

Community Blood Pressure Screening Tool: A Training Resource Project Evaluation 2025/26

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Executive Summary

Background

Hypertension is one of the leading modifiable risk factors for cardiovascular disease, which remains a major cause of morbidity and premature mortality in the UK and contributes substantially to health inequalities. In South East London (SEL), these inequalities are particularly pronounced within a large minority ethnic population, contributing to significant unmet cardiovascular health needs.

The “Community Blood Pressure Screening Tool: A Training Resource” was co-developed by community stakeholders and clinical partners in SEL to support the delivery of culturally sensitive blood pressure screening in community settings. The Community Blood Pressure Testing Project rolled out the Screening Tool by funding and supporting community groups to work alongside clinical partners to deliver blood pressure screening events.

Evaluation Approach

This evaluation aimed to understand how the project supported groups to deliver a community-based approach to high blood pressure detection and education. A mixed-methods approach was used, combining routine monitoring data, resident and provider surveys, interviews with key informants, observations of community events, and a review of project documentation.

Findings

Between September 2025 and March 2026, 12 community–clinical collaborations delivered 27 events across all six South East London boroughs. A total of 1,747 residents attended, with 944 receiving a blood pressure check. Of those screened, 233 (24.7%) were identified as having an Amber or Red reading and were signposted for further support. The events successfully reached many residents at increased risk of poor hypertension outcomes, including older adults and Black residents.

The evaluation found that community-based blood pressure screening was feasible and highly acceptable mainly due to project funding and support, rather than in the Screening Tool itself. Community–clinical partnerships were central to the project's success, helping to build trust, facilitate referrals and reach people who may not otherwise access traditional healthcare services. Delivering blood pressure screening within trusted community settings created a welcoming, non-clinical environment that encouraged engagement and enabled conversations about wider health concerns. Resident feedback was overwhelmingly positive, with value placed on the convenience and low barrier to access, as well as the friendly and warm atmosphere at the events.

The Screening Tool was viewed positively by those who used it and was reported to improve confidence in discussing blood pressure and supporting residents. However, use of the resource varied, and some providers felt that the document was too detailed for busy community events.

Community-clinical collaborations generally valued the support provided by the project, although attendance at webinars declined over time.

Several challenges were identified. Some community groups experienced difficulties securing clinical partners and consequently two funded groups were unable to deliver events. Concerns were also raised about funding levels relative to reporting requirements. The evaluation also highlighted opportunities to strengthen follow-up procedures for residents with raised blood pressure and improve the consistency of data collection and monitoring.

Conclusions

Overall, the evaluation demonstrates that community-based blood pressure screening is both feasible and acceptable in South East London. Future development should focus on strengthening community–clinical partnerships, simplifying implementation resources, improving monitoring processes, and clarifying how the model aligns with other cardiovascular prevention initiatives. Key recommendations include developing a shorter version of the Screening Tool, providing more active support to establish community–clinical partnerships, strengthening follow-up arrangements for Amber and Red readings, and improving data collection systems.

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Glossary and abbreviations

BP	Blood Pressure
CESEL	Clinical Effectiveness South East London
CIC	Community Interest Company
CVD	Cardiovascular Disease
HIN	The South London Health Innovation Network
KCL	King's College London
KHP	King's Health Partners: one of six Academic Health Sciences Centres (AHSC) in England. KHP is made up of three NHS Foundation Trusts – Guy's and St Thomas', now incorporating Royal Brompton and Harefield, King's College Hospital and South London and Maudsley – and a globally renowned university, King's College London.
KHP WCH	King's Health Partners Women and Children's Health Clinical Academic Partnership (previously Institute of Women and Children's Health).
KII	Key Informant Interview
PSR	Provider Survey Response
SEL	South East London
SEL ICS / ICB	South East London Integrated Care System /Integrated Care Board
South London Cardiovascular ODN	South London Cardiac Operational Delivery Network
T&F group	Task and Finish Group

1. Introduction

Hypertension is one of the leading modifiable risk factors for cardiovascular disease (CVD), including stroke, coronary heart disease, heart failure and chronic kidney disease (Burnier & Damianaki, 2023; World Health Organization, 2025). Cardiovascular disease remains a major cause of morbidity and premature mortality in the UK and contributes substantially to health inequalities (British Heart Foundation, 2026a, 2026b).

Early detection and effective management of raised blood pressure can significantly reduce the risk of cardiovascular complications and improve long-term health outcomes (Schmidt et al, 2020). However, despite the available effective treatment and monitoring strategies, hypertension is frequently underdiagnosed, undertreated and poorly controlled, particularly among underserved populations.

Existing evidence demonstrates that Black African and Black Caribbean communities experience disproportionate cardiovascular inequalities, including higher prevalence of hypertension, earlier onset of disease, and greater risk of adverse cardiovascular outcomes compared to White populations (Cooper et al, 2016; Ali et al, 2021; Davis et al, 2007; Rison et al., 2023). In South East London (SEL), these inequalities are particularly pronounced within a large minority ethnic population, contributing to significant unmet cardiovascular health needs (Schofield et al., 2011; Emmett et al, 2026; NHS South East London Integrated Care Board, 2024).

Cardiovascular inequalities experienced by ethnic minority groups are influenced by barriers to healthcare access and engagement, including low trust in healthcare services and limited culturally tailored support (Ojo-Aromokudu et al, 2023; Yogarajah et al, 2025; Mabadiliko CIC, 2023). These barriers may contribute to delays in blood pressure screening, diagnosis and ongoing management, suggesting that traditional healthcare pathways alone may be insufficient for engaging communities at high risk of poor hypertension outcomes, highlighting the need for more accessible, community-based approaches to cardiovascular prevention and education.

1.1. Improving cardiovascular inequalities

A literature review of the available evidence suggests that community-based and culturally tailored approaches can improve engagement with cardiovascular disease prevention and management among underserved populations and may support improvements in hypertension awareness, detection and blood pressure control (Ferdinand et al., 2012; Nasser and Ferdinand, 2018). Several studies have demonstrated the potential benefits of delivering interventions through trusted community settings and partnerships between healthcare providers and community organisations.

In the United States, community outreach programmes delivered through churches, barbershops and community organisations have been shown to improve hypertension awareness, screening and blood pressure control among African American populations (Nasser and Ferdinand, 2018; Victor et al.,

2019). Similarly, a community-based participatory intervention delivered through a nurse practitioner and community health worker model improved engagement with cardiovascular risk reduction among underserved minority populations, highlighting the value of culturally responsive and community-informed approaches to addressing health inequalities (Allen et al., 2011). A community–academic partnership intervention was also associated with improved blood pressure outcomes among African American participants, further supporting the role of community-based hypertension programmes (Levine et al., 2003).

Evidence also suggests that interventions incorporating ongoing support mechanisms can improve engagement with prevention and self-management. Community outreach programmes involving community health workers and telephone-based counselling have demonstrated positive effects on engagement with disease prevention and management among populations at increased risk of poor health outcomes (Nolan et al., 2011; Palmas et al., 2014). Consistent with these findings, a systematic review identified lay health worker and volunteer-led community blood pressure programmes as a promising area for hypertension detection and management outside traditional healthcare settings (Skar et al., 2015).

Outside the United States, findings from an Irish community outreach programme similarly suggest that delivering preventive health initiatives through community settings can improve engagement among underserved groups and help reduce barriers to accessing healthcare services (Niranjan et al., 2022). Closer to home and more recently, research conducted through by Mabadiliko Community Interest Company (CIC) highlighted the value of community-based approaches to blood pressure detection and education among Black African and Black Caribbean communities in South East London. Findings demonstrated that blood pressure testing and education delivered through community-clinical partnerships was both feasible and acceptable, supporting the potential of such approaches to improve hypertension detection and engagement among underserved groups (Mabadiliko CIC, 2023).

Collectively, the literature shows that community-based cardiovascular interventions are feasible and acceptable approaches for improving engagement with hypertension prevention and management in underserved groups. However, evidence relating to implementation within UK community settings, particularly within South East London, remains limited. Further research is needed to understand how community approaches can support sustainable blood pressure detection and education interventions within diverse urban populations.

1.2. Blood pressure screening in South East London

The Community Blood Pressure Testing Project is the result of many years of cascading hypertension funding in South East London. The initial resource came from the 2021/22 OneLondon Pathfinder programme, a pan-London initiative to demonstrate how using data at scale can improve health outcomes. The Hypertension Pathfinder, aimed to increase the detection and management of hypertension and reduce inequalities. The programme included public and patient engagement

activities undertaken by Mabadiliko CIC, which found that low trust in- and poor access to- healthcare services were barriers to both the detection and management of high blood pressure (BP).

Further resource from the NHS England (2022-2025) led to the Hypertension Inequalities Project, a collaboration between Clinical Effectiveness South East London (CESEL), Mabadiliko CIC, the South London Health Innovation Network (HIN), King's Health Partners (KHP), and the South London Cardiovascular Operational Delivery Network (ODN). As part of this project, community stakeholders and clinicians co-developed a blood pressure screening training resource, which was with tested within general practice and community settings between 2023 and 2025. The finalised "Community Blood Pressure Screening Tool: A Training Resource" was rolled out through the Community Blood Pressure Testing Project by 12 community groups from across South East London.

1.3. About this document

KHP Women and Children's Health (WCH) were commissioned to evaluate the rollout of the Community Blood Pressure Screening Tool in 2025/26. The evaluation aimed to understand how the project supported groups to deliver a community-based approach to high blood pressure detection and education.

The document sets out the findings from the mixed method evaluation. The next section describes the multiple components of an intervention designed to improve the uptake of blood pressure screening in communities that are seldom reached through traditional methods. The third section sets out the evaluation approach and methods and the overall aims and objectives. Section 4 comprises findings from both the qualitative and quantitative data. The conclusions and recommendations are presented in the final sections of the report.

2. Intervention description

This section sets out in detail the three components that form the intervention under evaluation: 1) the BP screening tool, 2) the Community BP Testing Project supporting the rollout of the tool and 3) community BP screening events.

2.1. Community Blood Pressure Screening Tool: A Training Resource

The “Community Blood Pressure Screening Tool: A Training Resource” is a comprehensive, interactive, 77-page document that is publicly available online. It aims to equip healthcare professionals and community members with the skills and knowledge to deliver effective, culturally sensitive blood pressure checks. The document includes information about hypertension and its impact in the local area, as well as background information on the Hypertension Inequalities Project.

Users of the tool are given a step-by-step guide for administering a personalised, jargon-free, culturally appropriate BP screen that focusses on building rapport and empowering participants (see Figure 1). Each of the five steps includes detailed flow diagrams, an illustrative script, the behaviour change rationale underpinning the script, and tips for ensuring the patient remains informed throughout the procedure.

Key lessons and recommendations that arose from the testing phase of the project are included in the document, with particular emphasis on the importance of collaboration and stakeholder engagement when implementing the tool. Additionally, the document includes live links to local support resources for each of the six SEL boroughs, and live links to resources for clinical and non-clinical GP teams.

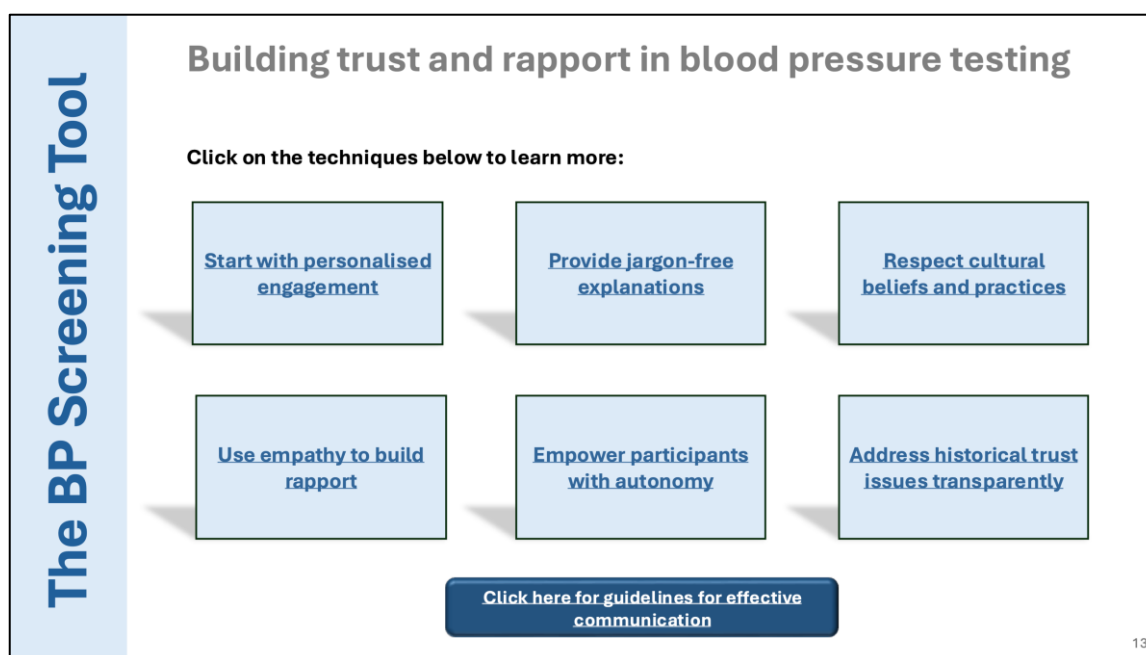


Figure 1: “Steps to Deliver the Screening Tool” in *Community Blood Pressure Screening Tool: A Training Resource*

2.2. Community BP Testing Project 2025/26

In 2024/25, Health Inequalities funding was made available for community groups across SEL to engage with clinical partners to use the Tool to “kick start their journey to collaboratively develop and deliver a community-based blood pressure clinic” (KHP et al., 2025). A Task and Finish (T&F) group, made up of individuals from KHP, the HIN, CESEL, and the South London ODN, supported the project.¹

2.2.1. Selecting the Community Groups

The T&F group invited expressions of interest from community groups from across SEL to roll out the Tool and deliver community blood pressure education and testing. Groups were offered £2500 to cover costs and were permitted to deliver the BP sessions either as standalone sessions or alongside other outreach activities. In total, 34 funding applications were received from a range of community groups, including faith groups, football clubs, health improvement charities, and community interest companies delivering community-based therapeutic services. Fourteen groups were selected using a loose scoring system based on a) previous experience of delivering community events; b) populations served; c) hypertension prevalence of the population served; d) the stated delivery approach; and e) the overall quality of the application. Community groups with pre-existing clinical partners and some understanding of blood pressure monitoring and prevalence were prioritised for selection.

¹ The T&F group at the time of the evaluation included two general practitioners, two project managers and a project administrator. The team varied over the course of the project. None of the T&F group were directly funded to deliver the work.

Funded community groups without a clinical partner were advised to approach GP practices or pharmacies with light support from the T&F group, and this was usually effective. Nonetheless, delays in establishing partnerships were a key implementation challenge, and groups unable to secure a clinical partner withdrew from the project.

2.2.2. Supporting the Community Groups

Support from the T&F group was intentionally light-touch and comprised webinars, an event checklist, and query handling via email, phone and online forms. The T&F group did not issue equipment or training beyond providing the Screening Tool. An introductory webinar in May 2025 set out timelines and project aims, followed by periodic webinars on project progress, finances, and monitoring and evaluation. Community-clinical collaborations were invited to share learning about their events during the webinars.

Support channels for community groups included email and a WhatsApp group to enable direct cross-communication on event planning, potential date overlaps and mutual support across boroughs. An event checklist and a flyer template (see annexes) were supplied, although groups were not obliged to use them and they retained flexibility about how to deliver the events.

2.3. Community blood pressure screening events

Community BP screening took place at a range of outreach activities, from standalone BP screening events to screening incorporated into wider activities such as St Patrick's Day celebrations or "wellbeing sessions." Screening was delivered in both community and clinical venues, including leisure centres, libraries, hired halls, churches and GP surgeries. Some events were informal, with attendees browsing BP screening stalls alongside food stalls, art therapy, massage, music, dance and other entertainment, while others were structured, group-based educational sessions in which clinicians presented slides on hypertension before undertaking blood pressure checks.

2.3.1. Data collection at events

Community events were informal and blood pressure screening was voluntary. To standardise and simplify data collection, the Task and Finish group developed two online forms and shared them with community organisations via QR codes. Groups submitted a brief summary of each event along with basic information on blood pressure checks. Residents who took part in screening were invited to complete a short feedback form capturing sociodemographic details and the blood pressure readings recorded on the day.

3. Evaluation approach and methods

This section outlines the evaluation approach and methods used to explore how the intervention supported delivery of a community-based model of blood pressure detection and education. It first sets out the core evaluation question and four domains of enquiry. We then describe the mixed-methods data collection, including quantitative monitoring data alongside qualitative data from interviews with key informants and observations of outreach events.

3.1. Evaluation questions

The evaluation aimed to understand how the Community BP Testing Project supported groups to deliver a community-based approach to BP detection and education, and to assess the feasibility and acceptability of the “Community Blood Pressure Screening Tool: A Training Resource” for community groups and clinical partners. The core evaluation question was:

How has the Community BP Testing Project supported groups in delivering an acceptable, community-based model of blood pressure detection and education?

This is addressed through sub-questions across four domains.

1. Delivery and reach

- What is the prevalence of BP uptake at events (numbers attending, numbers receiving BP checks, proportion with amber/red readings)?
- Who is reached by the events in terms of age, gender, ethnicity, and does this reflect populations at highest risk of poor hypertension outcomes?

2. Pathways, signposting and follow-up

- To what extent are residents with amber/red readings appropriately signposted or referred to healthcare services, and what factors support or hinder this?
- How do community groups perceive the clarity and usefulness of information and advice provided during sessions?

3. Screening Tool implementation and support package

- How was the Screening Tool and the support package (including webinars and documents) used across different collaborations, and how did use vary by context?
- What were the key barriers and facilitators to implementing the Screening Tool (e.g. staffing, skills, relationships, logistics, technology)?
- To what extent did the Screening Tool and support package improve staff confidence, knowledge, communication skills and ability to collaborate across community and clinical teams?

4. Acceptability, perceived impact and sustainability

- How acceptable was the model to community groups and clinical partners, including perceptions of cultural safety, trust and accessibility?
- In what ways did the project appear to improve awareness of raised BP, detection among people who might not attend traditional services, and trust in health services?
- How might the use of the Screening Tool be sustained or scaled up?

3.2. Data collection and analysis

3.2.1. Quantitative data

Monitoring data

Routine monitoring data collected from community BP screening events were used to assess reach, delivery and participant characteristics. Variables included event location, type of event, number of attendees, number of participants receiving a BP measurement. These data underpin the main quantitative analyses of event numbers, attendance, uptake of BP checks and signposting.

Feedback forms

Residents who attended a community BP event and received a blood pressure check were invited to complete a short feedback survey. The survey collected demographic information, reported BP readings and brief reflections on participants' experiences of the event. A total of 84 feedback forms were returned, providing additional detail on the characteristics and outcomes of a subset of participants; however, the low response rate means these data are not representative of all attendees and are interpreted cautiously.

Provider survey

Community-clinical collaboration teams completed a survey about their experience of delivering the sessions and using the Community Blood Pressure Screening Tool. The survey combined a mix of Likert scale, checkbox, and free-text questions covering respondents' roles, settings in which they worked, typical session attendees, and their perceptions of how the Community Blood Pressure Screening Tool functioned in practice. Provider reports are used to complement the monitoring and feedback data by offering a high-level overview of who mostly attended sessions and how the delivery model operated, but the small number of responses limits the strength of evidence about the wider population reached.

All quantitative data cleaned, combined and analysed in Stata 19.5 (StataCorp. 2025 College Station, TX: StataCorp LLC). Descriptive statistics are presented; due to the small sample size no statistical tests were undertaken.

3.2.2. Qualitative Data

In-depth interviews

Nine semi-structured interviews were conducted with key informants from the project team (n=4), community groups (n=4), and a clinical provider (n=1). Interviews were conducted online and

recorded. The interviews followed a topic guide with open ended questions focussing on the experiences of using the Community BP Tool and delivering outreach sessions. Interview recordings were initially transcribed using a technical transcription service (Just Transcript), and subsequently manually reviewed for accuracy by the interviewer to ensure verbatim transcription.

Observations

Members of the team visited three events to observe how the intervention was being delivered. Researchers used the passive participant observation method and did not actively involve themselves in the event. At the end of each session, the researcher wrote extensive, detailed fieldnotes documenting what they had seen and heard during the observation. Researchers also reviewed the recorded webinars and assessed them for engagement and content.

Thematic analysis was conducted in NVivo 15 (Lumivero, 2023), which served as the platform for storing, managing and coding the interview transcripts and fieldwork notes. The approach drew on Braun and Clarke's guidelines.² Coding began from an initial framework that was revised iteratively as the analysis developed and new patterns emerged. Reviewing the resulting codes then informed the identification of key themes, lessons and recommendations.

3.3. Limitations

This evaluation is subject to several limitations that should be considered when interpreting the findings. The qualitative component was based on a small number of participants: interviews were conducted with only four community group representatives and one clinical provider, and just three events were observed. These numbers limit the range of experiences captured and the extent to which the findings can be generalised. The quantitative data were also limited in scope and completeness. Monitoring data captured only the total number of Red and Amber readings rather than fuller information on participants or outcomes, and there are concerns about whether all activity was recorded. For example, the team attended one session that did not appear in the records subsequently received, suggesting some events or checks may be missing from the dataset. Feedback form coverage was low, with only 84 forms completed against approximately 950 BP checks delivered, meaning the demographic and experiential data are drawn from a small and potentially unrepresentative subset of participants. Similarly, the provider survey received a small number of responses (only seven people answered all questions), restricting the conclusions that can be drawn about the Screening Tool and the delivery experiences. Together, these factors constrain the strength of conclusions that can be drawn.

² Braun V, Clarke V. Using thematic analysis in psychology. *Qualitative Research in Psychology*. 2006;3(2):77-101.

4. Findings

In this section we set out the results from the mixed methods evaluation of the Community Blood Pressure Testing Project. Each of the four domains of enquiry are discussed using both qualitative and quantitative findings.

4.1. Delivery and reach

Twelve community-clinical collaborations delivered 27 community blood pressure screening events across six boroughs between September 2025 and March 2026 (Figure 2). Six of the community groups reported delivering one event, while a few delivered three or more (see annexes for full details). Collaborations in Greenwich hosted the most events (8 of 27), with the remainder spread across the other five boroughs. (Figure 2).

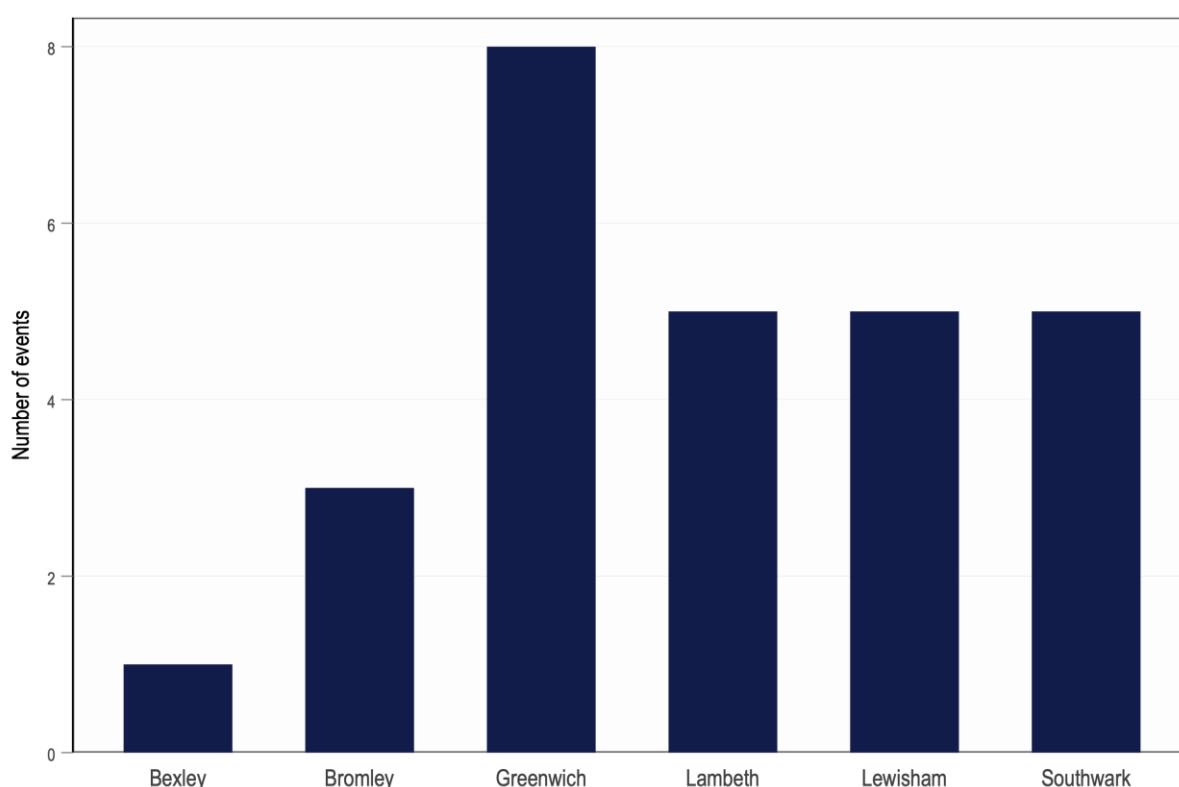


Figure 2: Number of Community Blood Pressure Testing Events, by Borough.

Attendance at the activities varied considerably, with the smallest event drawing nine attendees and the largest attracting 318 residents (Figure 3). Community-clinical collaborations in Southwark held a small number of larger events (average 150 attendees) and accounted for the highest volume of residents (43% of all event attendees). In comparison, groups in Greenwich held a larger number of relatively smaller events (average 42 attendees), while organisations in Lewisham provided testing at a mix of large and small events (see annexes).

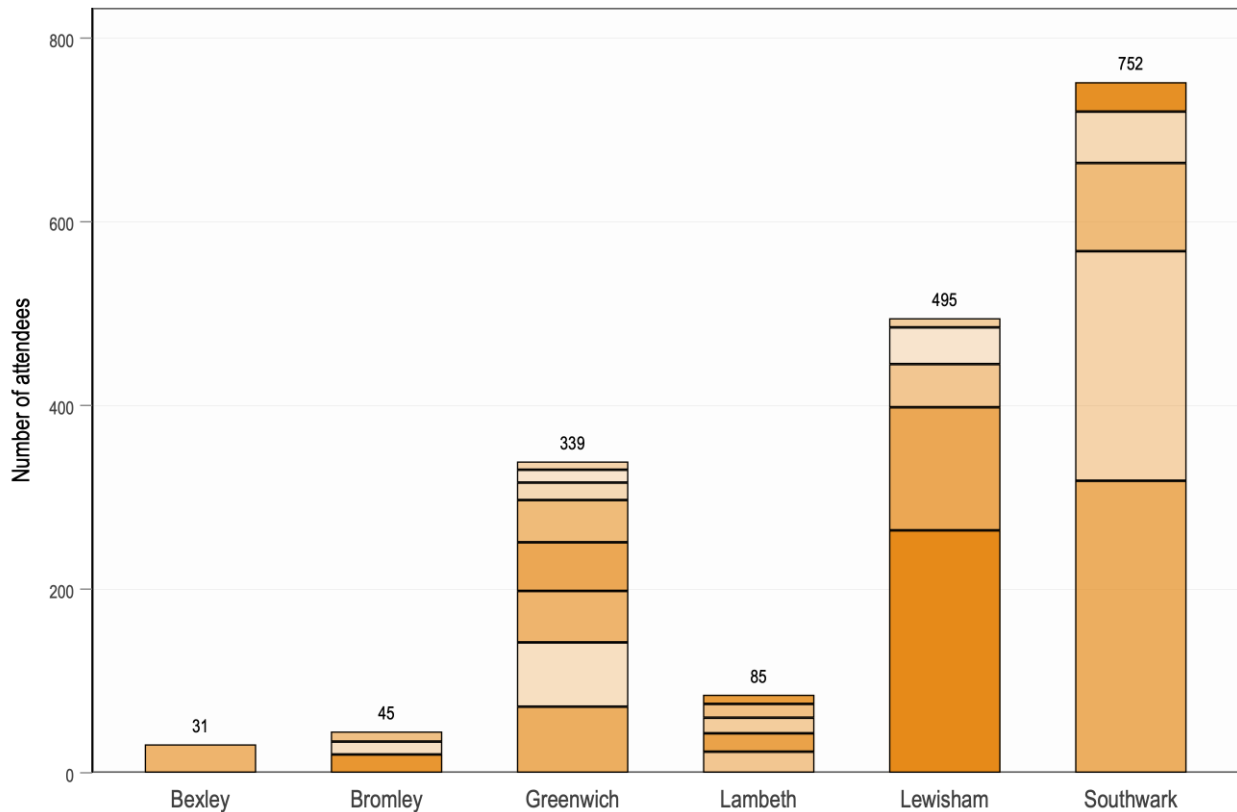


Figure 3: Total number of event attendees, by borough. Each segment represents one event and illustrates the variation in number of attendees.

4.1.1. Explaining variation in delivery and uptake

Qualitative data from key informants helps explain why community groups varied in both the number of events delivered and levels of resident uptake. While promotional approaches differed across sites, these did not map onto attendance patterns: events that attracted more than 70 participants and those with fewer than 15 participants used similar combinations of flyers, social media and word-of-mouth. Instead, existing clinical partnerships, capacity, and use of incentives and space appeared more important in shaping delivery.

Existing relationships with clinicians made implementation straightforward for some organisations and influenced whether they participated in the project at all. Community groups that were already matched with a clinical partner were able to integrate the Screening Tool quickly into activities they were already running, whereas others may have faced greater barriers to engaging:

“The reason we went for this was because we were already matched with a clinician, it made sense, it was easy for us to achieve the aims of this project. I think there were other people where it wasn't so easy, and I probably, had it not been easy for me to do it, I wouldn't have gone and bid for the money.” – Key Informant Interview (KII) 1, Community Group

Use of incentives and the wider event “offer” further shaped uptake. Some organisations used project funding to provide food, music and other entertainment, while others offered shopping vouchers to residents who attended and had their BP checked. As the quotes below illustrate, these strategies were reported to boost participation.

“The atmosphere, there are things that we're gonna still maintain, the music, the food supply, the food, the food bank, that will definitely be on board anytime that we're doing it because it's something that motivates them to come over.” – KII 2, Community Group

“[W]e decided to offer them Tesco vouchers. So, they all turned up in droves.” – KII 3, Community Group

The physical setting of events and whether organisations had an established, trusted space also influenced attendance. Hosting BP checks in familiar venues, at times that aligned with popular classes or sessions, meant organisations could reach both regular attendees and other groups using the same centres:

“We decided that we will host the blood pressure testing at our most popular centre [...] which it's made up of normally hard to reach people who probably wouldn't go to GPs. [S]o not only did we get participants to our sessions, but we got all the other groups that are usually there at the community centre.” – KII 3, Community Group

“We have a main studio space, which is where our event is... And then usually the clinicians will also come into the space and chat to people. So, it works quite naturally because then people don't feel the pressure of going there.” – KII 4, Community Group

4.1.2. Who was reached

Routine monitoring data from the 27 events provides counts of attendees, BP checks and signposting, but only limited information on who was reached. To supplement this, two brief surveys were completed: a feedback form by participants who received a BP check and a provider survey by community–clinical collaboration teams about who typically attended their sessions. In total, 84 feedback forms and a small number of provider survey responses were returned, so these data offer only a partial picture of attendee characteristics.

Feedback forms suggest that the events mainly engaged adults in mid and later life living in South East London. Two thirds (67%) were women, around two-fifths (43%) were aged 50–69 years, and a further quarter were aged 40–49, with smaller numbers under 30 and over 70 years (Table 1). Around one third identified as Black and one third as White, alongside Asian, Mixed and other ethnic groups; 1 in 7 participants lived outside South East London (Table 1). Respondents to the provider survey similarly reported that sessions were most attended by people aged 55–74 years, with an equal mix of men and women or mainly women, and that many events reached Black African, Black Caribbean or Black British residents (data not shown).

In summary, these patterns suggest that the events reached groups at elevated risk of poor hypertension outcomes: older adults, women, and a substantial proportion of Black residents, the population among whom cardiovascular inequalities in South East London are most pronounced. This is consistent with the project's aim of engaging communities less likely to be reached through traditional services, although the low feedback-form response rate means these characteristics should be treated as indicative rather than representative of all attendees.

Table 1: Sociodemographic characteristics of residents completing community event feedback forms.

	Gender n (%)		
Characteristic	Male	Female	All
Gender	27 (31.8)	57 (67.1)	84 (100)
Age group (years)			
Under 18	1 (3.7)	2 (3.5)	3 (3.5)
18–29	3 (11.1)	6 (10.5)	9 (10.7)
30–39	6 (22.2)	5 (8.8)	11 (13.1)
40–49	7 (25.9)	13 (22.8)	20 (23.8)
50–59	6 (22.2)	8 (14.0)	14 (16.7)
60–69	3 (11.1)	19 (33.3)	22 (26.2)
Over 70	1 (3.7)	4 (7.0)	5 (6.0)
Ethnicity			
Asian	3 (11.1)	7 (21.3)	10 (11.9)
Black	9 (33.3)	21 (36.8)	30 (35.7)
Mixed	4 (14.8)	5 (8.8)	9 (10.7)
White	11 (40.7)	18 (31.6)	29 (34.5)
Other/Prefer not to say	0 (0.0)	6 (10.6)	6 (7.2)
Resident in South East London	23 (85.2)	48 (84.2)	72 (84.7)

4.2. Pathways, signposting and follow-up

Monitoring data show that across all 27 events there were 1,747 attendees, of whom 944 received a blood pressure check (54.6%). Of those screened, 233 (24.7%) had an Amber or Red blood pressure result and were signposted for further support (Figure 4); this corresponds to 13.3% of all attendees and is broadly in-line with the Quality Outcomes Framework prevalence in South East London in

2024/25 (12.1%).³ When examined by borough, there was substantial variation in the proportion of attendees who had a check and the proportion of those checked who were signposted (Figure 5), perhaps reflecting differences in event size and the populations reached.

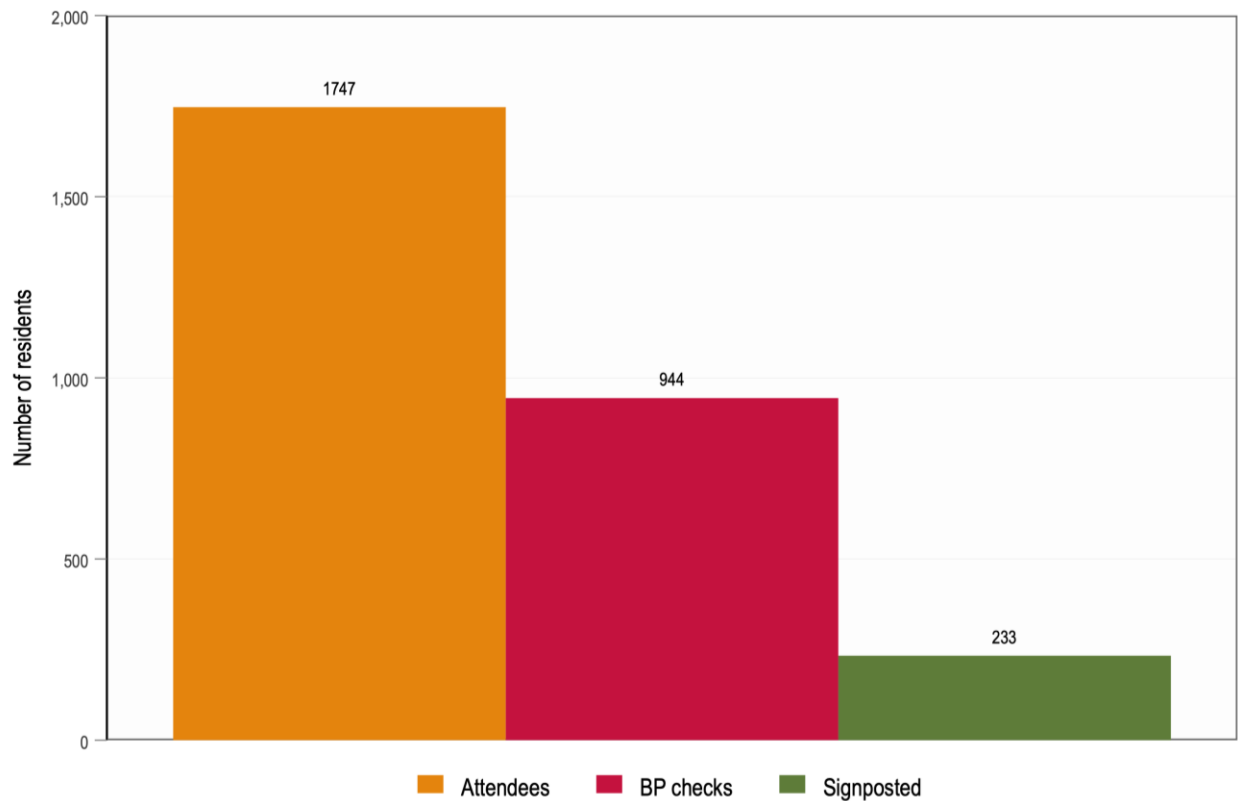


Figure 4: Overall activity for the Community Blood Pressure Event. Number of attendees → number of checks → number of residents signposted.

³ Office for Health Improvement and Disparities. Public health profiles. 2026 <https://fingertips.phe.org.uk/> © Crown copyright 2026

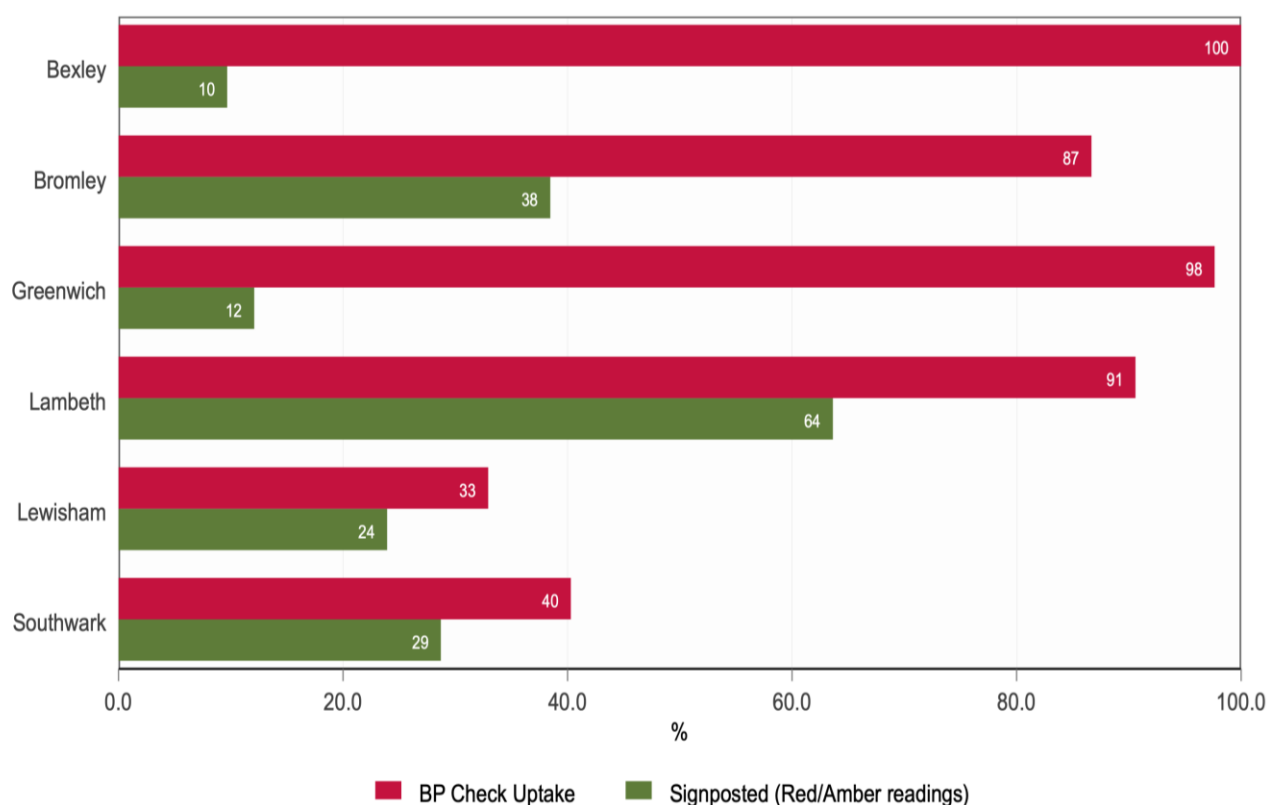


Figure 5: BP check uptake and signposting by borough. Uptake = percentage of event attendees who had a BP check. Signposted = percentage of people who had a BP check who were signposted.

Feedback survey data broadly align with the routine monitoring data on BP outcomes. Around one quarter of respondents (25.6%) reported a Red or Amber reading, and one fifth (19.5%) said they had been advised to seek further care (Table 2). However, one community group noted that five residents with amber readings had not received advice or referral when they should have, highlighting the importance of robust follow-up procedures. The group recommended that, at future events, supervising clinicians “sign off all amber and red forms at the time the BP is taken to ensure adequate clinical follow-up is advised.”

Table 2: Blood pressure outcomes for residents completing community event feedback form.

	Gender N (%)		
Characteristic	Male (n=26)	Female (n=56)	All (n=82)
Blood Pressure RAG rating			
Red	2 (7.7)	1 (1.8)	3 (3.6)
Amber	8 (30.8)	10 (17.9)	18 (21.4)
Green	16 (61.5)	45 (80.4)	61 (72.6)
Advised to seek further care	8 (30.8)	8 (14.3)	16 (19.5)

For some residents, engagement went beyond a single check, with people returning to events to monitor changes in their blood pressure over time. This allowed clinicians to assess improvements and reinforce advice across multiple contacts.

"...[A]nd some of them tested their blood pressure twice to see if it improved and even when I say twice, they might come in the first day - because we have four days - and they may come back on the last day or the third day or the second day or something like that. So, the clinicians were able to assess their improvement [...]." – KII 3, Community Group

4.2.1. Clarity and usefulness of information and advice

Interviewees reported that the events provided a setting for residents to receive clear, straightforward information that enabled them to better engage with their health and access further support when needed. Collaborative working between community groups and healthcare professionals helped identify serious health concerns, encourage appropriate medical follow-up, and tailor advice to residents' circumstances.

In some cases, the community-focused approach helped overcome barriers to accessing urgent care, ensuring residents received treatment without being pushed out of their comfort zone. This example of how one group responded to a very high reading illustrates how community-clinical partnerships can escalate and expedite referrals in line with the Screening Tool's "resident-led" approach.

"If we'd called them an ambulance, they would have refused to get in it. Instead, the GP went back, put it on for one of the [GP] partners. The following morning the partner rang them up and sorted out new medication for them, had them into the surgery, made an appointment for them and they all got sorted out." – KII 1, Community Group

4.3. Screening Tool implementation and support package

4.3.1. Use of the Screening Tool

The Community Blood Pressure Screening Tool was described as easy to understand and, when used, helpful for structuring conversations about blood pressure. Survey respondents who had used the Screening Tool reported that it increased their confidence in talking about BP, supporting residents with their readings and spotting people who might need more support. However, use was uneven: of 12 providers completing the survey, only six reported using the Screening Tool when working with residents, three said they had only read or looked through it, and three had not read or used it at all.

Beyond confidence, provider survey respondents reported that the Screening Tool supported their own understanding and their ability to work across teams. Of those who answered, three of four said the Tool had helped them understand blood pressure "a lot" and one "a little", and most agreed or strongly agreed that it had made it easier to work with clinical teams (3 of 4) and with community groups (3 of 4) on blood pressure. Respondents valued the clear, safe advice for high and low readings and the step-by-step structure, which several felt improved how they communicated with residents.

Key informants' accounts show that the Screening Tool was often integrated into existing community activities rather than standalone events. Some partners described the Screening Tool as sitting naturally within what they already did and providing a clear checklist and flow chart for planning sessions and clarifying roles:

"We're really lucky from our side of things because it just really naturally sits within what we do and it just feels like a really great benefit to the community." – KII 4, Community Group

"As far as the toolkit's concerned, it worked well. I mean there was the planning bit, the checklist was great, we had all the forms and everything else when we turned up." – KII 3, Community Group

One respondent reported using the Screening Tool directly with residents in waiting areas to explain readings and next steps before BP checks were carried out by pharmacists or other clinicians.

"[Pharmacy] were using their own materials, but we [GP] were using the toolkit with the patients in the waiting room, so we were going through it with them, to talk about blood pressure and if it's high or low, this is what's gonna happen, but then they would go in and have the blood pressure taken by the community pharmacist." – KII 5, Clinical Partner

Across both the survey and interviews, most felt the Screening Tool was broadly appropriate for the communities they worked with and only reported needing to adapt how they used it for residents with learning difficulties, limited English or unstable housing. Rather than seeing the Screening Tool itself as a "cultural" product, one key informant emphasised that what mattered most was the way community and clinical partners interacted with residents during events:

"I don't think it's culturally anything... I think because we're operating at volume, there's not time to go through each page of it." – KII 1, Community Group.

4.3.2. Webinars

The introductory and shared learning webinars were initially well attended but participation declined over time. The first webinar included around 35 participants, but by February only five people were attending. Some of those who joined valued the opportunity for shared learning and reflection, whereas others found it hard to attend the webinars regularly.

"Although I think it's over the top for the size of the fund, I do think having monthly catch-ups scheduled is actually really good. There's a lot of funders out there who don't do that [...] In the beginning, it was a little bit like, "What's there to talk about?". But then as we went on, we would hear other people's stories, the way it went for other people, I think that that type of learning and sharing is always good." – KII 1, Community Group

"More individual support from the team would have been appreciated as the organisation I work for is very small so I could not make the majority of webinars and felt a little isolated. The webinars were convenient to the team not the community organisations." – Provider Survey Response (PSR) 1, Community Group

Views among those who took part were generally positive: of 11 providers responding to the survey, most rated the webinars useful for planning and delivering sessions (four "very useful" and one "extremely useful"), while two had not attended any. This suggests the webinars were valued by those who engaged, even as overall attendance fell over the course of the project.

4.3.3. Barriers to implementation

Respondents highlighted barriers to using the Screening Tool in full. Many described the documents as too long and detailed for busy events, leading staff to use only selected components.

Once you start delivering a volume, there's no way you can use that tool in real life. It's way too long, far too much stuff in it that you just wouldn't say to somebody. If you're working with groups who have never ever done this before, I think it's a very good step-by-step." – KII1, Community Group

"We skipped all the way down to the flow chart bit. [...] It is really long." – KII 5, Clinical Partner

One partnership introduced small cards showing residents' blood pressure so they could discuss their readings with friends and family. Several informants suggested that a shorter, more navigable version of the Screening Tool would be easier to use at high-volume events. It was unclear whether these individuals were aware that the Screening Tool is an interactive document, or if more interaction is required.

"Support documents need to be much more streamlined. It felt over complicated for what was being achieved." – PSR 2, Community Group.

"Is there an easier way to navigate the BP comms pack for the BP takers" – PSR 3, Clinical Partner

Practical constraints around staffing, equipment, funding and logistics further shaped implementation. Some events were busier than anticipated, with insufficient staff or BP machines.

"[W]e underestimated the number of people turn up, so the BP check machines initially was not enough because we don't want people to be queuing." – KII 2, Community group

Key informants also stressed the importance of keeping events "light and pressure free," with clinicians integrating into the setting in a relaxed way; while residents were encouraged to get checked, this was framed explicitly as their choice. Balancing visibility of BP check stations with enough privacy for residents to discuss their readings was a recurring planning consideration.

4.4. Acceptability, perceived impact and sustainability

4.4.1. Acceptability, cultural safety and trust

The model was broadly acceptable to the community groups involved, with acceptability resting primarily on the community setting rather than on the Screening Tool itself. Delivering screening within trusted, familiar venues created a non-clinical, sociable atmosphere in which health

conversations felt safe and unhurried. Evidence from clinical partners was more limited but consistent with this picture.

Limited evidence from residents left in the feedback forms also concurred with clinical groups and clinical partners. Most comments were overwhelmingly positive and stressed the welcoming, social feel of the sessions, describing them as "a nice community thing to have" and a "nice social atmosphere", and praising staff for being approachable and making people "feel comfortable and informed throughout". Several respondents expressed warmth and trust towards the delivery teams, from "Love the team!" to appreciation of individual clinicians' and pharmacists' "professionalism and enthusiasm". These comments were unprompted and self-selecting, so they signal strong acceptability among those who chose to respond rather than a representative measure across all attendees.

Residents also valued the convenience and low barrier to access, with one describing it as "an amazing chance and easy to get my heart and blood pressure checked in one place".

4.4.2. Perceived impact: awareness, detection and trust

Those who completed the provider survey perceived clear benefits for awareness and trust. Most agreed or strongly agreed that the sessions had increased residents' awareness of raised blood pressure and its risks (8 of 9 respondents), and that they had improved residents' trust in services (6 of 8 respondents).

A recurring theme was that the check acted as an entry point to wider health and social conversations that might not otherwise take place.

"Overall, I felt the event was beneficial not only for identifying potential blood pressure concerns, but also for encouraging early conversations around wider health and social issues that may otherwise not have been raised." – PSR 4, Clinical Partner

Because screening was embedded in community activities and trusted venues, partners felt the model reached residents who would not typically present to general practice, supporting the aim of improving detection among people less likely to attend traditional services. This reach extended to residents outside mainstream services altogether. In one recorded instance, a resident with no fixed postcode was offered information on available support and signposted to a social prescriber based at their GP.

4.4.3. Sustainability and scale-up

While views on sustainability were positive in principle, they were bound by conditions that need to be in place for the continued delivery of community blood pressure events. Both residents and providers saw real value in continuing the model, sometimes in strong terms.

"This project must be continued to save lives and build the community confidence with the health system." – PSR 5, Community Group

However, funding was commonly perceived as too small relative to the administrative and reporting requirements. Only one of four survey respondents agreed that the funding provided was “About right” and one key informant noted that the administrative burden was similar regardless of whether they received £2,500 or £20,000.

“Was it enough to what we want to achieve? Of course, it was enough because we never overspent. However, is it worth it for that small amount of money to attend monthly webinars, have to fill in forms, etcetera? It's not really worth it.” – KII 3, Community Group

Beyond the funding and materials issues discussed above, the factor most specific to scaling was the requirement for community groups to secure their own clinical partner. Two of the fourteen community groups were unable to deliver any events because they were unable to secure a partner. One respondent noted that little was done to encourage Primary Care Networks to support this brokering.

“Some Community orgs found it difficult to partner with a clinician as the onus was on the community group... for those that didn't there was no encouragement to the PCNs to support this work.” PSR 2, Community Group

Roles within partnerships were clearly delineated in practice, with implications for how the model might be sustained. Although the Screening Tool was designed for use by non-clinicians, community groups did not feel able or trained to take residents' blood pressure themselves and saw this as the clinical partner's role, focusing instead on organising, promoting and engaging communities. Several expressed interest in future training so their staff could measure and log blood pressure and offer basic advice on hypertension. In doing so, community groups would reduce their dependence on securing a clinical partner and support scale-up.

It should be noted that views on sustainability and scale-up assume continued funding and ongoing support from the Community BP Testing Project. It is unclear whether community-clinical collaborations would continue to deliver BP screening events without being commissioned to do so.

4.4.4. Governance and accountability

The project's light-touch, flexible design raised further governance questions for future rounds. Where funded groups did not go on to deliver events, there was uncertainty about whether funding could be recovered, and the T&F group highlighted a need for clearer expectations and accountability. However, a longer and more formal application and vetting process might increase costs and would require additional resources and oversight from the T&F team. Similarly, increased data monitoring might create a separate pressure. Collaborations reported difficulties capturing resident data reliably, as handwritten forms were sometimes illegible, lost or discarded, yet collecting more information risks feeling bureaucratic and is at odds with the community-led approach.

Increased governance and accountability points towards greater structure and paperwork, which sits in tension with the flexibility that underpins the intervention. Feasibility and acceptability largely

depend on an adaptable, low-constraint delivery model that does not demand too much of either event attendees or the community groups commissioned to deliver them. Efforts to increase accountability and evaluability might therefore prove a significant barrier to scale-up.

4.4.5. The wider SEL context

A related challenge for scale-up was ambiguity about how the Community BP Testing project relates to other concurrent initiatives, particularly the Vital 5 Check. Despite the two being intended as distinct, groups reported that the Screening Tool and the Vital 5 Check were often used interchangeably, and there were inconsistencies in whether clinicians or health ambassadors were delivering the Screening Tool, the Vital 5 Check, or both at a given event. Additionally, one listed clinical partner declined to be interviewed for the evaluation because they were unaware members of their team had delivered BP screening as part of this project.⁴ This ambiguity points to a need for clearer role definition and messaging if the model is to be scaled alongside other programmes.

Finally, both residents and providers saw scope to broaden the offer. Residents suggested adding complementary checks such as an on-the-spot cholesterol test "while everyone is there anyway" and beginning sessions with a short health talk to raise awareness, while community groups proposed extending the model to other long-term conditions such as diabetes and respiratory disease.

Overall, sustainability and scale-up appear feasible but contingent on more active brokering of community–clinical partnerships, clearer role definition relative to other initiatives, and the funding and materials changes identified earlier.

⁴ Email correspondence 9 June 2026.

5. Conclusions

The Community BP Testing Project has demonstrated that a community-based model of blood pressure detection and education is both feasible and acceptable in South East London. Twelve community–clinical collaborations delivered 27 events reaching 1,747 attendees, of whom 944 received a blood pressure check and 233 (24.7%) were signposted for an Amber or Red reading. This signposting rate is broadly in line with the expected prevalence of hypertension in the local population, indicating that the events were detecting raised blood pressure at approximately the prevalence that would be anticipated, among people who might not otherwise have come forward.

The intervention's central strength lay in providing community groups with funding and support, rather than in the Screening Tool itself. Delivering the community BP screening events in trusted community venues, through familiar activities and established relationships, created a non-clinical, sociable environment in which residents felt comfortable engaging with their health. This was reflected consistently across community groups and residents and echoed by clinical partners. It enabled the events to reach adults in mid and later life, and a substantial proportion of Black residents, groups at higher risk of poor hypertension outcomes. For some residents, the check acted as an entry point to wider health and social conversations, and community–clinical partnerships were able to escalate urgent cases quickly and sensitively.

The evaluation identified consistent constraints on delivery and sustainability. The Screening Tool was valued where it was used, but uptake was uneven and many providers found the full document too long for busy, high-volume events, using only selected components. Central support from the Task and Finish group was appreciated, but webinar engagement declined sharply over the project, and smaller organisations reported feeling isolated by a format that suited the central team more than local groups. Funding was widely seen as too small relative to the administrative and reporting demands attached to it, and the requirement for community groups to secure their own clinical partner was a decisive barrier: two of the fourteen funded groups were unable to deliver any events because they could not establish a partnership.

Finally, the evaluation highlighted a tension at the core of the model. Its success depends on a flexible, low-constraint approach that does not overburden community groups or residents, yet the same flexibility limits accountability and evaluability. Efforts to strengthen governance, monitoring and data quality will need to be balanced carefully against the informal, community-led character that makes the model work. Ambiguity about how the project relates to concurrent initiatives, particularly the Vital 5 Check, further complicates a clear account of what was delivered and by whom.

These conclusions should be read while noting the evaluation's limitations: a small number of interviews and observed events, low feedback-form coverage, a small provider survey, and evidence of incomplete monitoring records. The findings are therefore best understood as a rich, credible account of how the model worked in practice rather than a definitive measure of its impact.

6. Recommendations

6.1. For the Task and Finish group and commissioners

1. Clarify and formalise the intervention model.

The evaluation found variation in how the model was understood and delivered, uneven use of the Screening Tool, and ambiguity about how the project relates to initiatives such as the Vital 5 Check. Develop an explicit theory of change, co-produced with community and clinical partners, that sets out the intervention's aims and the required activities. This will provide a shared reference point for delivery, sustainability and scale-up, clarify how the project aligns with Vital 5 and wider SEL hypertension work, and create a clear framework for future monitoring and evaluation.

2. Align the funding model with delivery and reporting requirements.

Review the funding model so it reflects the administrative, data collection and reporting burden placed on community groups. Consider more flexible or staged funding that explicitly includes time for relationship-building, community engagement and partnership development with PCNs and other providers

3. Actively broker community–clinical partnerships.

Rather than leaving community groups to secure their own clinical partners, commissioners and the Task and Finish group should consider taking a proactive brokerage role. This could include matching groups and PCNs and providing light-touch guidance and templates for data sharing, indemnity and follow-up processes so that groups without existing relationships are not excluded.

4. Provide a shorter, practical version of the Screening Tool

Retain the full training resource as the comprehensive reference, but develop a concise, quick-reference version (for example, a one-page flow chart plus a “what to do with each reading” guide) designed for use at busy, high-volume events. During webinars, reiterate that the full training resource is interactive and explain how to navigate it, as some providers were unaware of this functionality.

6.2. For community–clinical collaborations

5. Strengthen follow-up procedures for Amber and Red readings.

Ensure a supervising clinician signs off all amber and red forms at the time the reading is taken, so that no resident who needs advice or referral is missed.

6. Consider upskilling community staff.

Where groups wish to, offer training so community staff can measure and log blood pressure and give basic hypertension advice, reducing dependence on a clinical partner being present at

events. Ensure that referral pathways for Red and Amber results are in place so that residents have access to clinical support on the day of the event.

6.3. For future monitoring and evaluation

7. **Improve data capture proportionately.**

Where possible, expand the use of simple, reliable digital tools (such as online forms) to reduce lost or illegible records, while keeping data collection light enough not to deter residents or overburden groups.

8. **Strengthen event and activity recording.**

Put in place a straightforward process to ensure all events and checks are captured, so that reach and impact are not undercounted. Additionally, capture the number of Red and Amber readings separately.

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Annexe 1: Intervention resources

Community blood pressure testing and education event



Join us

 Insert date

 Insert time

 Insert location

 Run by [insert name of community organisation and clinical team]

What to expect

- Free NHS blood pressure checks for adults.
- Health information to help you keep your blood pressure at a healthy level.
- Signposting to the right support if your blood pressure is raised.
- Connect and chat with others in the community.

Insert your organisation's logo in the bottom right corner

Annexe Figure 1: Event flyer template given to community groups by the Task and Finish Group to advertise the Community Blood Pressure Screening Events

Annex 2: Additional data

Annexe Table 1: Number of community–clinical collaborations delivering 1–5 blood pressure screening events (September 2025 – March 2026)

Number of events delivered	Community-clinical Collaborations n (%)
One event	6 (50.0%)
Two events	-
Three events	4 (33.3%)
Four events	1 (8.3%)
Five events	1 (8.3%)

Annexe Table 2: Community Blood Pressure Screening event delivery and outcome by borough (September 2025 – March 2026)

	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	All
Number of events delivered*	1 (3.7)	3 (11.1)	8 (29.6)	5 (18.5)	5 (18.5)	5 (18.5)	27 (100)
Number of attendees	31 (1.8)	45 (2.6)	339 (19.4)	85 (4.9)	495 (28.3)	752 (43.0)	1,747 (100)
Average number per event (SD)	31 (.)	15 (4.6)	42 (25.1)	17 (4.9)	99 (103.1)	150 (126.4)	65 (82.6)
Blood pressure checks (% uptake)	31 (100)	39 (86.7)	331 (97.6)	77 (90.6)	163 (23.9)	303 (40.9)	944 (54.0)
Residents Signposted (% of checks)	3 (1.3)	15 (6.4)	40 (17.2)	49 (21.0)	39 (16.7)	87 (37.3)	233 (24.7)