Meeting of BNSSG ICB Board

Date: Thursday 4th December 2025

Time: 12:30 – 15:45

Location: The Vassall Centre, Gill Avenue, Bristol, BS16 2QQ

Agenda Number:	6.2
Title:	Cardiovascular disease - commissioning recommendations for tackling inequalities in hypertension treatment in Black African and Caribbean populations

Confidential Papers

Commercially Sensitive	No
Legally Sensitive	No
Contains Patient Identifiable data	No
Financially Sensitive	No
Time Sensitive – not for public release at this time	No
Other (Please state)	No

Purpose: Discussion

Key Points for Discussion:

A cardiovascular disease (CVD) system working group has been working together since April 2025 to explore how we tackle inequalities in the treatment of Black African and Black Caribbean patients for hypertension by 2029, as part of an BNSSG ICB equality objective.

The group are recommending a dual approach to integrated commissioning of VCSE and NHS services against ten outcomes (see section 4 of the report) over the next four years and beyond.

The group would like the ICB board to discuss:

- What the recommendations mean for future commissioning?
- What you are going to do next with these recommendations?

Recommendations:	See section 4 of the report.
Previously Considered By and feedback:	The BNSSG Long Term Conditions Operational Delivery Group 11th November 2025 have received the same report and recommended the work came to the ICB board for discussion.
Management of Declared Interest:	A thorough conflict of interest process was conducted with all members of the CVD working group. All twelve members of the group collectively agreed the recommendations. Case studies (in Appendix 1) were drawn from organisations not involved in the working group.
Risk and Assurance:	There are no risks identified with the recommendations at this stage.
Patient and Public Involvement:	The CVD working group involved two public contributors with lived experience of hypertension and CVD and four VCSE alliance ambassadors, alongside healthcare professionals and commissioners as equal partners.
Financial / Resource Implications:	Resource implications will need to be further explored during next steps.
Legal, Procurement, Policy and Regulatory Requirements:	There are no legal implications of the recommendations at this stage.
How does this impact on health inequalities, equality and diversity and population health?	The impact of implementing these commissioning recommendations would be to improve the treatment of high blood pressure in our Black African and Caribbean populations, thereby improving CVD outcomes e.g. fewer strokes. Any formal equality and inequality impact assessments would be conducted as part of later commissioning or service changes.
ICS Green Plan and the Carbon Net Zero target?	This work would contribute to the ICS Green Plan by reducing medicines waste and preventing ill health.
Communications and Engagement:	Feeback from the board and other senior ICS groups will inform next steps. Further engagement with communities is important as part of implementing recommendations.
Author(s):	CVD working group, coordinated by Ruth Whateley ICB Health Inequalities and Prevention team
Sponsoring Director:	Jo Medhurst

Agenda item: 6.2

Report title: CVD working group 2025 commissioning recommendations

1. Key points

We are the BNSSG cardiovascular disease (CVD) working group who have been working together since April 2025 to explore how we tackle inequalities in the treatment of Black African and Black Caribbean[1] patients for hypertension by 2029 (section 2.1). This document provides a summary of our work to date and a set of commissioning recommendations to consider.

- Our working group has focused on lived experience and Voluntary, Community and Social Enterprise (VCSE) voices to ground the data and evidence in local reality.
- Hypertension is one of the biggest risk factors for CVD, including stroke, and there is higher incidence of hypertension and stroke in Black populations.
- There are a complex set of factors and barriers impacting Black peoples' poorer CVD outcomes, higher risk of CVD, and hypertension, we cannot pinpoint one factor.
- There are a range of barriers to hypertension treatment adherence and the needs of different Black groups, communities and individuals vary. However we have identified the top barriers to treatment as a lack of trust and health literacy (see page 12).
- We are recommending a 'Dual Approach': integrated commissioning of VCSE and NHS services to deliver against ten outcomes (see page 13).
- We need to future proof any commissioning recognising that although the majority of Black people live in Bristol, Black populations are increasingly spread across BNSSG.
- Various VCSE projects exist or having been trialled to address hypertension inequalities, but they have relied on one off funding. Our recommendations aim to ensure sustainable change in the health and care system.
- Some of the barriers and outcomes we have identified will have implications beyond hypertension care and for other populations. We suggest our recommendations are considered as part of neighbourhood health planning and that a co-creation board of VCSE colleagues and patients is established to ensure we adequately considers the specific needs of minority ethnic patients with long term conditions across BNSSG.

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[1] We use the term 'Black African and Caribbean' consistently through this report to summarise the categories in the Census data and GP records of 'Black African', 'Black Caribbean' and 'Black Other'. Where we are specifically talking about a sub-group in the data we have stated this e.g. 'Black Caribbean'. In some cases, we have also reviewed data from Mixed Black populations (e.g. see Fig 2).

2. Background

2.1 The ICB Equality Objective

The CVD Working Group has been convened to focus on the following ICB Equality Objective set by the board in 2025, as part of the organisation's Public Sector Equality Duty under the Equality Act 2010:

> *Because cardiovascular disease (CVD) is one of the largest contributors to health inequalities BNSSG ICB aims to improve the treatment of high blood pressure in our Black African and Caribbean populations so that 80% reach treatment targets by 2029. We will also reduce the gap between our Black African and Caribbean populations and our white population to within 3 percentage points*[2]*.*

Why this equality objective?

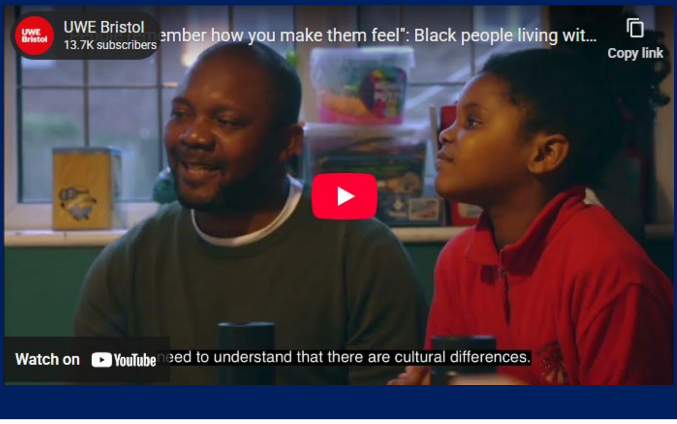
The objective was developed based on national CVD PREVENT data (see Fig.1), BNSSG system wide data, research evidence, and community insights, that identify significant inequalities in the treatment of Black populations for high blood pressure (the medical term for it is hypertension).

We know ethnic groups are affected differently by CVD. For example Black ethnic groups have a higher risk of and death from stroke than white groups, and South Asians have the highest death rates from coronary heart disease.

Black people are also more likely to develop hypertension earlier, including as children, and are less likely to be treated to target. BNSSG data also shows the inequality in hypertension treatment to target has widened since 2022 for both Black African and Black Caribbean populations.

Hypertension is one of the biggest risk factors for CVD, including stroke and health service provision doesn't always mirror the severity of this risk.

We recognise the catastrophic consequences of CVD in Black populations in the UK, including in BNSSG. Co-produced videos from the Inclusivity in Stroke Self-Management Support (ISMASS) project, led by UWE and Kingston University, clearly share Black people's experiences of stroke.



…ember how you make them feel": Black people living wit…

…eed to understand that there are cultural differences.

Video for patients & staff

Video for staff

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[2] The NICE treatment target for hypertension varies by age group (and for some high-risk conditions). The treatment level is for blood pressure to be at or below 140/90 mm/Hg for most people aged 79 *and* under, and 150/90 mm/Hg for most people aged 80 and over. The national hypertension treatment ambition is for 80% of patients diagnosed with hypertension to be treated to target by 2029.

2.2 About the working group

The CVD Working Group, is an Integrated Care System (ICS) working group under the Long Term Conditions Operational Delivery Group (LTC ODG) operating from April-October 2025.

Membership of the group:

Name	Organisation	Role
Cheryl Simpson	-	Public Contributor
David Soodeen	-	Public Contributor
Emma Smith	Caafi Health	VCSE Ambassador
Kaye Christopher	Life Changing community group	VCSE Ambassador
Kofi Antwi	Hypertension Clinic, UHBW	Secondary Care Rep
Lucy Murrell	One Care / Hanham Health	General Practice Rep
Martin Valls Garcia	GP Trainee / BNSSG ICB	Coordinator support
Ruth Whateley	BNSSG ICB	Coordinator
Sean Hourigan	Brigstowe (Peer Partnership)	VCSE Ambassador
Tabinda Rashid-Fadel	Accure Health	VCSE Ambassador
Adwoa Webber	BNSSG ICB	Commissioner Rep
Rachel Johnson	University of Bristol / Old School Surgery	Research & General Practice Rep

Our group has met six times for two hours and conducted additional one to ones and small group discussions with the ICB coordinator (Ruth Whateley) outside of meetings. The group agreed for meetings to be quorate there needed to be:

- One coordinator or commissioner representative
- Two VCSE ambassadors
- A general practice colleague
- One third of the group present are of Black African or Caribbean heritage.

Guests attended select meetings (e.g. ICB medicines optimisation pharmacists, a nurse conducting research on mistrust in Black Caribbean communities). The involvement of a public health representative was explored, but due to capacity and the focus on medical treatment, an agreement was made to circulate papers to colleagues.

3. Data, evidence and insights

In line with emerging strategic commissioning guidance for Integrated Care Boards we have sense checked national and local data, a rapid evidence scan and enhanced this information with our personal, community and professional insights.

An explicit decision was made not to conduct further community engagement at this stage given the wealth of information available on the issue and agreement that we need to move to action. This point was further reinforced by the Partnership For Black People's Health in London report in 2025 which states:

> *"There is a pressing need to move the narrative away from the consistent generation of data highlighting the misdiagnosis, mismanagement, mistreatment and poor outcomes faced by Black individuals (sometimes called 'a deficit model') to meaningful action that addresses the issues and their causes".*

This section provides a brief summary of some of the data and evidence we reviewed and our key insights from meetings, culminating in the development of our commissioning recommendations (section 4).

3.1 Data

We reviewed national CVD PREVENT data (see Fig.1) used to inform the development of the Equality Objective, Census 2021 data, and BNSSG system wide data on hypertension from the ICB Population Health Management team. The data showed:

- The majority of people of Black African, Black Caribbean, or Mixed White and Black African or Caribbean ethnicity reside in the Bristol area (Census 2021 shows in total 38,220 people live in Bristol, 8158 in South Gloucestershire and 2655 in North Somerset).
- 4737 of these people have been recorded as diagnosed with hypertension (see Fig 2) and are:
    - More likely to not be treated to targeted for high blood pressure at ages 20–50
    - More likely to have had a blood pressure reading in the last year. However where there is a reading it is less likely to be at or below the treatment target in the last year than those in the comparison group.
- There is significantly higher prevalence (see Fig. 2) of hypertension in the Black Caribbean population (29% prevalence) compared to all other ethnic groups (e.g. 11.1% prevalence in the Black African population).
- There is a proportionally higher prevalence of hypertension in Black Caribbean females, compared to Black Caribbean males particularly between ages 40-69.
- The ethnic disparities in hypertension are largest between ages 40–69 and narrow significantly after the age of 70.

Figure 1 Patients with GP recorded hypertension, whose last blood pressure reading is treated to target, in the preceding 12 months (CVDP007HYP) – Source [CVD Prevent](#) to June 2024.

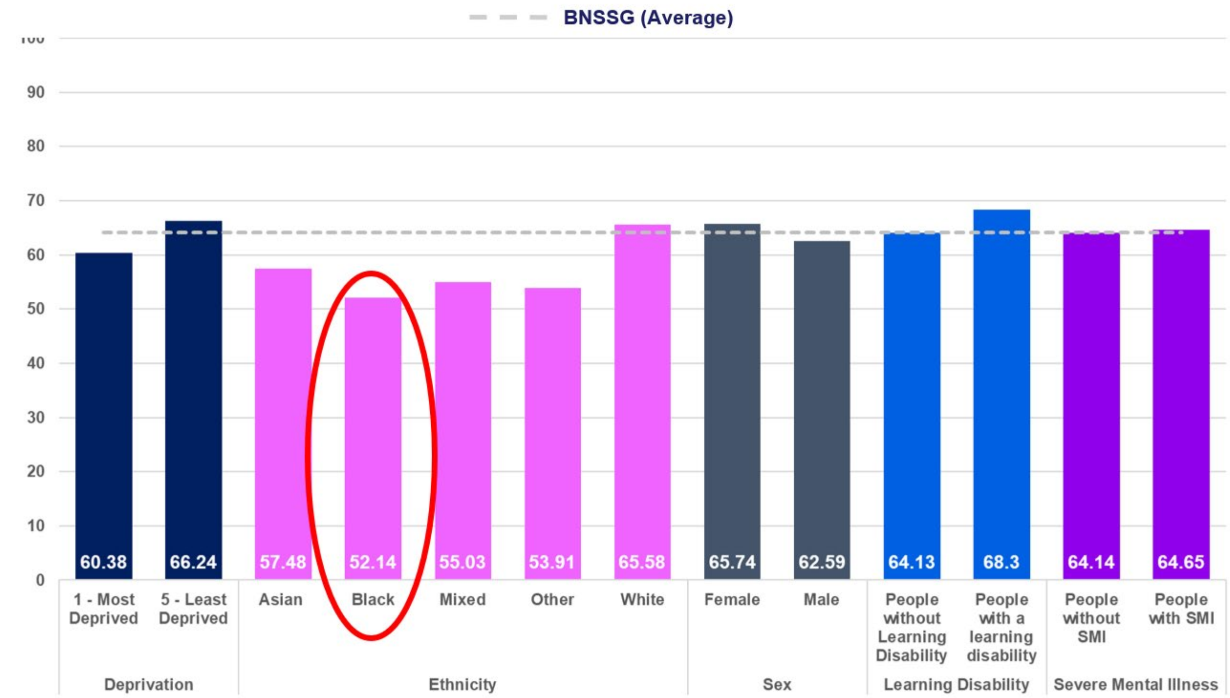
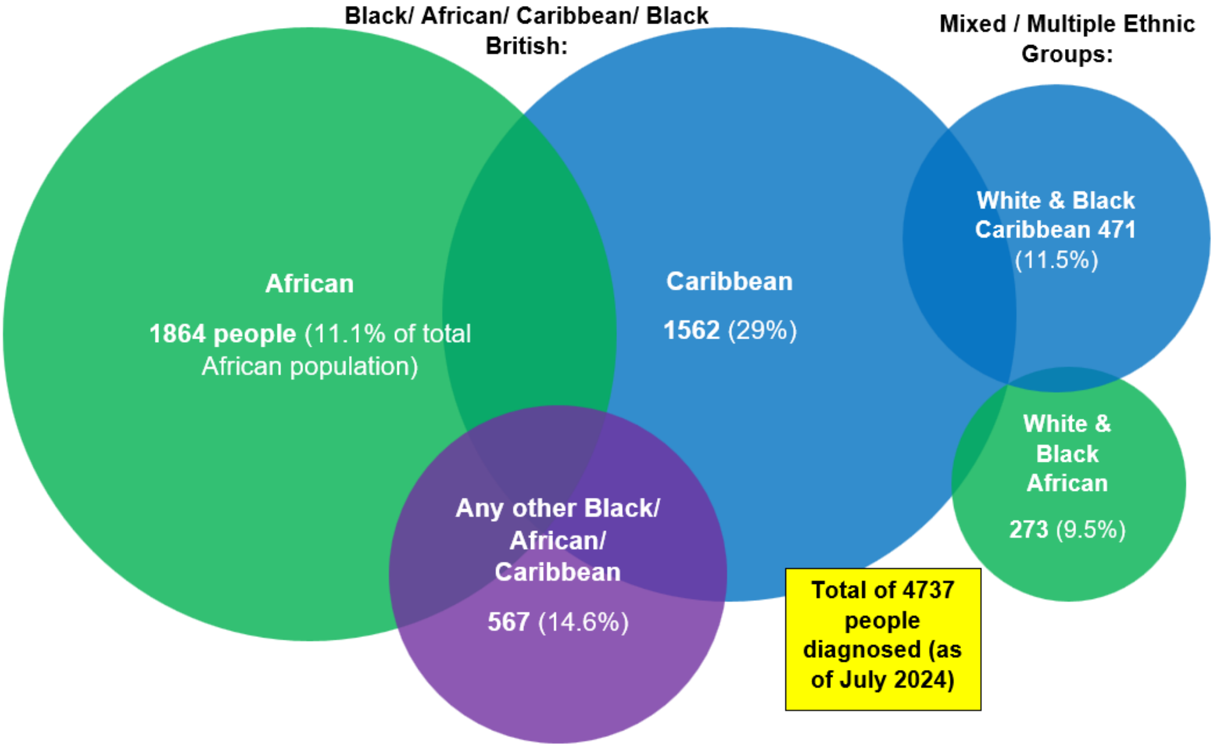


Figure 2 Infographic of hypertension data from the BNSSG System Wide Data (SWD) for Black populations. Bubble size reflects the number of people diagnosed with hypertension as of July 2024.



Our key insights when reviewing the data:

- Members of the group suggested infographic (Fig. 2) summarising the 4737 people diagnosed with hypertension underestimates prevalence in Black and Mixed Black populations i.e. there are a lot more people with undiagnosed hypertension.
- It is shocking there is 29% prevalence of hypertension in Black Caribbean populations in the system wide data set. Members of the group confirmed it is common knowledge in Black Caribbean communities that hypertension is very common and members shared stories of the devasting family and community impact of frequent adverse cardiac events and strokes.
- Reflecting on Census 2021 data, on where Black African and Caribbean populations and mixed Black ethnic groups live, we can see demographics in BNSSG have changed significantly in the last 15-20 years. Black communities are more dispersed across BNSSG and even since the census 4 years ago things have change e.g. increasing ethnic diversity in Old School Surgery in Fishponds was noted.
- Seeing the difference in demographics across Bristol, South Gloucestershire, and North Somerset our solutions need to reflect this so we can also reach those in the largest minority. For example 2.5% of the population in Weston Town are Black African, Black Caribbean or Mixed White and Black ethnicity, whereas 47% of Barton Hill are of this ethnicity, so solutions will be different.
- Recognition that we don't know the ethnicity of approximately 12% of the registered GP population and some people are not registered with the GP, which is likely to result in underrepresentation of younger or transient populations in this data.
- There was consensus in the room that the data provides an accurate steer as to a focus on younger people (between ages 20-70), acknowledging prevalence is proportionally higher in Black Caribbean communities but work should not be limited just to these groups.

3.2 Rapid evidence scan

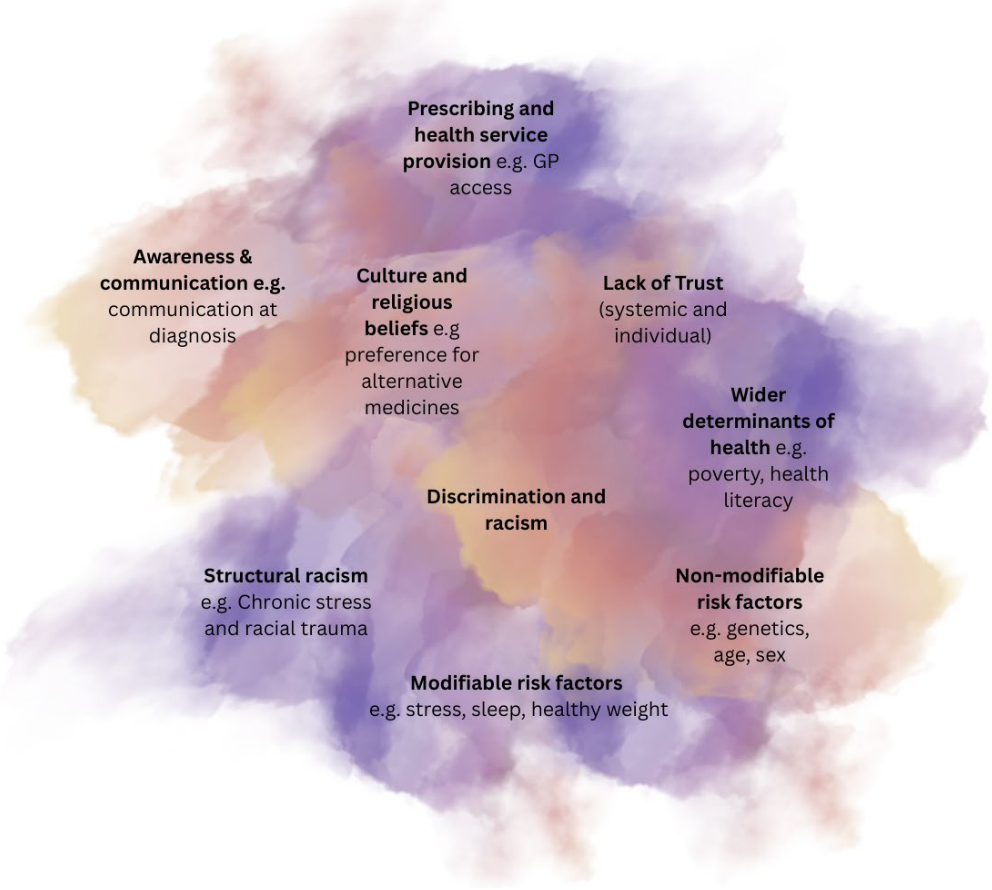
A rapid scan of recent evidence was conducted by Integrated Care Board colleagues to inform working group discussions.

The evidence clarified that CVD rates and clinical risk factors such as hypertension and diabetes are generally higher among Black and South Asian people than White people in the UK. Black people have a lower risk of coronary heart disease compared to the general population, but a higher incidence of, and death from stroke, and have strokes at a younger age. Black people are also more likely to develop hypertension earlier (including as children), have higher average 24 hour blood pressure levels and variability, have greater arterial stiffness, are less likely to have their hypertension treated to target, and are less likely to remain on regular treatment.

Several sources highlight the complex set of factors and barriers (see Fig. 3) impacting Black people's poorer CVD health outcomes, higher risk of CVD and hypertension. A 2025 British Heart Foundation report also emphasises an intersectional approach to CVD is required, as factors intersect and combine, resulting in multifaceted and complex experiences: no individual can be defined by a single characteristic.

The majority of hypertension medical treatment is currently provided in routine general practice or community pharmacy by pharmacists, practice nurses and health care assistants, although GPs are involved in diagnosis and complex cases. A small number of patients attend the tertiary hypertension clinic in Bristol Heart Institute for complex care, including for early-onset hypertension. There are also various VCSE services and groups who have provided culturally sensitive or health inequalities focused outreach and drop in services around hypertension and CVD more broadly in BNSSG over the last 5 years. However funding for these services has been inconsistent and at times based on one off national funding streams.

Figure 3 Visual summarising the complex set of factors identified in the evidence scan



Our key insights when reviewing the rapid evidence scan:

- The current system is geared at over 40s (e.g. NHS health checks for over 40s), but there is disease in under 40s disproportionately affecting Black people. Hypertension in under 40s may be more complex or require investigation for early onset.
- We need to break the intergenerational cycle where hypertension is seen as a natural part of ageing, when it is potentially preventable.
- Shock about the wasted money spent on unused antihypertensive medication highlighted in the research. Members of the group also shared local case studies of friends/contacts such as:

  - People collecting medication from the pharmacy and not taking it so they could get their more pressing health issue dealt with by the GP and avoid ‘hassle’.
  - People using herbal remedies from friends who live outside the UK due to lack of trust in antihypertensive medication.
- Black History month 2024 theme was ‘Reclaiming Narratives’: taking control of our stories, celebrating our heritage, ensure our voices are heard, which relates to this work.
- We need to make mainstream interventions that have been successful but only received one off funding.
- We need to avoid stereotypes and assumptions about Black people or communities in this work. For example there will be differences between:
  - Underserved communities versus more privileged Black people
  - Black British and people with mixed heritage
  - People that are racialised as white but have Black heritage
  - Different cultures and how this affects hypertension e.g. the group mentioned differences within and between different African/Afro-Caribbean cultures (e.g. Jamaicans, Trinidadians, Barbadians) and different African cultures (e.g. East African Somali and Ethiopians; West African Senegalese and Nigerians)
  - Recent migrants with no understanding of the NHS or recourse to public funds and concerns of being deported if they attend

3.3 Insights - top barriers to hypertension treatment

We discussed the complex set of factors and barriers impacting CVD in general and hypertension treatment specifically. Our insights highlighted what we consider to be the top barriers to hypertension treatment as summarised below.

Lack of trust

There are different types and definitions of trust. E.g. recent qualitative hypertension research in Greenwich in London (Yogarajah et al, 2025) distinguish between ...

Medical Mistrust

"group focused mistrust... due to historical and ongoing racial or cultural discrimination, would lead to one assessing the motives of systems meant to improve their health negatively. Similarly concerns over intentions of these systems could lead to decreased medication adherence, particularly if felt active harm could result"

SYSTEMIC

Lack of interpersonal patient-health care professional (HCP) trust

"interpersonal trust is an essential component of patient-HCP relationships and sound communication, confidentiality and competence are key skills a physican requires...patient trust [is summarised] as being earned through a belief that one's best interests are being served by their doctor..."

INTERPERSONAL

Cultural approaches can help build trust E.g.

- language and dialect access
- tailored dietary advice e.g. around salt consumption
- culturally tailored digital offer
- representation and option to see Black health care professional (not all people want this)
- shared decision making and involving families
- understanding medical mistrust and implementing anti-racist practices
- culturally sensitive VCSE offer (limited offer mainly in Inner City and East)

Sound clinican communication can help build trust E.g.

- provide clear explanation of diagnosis and risks
- address the health issue that matters most to the person
- enable patients to feel listened to (short consultations make this difficult)
- address medication concerns
- provide holistic treatment for people with multiple long term conditions
- provide continuity of care (hypertension treatment usually provided by Pharmacists or Allied Health Professionals. Only GPs or hospital care if complex cases)
- do assertive outreach to people 'lost to follow up'

Health literacy

Accepting hypertension diagnosis and severity of risk

- Language and dialect access and people not understanding what is being said
- it's asymptomatic, so it's hard to accept the risks
- Beliefs it's an acute problem with intermittent surges
- It is perceived as a natural part of ageing in some communities
- Misinformation about treatment is circulated

Understanding of and concerns with recommended medication

- using multiple medications and side effects
- preferring alternative medicines and feeling medication is pushed above lifestyle changes
- length of taking medicine "on it for life" is off putting
- why different medications may need to be tried over time if they don't work at first
- why you would take two or three combination medications from the start
- why there's a different treatment pathway by ethnicity

Home Blood Pressure monitoring skills

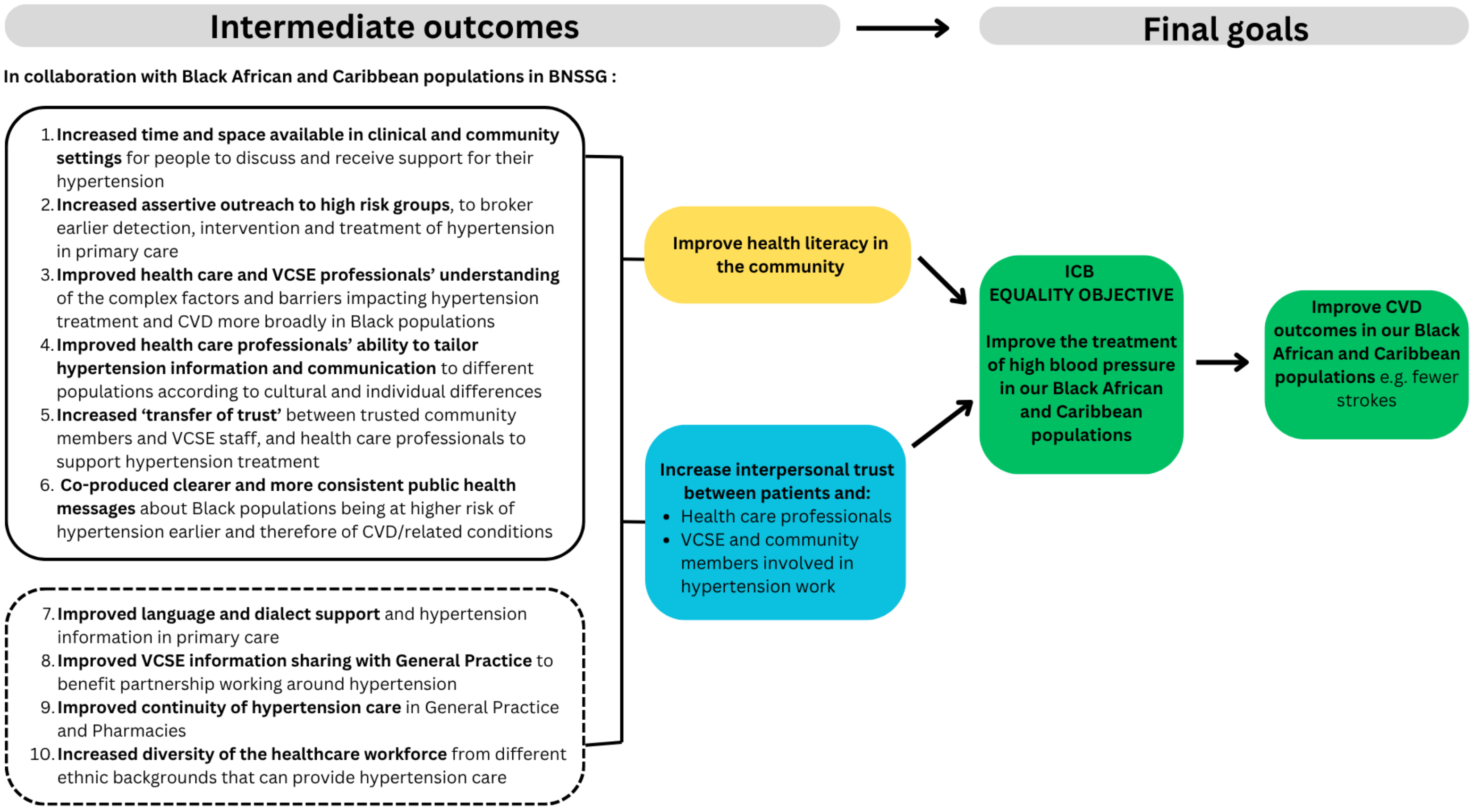
- how can we train and support people to monitor their blood pressure at home on an ongoing basis
- how do barriers and solutions relate to digital exclusion?

Variation in willingness or motivation to address hypertension (medication and lifestyle changes). E.g.

- some people are informed but resistant to diagnosis e.g. travel insurance maybe affected
- wider determinants - stress, employment, housing and socioeconomic circumstances
- how do we ensure decisions are informed?

4. Commissioning recommendations

We have created a set of ten outcomes we recommend the ICB should be commissioning services to achieve over the next 4 years and beyond. We also recommend a ‘Dual Approach’: integrated commissioning of VCSE and NHS services to deliver these outcomes in the community. A diagram summarising these outcomes is below and more detail is outlined in Appendix 2, pages 15-22.



Intermediate outcomes → **Final goals**

In collaboration with Black African and Caribbean populations in BNSSG :

1. **Increased time and space available in clinical and community settings** for people to discuss and receive support for their hypertension
2. **Increased assertive outreach to high risk groups**, to broker earlier detection, intervention and treatment of hypertension in primary care
3. **Improved health care and VCSE professionals’ understanding** of the complex factors and barriers impacting hypertension treatment and CVD more broadly in Black populations
4. **Improved health care professionals’ ability to tailor hypertension information and communication** to different populations according to cultural and individual differences
5. **Increased ‘transfer of trust’** between trusted community members and VCSE staff, and health care professionals to support hypertension treatment
6. **Co-produced clearer and more consistent public health messages** about Black populations being at higher risk of hypertension earlier and therefore of CVD/related conditions

7. **Improved language and dialect support** and hypertension information in primary care
8. **Improved VCSE information sharing with General Practice** to benefit partnership working around hypertension
9. **Improved continuity of hypertension care** in General Practice and Pharmacies
10. **Increased diversity of the healthcare workforce** from different ethnic backgrounds that can provide hypertension care

Improve health literacy in the community

Increase interpersonal trust between patients and:
- Health care professionals
- VCSE and community members involved in hypertension work

ICB EQUALITY OBJECTIVE

Improve the treatment of high blood pressure in our Black African and Caribbean populations

Improve CVD outcomes in our Black African and Caribbean populations e.g. fewer strokes

Dashed line = likely an enhancement of existing strategies, programmes, or contracts

Note: we recognise some of our outcomes might be considered process outcomes or outputs under some definitions.

5. Next steps

Our reflections as a group over the past six months are that inequalities in the treatment of hypertension in Black populations and ethnic inequalities in cardiovascular health[3] more generally have been under recognised and that acknowledgment of this is important to move to action.

This document provides a summary of our work to date and a set of commissioning recommendations to share with senior groups in the BNSSG health and care system to inform next steps.

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[3] Bridging Hearts - Addressing inequalities in cardiovascular health and care - BHF

Appendix 1 – Glossary of terms

Assertive outreach	Assertive outreach is a proactive, person-centered service or support that goes to people who need support but may not seek it on their own, in their own homes or communities
EMIS	(Egton Medical Information Systems): is supplier of electronic patient record (EPR) systems and software used widely across the NHS. EMIS is used by all General Practices in BNSSG to manage patient information, appointments, prescriptions, and medical history.
HCP	A healthcare professional is a person who is contracted to provide a healthcare service to a patient.
Healthier Together 2040	A strategic approach set out by BNSSG ICB to create a sustainable health system by 2040 that improves outcomes for everyone by addressing the needs of populations with declining healthy life expectancy today, and those at risk of experiencing similar challenges in the future.
Health Literacy	Health literacy refers, broadly, to the ability of individuals to ‘gain access to, understand and use information in ways which promote and maintain good health’ for themselves, their families and their communities. Health literacy is also not just a personal resource; higher levels of health literacy within populations yield social benefits, too, for example by mobilizing communities to address the social, economic and environmental determinants of health.
NICE	National Institute for Health and Care Excellence, an executive non-departmental public body, sponsored by the Department of Health and Social Care. NICE provides evidence-based guidance and advice for the NHS to improve health and social care.
Transfer of Trust	Transfer of trust in healthcare is the process by which a patient's confidence and willingness to rely on a provider is passed from one healthcare entity to another, such as from a hospital to a different clinic, or from a voluntary sector staff member to a doctor in general practice.
VCSE	Voluntary, community and social enterprises (VCSE) sector is an important partner for statutory health and social care agencies and plays a key role in improving health, well-being and care outcomes

Appendix 2 – Outcomes in more detail

Development of the outcomes on page 10 have been informed by a Theory of Change process, an approach commonly used for thinking about and planning change or improvement. This process has helped us to articulate our logic, goals and intermediate outcomes which will contribute to achieving the equality objective by 2029.

A 'Dual Approach' – we recommend integrated commissioning of VCSE and NHS services to deliver on the ten outcomes in the community.

This dual approach could be developed as part of the locality/neighbourhood health plans that will be written by our Health and Wellbeing Boards in 2025/26. We recognised these plans intend to reach broader populations and will likely focus on treatment for long term conditions in combination. However, **the scale of inequality in hypertension treatment in Black populations in BNSSG that is potentially preventable needs to be acknowledged and specifically addressed**.

Although the majority of Black people in BNSSG live in Bristol, any commissioning also needs to consider the needs of Black populations in South Gloucestershire and North Somerset and future proof for changes in demographics e.g. age and geographical location. We also recognise there should not be a one size fits all approach to hypertension treatment as community and VCSE resources are different across local authorities and neighbourhoods.

To inform the design of neighbourhood health plans we recommended the development of **a co-creation board/insights panel of VCSE colleagues and patients** (Healthier Together 2040 call a "Trusted listener function") that adequately considers the specific needs of minority ethnic patients with long term conditions across BNSSG, including Black African and Caribbean patients with hypertension.

1. Increased time and space available in clinical and community settings for people to discuss and receive support for their hypertension

We recommend that any commissioned work must acknowledge:

- One size does not fit all, some people will want confidential space with clinicians and some will want spaces in the community to discuss their hypertension (or both)
- Recognise people often have hypertension in combination with other long term conditions and any support needs to take this into account
- There are limits to what we can achieve in General Practice given current pressures (e.g. increasing time of appointments), but there are still opportunities
- The added value of non-formalised education, information sharing, conversations and signposting to more formal support available
- That sometimes patients or peers can be experts in how to manage their own conditions to complement clinical care
- We need to tailor offers to locality/neighbourhood considering the size of the population and to ensure cost effectiveness.

Example activities that could contribute to this outcome:

- Group consultations
- Tailored peer support offers
- Community drop in or open access clinics
- Targeted recall in general practice

Case study 1: Lambeth GPs

A 12 month project run by two GP practices in Lambeth aimed to reduce the significant difference in hypertension between Black and minority ethnic patients and white patients using centralised recall and pharmacist teams working alongside practice based pharmacists and health care assistants (HCAs).The emphasis was on contacting and connecting with Black patients supported by the diversity of the project team, many of whom also had lived experience of issues relating to hypertension and CVD. The project resulted in some of the best outcomes ever seen in South East London for overall hypertension control, with a 12% inequality gap for blood pressure control between Black and white patients eradicated. Find out more - https://share.google/o4lC3njFG5kT6Uh31

2. Increased assertive outreach to high risk groups, to broker earlier detection, intervention and treatment of hypertension in primary care

We recommend that any commissioned work must acknowledge:

- Targeted outreach is vital to engage more at risk groups (as opposed to general outreach such as generic invitations by text)
- Intergenerational approaches and earlier intervention is key if we’re to break the intergenerational cycle where hypertension is seen as a natural part of ageing.
- It’s important to think about the environments where we conduct outreach and peoples’ relationships to them in terms of trust and engagement
- People not attending appointments (‘DNAs’) should not automatically result in not being offered hypertension care or follow up (e.g. if they do not respond to GP text messages). Often people that do not attend are part of the most at risk groups and follow up should be considered on a case by case basis
- Consider how we incentivise engagement, learning from Covid vaccination and use of gift vouchers in healthy weight work
- The value of opportunistic outreach, such as visiting taxi offices in the evenings etc
- Outreach will have a downstream effect such as increases in imaging, secondary care referrals etc and this increase in demand needs to be considered.

Example activities that could contribute to this outcome:

- Community outreach programmes, health checks and opportunistic screening e.g. in churches, community centres, barber shops
- Community health and wellbeing worker or health ambassador roles
- Mobile outreach units, particularly for more rural areas
- Community days, health events or community conversations in collaboration with Primary Care.

***Case study 2: Bristol Inner City Primary Care Network** used risk stratification searches (UCLP Proactive Care Framework) across practices to identify hypertension risk category 1 patients, with a focus on patients of African-Caribbean heritage. They conducted a pilot at Montpelier Health Centre, inviting patients via SMS and calls to a drop-in event for blood pressure checks and consultations. They also held community conversations with local Caribbean groups, leading to a healthy blood pressure event in St Pauls, Bristol. The event, attended mainly by men from Black African, Asian, and Caribbean backgrounds, featured blood pressure checks, round table discussions with GPs, and consultations with dieticians and pharmacists. Elevated readings were linked to GP practices for further management. This initiative highlighted the effectiveness of in-person events in central community locations for improving health literacy and hypertension management.*

3. Improved health care and VCSE professionals’ understanding of the complex factors and barriers impacting hypertension treatment and CVD more broadly in Black populations

We recommend that any commissioned work must acknowledge:

- There are specific barriers and concerns people have around hypertension treatment that health care professionals (HCPs) should be aware of and adjust their treatment accordingly (see page 9)
- Anecdotal evidence suggests some cultural ‘awareness’, ‘sensitivity’ or ‘competency’ training for HCPs can feel like a tick box exercise and that it may be more effective for staff to directly engage with VCSE organisations, community members and patients to help understand and address needs
- Cultural awareness training or learning needs to remind HCPs that individuals differ and not to stereotype as cultural groups are not homogenous e.g. the needs of a Black British Rastafarian patient will likely differ to a more recent Jamaican migrant
- This isn’t just a local issue, there is national and international work happening to address this long standing problem. For example, in 2025 the NHS Race and Health Observatory and NICE have made tackling hypertension one of their priority areas for tackling inequalities along with maternal and neonatal health, mental health, genomics and sickle cell.

Example activities that could contribute to this outcome:

- Briefings, events or other communication with staff
- Longer term programmes of work and training such as Black Maternity Matters

4. Improved health care professionals’ ability to tailor hypertension information and communication to different populations according to cultural and individual differences

We recommend that any commissioned work must acknowledge:

- There are specific barriers and concerns people have around hypertension treatment that HCPs should be aware of and adjust their treatment accordingly (see page 9)
- Communication is a two-way process between patients and staff, patients also need to start embracing HCPs language and explanations of their conditions and risk

- A lot of hypertension management is not about medication, there needs to be discussion around culturally appropriate physical activity, diet advice etc
- The importance of tailoring of information e.g. under 40s
- The importance of providing information as part of earlier intervention, at diagnosis, and ongoing personalised review of treatment
- The importance of normalising taking long-term treatment as a way of prolonging good quality life
- Co-producing and tailoring information with communities is beneficial.

Example activities that could contribute to this outcome:

- Shared toolkits or a database of video resources in different dialects and languages that can be stored on Remedy and sent via Accurx text message to patients after a consultation. There are similar examples from Type 2 Diabetes resources and translated resources showing how to use the NHS app.

5. Increased ‘transfer of trust’ between trusted community members and VCSE staff, and health care professionals to support hypertension treatment

We recommend that any commissioned work must acknowledge:

- There is a difference between systemic medical mistrust and interpersonal trust identified in research on hypertension
- There are significant opportunities in health care to build interpersonal trust between HCPs and patients such as through continuity and supported care
- Although an increase in trust and the transfer of trust between people may be difficult to measure consistently it doesn’t mean it is not important. Building trust is key to unlocking better engagement in hypertension treatment that will have demonstrable impact on longer term hypertension treatment targets
- It takes time to build trust and there is a complex network of VCSE and community organisations that have built trust with different individuals and communities over many years
- Trust and expertise held within smaller VCSE organisations is important and their capacity to deliver quality work with small budgets should not be underestimated. However larger VCSE organisations are often well placed to apply for funding and provide stable and sustainable trusted services. Any commissioning of VCSE needs to consider collaboration between organisations to maximise benefit for the population.

Example activities that could contribute to this outcome:

- Primary care referral to trusted VCSE services and vice versa (increasing presence of VCSE in primary settings could assist this)
- Primary Care staff attending community groups, meetings and health hubs to build trust with VCSE partners and the people they work with
- Community health and wellbeing worker or navigator roles where trust is built with individuals over time and can support transfer of trust into health services.

Case study: Refugee Women's Health Hub (received an inclusion health grant as part of BNSSG Women's Health Programme 2025)

Refugee Women of Bristol (RWoB) provided a fortnightly Women's Health Hub designed to create a safe, supportive environment for women to engage with healthcare professionals. Led by their Drop-In Coordinator and supported by trusted community workers/interpreters (who were familiar with the women and had already established trust and mutual understanding) the hub offered workshops where women could ask questions, receive guidance, and be referred to appropriate follow-up services.

The team reflected that the lasting impact of this project lies in the increased health literacy, empowerment, and confidence it fostered among women in their community. They built strong relationships with local health professionals who are now more aware of the specific needs of the women they support. Many professionals expressed a desire to continue this outreach work in informal, community-based settings, which we will facilitate through our ongoing partnerships. Clinician feedback confirmed the project created a space for meaningful dialogue, removed barriers to access, and encouraged more thoughtful engagement with healthcare.

For members and the women who engaged with the hub, the long-term benefits include increased confidence and trust in navigating healthcare systems, greater awareness of preventative healthcare, and a stronger ability to advocate for their own health needs.

6. Co-produced clearer and more consistent public health messages about Black populations being at higher risk of hypertension earlier and therefore CVD/related conditions

We recommend that any public health messages should:

- Nurture people to accept that they have hypertension
- Not blame people for their hypertension
- Be precise, clear and 'in your face' - not skating the issue
- Be taken with empathy to where people are
- Be given at younger ages (earlier intervention)
- Be clear about the link with developing serious long-term conditions
- Acknowledge CVD is the biggest killer and cause of disability
- Promote preventative and culturally appropriate lifestyle changes
- Involve collaboration between the NHS, public health in local authorises and VCSEs
- Consider the needs of specific communities and be co-produced with them.

Example activities that could contribute to this outcome:

- Access to display material that people can carry to different community venues e.g. previous council funded health promotion resource centres, where VCSEs could borrow learning videos and access leaflets that are easier to understand.
- Coordination with organisations which develop resources and messaging, such as the British Heart Foundation.

Outcomes that are likely part of existing programmes, strategies or contracts

We recommend enhancement of work to achieve these outcomes:

7. Improved language and dialect support and hypertension information in primary care

We recommend any enhancement work recognises:

- Quality and trusted translation is key to building trust (it is currently very variable)
- Sensitivity to dialects is also key, not just language translation
- Many people speak their own language but can't read it. It depends on levels of literacy. A more labour intensive approach to translation may be required.
- Spoken English may be more accessible to some people than written English, for resources like videos maybe helpful.

Example activities that could contribute to this outcome:

- Improvements in translation of Patient Information Leaflets in the NHS app.

8. Improved VCSE information sharing with General Practice to benefit partnership working around hypertension

We recommend any enhancement work recognises:

- Opportunities to improve the sharing of blood pressure readings from the community and VCSE work into primary care records to improve treatment
- NHS App and E-consults are difficult for people who are not fluent in English, are there ways we can bridge the gap to benefit hypertension treatment
- VCSE access to EMIS is costly and not sustainable for most VCSE
- Every contact matters and we need to maximise opportunities to share information between VCSE and primary care.

Example activities that could contribute to this outcome:

- Improvements in referral processes and information sharing
- Support to use NHS App and E-consult processes
- Subsidised use of EMIS as part of specific VCSE contracts/grants.

Case study: Chinese Community Wellbeing Society (CCWS) GP referral form (part of 3-year Health Inequalities funding from Inner City and East Locality partnership)

The Black, Asian and minority ethnic (BAME) Dementia Support project recognises that those from East & Southeast Asian, South Asian and Afro Caribbean & African communities are at greater risk of developing dementia, and evidence shows that they are least likely to be registered with local services. In partnership with Bristol Black Carers and Dhek Bhal, the CCWS are delivering community events to support healthy ageing, proactive care and dementia

In 2025, a standard GP referral form has been designed for the CCWS to use at events following health checks. It includes a simple cover letter with standard information that has been design by GPs. This pragmatic solution has been facilitated through GPs at the Deep End who have also brokered relationships with five GP surgeries in Inner City and East Bristol who have agreed to trial receiving referrals from the CCWS.

9. Improved continuity of hypertension care in General Practice and Pharmacies

We recommend any enhancement work recognises:

- Some people may benefit from continuity with their hypertension care, particularly if they have complex hypertension
- We need to be realistic about what continuity is possible in the way services are currently organise e.g. people may see different healthcare professionals at each of their appointments or may be followed up remotely by text messages asking for results of blood pressure monitoring
- Breakdown of continuity in information sharing erodes trust when seeing a new professional who doesn’t know what is going on
- Continuity of notes and data is essential, but it does not ensure that healthcare professionals have sufficient time to familiarise themselves with a person’s notes
- Continuity along a pathway so people continue with their treatment is important e.g. continuity in primary care following appointments with the Hypertension clinic.

Example activities that could contribute to this outcome:

- VCSE offers that provide follow up support following primary care consultations
- Continuity of care through GP micro-teams assigned to a group of patients (e.g. this is being trialled in East Trees Health Centre General Practice).

10. Increased diversity of the healthcare workforce from different ethnic backgrounds that can help improve and provide hypertension care

We recommend any enhancement work recognises:

a) In service delivery:

- An ethnically diverse workforce in the VCSE and health care services can benefit hypertension treatment because staff are often able to bring a racial lense and cultural understanding
- Visibility of an ethnically diverse workforce and demonstrable anti-racist and non-discriminatory practices are important
- Some but not all patients want to be seen by someone of the same or similar ethnicity, but often this is about interpersonal trust and sound communication (see page 9)
- It is a long-term ambition to diversify the NHS workforce which may not show benefit within the timeframes of this work, but there may still be short term opportunities
- There is less diversity in primary care than secondary care
- There are barriers for medical professionals from other countries to register and practice in the UK.

b) In decision making:

- Ethnic diversity and representation in the workforce is not just about service delivery in VCSE or primary care. Expert and lived experience representation in commissioning decision making is vital to inform good decisions that benefit hypertension care for Black African and Caribbean populations.

Example activities that could contribute to this outcome:

- Supporting initiatives such as the NHS Race and Health Observatory roadshows, which share examples of good practice on tackling workforce race inequalities
- Supporting patient and public involvement work in service delivery and decision-making bodies or meetings
- Embedding of health inequalities targets or measures in services and decision making.

Case study: Strategic Health Inequalities, Population Health and Prevention (SHIPPH) BNSSG ICB committee

The purpose of the committee (established in October 2024) is to provide oversight, and assurance of the Integrated Care System's efforts towards tackling health inequalities and embedding preventative approaches.

The membership is designed to be representative of our system. As part of establishing the committee, four public contributors were recruited to act as critical friends, using their experiences and knowledge to bring an alternative perspective and voice to this committee.

Feedback from members of the committee is that the presence of public contributors and VCSE representatives has changed the dynamics and improved the quality of discussion and decision making in this committee.