

Targeting Health Inequality in Management of Cardiovascular Disease in Primary Care: Insights and Models of Care from Cornwall

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Libby Dawe, Project Manager, Health Innovation South West

Nic Ferreira, Evaluation Lead, Health Innovation South West

Project team:

Gareth Walsh, Public Health Practitioner, Cornwall Council gareth.walsh@cornwall.gov.uk

Lorraine Long, Deputy lead, long term conditions, health inequalities and population health, NHS Cornwall and Isles of Scilly Integrated Care Board lorrainelong@nhs.net

Amit Dhulkotia, GP Lead, Clinical Director, Launceston and Tamar Valley PCN amit.dhulkotia@nhs.net

Libby Dawe, Project Manager, Health Innovation South West, Libby.dawe@healthinnovationsouthwest.com

Nic Ferreira, Evaluation Lead, Health Innovation South West, nic.ferreira@healthinnovationsouthwest.com



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Section

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1 Background

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The Challenge

- CVD accounts for around 25% of all deaths in the UK, with up to 80% of premature CVD deaths considered preventable through modification of risk factors (BHF, 2025; The King's Fund, 2022).
- A 10mmHg reduction in systolic blood pressure is strongly linked to reduced risk of:
 - Major cardiovascular disease events by 20%
 - Stroke risk by 27%
 - Heart failure by 28%
 - Coronary heart disease by 17%
 - All-cause mortality by 13%(Ettehad et al., 2016)
- Premature mortality trend: After decades of decline, premature CVD deaths (those aged under 75) in England rose between 2019 and 2022 to 80 per 100,000 - the highest since 2011 (NAO, 2024; The Guardian, 2024).
- The number of people diagnosed with the most prevalent condition, high blood pressure (hypertension), has increased from 6.7 million to 9.4 million in that period. There have been similar increases in the number of people with other common CVD-related conditions (atrial fibrillation, strokes, and heart failure) (NAO, 2024; The Guardian, 2024).
- The NHS Long Term Plan identifies CVD prevention as the single biggest opportunity to save lives, with a goal of preventing 150,000 heart attacks, strokes, and dementia cases over 10 years (NHS England, 2019; reaffirmed 2023).
- There is a strong correlation with deprivation
 - People in the most deprived areas are 3x more likely to die prematurely from CVD than those in the least deprived (BHF, 2024).
 - Adults in deprived areas are 30% more likely to have high blood pressure (PHE, 2019).
 - Healthy life expectancy is up to 18 years lower in the most deprived communities (ONS, 2023).

The Project: The Management of High-Risk Patients with CVD

The *Management of High-Risk Patients with Cardiovascular Disease (CVD)* project ran from February to August 2025 across primary care practices in deprived areas of Cornwall. It built on the local pilot launched under NHS England's Innovation for Health Inequalities Programme (InHIP) in 2023.

Aligned with the Core20PLUS5 framework, the project targeted individuals at greatest risk of CVD, particularly those with poorly controlled hypertension or high cholesterol.

Using **UCLPartners searches** combined with **Index of Multiple Deprivation (IMD) overlays**, practices proactively identified high-risk or undiagnosed patients. Targeted invitations were then used to engage patients needing treatment reviews or improved disease control.

Delivered within primary care settings, the model was intentionally flexible and adaptable to local workflows, workforce capacity, and practice structures.

By identifying and managing these high-risk patients, the project aimed to:

- Prevent strokes and heart attacks
- Improve population health outcomes
- Strengthen Quality and Outcomes Framework (QOF) performance
- Reduce emergency admissions

The project's scoping and engagement phase took place in 2024, whereby practices were engaged, followed by searches and implementation from February 2025 to August 2025.

Participating sites

- This project focused on targeting health inequalities in areas of deprivation in Cornwall.
- Three of the practices involved in this work self-identify as deep-end practices in Cornwall: Sunnyside surgery, Bosvena Health Centre and Rosmellyn surgery.
- In addition, six other practices serve populations experiencing significant health inequalities, including pockets of deprivation within otherwise affluent communities.

Deep End practices are GP surgeries located in communities experiencing high levels of socioeconomic deprivation. These practices typically care for patients facing complex health challenges linked to poverty, housing, employment, and other social factors. The term "Deep End" reflects the reality that these practices often operate with limited resources while managing high demand, creating a gap between patient needs and available support.

Practice Name	Population	Team members involved
Sunnyside Surgery	6,652	Practice Manager
Bosvena Health Centre	23,955	Strategic Manager and GP Partner
Rosmellyn surgery	7,568	GP and Deputy Clinical Systems Manager
Morrab Surgery	8,900	Practice Manager and Admin/IT Lead
Health for Homeless	350	GP and Business Support Manager
Falmouth Health Centre	10,389	GP Partner
St Austell Healthcare	32,754	PCN Clinical Pharmacist
Tamar Valley Health	16,928	Compliance and Research Manager
Marazion Surgery	7,696	Practice Manager and Administrator

Implementation components and principles

The project was delivered in five core stages as shown in the image.

1. Scoping and evidence-based design

2. Stratify patients into priority categories

Practices used UCLP Proactive Care Framework searches, clinical system queries, and IMD overlays to create risk-stratified lists. This identified both patients at greatest risk (proactive case finding) and those already on registers but poorly controlled (targeted recall).

3. Invite most at-risk patients to a health check

Patients were proactively invited through SMS, phone calls, letters, and opportunistic contact, to maximise uptake and reduce access barriers.

4. Deliver CVD health checks

Checks were delivered in primary care, focusing on blood pressure measurement and optimisation, cholesterol management (including newer lipid-lowering therapies), cardiovascular risk assessment, lifestyle advice, and planned follow-up.

5. Findings, sustainability, spread



Implementation components and principles



The implementation approach and design drew on learning from the original InHIP programme. Building on that approach and core components, as well as the scoping and design work, a Hypertension Implementation Toolkit was created for this programme (Health Innovation South West, 2024). This ensured the approach could be:

- Tailored to practice context and workforce capacity
- Embedded into routine primary care workflows for sustainability
- Equity-focused, targeting Core20 populations to reduce health inequalities
- Supportive of the workforce through 1-2-1 support, tools, and structured templates to build confidence in hypertension and cholesterol management
- Data-driven, using stratification, dashboards, and QOF-aligned coding to monitor uptake, control rates, and outcomes

A more detailed breakdown of the approach and stages can be found in the [project toolkit](#).

Implementation team role (ICB, Public Health, Health Innovation South West)

- Evidence-led design built on InHIP learning & toolkit; ambitious but realistic goals.
- Programme management: structured delivery plan, 1:1 support with sites, and troubleshooting.
- Practice motivation: staggered incentive payments aligned with QOF, as well as working with champions, supported quality improvement focus and throughput.
- Operational enablers: templates, communication materials, and clinical guidance to embed delivery.
- Evaluation and reporting: evaluation infrastructure to support reporting, learning, and evaluation, monthly reflections, and independent evaluation.

Evaluation Approach

This evaluation captured learning from nine practices in Cornwall and the Isles of Scilly that took part in the targeted CVD and health inequalities programme.

The evaluation explored not only what was delivered, but how it was implemented, what factors supported uptake, and where barriers and enablers emerged.

A mixed-methods approach was used to assess both impact and experience:

- Uptake data: practice-level activity on pathway engagement and outcomes
- Implementation and staff experience: qualitative reflections, learning logs, monthly feedback sessions from (12 staff at nine practices)
- Patient reported experience: surveys and feedback on accessibility, acceptability, satisfaction and perceived benefits (n79 responses).

The evaluation drew on the Consolidated Framework for Implementation Research (CFIR) to explore the context, setting, and factors that influenced adoption. The COM-B model helped us understand practice behaviour: how capability, opportunity, and motivation combined to drive engagement and adoption.

Findings are informing improvements to the model and supporting future spread across CloS and beyond.

Evaluation Questions:

- How were the models implemented? What worked, for whom, and why?
- Was the approach successfully implemented, and what can be learned from challenges?
- What factors influenced adoption and implementation (barriers and enablers)?
- What was the reach of the intervention and effectiveness in engaging patients?
- What were staff experiences and perceived benefits?
- What was the patient experience of the pathway?



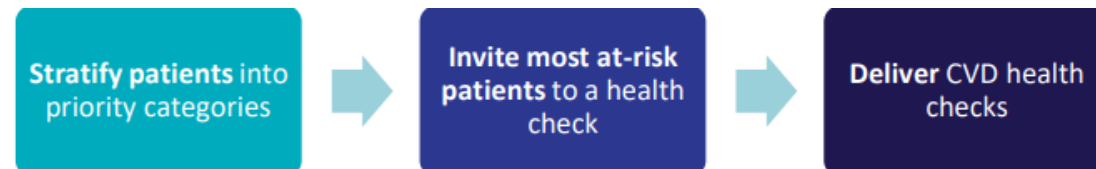
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Site models of delivery



GP practices used the free UCLPartners proactive care frameworks for hypertension and cholesterol to risk stratify patients already on disease registers. The Public Health team then overlaid Index of Multiple Deprivation (IMD) data by postcode, enabling practices to further prioritise those at greatest risk.

Implementation varied across sites, but clustered into three broad approaches:

1. Integration into existing workflows

- Checks embedded within routine LTC clinics or HCA/nurse appointments.
- Allowed delivery without large amounts of additional GP time.
- More sustainable but slower to reach target.

2. Dedicated project activity

- Practices set up targeted review clinics or allocated protected staff time.
- Generated faster throughput and clearer project identity.
- Depended on funding and added capacity; harder to sustain post-project.

3. Opportunistic and flexible approaches

- Patients picked up during other contacts (e.g. phlebotomy, same-day appointments).
- Efficient for harder-to-reach groups and reduced DNAs.
- Less systematic and relied on motivated staff remembering to act.

Operational insights:

Workforce mix: Most delivery by HCAs and nurses, with GPs/pharmacists stepping in for complex management.

Time demand: Typical review 10-15 minutes; reviewing/searching records often longer than delivery.

Equity focus: Models were strongest where digital invites were combined with proactive phone calls and delivery was built into routine care.

Key findings across sites

- The project showed that practices could successfully combine proactive case finding with targeted recall and treatment for hypertension and cholesterol management.
- Demonstrated feasibility even in high-deprivation, high-workload sites, showing this model can work where need is greatest.
- Risk stratification using UCLP searches and IMD overlays was highly valued, but administrative burden and IT limitations made delivery resource-intensive.
- Where delivery was integrated into existing roles such as with HCAs, and embedded within routine care, it was more sustainable than when reliant on additional GP time.
- Equity targeting worked best when practices layered text messages with phone calls and opportunistic invitations, ensuring harder-to-reach populations were engaged.
- Local champions (HCAs, pharmacists, managers) were central; capability was supported by templates and training, opportunity came from funding and flexibility, and motivation from engaged teams (COM-B). However, short timelines, workforce pressures, and reliance on individuals limited scale.
- Achieved full implementation within six months, a clear demonstration of pace and feasibility (after a period of scoping and design work in 2024).
- Incentivisation is critical to support adoption in primary care.
- Staggered payments enabled quality improvement, supported throughput, and kept practices engaged across the programme.
- Slides 13-15 give more detail on implementation insight from sites. See conclusion and recommendations slide for concluding messages.

Stratify patients into priority categories



Invite most at-risk patients to a health check



Deliver CVD health checks

"It's actually going to make a difference to those that need it the most, especially when you're looking at [highest] priority [patients] and you know [they] have got super high blood pressure, they could be at risk of having like an imminent stroke [walking] down the street."

Practice staff member

"When you actually do it and you get a person and make a change, it feels really positive because it feels like we would never have found these people otherwise."

Practice staff member

"I don't know what would have honestly happened [if we hadn't done this project]. Maybe those people would not have been picked up for a while."

Practice staff member

Learning from Implementation Process



Stratify

- Practices valued the UCLP searches with IMD overlays, which gave a structured and equitable way to identify high-risk patients.
- However, the process was labour-intensive: coding errors meant many records required manual review, often taking several minutes per patient. IMD data not being integrated into EMIS/SystemOne added further workload, as staff had to use spreadsheets and manual cross-checking.
- For scale, practices stressed the need for digital improvements (automated IMD integration, error-checking tools, and real-time dashboards) to make stratification more efficient and sustainable.

Learning from Implementation Process



Invite (engagement strategies)

- Uptake was strongest when practices used multiple invitation routes: texts for reach, personalised phone calls for engagement, and opportunistic offers during appointments.
- Self-booking links were popular and reduced admin, but not all patients could use them.
- Phone calls achieved the best response rates, particularly among deprived patients, but were resource-intensive, creating a trade-off between quality and volume.
- For spread, practices highlighted the need for smarter recall systems that integrate multi-channel communication (log follow-up attempts, and flag patients at highest risk automatically), plus additional admin support to sustain personalised contact.

Learning from Implementation Process



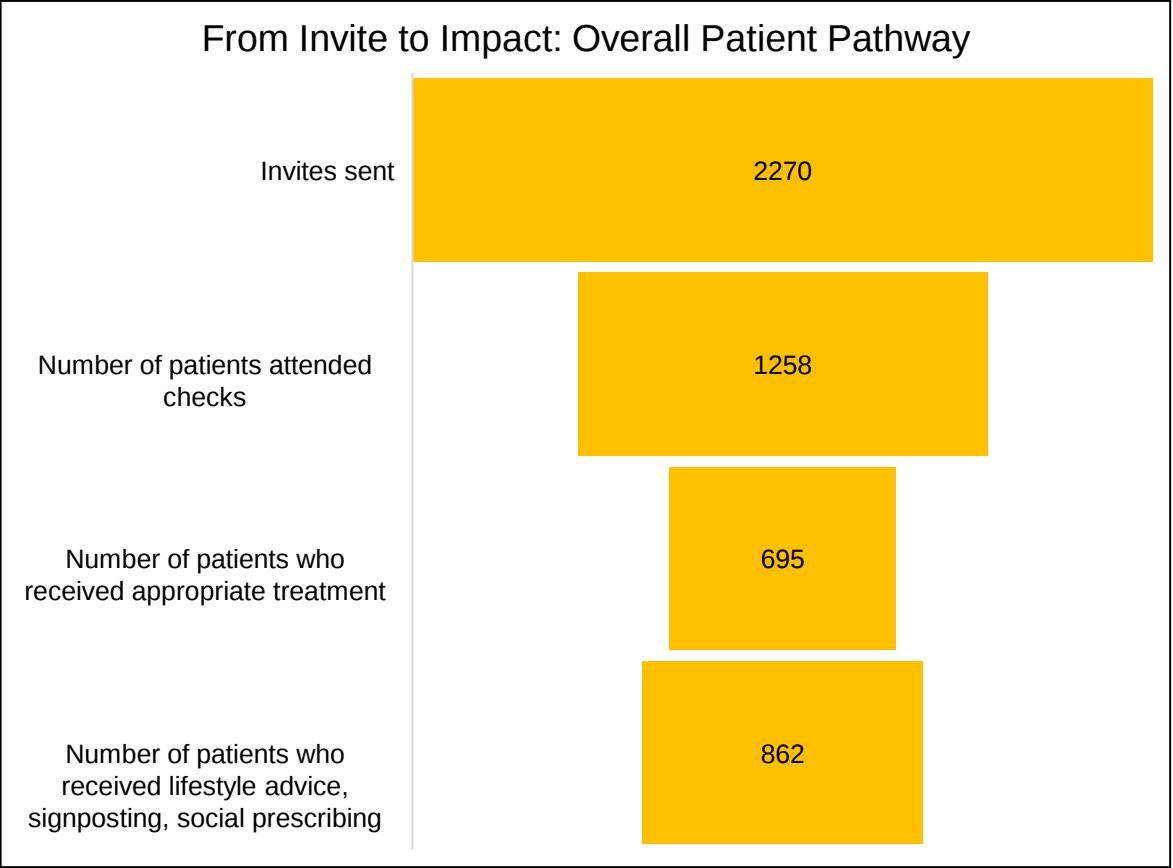
Deliver (health checks in practice)

- Once patients attended, CVD health checks were delivered consistently and effectively. Standard 10-15 minute checks covering BP, cholesterol, pulse and lifestyle advice were mostly completed by HCAs, nurses, or others, freeing up GP time. Some sites also used pharmacists for managing optimisation, showing scope for multidisciplinary delivery.
- The main challenge was capacity and variation: longer appointments put pressure on busy clinics, and opportunistic checks were applied inconsistently.
- Scaling up will require embedding checks into routine workflows. This will require protected clinical time, investment in flexible appointment models, and the use of QOF-aligned templates to standardise delivery. Such measures would improve consistency, support workforce confidence, and ensure that the intervention can be scaled sustainably across practices.

Summary of Impact

Over half of invited high-risk patients attended checks, leading to 695 treatment optimisations and nearly 900 lifestyle interventions

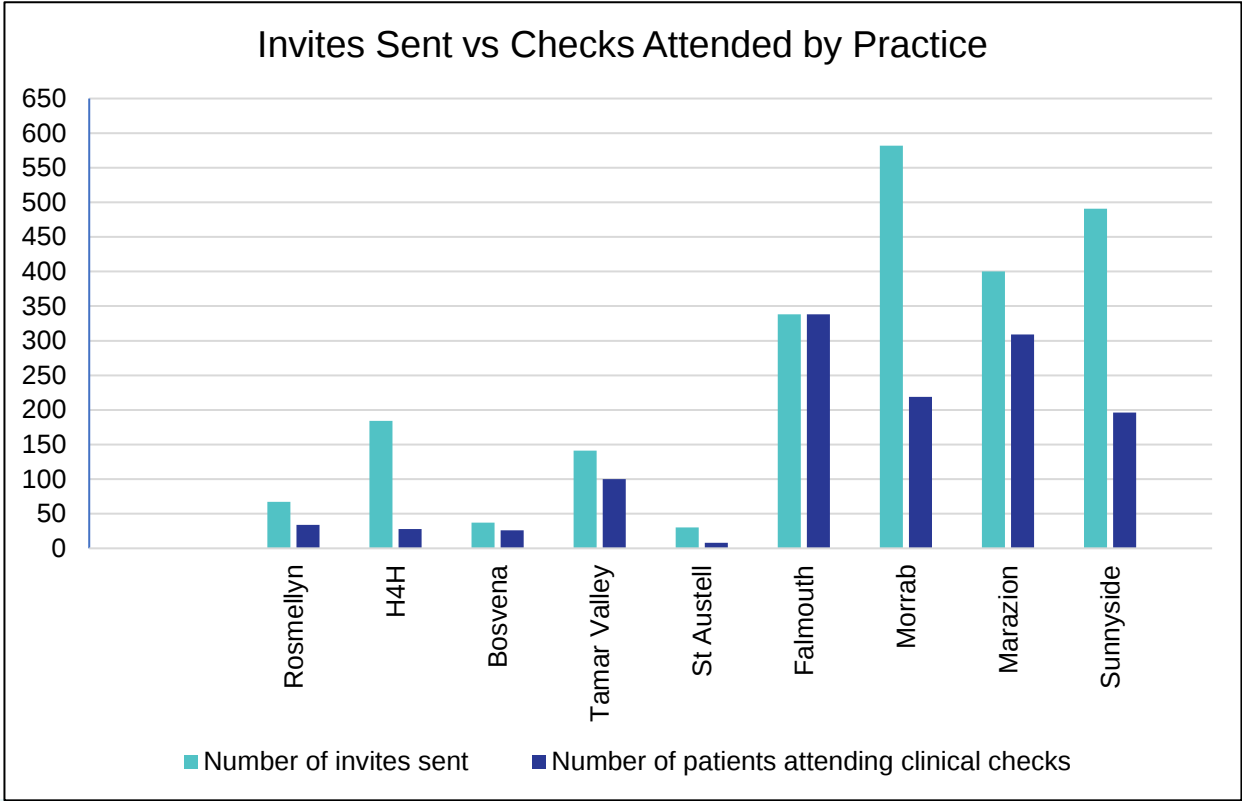
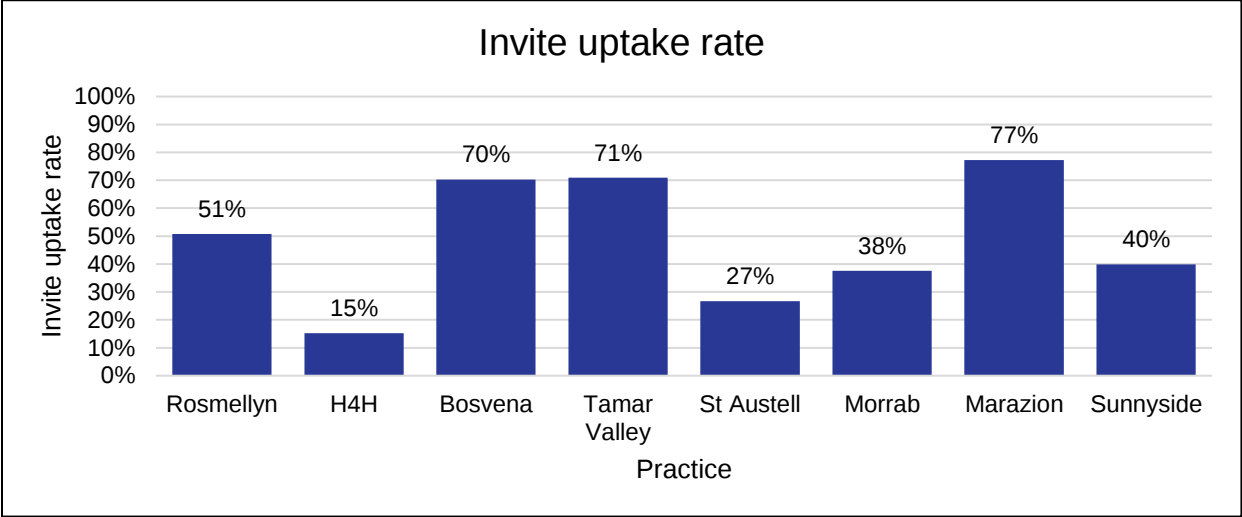
- **2,270 patients were invited** across nine practices in Cornwall and Isles of Scilly (February-August 2025)
- **1,258 patients attended checks**,
 - giving an overall **uptake rate of 55%**.
 - Some practices achieved more than **70% conversion**, including Marazion, Bosvena and Tamar Valley
- **695 patients received treatment** optimisation such as statins or antihypertensives
- **862 patients received lifestyle advice**, signposting or social prescribing, supporting prevention and self-management
- Practices with clinician-led invites, dedicated clinics or opportunistic integration achieved the strongest uptake and impact
- SMS-only models produced wide reach but lower conversion
- The project showed that targeted outreach using IMD data can engage high-risk patients, reduce missed cases and improve equity in access
- Practices also reported a shift towards more proactive and preventive care models that they would like to sustain



Impact: variation in uptake across practices

High conversion came from personalised approaches, not high-volume invites.

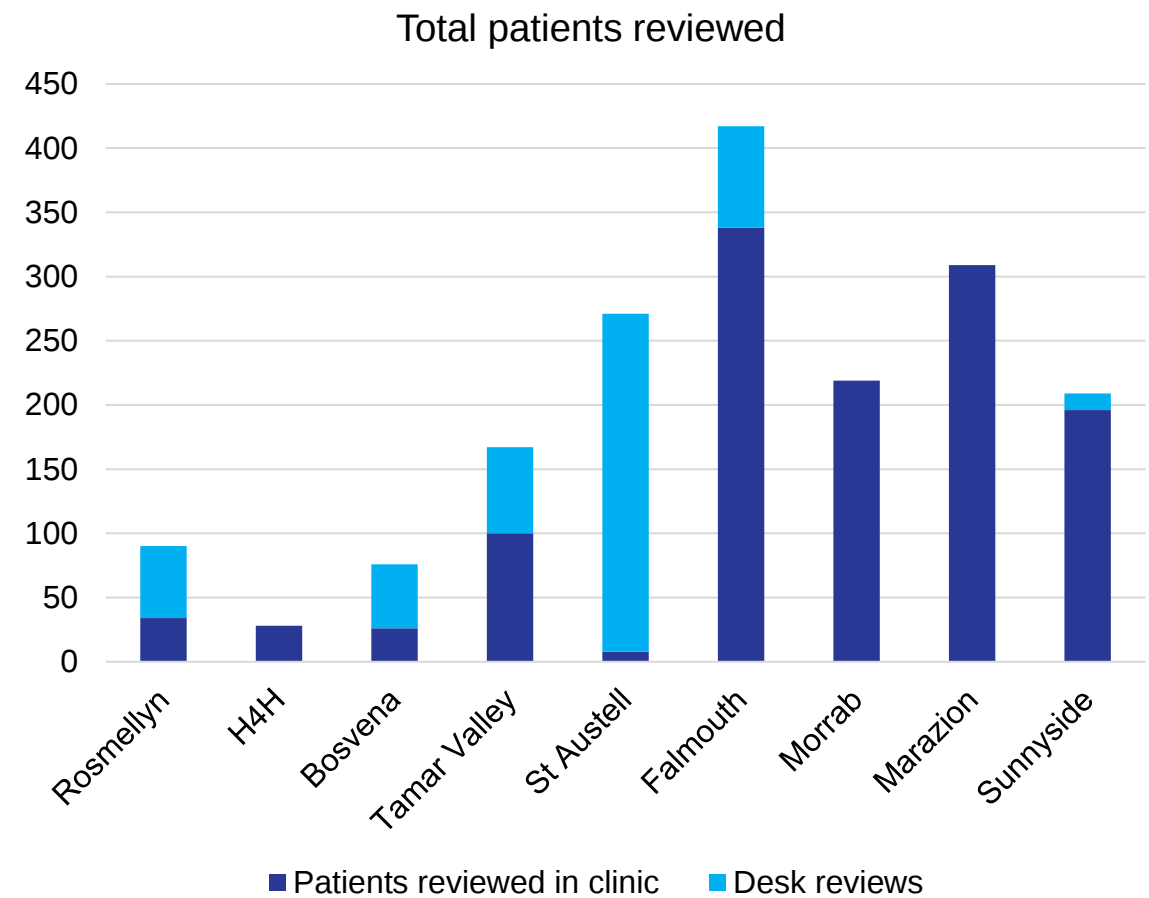
- Uptake rates varied widely between practices, from 15 percent to over 75 percent
- Highest conversion rates were achieved where practices used clinician-led calls, dedicated clinics or combined checks with existing appointments
- Mass SMS strategies generated the largest numbers of invites but lower conversion, particularly in deprived or transient populations
- This variation highlights the importance of local tailoring and resource allocation: smaller, more focused approaches often had greater impact than high-volume SMS alone and when considering complex needs of patients
- Practices varied widely in approach. Smaller, more personalised invite strategies (Bosvena, Tamar Valley, Marazion) achieved high conversion. Mass SMS approaches (Morrab, Sunnyside) generated volume but lower attendance. Falmouth data shows 100% conversion but the total number of invites is unknown and likely to be higher than 338, which is why it is not shown in the bar chart.



Impact: desk reviews

Many practices carried out high numbers of desk reviews but chose not to invite patients in as they were already well managed.

- The graph shows the total number of patients reviewed, combining the patients reviewed in clinic (attending clinic appointment) with patients desk reviewed as part of the list reviews.
- This gave practices the opportunity to check and update records that might have otherwise been missed
- This data shows that whilst the number of patients reviewed in clinic might not be especially high, this was because the records highlighted in the searches were for patients that did not need to be seen in clinic.
- Not all practices tracked this data, so actual numbers of desk reviews may be higher than has been reported.



Patient reported experience and outcomes

To understand how patients experienced the programme, a short survey was conducted with 79 participants across participating practices. Most responses (84%) came from one practice, meaning results are not fully representative of all sites and models, but still provide valuable insight.

The survey explored three main areas:

- **Access and acceptability**- whether invitations were clear, appointments were easy to attend, and the experience of being proactively contacted was acceptable.
- **Enablement and support** - the extent to which patients felt confident and informed to manage their blood pressure or cholesterol following the intervention.
- **Experience and satisfaction** - overall satisfaction with care, clarity of communication, and suggestions for future improvements.

Who took part in the survey

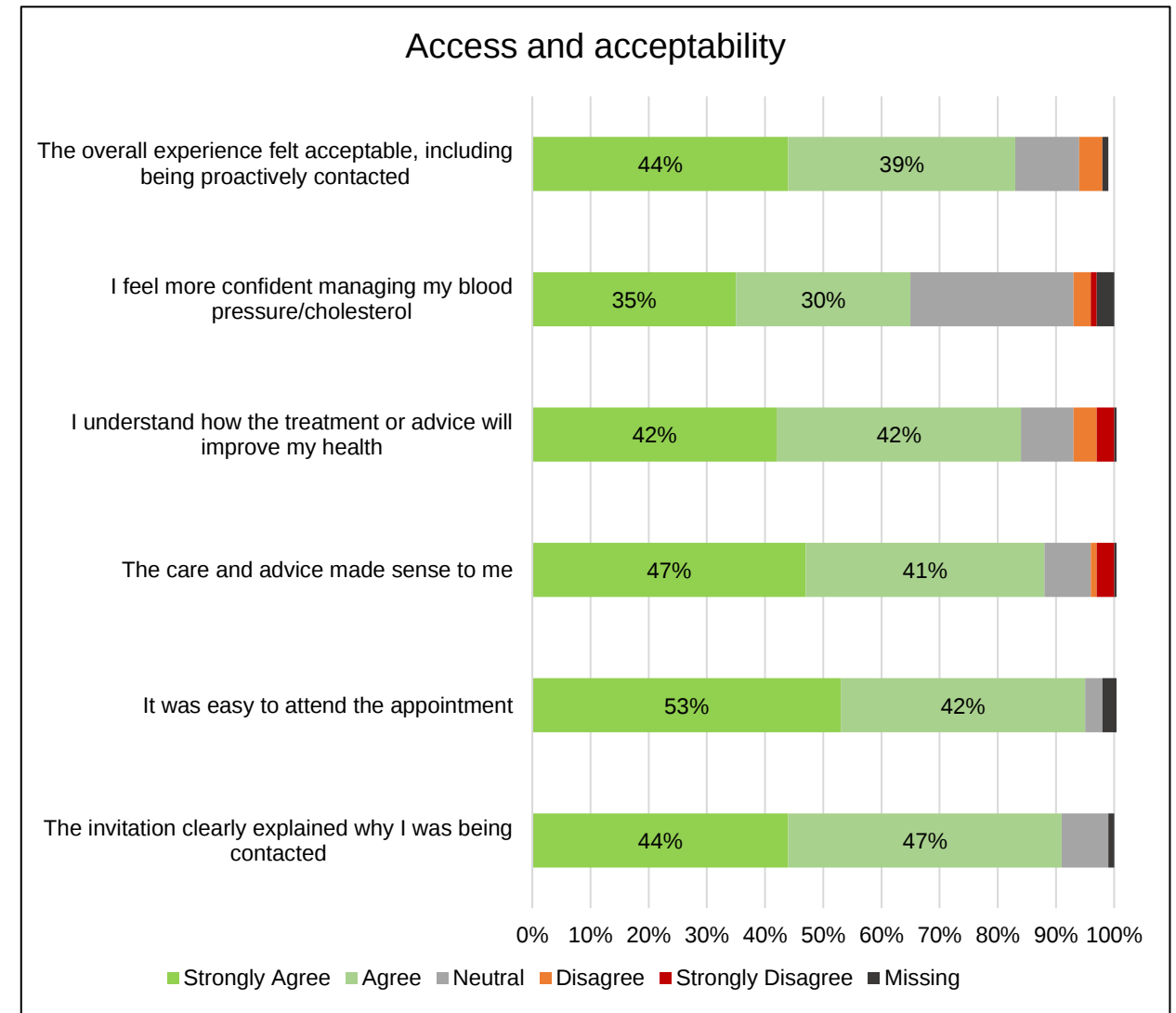
- The sample was largely aged 65-74, with slightly more women than men, and predominantly White British. Most participants were contacted by SMS or phone call and attended face-to-face appointments.
- Most appointments were face-to-face (80%), with some by phone (14%).
- Contact was primarily by SMS (68%), supplemented by calls or emails.
- Most patients attended for a combination of hypertension and lipid checks (41%), ensuring a more integrated review.



Patient reported experience and outcomes: accessibility and acceptability

Patients reported a broadly positive experience with strong evidence that the proactive approach was acceptable.

- **Acceptability of proactive contact:** 83% felt comfortable being contacted in this way, suggesting proactive outreach is feasible in primary care.
- **Clarity and ease of access:** 91% said the invitation explained clearly why they were being contacted, and 95% found it easy to attend their appointment (face-to-face or by phone).
- **Experience of care:** 88% felt the advice given made sense, and 84% understood how the treatment or advice would improve their health.
- **Confidence and reassurance:** 65% felt more confident managing their blood pressure/cholesterol after the appointment, although 28% gave a neutral response.
- **Qualitative feedback** showed that most patients faced no barriers to attending; a small number mentioned transport challenges or anxiety (“white coat syndrome”).



Patient reported experience and outcomes: enablement

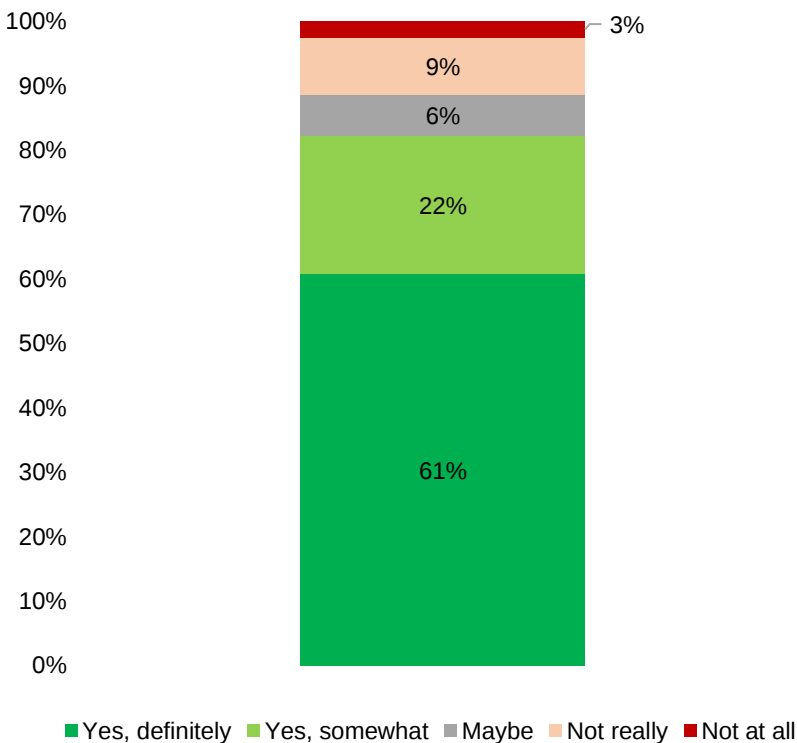
Enablement and support

- 83% felt they had received enough support and information to manage their blood pressure/cholesterol.

Follow-up support was mixed:

- After their appointment, patients reported a mix of onward actions and support.
- Around 1/3 described receiving a follow-up phone call from the practice, while others mentioned changes to medication (particularly statins), advice given, or further monitoring such as blood tests or blood pressure checks.
- A smaller number were referred to additional services or provided with self-management resources.
- However, just under 1/3 reported that no further support was offered, and some patients highlighted gaps such as awaiting results, missed follow-ups, or being told to rebook themselves.
- This indicates variation in what “happens next” and suggests that clearer pathways and consistency of follow-up could strengthen patient confidence.

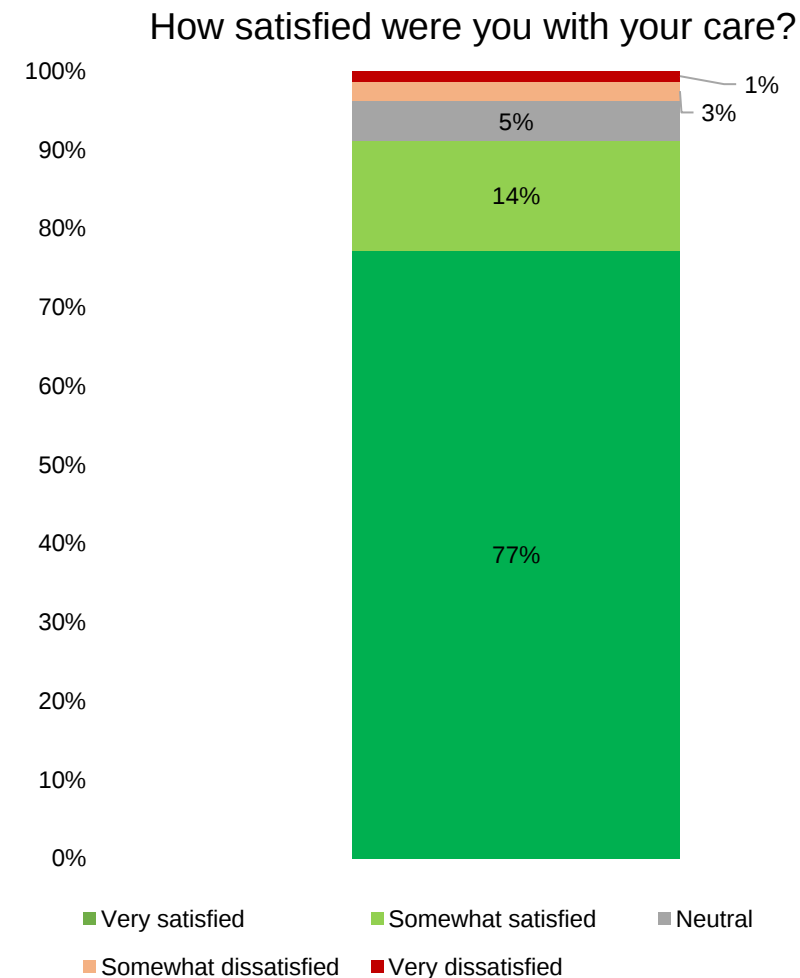
Do you feel you received enough support and information to manage your blood pressure/cholesterol?



Patient reported experience and outcomes: care experience

Overall care experience

- Most participants (91%) were satisfied with their care; only 4% expressed any dissatisfaction.
- Patients highlighted the value of clear explanations, ease of attending appointments, and tailored advice.
- A small number described barriers such as travel difficulties or anxiety in clinical settings, but these were generally mitigated by supportive staff.
- Qualitative feedback highlighted several areas where patients felt their experience could be strengthened.
 - Many wanted better access to appointments, particularly face-to-face, and more regular monitoring to reassure them about their progress.
 - Others emphasised the importance of clearer information and feedback, including written results and timely updates if things changed.
 - Some suggested the need for digital tools and resources to help them manage at home, while others asked for more explanation to understand the reasons for treatment, especially regarding the use of statins.
 - Lifestyle and self-management support, such as help with weight management, was also valued.
 - At the same time, a number of patients said they were content with their current care and required no additional support.



1 Project Background

2 Desk Research

3 Conclusion



Enablers

Overarching programme set up and preparation

- The central implementation team carried out early scoping in 2024, drawing on past learning and evidence.
- This ensured the project was well designed, with ambitious but realistic goals that practices could buy into.

Resourcing, incentives, and motivation

- Dedicated funding and QOF alignment (HYP008) gave practices both the financial means and the motivation to act.
- Staggered payment model kept teams engaged, rewarding progress.
- The payment thresholds encouraged throughput and gave the project clear targets.

Implementation function support and tools

- Structured templates, project toolkits, and flyers from Public Health Cornwall supported patient conversations.
- One-to-one engagement with each site was a defining feature. Regular touchpoints with the programme team kept momentum high, addressed challenges quickly, and gave practices confidence that they were supported throughout.

Operational supports

- Self-book functionality, opportunistic checks during other appointments, and sufficient appointment availability made delivery more efficient and reduced administrative workload.

Leadership and relationships

- Local champions, especially HCAs, pharmacists, and proactive managers, were key to momentum.
- Regular check-ins from the project team provided reassurance, troubleshooting, and clear expectations.



Images sourced from lifestyle advice flyer created by Cornwall Council

"It's been really well run, the support for it and the comms and everything has been brilliant."
Practice staff member

Barriers

Data integration gaps

- IMD data could not be embedded in EMIS/SystmOne, forcing teams to rely on manual spreadsheets. This was labour-intensive, slowed progress, and created variation in how consistently patients were identified.
- Practices were reliant on Public Health for integrating the IMD data into the UCLP search results, causing delays and additional admin time.

Time and workforce pressures

- Reviewing records and running searches often took longer than clinical delivery itself.
- Reviews ranged from 10-15 minutes per patient and added to already stretched clinical workloads. Protected time was essential but rarely available.

Patient engagement challenges

- High-deprivation groups found it difficult to prioritise health over work commitments, and some patients had limited digital access.
- Health literacy also created barriers, particularly with terms like “cholesterol” and “hypertension.”
- Follow-up care for homeless patients was particularly challenging due to the transient nature of this population.

System and communication issues

- Early delays reflected internal communication gaps and the complexity of aligning multiple staff groups. Where processes weren't embedded into routine systems, delivery was more fragile.



Conclusions

This project demonstrated that proactive case finding and recall can be delivered successfully even in deep-end practices working with high deprivation and heavy workloads.

That makes it a strong proof of concept for wider adoption, especially as the programme achieved full implementation in six months, proving pace and feasibility. A central driver of success was the presence of motivated local champions (supporters) who created the energy and leadership needed.

In COM-B terms, capability was built through training and templates, opportunity came from dedicated funding and a flexible model, and motivation was provided by engaged team members. This combination was critical to uptake.

The spread of this innovation also reflected the diffusion curve: champions in practices enabled rapid adoption and sustained engagement with the programmes, indicating that for future spread and scale, engagement is not likely to be even across sites.

- **Reach and engagement were significant:** Over half of invited high-risk patients attended checks (1,258 of 2,270) (55%), with some practices achieving conversion rates above 70%. This led directly to 695 treatment optimisations and 862 lifestyle interventions in less than 6 months of implementation, which may have helped prevent strokes and heart attacks.
- **Feasibility:** The project showed proactive case finding and recall are feasible in primary care, but delivery models need to adapt to context (such as being embedded in LTC reviews, dedicated clinics, or opportunistic checks).
- **Equity and access:** Combining SMS with personalised phone calls achieved the strongest uptake, engaging patients who would otherwise be missed.
- **Positive patient experience:** Survey feedback showed 91% satisfaction, with most finding appointments easy to attend and advice clear. Many valued proactive contact and personalised care, though consistency of follow-up could be improved.
- **System learning:**
 - Practices reported that the project helped them identify overdue patients, improve record accuracy, and refine internal workflows.
 - Highest conversion rates came from clinician-led, personalised invites and integrated delivery models. Mass SMS invites achieved reach but lower attendance, underlining the need for tailored approaches.

Recommendations for Spread and Adoption

- **Allow sufficient setup time:** Build in early scoping and design phases, drawing on past learning, to set ambitious but realistic goals.
- **Streamline data and systems:** Invest in digital solutions to automate risk stratification and reduce admin burden. (Reduce administrative burden with digital solutions (automated IMD integration into EMIS/SystmOne, error-checking tools, real-time dashboards, and smarter recall systems that log follow-up attempts).
- **Resource workforce capacity:** Protect staff time and make best use of HCAs/nurses with clear GP/pharmacist support for complex cases.
- **Build equity into delivery:** Standardise multi-route invite strategies (SMS + phone + opportunistic) to engage deprived populations.
- **Standardise follow-up pathways:** Provide consistent guidance on next steps (medication, monitoring, referrals), reducing variation across practices.
- **Support patient enablement:** Enhance written/digital feedback, ongoing monitoring, and continuity of care to build confidence in self-management and consistent lifestyle advice.
- **Support local champions:** Identify and nurture champions (HCAs, pharmacists, managers) as they are central to uptake and momentum (COM-B: capability, opportunity, motivation).
- **Sustainability:** Favour models embedded into existing workflows, while recognising dedicated project activity can accelerate uptake in early phases.
- **Sustainability:** It is considered an enhanced service for GPs, and funding is essential for proactive care to happen.
- **Spread and adoption:** Learning from this model can be applied to similar pieces of proactive care work targeting high-risk patients or health inequalities. The model worked in high-deprivation, high-workload sites, but spread will require tailored support where such champions or engagement are not present.

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