suvera reports

Enabling the Three Shifts

How HIOW ICB Delivered Hypertension Management Through Community-Based Digital Care

Contents

CHAPTER 1

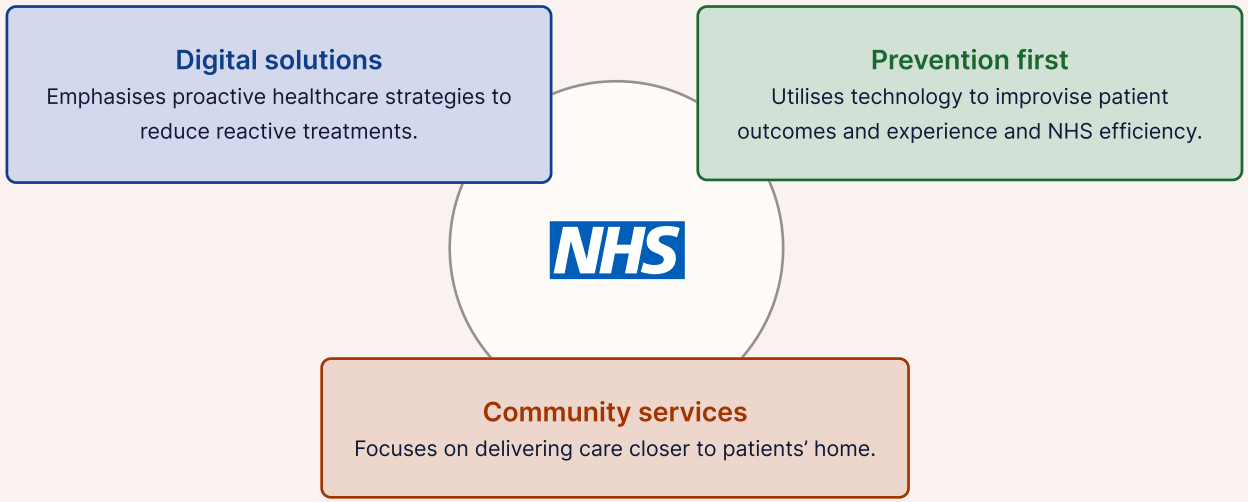
Introduction

The NHS has been deemed to be in ‘critical condition’. For readers, it has become all too commonplace to hear of financial deficits across the country and severely constrained budgets. The challenge is set to intensify - the population of over-75s has grown by 21% since 2013, while the workforce grows increasingly fatigued. More clinicians than ever are considering alternative career paths, with many not leaving the medical profession itself, but moving to alternative healthcare systems where they feel more valued. This is saddening, unsustainable but preventable.

In response, the government's 10 Year Health Plan represents both an ambitious and essential transformation agenda. It centres on three fundamental shifts: from hospital to community, from analogue to digital, and from sickness to prevention. Yet, given the harsh financial climate, the system is asked to re-think and innovate with limited resources. This case-study aims to address those two opposing ideas directly.

This case-study represents a meaningful step toward realising the 10 Year Health Plan. It demonstrates that the digital and operational transformation required by these three shifts is not a future aspiration but a present reality. It de-risks scaling these initiatives by showing they deliver cost savings, improved patient outcomes, and enhances staff wellbeing. However, a crucial question remains: can we, as a system, ensure that financial transformation follows the digital and operational transformation evidenced and that we redirect investment upstream to where prevention is most needed? This case-study builds on growing evidence also in South East London (SEL) and North East London (NEL) ICBs, which exemplify what is possible, right now.

The urgency could not be greater. Our mindset must evolve beyond simply identifying the risks in new ways of **working to analysing the risks and consequences of inaction.** These three transformational shifts are not abstract aspirations but essential responses to a system struggling under current demand. Evidence-based, scalable transformation is the only path to a sustainable NHS, and one that other health systems will look to us as a model. Without it, the service risks continuing to be financially unsustainable, with widening inequalities and deteriorating outcomes for those who need care the most.

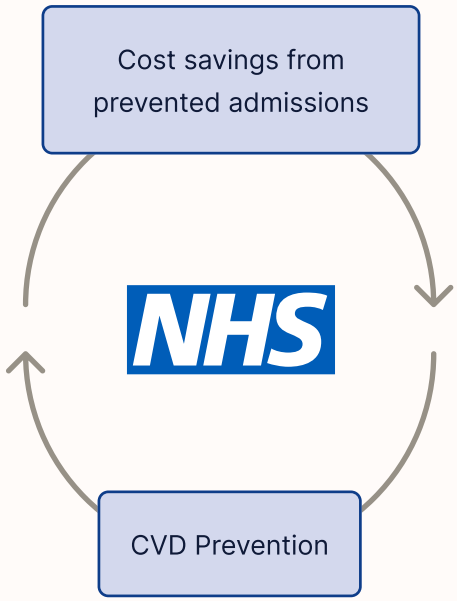


Why Cardiovascular Disease Management

Cardiovascular disease (CVD) prevention exemplifies why these shifts matter. In the UK, 7.6 million people live with CVD, with a further 16 million at risk. It causes 25% of all deaths, nearly 140,000 annually, and costs the NHS £7.4 billion per year. The wider economic burden reaches £15.8 billion. This is largely preventable.

The opportunity is significant and immediate. If 80% of people with diagnosed hypertension achieved optimal blood pressure control, the NHS could save over £200 million in just three years. Yet currently, preventable heart attacks and strokes continue to occur at alarming rates, while the system focuses majority of resources on treating crises rather than preventing them.

As Integrated Care Boards (ICBs) take on their role as strategic commissioners of population health, using data is essential to identify care gaps and commission targeted interventions. The shift to neighbourhood working and digital first care offers new methods to reach patients earlier, manage conditions proactively, and prevent avoidable crises. However, success depends on overcoming real barriers including poor estates, fragmented services, and variation in performance across the system.



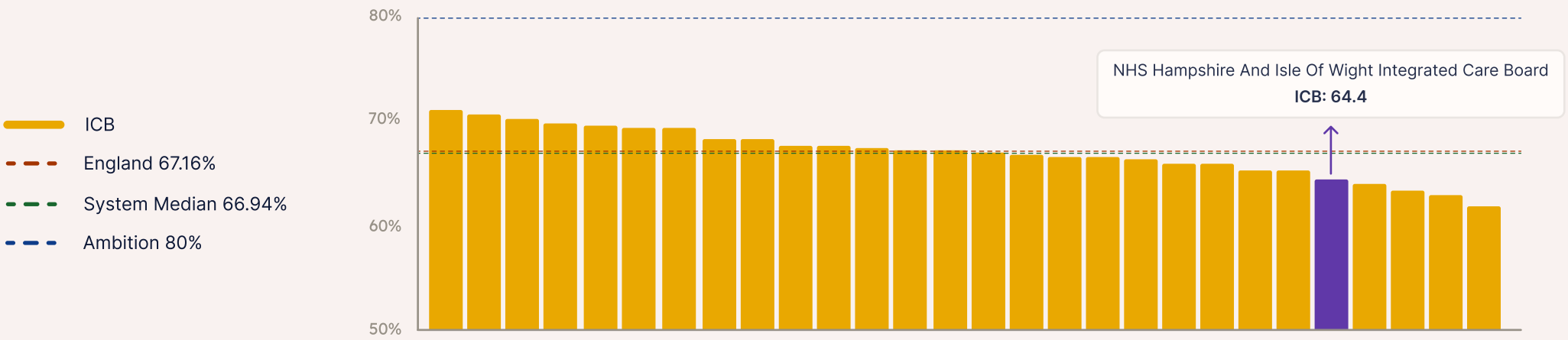
CHAPTER 2

The Specific Challenge in Hampshire and Isle of Wight ICB

Hampshire and Isle of Wight ICB (HIOW ICB) serves 2 million patients, with 322,000 known to have hypertension. It illustrates both the scale of the CVD challenge and the opportunity for transformation. The ICB ranked as the fifth lowest performing nationally (bottom 12% for CVD Prevent hypertension control) with only 67% of patients achieving target blood pressure levels (CVD Prevent Data). This performance gap leaves 106,000 patients with known hypertension, untreated, and requiring immediate attention. This is not accounting for the unknown cohort, with Public Health England (PHE) estimating in 2017 that for every ten people diagnosed with hypertension, another seven remain undiagnosed and untreated. This suggests another 225,400 people in Hampshire are likely to have undiagnosed hypertension.

The challenge extends beyond clinical outcomes to the physical infrastructure of care. Many GP practices report that their premises are fundamentally unsuitable for modern care delivery. As of September 2025, a survey by the British Medical Association (BMA) found that 50% of GP premises in England are not suitable for current needs, with 83% considered unsuitable for future service delivery. Hampshire faced this same reality and therefore sought modern, technology driven solutions delivering holistic virtual care.

As a result, HIOW ICB engaged Suvera to support management of hypertension across seven practices, inviting 8,000 patients to participate in Suvera's proven virtual clinic to improve hypertension outcomes. The project was initiated in February 2025, and it represents a practical example of the 10 Year Health Plan's vision in action: moving care into the community, preventing avoidable hospitalisations, and empowering patients through technology. This is not a pilot for the future, it is a transformation happening now.



CHAPTER 3

Suvera's solution

Suvera, a population health service, specifically designed to address health inequalities and support primary care to manage long-term conditions by providing both a clinical workforce and an integrated technology platform to deliver a new model of care. **Approved by the CQC and NHS Digital, Suvera's holistic, virtual service** is designed to coordinate care for GP practices, streamline management of complex patients and provide significant efficiency gains compared to traditional general practice.

Suvera's in-house analytics team identifies at-risk patients, and then invites individuals to a user-friendly, accessible platform. A specialist cardiovascular team manages patients from the comfort of their own home.

The service facilitates early detection and prevention, and enables care to be provided with fewer clinical resources with the ultimate aim of improving patient outcomes.

Key benefits to patients and staff

- Achieving condition target control
- Timely access to care
- User-friendly interface
- Efficient triage system
- Reduction in staff workloads
- On-demand referrals
- Automated, streamlined call and recall
- Increased capacity
- Increased patient engagement with translation services

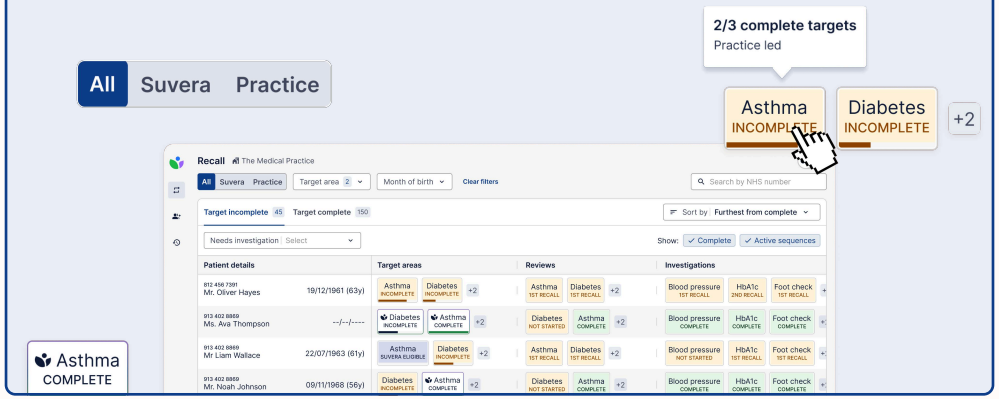
Planner

To identify who needs seeing

Suvera analysts **ensure EMIS and S1 integrates** with the Planner.

Suvera's Planner **automates risk stratification** and care prioritisation.

Suvera's governance team ensures **patient care eligibility** to the clinic.



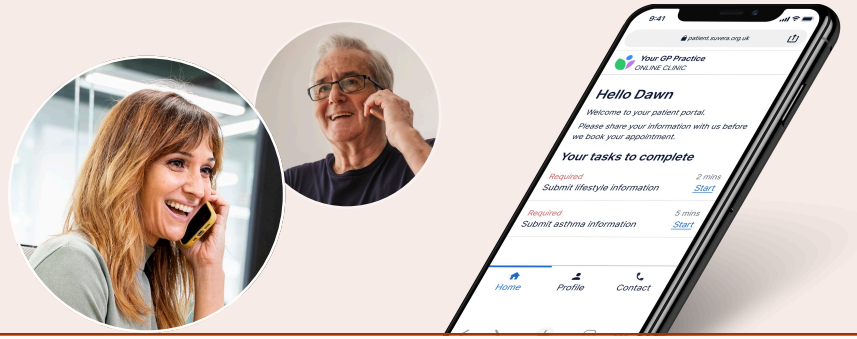
Virtual Clinic

To manage patients identified

Complete **patient care** with consultations, prescriptions, and follow-ups to target range.

Automated platform matches **patients with multiple conditions** to clinicians with the right skillset.

Suvera's dedicated GP supervising team ensures **safe, seamless care delivery.**



CHAPTER 4

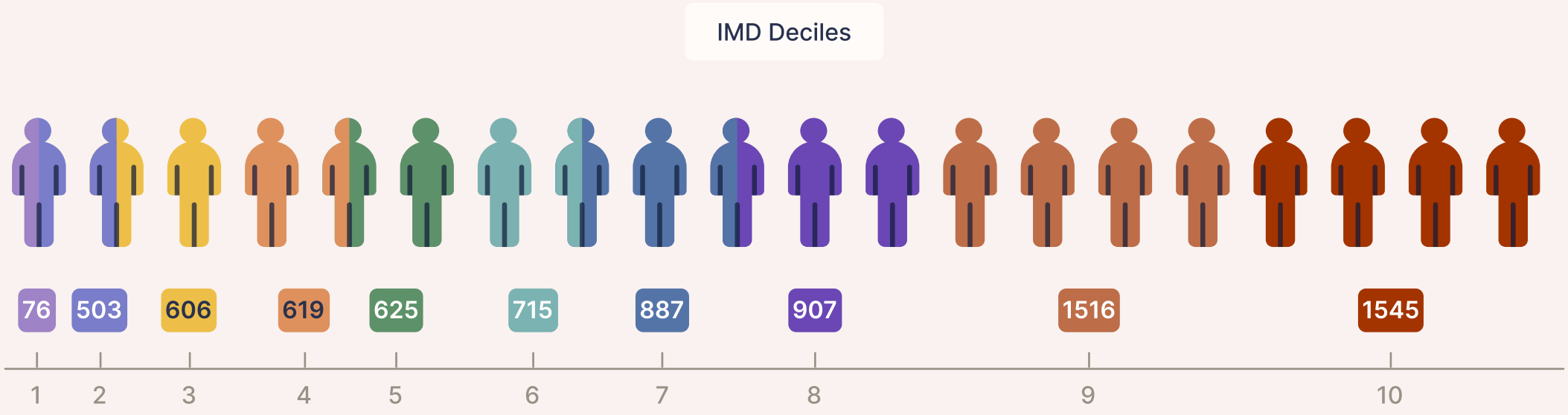
Patients managed by Suvera

A key goal for the HIOW ICB programme was to engage patients from deprived localities and those who face barriers accessing traditional GP services.

Across the seven practices, 8,000 patients were invited to participate through neighbourhood based, multi-channel communication.

- Meon Health
- Coastal Medical Partnership
- The Willow Group
- Crown Heights Medical Practice
- Red and Green Practice
- Forestside Medical Practice
- Waterfront & Solent Surgery

The programme offers patients variety in how they access care. Patients can submit blood pressure readings anytime via the Suvera Patient Web Application, which clinicians review based on risk level. This flexible, virtual focused approach ensures people who struggle to reach their practice can still receive timely hypertension management. By bringing care closer to home with multiple access points, the programme embodies the shift from hospital to community.



IMD Decile: 1- Deprived, 10 - Affluent

CHAPTER 5

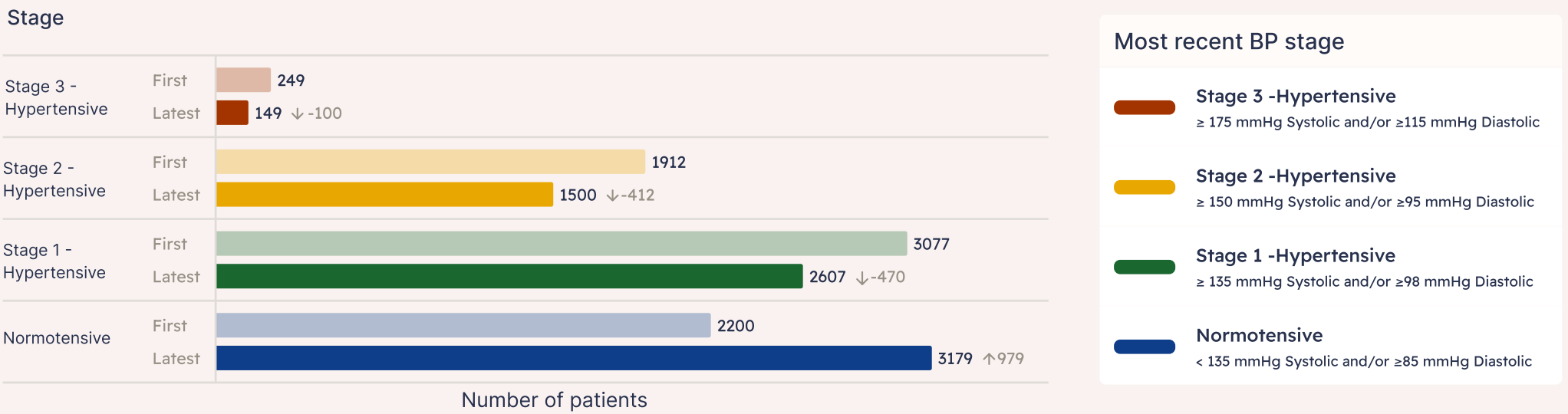
Clinical impact

The virtual clinic saw significant improvements in patients' blood pressure in HIOW. The graph below demonstrates that upon enrolment in the programme, Suvera's Virtual Clinic reduced patients' systolic blood pressure **by an average of 8.43 mmHg.** This resulted in 979 new patients were brought into normotensive control, who were previously in stages 1 - 3 of hypertension. There was a further 40% reduction in Stage 3 hypertension patients from enrolment in the Virtual Clinic.

The findings demonstrate that Suvera's Virtual Clinic, provides patients with more diverse forms of access to clinical services.

Overall, the clinical achievement, and engagement rates of 82% (which are to follow in the next section) demonstrate the triad of enhanced clinical outcomes, at lower cost to the system with positive patient and staff sentiment.

Change in BP Stages in patients in HIOW with Suvera's Virtual Clinic



34,642

Total Blood Pressure Readings

3.39

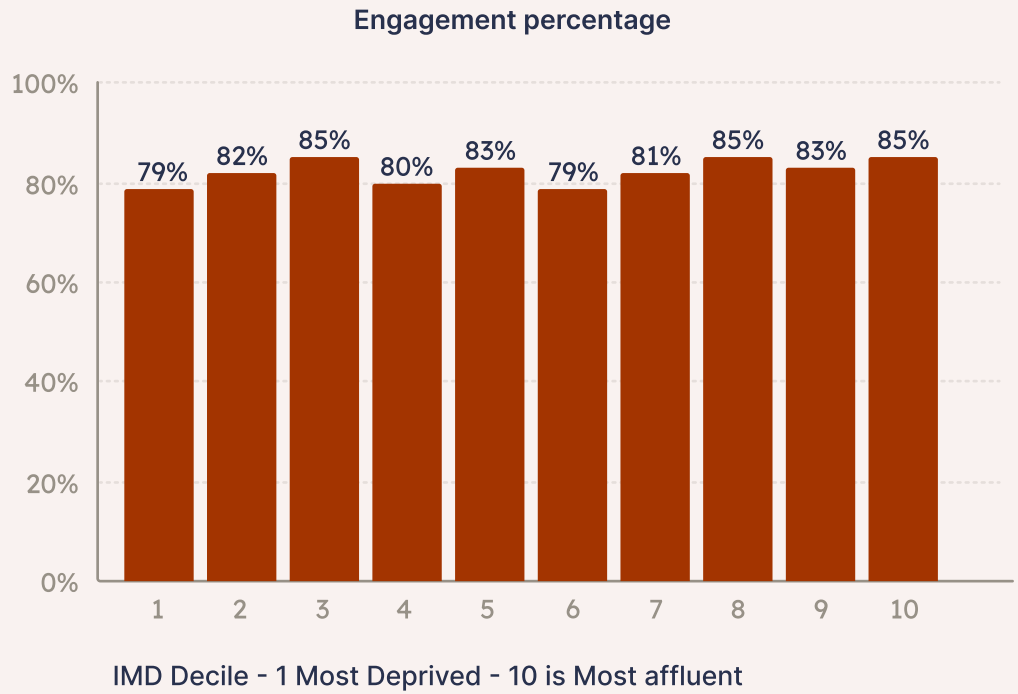
Avegare Blood Pressure readings per patient

8,077

Total reviews

99,753

SMS Messaging to the patient



"I like the messaging option, very useful and quick response. I also had to phone up for help which was quick and easy.

"Deepa gave me ownership of my Health it was a positive outcome when I was despairing of my blood pressuring readings.

"Everything was easy caring professional

"Absolutely excellent experience

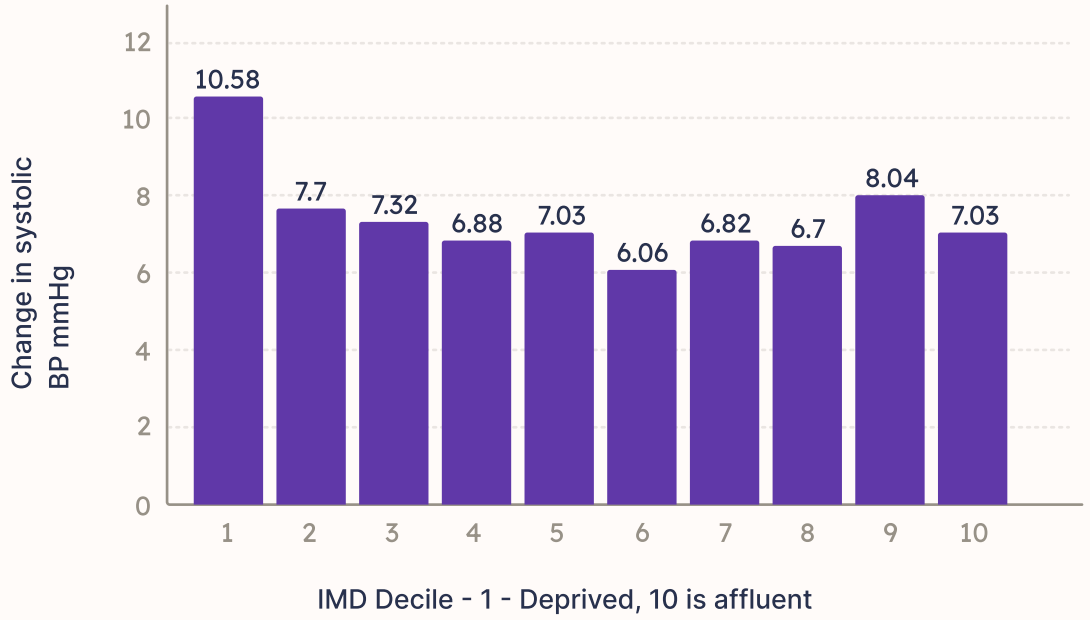
Closing the gap in CVD outcomes

Blood pressure improvements in groups that need the most support

One of the key national goals is to reduce health inequities in our population. It is known that patients who often require the most support are often the ones who fail to engage. The Virtual Clinic programme not only demonstrated it's ability to reach patients across the most deprived cohorts, but that it also achieved the greatest impact.

Patients from **the most deprived areas** (IMD-1) showed the **largest blood pressure reductions of 10.58 mmHg.** This is contributed by the fact that, on average, they started from poorer baseline control. This is objective recognition that the risk is highest in these cohorts and correlates with the difference in life expectancy from IMD 1 compared to IMD 10.

An observation was that the improvement of blood pressure in IMD-9 was higher. This affluent cohort achieved strong results, potentially, due to understanding, empowerment and compliance towards lifestyle changes and medication changes. Overall, it is clear that the Suvera Virtual Clinic intervention engaged patients and improved their clinical outcomes, regardless of their circumstance.



-8.43 mmHg

Improvement in Systolic BP Reading Average

27.32

Days average to Achieve BP Control Average

CHAPTER 6

Patient Experience

Achieving positive patient sentiment for General Practice is challenging for the NHS in the best of times, not least in this current climate. When analysing all Google Reviews across the seven participating practices involved in this project, it reveals the scale of this challenge: 1,316 reviews accumulated averaged just 2.2 out of 5 stars. Therefore, the Suvera Virtual Clinic achieved a significant shift in patient sentiment, with **72% of 145 surveyed patients rating their experience as Good or Very Good.**

64 years of age

is the average age of patients that used the Suvera Virtual Clinic in this project

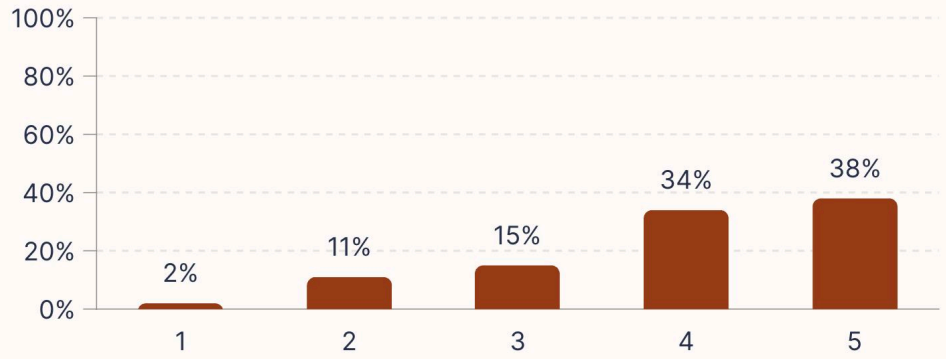
72% of patients rate 4/5 or higher

would recommend the service to a family or friend (N=145)

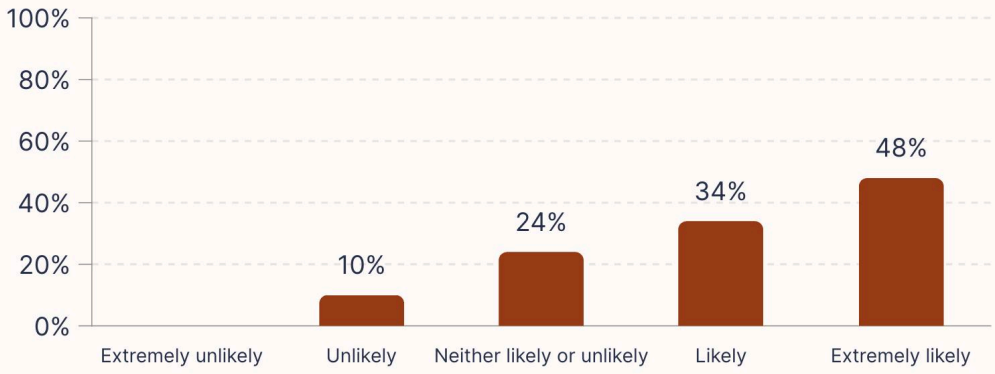
Multiple languages offered

numerous languages have been requested and translated for patients in live while on the phone or on video

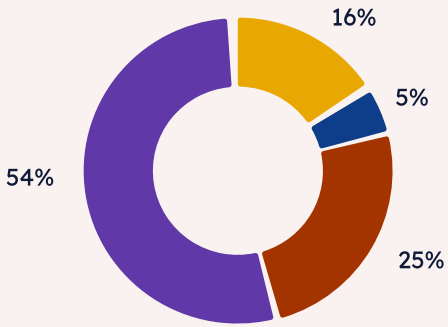
How would you rate your experience?



How likely would you be to raccomend us?



How well were you listened to during your care?



CHAPTER 6

Partner Experience

Practice staff are under enormous strain from patient demand, making any new service introduction understandably met with cautious optimism. Suvera's Virtual Clinic model addresses this through three critical integration points that relieve practice workload.

Technical Integration

Full compatibility with EMIS and S1 ensures all interactions are stored in the practice system and surfaced in the NHS App, creating one seamless system.

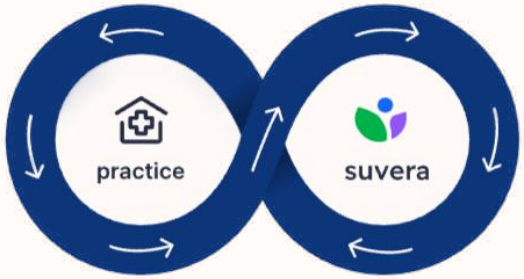
Operational Integration

The operations team works bespoke with each practice, adapting everything from pathology ordering to SMS communication style. The Suvera Planner enables practices to stratify recall registers with clear patient ownership visibility.

Clinical Integration

Clinical teams from both practice and Suvera meet regularly to agree standards, referral criteria and escalation points, ensuring consistent care.

Together, these elements provide additional practice resilience while building foundations for technical sustainability and scalability across different geographies.



> “ We have been working together since the start of the year, and overall, it has been a positive experience. It's fantastic to see the progress in the monthly activity overviews; and I really appreciate your support in reviewing patients with hypertension. T**hank you! I have enjoyed working with your staff who have been consistently friendly and very responsive to emails.**” - Coastal Medical Partnership

> “ We **truly value the fantastic service** you have provided and are very grateful for all your hard work and dedication.” - Willow Group

> “ Your **work on blood pressure is truly astounding”**

> “ {the best part about working with Suvera has been} Supporting our patients and the **ease of connecting with individuals for queries or concerns**” - Meon Health

> “ The **service was great and has been really helpful kick starting our HTN management.** The model certainly works for a good proportion of patients.” - Red and Green Practice

> “ Having the service has been a **huge help with our hypertension workload!”** - Forestside Medical Practice

CHAPTER 7

Economic modelling of the Prevention Agenda

The Suvera virtual care model fundamentally evidences the financial savings achieved from reactive hospital treatment to proactive community prevention. Managing hypertension systematically through a modern virtual model, the programme illustrates the compounding benefits of prevention. The impact is clear, based on the Lancet paper, with an 8.4mmHg average systolic blood pressure reduction in the patient cohort, it prevents 68 major cardiovascular events, including nearly 30 strokes, 11 Myocardial infarctions.

Each event prevented represents both a cost saving to the system, but more importantly, **a potential life preserved.**

Reduction in cardiovascular events:

A 10 mmHg decrease in systolic blood pressure lowers the risk of major cardiovascular events by 20%, coronary heart disease by 17%, stroke by 27%, and heart failure by 28%. It also reduces all-cause mortality by 13% - Lancet 2016.

68 CVD events

Strokes, Heart Attacks, Heart Failure, TIA

Exceptional Value for Money

£11 for every £1 spent Return On Investment (ROI) significantly exceeds typical NHS investment returns

Rapid Payback

1.3-month payback period means immediate cashable savings for the system

Scalability

Model can be replicated across other PCNs/ICBs regions in England

Triple Aim Achievement

- Better health outcomes (68 CVD events prevented)
- Better experience (community-based care, reduced hospital visits)
- Lower costs (£1.8m net annual savings)

Triple Saving: Primary, Secondary and Societal Costs

In primary care, the virtual model saves £368,000 annually by reducing General Practice appointments, outreach phone calls, administrative recall and management of patients. Furthermore, it provides much needed capacity given the estate's constraints and amplifies the savings by eliminating travel time, improving adherence and creating a virtuous cycle of better outcomes with less reactive workload.

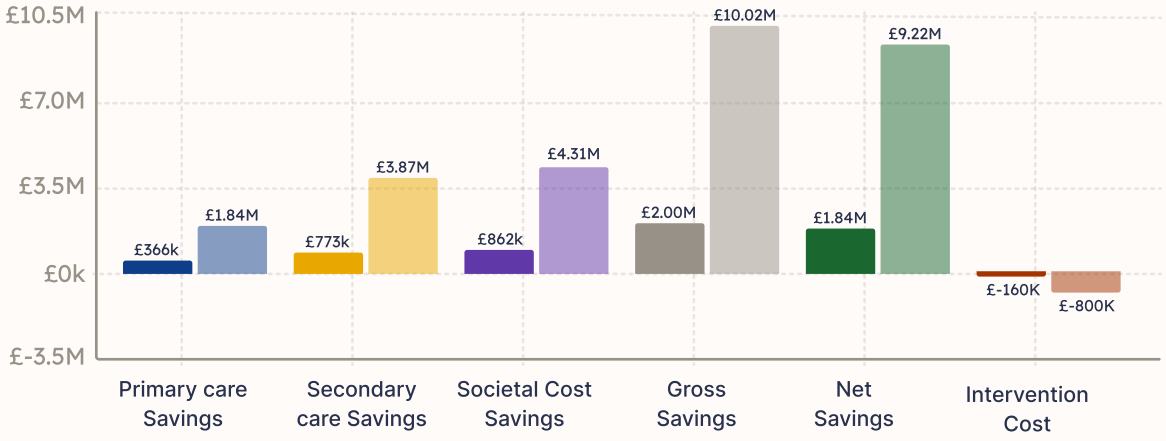
Secondary care offers the most substantial economic impact at £773,157 saved annually. Every stroke prevented saves the NHS £14,006 in acute treatment, every heart attack avoided saves £4,641, and every case of heart failure prevented saves £2,719. Suvera's model of consistent patient engagement enables early intervention before complications develop, effectively reducing hospital admissions, bed days, and emergency department attendances.

Societal savings of £862,385 capture benefits beyond NHS budgets. Social care savings of £393,465 reflect disabilities requiring care homes and support packages. This model adds £373,920 in productivity savings by preserving 1,848 working days annually purely from not needing to take a day of leave to attend appointments as evidenced by NHS West Midlands. Each virtual appointment saves 1.8 hours compared to face to face care, allowing working age patients to attend during lunch breaks without employment disruption while saving £82,000 collectively in travel costs.

Category	Year 1	5 Year Total
Primary Care Savings	£368,000	£1,840,000
Secondary Care Savings	£773,157	£3,865,785
Societal Cost Savings	£862,385	£4,311,925
Total Gross Savings	£2,003,542	£10,017,710
Intervention Cost	(£160,000)	(800,000)
Net Savings	£1,843,542	£9,217,710

Healthcare Intervention: Cost Benefit Analysis

Annual Intervention cost: £1600,00 | 5-year total: £800,000



CHAPTER 8

Conclusion: The Cost of Inaction and the Path Forward

The strategy of the three shifts is clear for the NHS, but as we all know, plans are only as effective as the operational delivery. This project encapsulates the vision for where the health system could be. Every year the system delays scaling interventions, like this case-study and others, cardiovascular events will occur that could have been prevented. **The key to highlight is the implications of inaction**. The current trajectory is unsustainable and needs to be changed. Even in a relatively modest population of 8,000 patients, if inaction persists, it compounds annually: £1.84 million in gross savings foregone, emergency department attendances that could have been avoided, and GP capacity consumed by reactive care instead of proactive prevention. Most critically, the human cost, measured in burnout from well-intentioned staff and more patients than ever not receiving care when they need it most.

This case-study is not an experimental innovation awaiting validation. ‘Death by a thousand pilots’ is an unfortunate reality in the NHS. Suvera's neighbourhood prevention model has already been successfully deployed across hundreds of practices, managing over 200,000 patients and commissioned by multiple ICBs.

With a 1.3 month payback period for the health system and £11 saved for £1 spent return on investment for the country - this model proves that the three shifts outlined in the 10 Year Health Plan are not future aspirations but present realities delivering measurable impact today.

The scalability of this model addresses the fundamental challenge facing the NHS: how to deliver more with constrained resources.

Every practice adopting this model immediately frees up internal clinical capacity whilst simultaneously improving outcomes and patient experience.

This is transformation that pays for itself whilst building system resilience. The hope is that the NHS can become an example on the global stage that proves our health system can be both ideologically brilliant as well as financially sustainable, rather than a cautionary tale where positive intentions crumble under economic reality.

NHS
Providing NHS services

Thank you for reading, contact us on:

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