

Cardiovascular Disease Community Prevention Programme Evaluation Report



Executive summary

The CVD prevention programme, funded by NHS England via Bristol, North Somerset, and South Gloucestershire Integrated Care Board and delivered by Accure Healthcare Consultancy. Using a community-based model, the programme was designed to engage diverse populations. The programme focused on three key components: CVD case finding, targeted outreach to high-risk groups, and the recruitment of volunteer community champions. Screenings for blood pressure, diabetes, cholesterol, and atrial fibrillation were conducted in community settings.

Effectiveness of the community-based model

- Local Community Champions ensured effective, culturally appropriate outreach.
- The model successfully identified and addressed CVD risk factors in vulnerable communities.
- The targeted approach successfully reached previously underserved groups, including Black, Asian, Gypsy, Roma and Traveller communities, and low-income groups.
- The model had collective buy-in across Locality Partnerships.
- This programme was able to help individuals overcome barriers like mistrust and difficulty accessing GP services.

Long-Term Impact

- Increased community awareness and empowerment around CVD prevention.
- Community Champion model provided valuable workforce training.
- Recognized as a scalable model for other public health initiatives.
- Provided key insights into CVD risks in hard-to-reach communities.

Recommendations

- Targeted health checks to high-risk communities can provide a cost-effective model of CVD prevention.
- Expand Locality Partnerships to improve reach.
- Secure long-term funding for sustainability.
- Standardize data collection and integrate with NHS platforms.
- Establish a clear evaluation framework to streamline reporting.

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Introduction

This evaluation assesses the effectiveness and impact of the Cardiovascular Disease (CVD) Prevention Programme implemented in Bristol, North Somerset and South Gloucestershire (BNSSG). The programme was conducted by Accure Healthcare Consultancy Ltd (Accure). This programme was designed following an initial hypertension case finding pilot in Inner City and East Bristol (ICE) which was also conducted by Accure. The final programme was designed to raise awareness and address key risk factors associated with CVD, including hypertension, high cholesterol, diabetes and Atrial Fibrillation (AF). It then provided tailored health advice to individuals to reduce their risk of CVD. This was done through targeted interventions such as health education, lifestyle modification support, and where appropriate, referral to their General Practice (GP) for further monitoring and/or treatment.

The primary audiences for this evaluation include policymakers at national, Integrated Care Board (ICB) and Local Authority level, healthcare commissioners, programme funders, and frontline healthcare providers. The findings will inform the provision of prevention programmes, specifically the potential impact that targeted community programmes can have in identifying and preventing risk factors in vulnerable communities. The evaluation will be shared with stakeholders for wider application in CVD prevention initiatives.

The scope of the evaluation encompasses both process and outcome measures, incorporating both qualitative and quantitative data. This is a **summative** evaluation, aimed at assessing the overall impact of the programme upon completion, rather than its developmental aspects. The evaluation examines programme reach, participant engagement, stakeholder uptake, and stakeholder perceptions.

The overarching aims and objectives of the CVD Prevention Programme were to:

- Deliver a case finding model for all CVD risk factors across BNSSG.
- Increase awareness and knowledge about the prevalence of CVD risk factors in BNSSG.

- Hypertension case finding in vulnerable populations that had been highlighted by the localities.
- Offering lifestyle advice and support to communities at risk of CVD.
- Recruiting and training local volunteer community champions to support CVD awareness

The specific aims and objectives of the evaluation were to:

- Understand if the programme was implemented as intended in the local context.
- Understand the experience of participants and stakeholders who were part of the project.
- Assess the effectiveness of the programme in supporting people to improve CVD risk factors.

These evaluation objectives were developed based on the programme's initial evaluation framework, consultation with key stakeholders, and a review of best practices in Public Health programme evaluation. The evaluation was conducted with the involvement of Public Health professionals, local authority staff, key stakeholders and participants. Resources for the evaluation included funding from NHS England, support from local authorities and the BNSSG integrated care board.

Background

National and Local Context

Cardiovascular disease is one of the leading causes of morbidity and mortality across England (Raleigh et al., 2022). CVD morbidity and disability remains one of the biggest contributors to health inequalities in the UK (Office for health improvements and disparities, 2022). Current government goals are to reduce CVD premature mortality by 25% within a decade (NHS England, 2025), however, to do this, significant work to reduce inequities must be done. Local and National evidence show that CVD inequality exist within the South Asian and Afro Caribbean communities (Razieh et al., 2022; Ferraro, 2022).

It is estimated that 80% of premature deaths from cardiovascular disease are “modifiable” (Raleigh et al., 2022). The increasing prevalence of risk factors such as obesity, diabetes, and hypertension underscores the urgent need for comprehensive prevention strategies. As highlighted in the “size of the prize” report, there exists a gap within our current management of CVD where more could be done to save both lives and costs within our healthcare service (UCL Partners, 2024).

At the local level, tackling CVD has been identified as one of the nine key commitments within the BNSSG Integrated Care System (ICS) Strategy. Support from Locality Partnerships was established which includes: primary care, volunteer sector and social care with citizens and community as equal partners. The six BNSSG Locality Partnerships, supported by North of England Care Support (NECS), identified CVD as a priority for all BNSSG Localities and reflected this in the ICB’s Joint Forward Plan commitments (BNSSG ICS, 2024). Local priorities involve improving recording of blood pressure (BP) for vulnerable communities and local analysis by the ICB has found that people of Caribbean ethnicity have higher higher-than-average rates of uncertain blood pressures or high blood pressures compared to other ethnicities.

Drivers for Change

Several key policy and strategic frameworks have driven the implementation of the CVD Prevention Programme:

- National Health Service (NHS) Long term plan emphasises the need for prevention and early intervention is necessary to help people stay healthy (NHS Long Term Plan, 2019). Tackling inequalities is also central to the long-term plan, acknowledging that inequalities have significant impact on people's health and the economy.
- The Lord Darzi report emphasises the need to shift interventions to the community and to deliver care nearer to places where people live (Darzi, 2024).

- Core 20 plus 5 is a national NHS England approach that aims to reduce inequalities for those in the 20% most deprived of the population. One of the 5 focuses is identification and optimal management of hypertension and lipids in this cohort (NHS England, 2021).
- Economic considerations – the cost burden of treating CVD-related conditions is substantial. Estimated costs suggest that the combined costs of CVD morbidity and mortality to be 29£ billion (Shih et al., 2025).

Evidence Base

The CVD Prevention Programme was developed based on both national and local demands for community interventions that tackle cardiovascular disease. These interventions show the effectiveness of lifestyle interventions, risk factor screening, and health promotion strategies happening in the community. Key sources informing the programme include:

- Clinical guidelines and evidence base from NICE and NHS health checks were used in the creation of this programme. These recommend proactive management of CVD risk factors through a combination of medical and lifestyle interventions.
- Evidence currently shows that hypertension case finding and CVD risk factor prevention can provide significant return of investment. NHS health checks have been estimated to have a return of investment (ROI) of 3-5£ per 1£ invested. While community health checks can have the potential of having an even higher ROI (Wood et al., 2024).
- Locality work over the last few years has highlighted the benefits of working with and within communities. Specifically for CVD, work has been carried out in ICE, Pill and Kingswood which emphasises the need to reach out to vulnerable communities that would not normally engage with the services.

Throughout the course of the programme, emerging evidence has been continually reviewed and incorporated into implementation adjustments. This ensures that the programme remains aligned with the latest research findings and best practices in CVD prevention.

By evaluating the CVD Prevention Programme within this context, the findings will contribute to a broader understanding of effective prevention strategies and support future public health planning and commissioning.

The project

The one-year programme was funded by NHS England, via BNSSG Integrated Care Board.

The clinically led organisation Accure Healthcare consultancy (Accure) led the delivery of this programme. The programme was delivered by a range of clinicians in various community settings. It was delivered across all six BNSSG localities.

Approach

A community-model was used to deliver this programme.

Accure developed a flexible, tailored, approach to reach out and include a wide range of communities. This was achieved by working collaboratively with key stakeholders to understand population needs, and directly with the communities themselves to ensure their needs were met and addressed. For example, the mobile health sessions were delivered within local settings and at times and days when attendance would be highest, as agreed by the communities and venues.

The tailored community-based approach was patient centred and quality focused.

There were three main components to the model and programme:

1. CVD Case finding

Four risk factors were highlighted for case finding: Blood pressure, diabetes, cholesterol and atrial fibrillation. Community venues such as shopping centres, community cafe's, sport venues and workplaces were used to ensure case finding was achieved.

2. Ensure vulnerable and high-risk groups were targeted and included

Each locality worked with Accure to identify any specific groups and geographical areas of focus. The specific groups were supported within their community settings and these included places of worship, food clubs, welcome spaces, over 55 groups and other meeting places, also on site for the Gypsy Travelling and Roma communities.

3. Appoint local Volunteer Community Champions to continue to raise the awareness of CVD and risks and make Blood pressure monitoring accessible in a variety of community settings.

The local volunteers were all recruited, trained and supported by Accure and these were either from local community settings such Barber shops, places of worship and community sites and Accure also worked with several colleges and universities to offer this opportunity to Health and Social Care students and their placements. All volunteer champions received training on BP recording, lifestyle conversations and a free blood pressure monitor

Services provided

The mobile health clinic offered the following checks:

- Pulse check supported by a single lead ECG to diagnose Atrial fibrillation.
- Blood pressure checks using Salter BP monitors
- Pulse and finger oximetry checks
- Free BP monitors were provided to any individuals who were considered vulnerable and in need.
- The clinical teams worked with the NICE guidance.

- Diagnostic point of care testing was offered using the Abbott Affinion 2 analyser for HbA1c and full lipid profile
- Point of care testing criteria was applied for both HBA1c testing and full lipid profile to manage demand and offer testing where required.
- HbA1c testing was offered to individuals, without known diabetes, using the following criteria:
 - Black, Asian or any other ethnic group with BMI equal or greater than 27.5
 - An individual with BMI greater than or equal to 30
 - Those individuals with blood pressure at or above 140/90 who have not had a diabetes check in the last year.
 - People who have a first degree relative with type 2 diabetes or ischaemic heart disease.
- Individual's with known diabetes were not tested
- Full lipid profile testing was offered to those with the following criteria:
 - Individuals with family history of Ischaemic Heart Disease and or high cholesterol.
 - Individuals over 40 and with a BMI greater than 30
 - Individuals who were on statins or who had a cholesterol test in the last year were not tested.
- Everyone received lifestyle advice supported by British Heart Foundation, Diabetes UK literature any community specific information generated by Accure for the delivery of this programme.
- Referrals were sent on an agreed proforma which included CVD risk factors via secure NHS email to the GP practices for those individuals that required additional support or results to be added to their records.
- Medical practices were only sent results for those patients with the following findings:
 1. New hypertension
 2. Known hypertension requiring review.

3. Symptomatic severe hypertension to notify that the individual was advised to attend a same day review via local A&E.
4. Asymptomatic severe Hypertension
5. Rhythm abnormalities that were found on the ECG
6. All Diabetes (Hba1c result), Lipid profile results from our point of care analyser
7. Other risk factors such as smoking status and alcohol consumption and weight management support that the individual requires.

Design and Methods

The evaluation adopted a **mixed-methods approach**, integrating both quantitative and qualitative data collection to provide a comprehensive assessment of the programme's impact. This was a **summative** evaluation, conducted after programme implementation to measure its effectiveness and outcomes.

Data Collection Methods and Sources

Data collection was designed to align with the evaluation's aims and objectives:

Quantitative Data

Data was collected in two different tables: the first table was for every participant who presented, the second table included every patient who was referred to a GP for further consideration.

Data collected from every participant included: self-described Ethnicity, Age range, General Practice they were registered in, time since last blood pressure, location of last blood pressure, blood pressure result assessed, if the participant had known hypertension.

Data collected from those referred included: Age range, venue, General Practice they were registered in, blood pressure result assessed, if the participant had known hypertension, cholesterol result (if assessed), HbA1c result (if assessed).

- Raised blood pressures were analysed by ethnicity, age and gender
- Raised diabetes and cholesterol blood tests were analysed by gender and age as ethnicity was not available for this cohort.
- Participants who were referred had their heart rhythm checked, this was analysed by age and gender.
- Follow up analysis was conducted at one General Practice surgery to assess continuity of the data and health outcomes.
- Number of blood pressure champions recruited and trained was collected.

Qualitative Data

- Feedback from participants was thematically analysed and grouped.
- Case studies highlighting individual participant journeys and programme successes were developed.
- Stakeholder experiences were collected to synthesise how this programme impacted the wider context of healthcare provision to people with cardiovascular disease and those at risk of developing cardiovascular disease.

Data was compared, where possible, with local BNSSG data. If no comparison data was found, national data was used to compare rates, prevalence and outcomes.

Feedback provided by the Warm Welcome director on the provision of health checks delivered by Accure at the Warm Welcome community spaces.

David Barclay - Warm Welcome Campaign Director

“This is such a win-win for everybody. For the people running the spaces, to be able to have people like you and your colleagues coming in, is a huge benefit that the spaces can provide and it’s another way of attracting people to come to the space. Clearly there’s a big win for the individuals in terms of their health. But also, it’s really interesting to think about the win that this represents for the health system in terms of being able to reach those different communities and the idea of prevention. A big part of fixing the NHS is about getting healthcare out into the community and you’re blazing a trail, Tabinda, in how to do that practically. Thank you for all that you’ve done. We would encourage other integrated care boards to take a similar approach.”

Data Analysis

Quantitative data was analysed using statistical methods to help describe the population identified and to compare to local and national rates.

Qualitative data was thematically analysed to identify key themes relating to the programmes effectiveness and it's barriers.

Limitations to methodology/data

- **Ethnicity data** was collected using a self-reported method. Participants were allowed to describe their ethnicity in any preferred method and no options were provided. This resulted in a non-standardised form that led to potential errors in classification.
- **Inability to refer all** – The majority, but not all GPs agreed to be involved in the onwards referral process (14 out of 74 General practices in BNSSG opted out of referrals).
- **Blood tests** - Clinician discretion based on guidelines was used when choosing to perform blood tests. Therefore, these were only analysed by gender and age as we did not have large enough proportions of statistically significant ethnicity groups
- **Selection bias** – Participants who engaged with the programme may be more health-conscious than those who did not, potentially influencing results.
- **Data completeness** – There was a participant attrition of around 50% from who was eligible for a referral and who was then referred.
- **Deprivation data** – deprivation data was inferred from patient's GP practice. We know that there can exist high variability of deprivation within a GPs catchment area and therefore interpretation of this data is limited in its application.

Findings

The findings were collated into a presentation, delivered and recorded on teams.

The video and transcript are linked below.

[CVD findings video and transcript](#)

Discussion

Insights

Insights were gathered through analysis of feedback from stakeholders, participants and community champions.

Insights from stakeholders

Targeting of specific health inequality groups was seen as especially valuable by stakeholders. For example, groups such as those with learning disabilities and the Gypsy, Roma and Traveller community suffer disproportionately from CVD. Both these groups often struggle to access traditional health-care services as services can find it difficult to accommodate and provide the specific needs for these communities. (Unwin et al., 2023).

Feedback received by organisers showed that there was high turnout and engagement of these events from these vulnerable communities. Themes such as being “supportive” and “adaptable” stood out from the feedback. This feedback echoes Matos 2019 paper (Campos-Matos et al., 2019) on inclusion health that states that universal action alone is unlikely to improve the lives of those who have the worst health. Accure was able to provide a more targeted approach that reduced inequalities in service. This aligns with Michael Marmot’s “middle ground” pathway of proportionate universalism as an alternative approach to reducing health inequalities (Carey et al., 2015).

Co-production was a key element when reaching communities that do not typically engage with traditional healthcare structures. This was done through trust building activities such as: attending weekly meetings with community organisers, adapting sessions to what communities needed (such as first aid classes), and shaping around events that were already being organised in the community.

Feedback from Emily Richardson - Adult Learning Disabilities lead at Sirona Health & Care CIC

'Tabinda and her team (Accure) were incredibly supportive and reassuring when we visited two care homes for people with a learning disability and held two community group events to give people with a learning disability the opportunity to have CVD screening.

We worked together to organise the events and provided easy read information about the screening which was helpful for the people attending. Accure Health were able to spend time explaining and reassuring the participants and some people who were not keen on have the finger prick tests to begin with, did have them and the atmosphere was very supportive.

We really hope to continue to work with Accure Health to improve early diagnosis of cardiovascular disease for people with a learning disability.'

Feedback from Nicky Rice - Acting Manager for Care for the Gypsy, Roma and Traveller community

I just wanted to thank you for the fantastic event you held on Highwood Park today. The model you used worked perfectly for our families and the engagement you received speaks volumes about how you worked with them and how important building relationships is to this type of work. We have never had such a high turnout for an event and the families were full of praise about the service they had received from you. This is a really important piece of work and bringing it direct to the sites to such a vulnerable group has made a significant impact.

Insights from participants

There were multiple reports from participants stating the ease of access and how this had a significant ability on their ability on both their ability to attend. As the locations were near people's place of work or residence, people reported being able to encourage family members and colleagues to come thereby increasing turnout.

Some participants mentioned how they had not been able to attend a health check due to the difficulty of preparing for and attending GP appointments. Trauma-

informed research shows that healthcare spaces can be associated with difficult experiences and may keep people hesitant from accessing vital care. Having health checks in community spaces allowed people who would otherwise not access these services to have this opportunity (Gopal et al., 2023).

Participants mentioned how the supportive element and clear information made them feel supported and encouraged to act on advice given. Having instant results was mentioned in feedback as something that participants appreciated as they were able to have tailored advice on the day based on HBA1c or Lipid result.

Feedback from one anonymous participant

"I recently attended one the Accure Health community clinics which was available through the Fit Robins programme. The team, led by Tabinda were both empathetic, knowledgeable and professional, taking time to listen and support. As part of the confidential consultation they discussed a number of elements of health, and had the on-site capability to take tests. This not only provided immediate results but also removed any worrying while the results went off to a lab. The overall consultation and tests over took a short time, but they were there to discuss further if needed.

It meant that rather than needing to arrange a Dr visit, or some other consultation, it was all performed speedily and easily. So having this service available in the community is really important, not just for taking the load of other busy services, but also to be able to see someone when you needed it.

Feedback from Ian Riddell – Voluntary and community sector Liaison officer for North Bristol NHS trust

It is clear to me and my colleagues at NBT how important your project was to a huge range of health events. I work with several organisations that run health events in community settings across BNSSG and they all see you as the "marquee" service that needs to be secured before the rest of the services are invited. Your team's friendly nature and professionalism ensured queues of people waiting to talk to you. Finally, the feedback from healthcare professionals and community organisations always mentions the high quality of your work. Thank you so much for supporting such a wide range of communities throughout your project.

Insights from community champions

Feedback from community champions showed how that community members continued to highlight the risks of CVD to their communities, highlighting the

programme provided a long-term benefit after the ‘intervention’ finished. Community champions were able to contribute blood pressure readings back to accure and provide sign posting and advice of next steps.

Feedback from SGS college

During her visit, Tabinda inspired 24 of our learners to sign up as Cardio-Vascular Disease Champions! These students will soon receive training, a free blood pressure monitor, and a certificate recognising their achievement. This will allow them to conduct blood pressure tests for friends, family, colleagues, and even adults at their placements (with permission). This accolade is not just a fantastic opportunity for hands-on learning but will also boost their CVs, job applications, and university prospects. A huge thank you to Tabinda for her time and for empowering our learners with skills that can make a real difference in their communities. We can’t wait to see them in action!

Demographic analysis of total participant population

The evaluation revealed that the programme successfully reached populations typically underserved by existing healthcare services, including lower-income groups and minority ethnic communities.

Most of the participants were female (60%). Being at work during the events was unlikely to be a reason for this as women and men tend to work at similar rates across BNSSG (ONS, 2024a). Instead, it is likely that the events/community spaces targeted by Accure were frequented more often by women: women are more likely to have caring responsibilities that requires them to leave the house more often; they may frequent public spaces more frequently; and women use public transport more often (Catterall, 2021). It has also been found that women are more health conscious. To support this, NHS Health Check data shows men are less likely to attend than women (Coghill et al., 2018).

Rates of turnout were highest amongst those 60 years old and over. This likely represents a combination of the targeted nature of the events towards those who may have CVD health needs as well as the likely element of retired people having more time to frequent community spaces. This outcome is reflected within NHS Health checks (Tanner et al., 2022).

Geographically higher turnout was seen in the Bristol localities and the North Somerset (Woodspring and Weston) localities. The low turnout of South Gloucestershire may reflect the rurality and higher proportion of working age individuals in this locality.

There were high rates of turnout from Arab, Chinese, Pakistani and Bangladeshi ethnicities and people who describe themselves as Gypsy and African. This aligns with the initial aims of the project, demonstrating that the programme was effective in engaging at-risk populations. Two categories that stand out are 'Other Asian' and 'Other Black' which are likely over-represented due to the fact that participants did not give complete ethnic backgrounds when asked and therefore were placed in the "other" category at data analysis stage. It is likely that if we had more information other categories such as Black African and Asian subcategories may be even further represented. This may be an area of further exploration as NHS Health checks show low turnouts amongst the Chinese and Black African communities (Robson et al., 2021).

There was a small positive correlation between deprivation and rate of participation from each general practice. This suggests there was more participation from areas with higher deprivation. Looking further at each individual IMD deciles, we can see a 'U' curve, representing high turnout in both the least deprived and most deprived areas. This could explain the weak correlation despite high turnout from areas of high deprivation. A potential explanation for this could be that events were a mix of open access events and targeted health events. Universal interventions can sometimes worsen health inequalities if not appropriately designed (Chaudry et al., 2021). NHS Health checks have higher turnout from those less deprived which stands in contrast to this population (Tanner et al., 2022)

Hypertension case finding data analysis

The hypertension data analysed in this report is on those with **previously unknown/unreported hypertension**. Those with known high blood pressure were not included (6% of those seen). This portrays 'hypertension case finding' as per the Core20plus5 areas of clinical focus. 20% of those seen fell into this cohort. This is a

higher percentage than the ICB's reported prevalence of hypertension (16.4%) (CVDPREVENT, 2025).

Rates of disease were slightly higher amongst men than women. This correlates with higher rates of hypertension found amongst men (CVDPREVENT, 2025).

As expected, the data shows increased prevalence of hypertension as age increases. However, this programme also found a significantly higher proportion of those aged 40 and below with raised blood pressure compared with the CVD prevent dataset. Prevalence of undiagnosed high blood pressure in the under 40's cohort was around 15% while CVD prevent data sits under 2% (CVDPREVENT, 2025).

Local data shows that this cohort has the largest number of missing or unknown blood pressures (Ferraro, 2022). It should be noted that this population is not currently targeted by NHS health checks. **This suggests a gap in existing screening services and presents an opportunity for future policy adaptations.**

The ethnic makeup of those with undiagnosed high blood pressures shows that there where high rates of disease amongst white, mixed ethnic group and black ethnic groups. This correlates with the highest observed high blood pressures in England being within Black Caribbean, White British and White Irish populations (NHS Digital, 2022). Part of the reason why rates were higher in the white ethnic groups than the black ethnic groups could be the fact that 89% of those >70 with undiagnosed high blood pressure identified as white.

Feedback from Harry Lobb – GP trainee in Weston, supported event at Rugby Club
It was great to meet you last night and to get a taste of what Accure do and to see the great work you're doing in early disease detection. As you know, I was amazed at how hypertensive some of these young men were without any idea of it.

Diabetes and pre-diabetes case finding data analysis

Diabetes detection rates mirrored broader population health trends, indicating the programme's role in identifying previously undiagnosed cases. The programme found 8% of those tested for diabetes had levels consistent with prediabetes and 4% with diabetes. This is comparable to ONS data from 2019 which suggested

approximately 12% of the population could have pre-diabetes and 7% diabetes (30% of which do not know) (ONSb, 2024).

As with hypertension, this programme found a significant number of raised HBA1c in those under 40. This could reflect wider trends showing that pre-diabetes in those under 40 increased by 25% between 2022 and 2023 (NHS England, 2024).

However, it is important to note that only 18 people under 40 were tested for diabetes, therefore more evidence is needed in identifying rates of pre-diabetes in those under 40.

Raised cholesterol case finding data analysis

Cholesterol rates were highest amongst those in the 45-60 age group. Rates of high cholesterol were higher amongst women. This reflects a wider national trend where women are less likely to both be prescribed lipid lowering therapy and less likely to have good cholesterol control (CVDPREVENT, 2024; NHS Digital, 2023).

Follow up analysis

Data from one GP practice was investigated. This found that the programme resulted in abnormal readings being coded appropriately into the GP's system. Participants with abnormal findings triggered a review and in one case a change in medication, which suggests that this model of community case finding can translate into necessary treatment changes at a General Practice level. However, only one third of all participants had their readings sent to their GP, meaning a significant amount of data was lost without follow up or being registered in the system. On a positive note, GPs did not feel that the community-based programme over-whelmed their already-stretch primary care service, as was feared initially.

Unfortunately, further analysis of different practices could not be done at this time as industrial action limited engagement with different practices. While the data supports the effectiveness of the programme model, limitations such as the inability to establish long-term health outcomes must be acknowledged. Future evaluations could integrate follow-up periods with specific GPs or pharmacies to assess

sustained impact. There is also ongoing work to model short-term intervention impact on long-term health and prevention.

Conclusion and implication for further research

The evaluation of the CVD prevention programme in BNSSG highlights its effectiveness in identifying and addressing CVD risk factors within vulnerable communities. Led by Accure, the programme used a community-based approach, delivering mobile health clinics in locations such as places of worship, barber shops, community centres, and workplaces. By providing on-site screenings, lifestyle education, and referrals, the initiative successfully raised awareness and improved early detection of hypertension, high cholesterol, and diabetes among underserved populations.

One of the programme's greatest strengths was its ability to engage communities that typically face barriers to accessing healthcare, including Black, Asian, Gypsy, Roma and Traveller, and low-income groups. This stands in contrast to NHS Health checks that can struggle to target these communities (Tanner et al., 2022). The recruitment and training of local Community Champions played a key role in sustaining outreach efforts and ensuring culturally appropriate engagement. The programme demonstrated significant rates of all CVD risk factors in these communities reinforcing the urgent need for proactive community interventions. This echoes previous evidence calling for targeting of high risk groups (Tanner et al., 2022; Robson et al., 2021).

Feedback from stakeholders, healthcare professionals, and community members overwhelmingly supported the programme's accessibility, adaptability, and impact on reducing health inequalities. Many participants noted that they would not have otherwise sought medical attention due to various barriers, including difficulty

accessing GP appointments, mistrust of healthcare institutions, and past negative experiences.

Despite its successes, the evaluation also identified several challenges and limitations around data. Notably, 14 out of 74 GP practices opted out of participating in the referral process, which restricted follow-up care for some participants.

Additionally, long-term health outcome tracking was limited, making it difficult to assess the programme's sustained impact on participants' health. Inconsistencies in data collection, such as non-standardized ethnicity reporting, and limited access to blood tests also posed challenges in fully capturing the programme's effectiveness.

To enhance the sustainability and scalability of this initiative, several recommendations are proposed:

- Expanding community partnerships with local organisations, businesses, and faith groups could help extend the programme's reach, particularly in rural areas where participation was lower.
- Establishing multi-year funding would support the long-term viability of this initiative.
- Improving data collection methods by standardizing ethnicity reporting and integrating follow-up mechanisms with GPs, pharmacies, or digital platforms would ensure more comprehensive tracking of long-term health outcomes.
- Integration of data collected by community programs directly into data platforms such as EMIS or System one to prevent duplication and streamline data collection.
- Establishing a clear evaluation plan prior to collection of data would help streamline this process and avoid duplication.

Looking ahead, this model has significant potential for replication and adaptation beyond CVD prevention. The programme's community-centred approach could be embraced to provide NHS Health Checks to communities that may be hard to reach. Additionally, conducting a financial impact analysis would provide valuable insights into the programme's cost-effectiveness and return on investment, strengthening the case for wider adoption.

Long lasting impact

There are several long-lasting impacts from this one-year programme including but not limited to:

1. **Health empowerment in communities** - Increased awareness in communities of CVD as a disease and its risk factors. This has empowered some communities to look at ways of continuing health-focused programmes within their settings.
2. **Workforce** - The community champion model and working directly with universities and colleges was not only considered as a social duty for young people but it delivered a very successful opportunity for students, colleges and local community. This engagement and approach can also support some of the challenges in healthcare workforce and for some students an opportunity to gain experience of health inequalities.
3. **Transferrable model** - Accure have presented this model to BNSSG's Long Term Conditions Group, Local Authorities, and providers of support services for other conditions. Reaching into communities has been seen as an excellent approach with far reaching benefits, to be adopted in plethora of areas. For example, the NHS health checks programme.
4. **Insights** - For the ICB and the six localities the programme and mapping of their hard-to-reach communities has provided a greater insight into the CVD health challenges and population health

In conclusion, the CVD Prevention Programme has demonstrated its ability to improve accessibility, increase early detection of CVD risk factors, and reduce health disparities in historically underserved communities. By refining data integration, strengthening follow-up mechanisms, and expanding its reach, this approach has the potential to reshape preventive healthcare, making it more inclusive, community-driven, and sustainable in the long term.

Sazia is an asset builder in Weston, working at the For All Healthy Living Centre. We felt like her feedback encapsulated the impact and context this intervention had on the communities it worked with.

Feedback from Sazia Salim - South Ward Asset Builder in Weston at The For All Healthy Living Centre

When I heard about Tabinda's project, I knew this was exactly the kind of work I wanted to be involved in—breaking down barriers to healthcare and ensuring that people, regardless of their background, have access to the support they need. That's why this partnership with Accure Healthcare was so valuable. I am a trusted person within these communities, with strong connections to the spaces and organisations that people rely on. This trust is crucial in encouraging engagement without the process feeling intrusive or overwhelming. However, as I am not a healthcare professional, I am unable to run clinics myself, which is why partnerships like this are essential in making community-led healthcare a reality.

My work is centred around reducing health inequalities and health inequities, particularly in areas like Bournville and Central Weston, where deprivation, lack of trust in healthcare services, and difficulty accessing appointments create significant barriers. While people in more affluent areas are often willing to travel for health checks or screenings, many in these communities do not seek healthcare until they have no other choice. For some, additional check-ups simply wouldn't cross their minds due to existing traumas, past negative experiences, or practical constraints such as transport and cost.

By bringing clinics into trusted community spaces and working alongside familiar, respected individuals, we were able to break down these barriers. With my local connections, Accure Healthcare delivered multiple drop-in sessions at the For All Healthy Living Centre, tapping into various groups; North Somerset Training, and a recovery centre. We carefully planned the session to align with existing activities—such as art classes, aftercare services (recovery), and SEND support—to ensure maximum engagement. This approach enabled us to reach people who might not otherwise have accessed health support, while also encouraging passers-by in the busy town centre to take part. Accure Healthcare also ran a session at a local recovery centre, further expanding the initiative's reach.

The impact was clear from the feedback we received:

“I've always avoided going to the doctor because of my anxiety, but having the clinic here in a familiar space made all the difference. I felt comfortable and at ease.”

“I usually get really high blood pressure readings at the GP because of my white coat syndrome, but here I felt relaxed, and my reading was much lower than expected. It’s made me rethink my fear of check-ups.”

“I didn’t even know I was eligible for a health check until I walked past and saw this happening. If this had been at a surgery, I wouldn’t have gone, but being here made it easy for me to say yes.”

Another key success of this project was the training opportunities it created. I had previously been contacted by Sirona Healthcare about a young man, Mohammed, who was seeking direction in the health sector. I introduced him to Tabinda, who invited him to attend some drop-in sessions and engage with health professionals. As a result, he trained as a Health Champion and is now able to run community-based clinics, offering blood pressure checks and health advice.

This initiative has demonstrated the power of bringing healthcare into the community. By embedding services within trusted environments and offering flexible, accessible options, we can improve health outcomes and build stronger, healthier communities. This is the future of reducing health inequalities—not expecting people to navigate complex healthcare systems alone, but instead bringing the support to them, in spaces they trust.

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