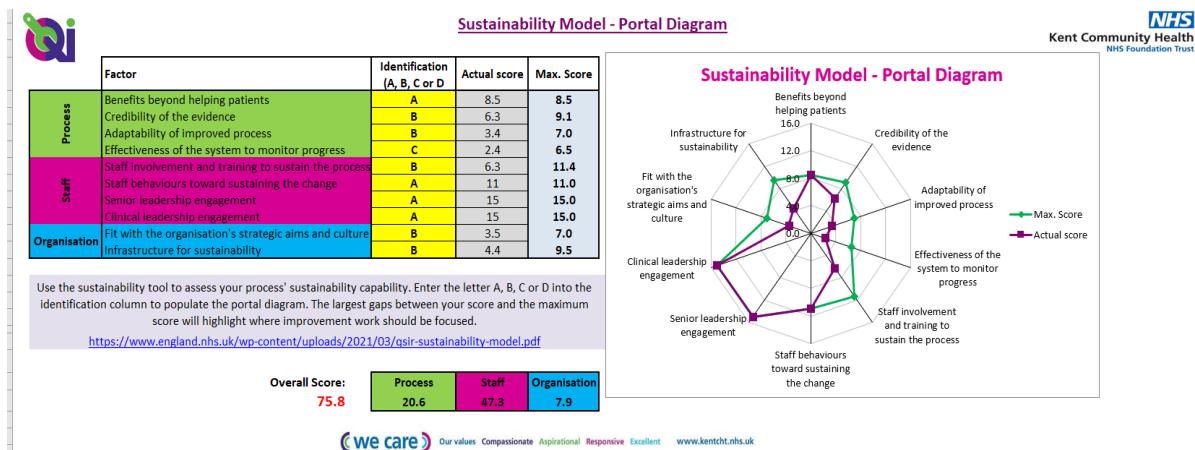
- Clinical leaders are highly involved and visible in their support of the change process. They use their influence to communicate the impact of the work and to break down any barriers.
 - Staff regularly share information with, and actively seek advice from, clinical leaders.
- What would be even better if?
 - Staff are trained and have opportunities to learn the new way of working.

ORGANISATION

- What has gone well?
 - The goals behind the change are clear and have been shared widely. They are consistent with and support the organisation's strategic aims for improvement.
 - The organisation is able to demonstrate success in sustaining previous improvements and develops a 'can do' culture off the back of the recent merger and re-structure.
 - Staff are confident and trained in the new way of working.
- What would be even better if?
 - Job descriptions, policies and procedures reflect the new process and facilities and equipment are set up to sustain it.
 -

To build on these findings, the team is undergoing a review and planning process between January and March 2024 to ensure that, where possible, sustainability can be strengthened. Areas for future development have been defined as:

- integration of evaluation and learning tools and mechanisms into the service itself;
- education and resource development (patients and health care professionals);
- engagement of stakeholders around key areas such as co-ordination of FH focused work;
- maximisation of the involvement and impact of the patient representative role; and
- further service model development in terms of workforce expansion.



	Process	Staff	Organisation	
Score	20.6	47.3	7.9	75.8
Max Score	31.1	52.4	16.5	100

Fig 8: Outcome of the Somerset Lipid Project Sustainability Review using the Kent Community Health NHS Foundation Trust tool

Resources

Tools to support implementation thinking and sustainability at design phases	Location
NHS sustainability model	NHS sustainability-model. 2010.pdf. Available at: https://www.england.nhs.uk/improvement-hub/wp-content/uploads/sites/44/2017/11/NHS-Sustainability-Model-2010.pdf
Non-adoption, abandonment and challenges to scale-up, spread and sustainability NASSS	Applying the NASSS framework to Learning Health Systems - the learning healthcare project (2021) The Learning Healthcare Project - Emerging developments and their implications. Available at: https://learninghealthcareproject.org/sources-of-complexity/nasss-framework/
Consolidated Framework For Implementation Research (CFIR)	Damschroder LJ, Aron DC, Keith RE, Kirsh SR, Alexander JA, Lowery JC. Fostering implementation of health services research findings into practice: a consolidated framework for advancing implementation science. <i>Implement Sci.</i> 2009. August 7;4:50 10.1186/1748-5908-4-50
Sustainability Model Analysis Template	Kent Community Health NHS Foundation. Sustainability Model. Available at: https://qi.kentcht.nhs.uk/sustainability-tool/
Improvement Leaders' Guide: Sustainability and its relationship with spread and adoption	NHS Institute for Innovation and Improvement. Sustainability and its relationship with spread and adoption. Available at: https://www.england.nhs.uk/improvement-hub/wp-content/uploads/sites/44/2017/11/ILG-1.7-Sustainability-and-its-Relationship-with-Spread-and-Adoption.pdf

C. Stand-alone Snapshots

The follow sections are a snapshot view of the evaluation report in 1, and the detail of our population and context in 2. The population detail and context also provide additional tools that can help you think about your context.

1. Evaluation Report Executive Summary

Context

Cardiovascular disease (CVD) causes a quarter of all deaths in England and is the leading cause of premature mortality in deprived areas (Raleigh, et al., 2022). Heart attacks and strokes can be prevented, and the NHS has made CVD prevention a priority, committing to preventing 150,000 heart attacks and strokes by 2029 (Ahmad, et al., 2022).

It is estimated that 20 million people in England have elevated cholesterol levels, and the national prevalence of familial hypercholesterolaemia (FH) is approximately 1 in 250 (BHF, 2022).^o Cholesterol levels can be lowered through lifestyle changes, and medicines initiation and optimisation. There is a need to ensure those at risk are identified and offered effective treatment, and clinicians are supported in identifying and managing patients. Previous studies and modelling have indicated estimated benefits from identification and treatment:

- statin therapy, to reduce cholesterol by 1mmol in people with a 10-year risk of CVD where the risk is greater than 10%, reduces risk of CVD events by 20-24% (Kearney, 2017). After the first year of statin use, each 1mmol/l reduction in LDL-C leads to 20-25% relative reduction in CV risk, including 20% decrease in coronary mortality (Cardoso, et al., 2018); and
- modelling shows that if 90% of people with CVD were prescribed a statin and 70% were put onto an optimal dose, over 800 strokes and heart attacks could be prevented in five years (UCLP, 2022).

In 2023, through the National Implementation Agreement, Health Innovation North East and North Cumbria, NHS England, and Novartis (The Tripartite) funded successful applicants to build on approaches to delivering lipid management optimisation through The Collaborative Lipids Fund (CLF). The CLF projects were designed and delivered over 12 months from April 2023 to March 2024 to help improve and build services and models, implement best practice, and develop cross-organisation working in local geographies.

Somerset Context and Lipid Service Model

In Somerset, with a population of 571,600, around 82,000 people are living with circulatory diseases, 23,000 are living with coronary heart disease, and there are around 14,000 stroke survivors in the Somerset area (Somerset Intelligence, 2021) (BHF, 2023). Heart and circulatory diseases kill more the 1 in 4 people in the Somerset Area (BHF 2023).

^o Familial hypercholesterolaemia (FH) is a condition caused by a defective gene that causes high levels of cholesterol in the blood. Commonly inherited from one parent but in rare instances can be more serious and inherited from both parents.

Somerset detection and treatment of hyperlipidaemias (including FH) in primary care is low, putting a significant proportion of the population at increased risk of cardiovascular disease (CVD). Detection rates (as of September 2021) of a genetic diagnosis of Familial Hypercholesterolaemia were 0.7% of the anticipated individuals affected, which is significantly under the national average, and short of the NHS Long Term Plan of 25% diagnosed and treated optimally.^p In early 2023, of those aged 40-74 in Somerset, only 27% had a QRISK score recorded in the previous five years, 17% recorded QRISK score more than five years ago, and 56% had no score recorded.^{qr} The NHS Long Term Plan CVD ambitions are for 75% of people aged 40-74 to have received a formal validated CVD risk assessment and have their cholesterol reading recorded. Of those detected as having a 20% or greater risk of developing CVD in primary care, 45% are to be treated with statins (NHS England, 2019).

In addition, there was a limited provision of lipid clinics and specialists within the region in 2021, with one consultant-led clinic a month in secondary care. There was a growing waiting list and lengthy waiting times from referral to appointment for patients (waiting time above 79 weeks for some patients and a 92nd percentile waiting time of 77 weeks for those referred in 2021) due to limited service provision and capacity.

To address these challenges, Health Innovation South West, in partnership with the regional teams and leads, developed a phased approach to designing, delivering, and deploying an innovative lipid service in Somerset and Devon (with the ambition to spread more widely across the peninsula). The Somerset Lipids Project has been developed to work across primary (64 practices / 13 PCNs) and secondary care to transform primary care pathways, improve identification, and optimise treatment for familial hypercholesterolemia, and cholesterol (primary and secondary prevention). Additionally, it is seeking to increase service provision through specialist care service capacity and new ways of working and collaborating with primary care.

The core components of the service redesign model included:

- building knowledge, skills, resources, and capacity in primary care;
- building capacity and capability in secondary care;
- building approaches to support collaboration and coordination between primary and secondary care; and
- building a team, a vision and implementation plan.

Evaluation of the project

An evaluation was commissioned as part of the Collaborative Lipids Fund project to support Somerset and Devon. Health Innovation South West has worked collaboratively with Somerset and Devon lipid service teams to both build the foundations for evaluation and learning within the teams as the project developed and capture early insights on implementation and early outcomes achieved from the model. A mixed methods process evaluation was designed to understand implementation insights and the short-term outcomes of the project in Somerset from April 2023 to February 2024.

^p CVD Prevent 2023; PHE 2023 Lipid Service Redesign Workshop. Unpublished.

^q CVD Prevent 2023; PHE 2023 Lipid Service Redesign Workshop. Unpublished.

^r QRISK is a prediction algorithm for cardiovascular disease

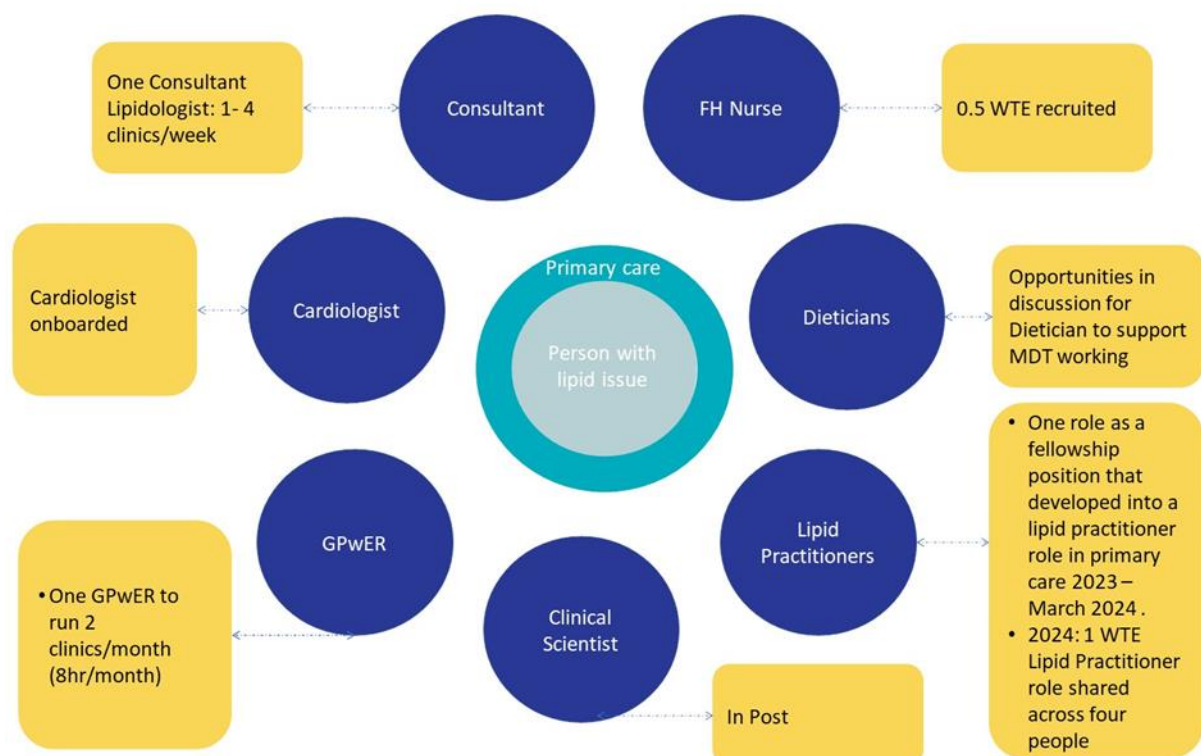
Results

The main findings from the evaluation are as follows:

- the model is seen as acceptable and appropriate at this early stage amongst key staff;
- the education and resource arms are improving access to resources with nearly half of Somerset practices accessing resources on TeamNet (29 of 64 practices), and more than 621 health care professional attending education sessions;
- the education sessions are increasing perceived knowledge and confidence of the primary and secondary care workforce attending education sessions;
- the new lipid practitioner role has been positively experienced and perceived to be influencing role development and satisfaction for the lipid practitioner;
- there is progress at primary care level with implementation of targeted lipid management through the embedded role with 323 patients reviewed, and patient feedback is positive; and
- the number of specialist lipid clinics run each month has increased from one to four per month, and there are indications that the lipid clinic waiting times are reducing.

Workforce

There is increased capacity, with new roles in primary and secondary care supporting a more targeted and joined up service. There has been a range of roles recruited or receiving training to support the project as seen in the figure below.⁵



⁵ GPwER: General Practitioner with Extended Role

The practitioner supporting primary care has had positive experiences of implementation. They feel they have **greater knowledge in the lipids field and operating in primary care**, and **greater satisfaction within their role**. The opportunity to develop their clinical role within an area of interest, and opportunity to work in more detail with primary care has been an enabler to their motivation and role development as a clinical pharmacist. The personal development and learning structure have **increased their knowledge and capability to manage patients with lipids in primary care**, and the practical and technical learning within the practice system has grown their technical skills and communication skills in primary care. The mentorship offered psychological safety to develop in the role and empowerment to take initiative.

“A really positive input. It's been really satisfying... I feel like I have a positive contribution. It certainly led to more satisfaction and understanding of my own role and how I fit in primary care.”

— LIPID PRACTITIONER



Resources, education, knowledge and confidence

A core part of the project involved the steering team developing accessible resources about lipids management and pathways, as well as delivering education sessions to primary and secondary care. **The Somerset Lipids Project has reached more than 71 healthcare organisations over 11 months**. The health organisations reached have been in primary care (55), and across secondary care hospitals, trusts, urgent care, and research institutes in the South West Region, not only Somerset. Further details are below, along with feedback from a survey administered after the education sessions.

- 21 education sessions have been run across Somerset, and 621 people from various clinical roles in primary and secondary care have attended education sessions.
- 45% of practices in Somerset have accessed the new lipid service page and resources on the TeamNet. Resources and tools have been accessed 137 times by 29 (of 64) practices.
- 18 education sessions were evaluated and had n131 responses to the evaluation survey:
 - 99% of survey respondents strongly agreed or agreed that the session had **improved their understanding** of lipid management (figure 7);
 - 98% of survey respondents strongly agreed or agreed that they felt that they **had more confidence to manage patients** with lipid disorders, including FH; and
 - 96% of survey respondents strongly agreed or agreed that they felt **better able to implement** or support the implementation of the lipid pathway within their role.

Survey participants from across the clinical workforce attending education sessions felt that the sessions were clear and interactive, with useful and new information as seen in the quotes:

“A refreshing reminder of the rationale for statin use.”

“New information regarding management.”

“Excellent first principles-based teaching. Now have a good understanding.”

“Good overview of a generally neglected area in secondary care.”

“New agents for lipid lowering therapy. Learning how to identify genetic causes of hyperlipidaemia.”

— EDUCATION SESSIONS SURVEY RESPONDENTS



Primary care site and patients

The lipid management targeted approach at two case study practice sites was implemented successfully by the lipid practitioner working one day a week. **Across two primary care sites the lipid practitioner was able to review 323 patients** across Quality and Outcomes Framework (QOF) indicators CHOL001/2, DM022/3, and QRISK>20%. Searches for those at risk of FH were conducted in site 1.

- 88 patients started statins or lipid lowering therapy (LLT).
- 30 patients had therapy increased or changed to HIST.
- 93 patients declined statins or LLT.
- 50 patients declined escalation of therapy.
- 40 patients were exception coded.
- Following the SMS invitations at both sites, 10% of patients declined the invitation at site 1 and 11% at site 2. The uptake rate of the lipids reviews was 12% at site 1 and 34% at site 2 and lessons can be learned to understand what engagement methods with patients would increase uptake, including uptake from those most deprived and digitally excluded.
- The lipid practitioner will not be an embedded post, which is a risk to the continuity and sustainability of the targeted lipid management approach at the practice. Increasing the days per week that the four lipid practitioners focus on searches and reviews once they are in post would support progress and enable practitioners to test engagement methods.

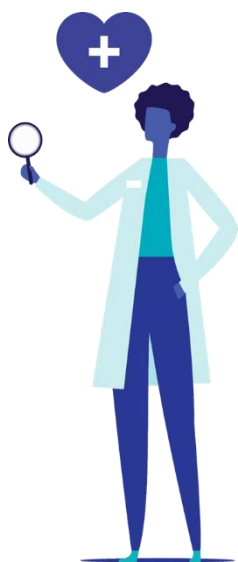
Early insights from **a small number of patients** (n7) suggest that the targeted service is **acceptable and accessible** but there is room to improve the information and support with lifestyle changes. There were mixed responses from the seven patients about how confident they felt managing their own cholesterol following the review. The patients indicated that information and support with lifestyle changes such as diet and exercise, having regular annual meetings with the cardio nurses, and having more information on managing cholesterol, including what the medications do would help them feel more confident in managing their cholesterol and health.

“Friendly & informative”

“Explained perfectly”

“Very helpful service, informative & encouraging.”

— PATIENT FEEDBACK



Lipid Clinic

The lipid clinic enhanced service is still being established but early insights suggest that there has been an increase in the number of patients who have had a lipid clinic appointment after their referral, from n26 in 2021, to n46 in 2022, and n108 in 2023, while the average number of referrals has remained at 11 per month from 2021 to 2023. Not captured in the formal referrals and referral to treatments per month is the informal advice and guidance that is given via emails and phone calls, that would have otherwise been a formal referral but still requires resource from the consultant. The enhanced service model will be fully established in 2024 as three new roles start, which will increase the number of clinics to more than six per month. Currently in the early development of the service, the consultant-led clinics have increased from one to four per month, and there is a reduction in the average and median waiting time from referral to treatment that can be seen. The median wait for those who have a completed pathway was 59 weeks (half the patients were seen within 59 weeks). The 92nd percentile waiting time was 75 weeks (table 4). Of the current patients waiting to start treatment (n145) (incomplete pathway), the median wait time is 37 weeks and the 92nd percentile waiting time is 49 weeks (table 5).

Implementation insights

Implementation science research suggests that implementation strategies should be tailored to address the multiple contextual levels of the project: the individual level behavioural change, the collective level change (team, organisation, meso), and the structural/socio-political level (macro level) (Damschroder et al., 2009). The key to setting up and implementing a redesigned lipid service model in Somerset involved several important factors within the wider context, external conditions of influence and opportunity, inner dynamics of the team and individual behaviour change areas, and implementation setting in primary care.

Designing and adapting for context

The project team highlighted the health challenges and needs in the region, particularly concerning cardiovascular disease (CVD), and lipid services. The challenges include:

- issues related to health services overall;
- workforce retention/recruitment;
- an aging population with a high CVD prevalence; and
- health inequalities faced by the population, especially unequal access to services and local access to specialist care (patients face difficulties accessing services due to the distance to clinics and long wait times).

Recruiting and retaining a suitable workforce in the region is a key challenge. To address this, the team considered roles beyond consultants in helping to deliver lipid clinics and lipid management. Initially, the project leaned towards a consultant-heavy model, but feedback and insights from team members led to a more diversified approach, considering various roles such as FH specialist nurses and clinical pharmacists able to deliver lipid management in primary care, as well as support secondary care clinics. They also recognised the need for local delivery across the county and adjusted the model accordingly, by placement of a GP with an extended role in the north of the county and collaborations with neighbouring regions to expand service access.

External conditions and opportunity

The external conditions for change and timing were critical factors in enabling the service redesign and project. Policy, financial incentives for primary care to focus on cholesterol and familial hypercholesterolemia, FH genetic testing becoming available as a nationally commissioned service, and wider policy attention being placed on CVD prevention programmes were influential in setting up the opportunities for change to take place. During this time, a driver for change was ensuring there was cross organisational and system communication of the issues in the service, and the risks with a growing waiting list. The challenges were placed on risk registers in the Trust, and the then Clinical Commissioning Group was made aware.

Capability, motivation, and ways of working

The capabilities and motivation of the core project team have been a key driver in initiating change, developing the model, and adapting for implementation. A team with experience in service development and clinical knowledge was seen as critical to early success in building the foundations and developing a pathway and full-service vision and outcomes to work toward:

- clear leadership and partnership across the team and organisations;
- adaptability and learning culture that has been built in;
- good communication processes and networks with regular meetings and sharing; and
- clarity of vision and shared motivation to improve patient health outcomes.

Implementation in primary care

The key enablers in the implementation at practices included:

- priority and tension for change and existing support for change at the practice;
- good compatibility between the lipid practitioner role and existing site functions and processes and people, enabling targeted lipid management in practices;
- incentives for primary care (QOF points), influencing motivation to adopt targeted lipid management approaches in primary care and work with the lipid practitioner; and
- access to knowledge and information from the clinical team for the lipid fellow/practitioner's, which was essential for the new role to build confidence and capability as a lipid practitioner.

The implementation process at the primary care site has benefited from familiarity with the practice and system, tailoring the approach to target at-risk patients effectively, and working closely with practices to meet their needs, including supporting QOF points.

Challenges

- Initial buy-in for the model was a challenge. Despite the existing external opportunities and policy drivers, ultimately the waiting list was the critical driver in receiving funding.
- Core team capacity is an ongoing challenge as service design and steering group membership are not necessarily inside their usual roles.
- Pace of working on service design is slow and takes time to work across organisations.
- Ensuring patient representation was built into the steering group early was a challenge, and early follow up and clear guidance is needed from the start of projects.

Barriers to implementation and patient engagement

- Reaching patients via SMS, and digital access barriers for patients was a key challenge.
- Uptake of the pathway can be improved.
- Managing time per patient and understanding capacity needed is a challenge for lipid practitioners testing the approach.
- Implementation at the first practice has been seen as easier to embed due to past/current experience that the lipid practitioner has with the practice. Time to adopt and embed could take longer for new postholders who are not familiar with the practice system or practice staff (knowing who to book an appointment with, names of the healthcare assistants).
- Ability to prescribe, and ability to navigate ethical challenges with FH, will be potential barriers for future roles.

Conclusion

The early insight from the evaluation shows that the project has progressed between April 2023 and February 2024, with core elements developed and implemented as planned. The evaluation activity alongside the project implementation has supported embedded learning and data collection for

service improvement. Evaluation and ongoing monitoring should continue as the programme matures and the new roles across primary and secondary care begin and embed in 2024. The successful design and early implementation of the model, coupled with early adoption success, position the project well for further implementation.

- The next phase of the project will move from early adoption to embedding, and further spread into other practices which will benefit from ongoing evaluation and learning. A key challenge will be ensuring the model utilising lipid practitioners is sustainable and that lipid management approaches continue in practices, beyond any initial targeted work. Patient uptake of the consultations will be an area the project can focus on, and learn what engagement approaches support higher uptake. This will help ensure patients most at risk and facing health inequalities, including digital exclusion, are actively engaged with and have access to treatment and support. The project has embedded tools and approaches to evaluation, including working closely with Somerset Public Health on a cardiovascular disease (CVD) dashboard, which will support the further evaluation of patient health outcomes and system benefits in time.
- There are early indications that the model will support the reduction in lipid clinic waiting times. The consultant and team are being further supported to test a demand and capacity model for the service.
- While the education sessions have positively influenced how the workforce perceive their knowledge and confidence in lipid management, and the resources on TeamNet are being accessed by nearly half of the practices in Somerset, application of that knowledge and use of resources will need to be assessed.
- For others developing lipid management approaches or a service redesign, clear and effective steering is critical, alongside leadership and co-ownership of the change and processes. Importantly, diverse representation within the project development team is central to the successful development of the project and system thinking. Cross system collaboration, early engagement, and ongoing coordination support are equally important for the change process and have been central to the Somerset Lipids Project service redesign approach and its early success.

[Read the full report here](#)

2. Population and Context: Rural and Coastal Communities

The Somerset team prioritised understanding the population and the context of the county, which was a critical element to defining the problem and designing the service.

[The Nearest Neighbour Tool](#) helps teams from any area of the country understand the context they are working in and where there are similarities and differences with neighbouring practices using a variety of data to target your project questions and adoption and spread approaches.

During the design phase of the Somerset project, aspects of the model were adapted to better support the context, such as the thinking about a hub and spoke model to better support the population and access needs, the workforce challenges with recruitment and capacity, and lipid clinic demand and capacity challenges.

The following details give the reader insight into the population and challenges facing our South West region and what was relevant to consider when designing a more accessible service for patients.

The South West Context

The South West – and in particular NHS Cornwall and the Isles of Scilly ICB and NHS Somerset ICB – have high prevalence of CVD recorded in General Practice as can be seen from the map below (fig 9).

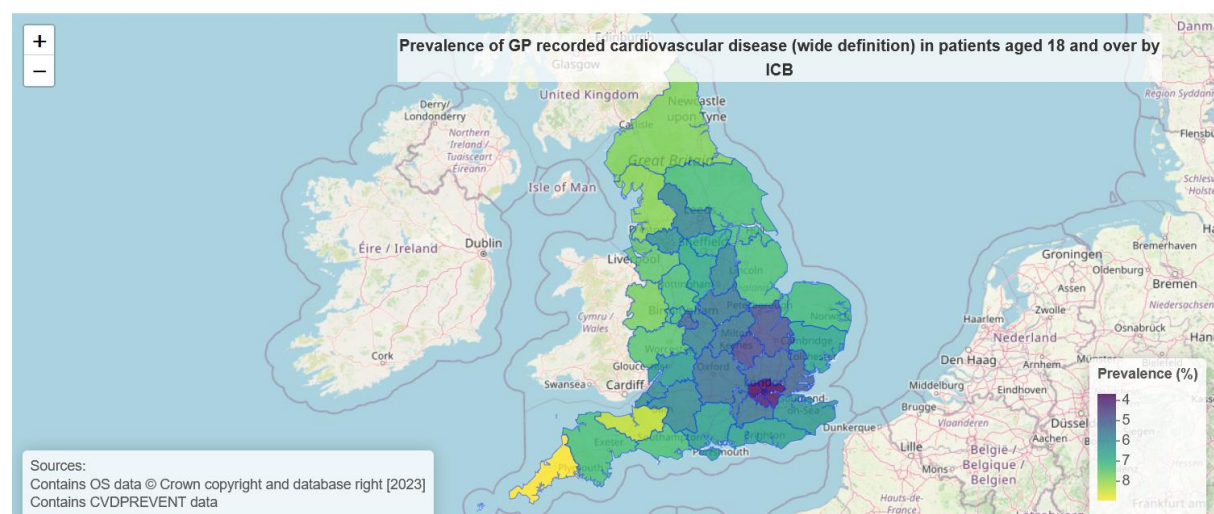


Figure 9. Map showing CVD prevalence in the country

It should be noted that much of this is driven by the fact that the population in the South West is older than most of the other NHS England regions. If the prevalence is adjusted for age, we can see in the map below (figure 10) that the need is greater in the North of England, but even after adjusting for age, NHS Cornwall and the Isles of Scilly ICB and NHS Somerset ICB both remain high, with NHS Cornwall and the Isles of Scilly ranked 7th of the ICBs in England and NHS Somerset 11th.

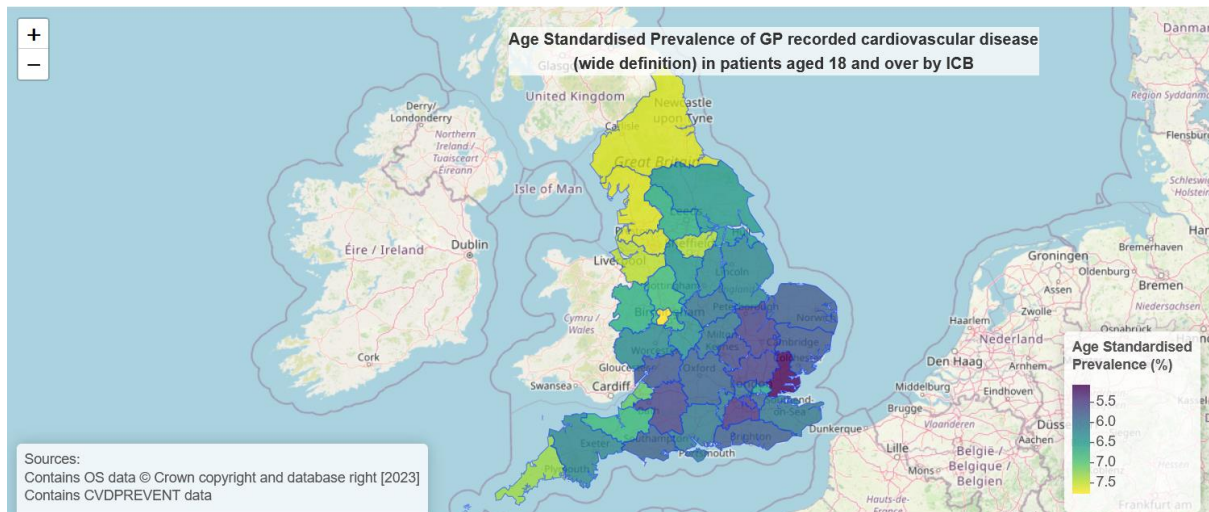


Figure 10. Map showing CVD prevalence in the country age standardised

One of the major issues for the South West is the distance patients have to travel to access services, which is exacerbated by poor transport links across the region. The map below (figure 11) shows the shortest travel time by car to a Type 1 Emergency Department (used as a proxy destination for acute services) for each Lower-layer Super Output Area 2021 in England.

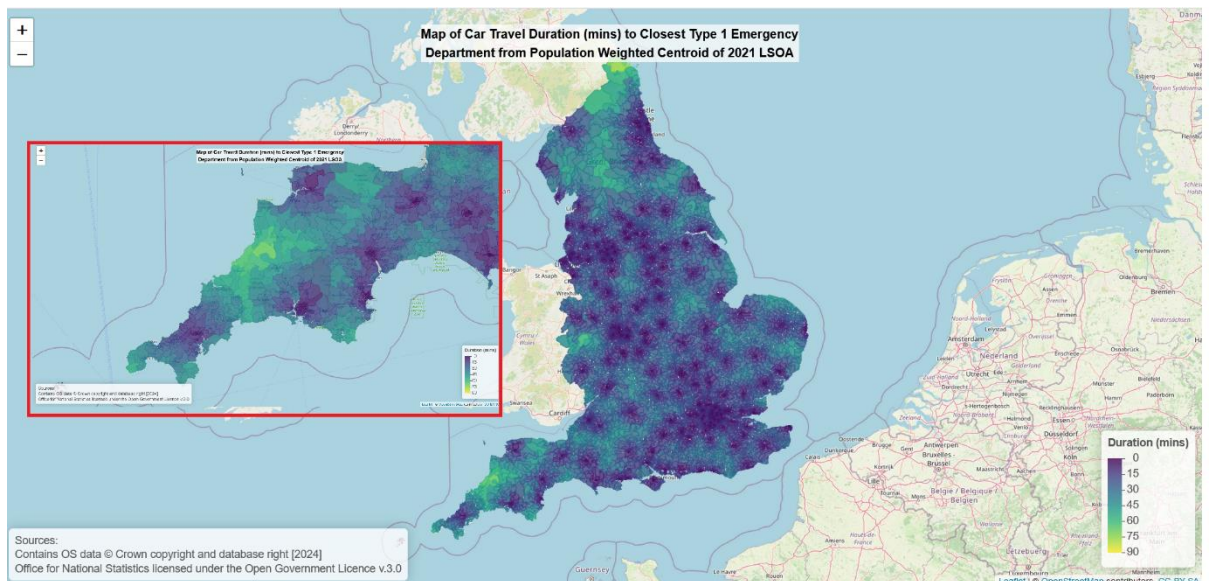


Figure 11. Map showing car travel duration to closest Emergency Department

In addition to the distance to services there is also a paucity of options to choose from. Again, using Type 1 Emergency Departments as a proxy for acute services, we can see from the figure 12 below that the options within a 30-minute travel time are a maximum of two departments for the South West population, with a significant proportion (25.9%) of our population with no service within 30 minutes travel (figure 12). However, in London, the population lives within 30 minutes of a service and have a range of 2 to 17 services to choose from within that catchment area.

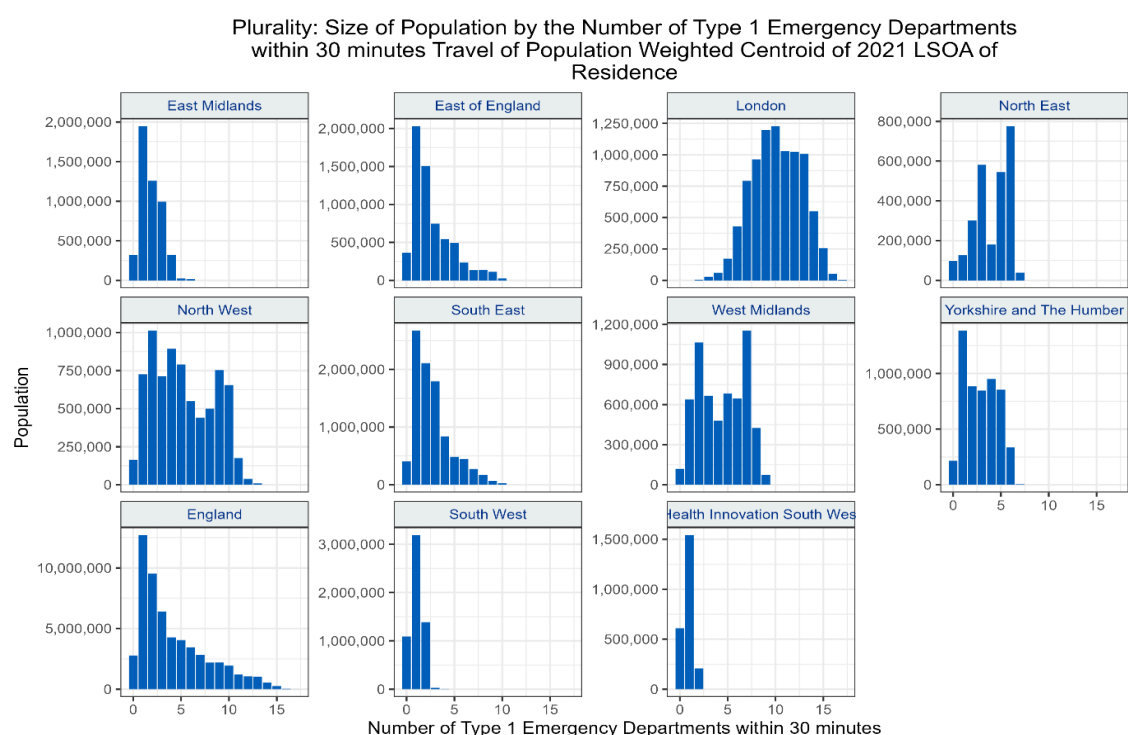


Figure 12 1. Size of population by the Number of type 1 Emergency Departments within 30 minutes travel of population

“The problems that we're seeing is that yes, there's no there's no service local to them. It's all based in Yeovil which if you're in West Somerset is takes an hour and a half to get there potentially. The accessibility not just in terms of distance, but in terms waiting time to get through to clinic of 72 weeks, you know, there's that sort of problem. So I guess for a lot of people, though, and this isn't just about patients, this is workforce.”

“Somerset will have gone from having no real lipid service and just one consultant picking this work up for the whole County... to having not only a lipid service but also an FH service. This will significantly increase equity of access to care and improve inequality in outcomes as regards cardiovascular morbidity and mortality for Somerset population. This is a huge achievement.”

“...my initial thoughts were very consultant heavy... then speaking to others, my eyes were kind of open to thinking more about other roles, which also made me think, well, actually, we do live in a rural area, and people don't like to travel, even 10 miles, let alone 40. And so that is now part of the model, thinking about how we deliver locally...”

Resource

Tool/resource template	Location
Nearest neighbour tool	See website

D. Annex

Feedback for future development

As part of the review process Health Innovation Network colleagues from Imperial College Health Partners and Health Innovation Oxford have reviewed the toolkit content, usability and usefulness to inform areas for future work, development and improvement. Their feedback has been reviewed, incorporated where appropriate and captured to inform any future work. For a more high-level summary of their feedback please contact us at harriet.matthews@healthinnovationsouthwest.com.

An overview of Health Innovation South West

Health Innovation South West is one of 15 health innovation networks set up by NHS England in 2013.

We exist to help transform the way our health and care systems in the South West identify, adopt and spread innovation to transform lives, improve population health, and drive economic growth.

Our work is funded by NHS England and Office for Life Sciences nationally commissioned programmes, and contributions from our members, as well as income generated through other activities aligned to our core mission and purpose.

Our impact in 2022/23 includes:

- helping 177,733 patients and service users;
- leveraging £7,434,345.55 of investment funding;
- working with 264 companies;
- supporting the creation and safeguarding of 75.6 jobs.

You can find more information on our [website](#).

Resources overview

Resource name	Format	Location
<i>Creating a team</i>		
Somerset Lipids Project Steering Group TOR v6	PDF	Health Innovation South West Website
Somerset Lipids Project Governance Structure	PDF	Health Innovation South West Website
<i>Refining the problem definition, defining the strategy and service needs and creating a service vision</i>		
Somerset Lipids Project Vision	PDF	In document (p10)
Somerset Lipids Service Patient Journey Process Map	PDF	In document (p11)
Somerset Lipids Service Redesign Workshop Report	PDF	Health Innovation South West Website
Somerset Lipids Service Redesign Workshop slides	PDF	Health Innovation South West Website
NHS England and Improvement tool – Creating a Vision	Webpage	Link to webpage
<i>Putting in place a robust evaluation and learning framework</i>		
Somerset Lipids Project Logic Model	PDF	Health Innovation South West Website
Service User Feedback Survey flier	PDF	Health Innovation South West Website
Patient experience: resources on measures and information sheet & consent form template	PDF	Health Innovation South West Website
Example data collection tool – primary care lipid practitioners	Excel	Health Innovation South West Website
Logic model and measurement framework template	Excel	Health Innovation South West Website
<i>Developing an education and engagement plan for primary and secondary care & Delivering lipid management and education</i>		
Somerset Lipid Management Clinical Guidelines	PDF	Health Innovation South West Website
Somerset Lipid Service TeamNet Link	Webpage	Link to webpage
Communication to primary care new service page and resources	PDF	Health Innovation South West Website
The Somerset GP Education Trust (SGPET)	Webpage	Link to webpage
Somerset Lipid Project Primary care education and engagement survey flier	PDF	Health Innovation South West Website
Lipid Management Presentation primary care	PDF	Health Innovation South West Website
Lipid Service education session log example	Excel	Health Innovation South West Website
Kirkpatrick's Four-Level Training Evaluation Model	Webpage	Link to webpage
Centers for Disease Control and Prevention. Recommended Training Effectiveness Questions for Postcourse Evaluations User Guide Atlanta, GA: CDC, 2019.	Webpage	Link to webpage
<i>Workforce model and recruitment</i>		
Somerset Lipids Project GPwER job description	PDF	Health Innovation South West Website

Somerset Lipids Project Specialist Lipid Practitioner job description draft	PDF	Health Innovation South West Website
Somerset Lipids Project FH Clinical Nurse Specialist Job description	PDF	Health Innovation South West Website
Project Co-ordinator Role overview	PDF	Health Innovation South West Website
<i>Embedding sustainability</i>		
NHS sustainability model	Webpage	Link to webpage
Non-adoption, abandonment and challenges to scale-up, spread and sustainability NASSS ,	Webpage	Link to webpage
Consolidated Framework for Implementation Research (CFIR)	Webpage	Link to webpage
Sustainability Model Analysis Template	Webpage	Link to webpage
Improvement Leaders' Guide: Sustainability and its relationship with spread and adoption	Webpage	Link to webpage
<i>Population and Context: Rural and Coastal Communities</i>		
Nearest neighbour tool	Webpage	Link to webpage