Health Inequalities Cardiovascular Disease Prevention Project.

Deans and Central Brighton PCN

East and Central Brighton PCN

2024/25

This project focused on reducing health inequalities through provision of accessible hypertension and lipid lowering healthcare.

It was made possible by NHS Sussex successfully bidding for NHSE health inequalities funding of £171,000. This provided a unique opportunity for partnership working between two primary care networks and the Trust for Developing Communities (TDC)

Project design was supported by local ICB clinical leads and PCN pharmacists. CVD prevent data was used to identify specific groups who were less likely to be treated to target.

Over 1,500 patients were contacted with an average of 3.5 contacts per patient.

Project outcomes show improvements across the whole hypertension register for all three key indicators:

- Blood Pressure Treatment To Target up by 2.9%,
- Blood Pressure monitoring up by 1.96%
- Lipid Lowering Therapy prescribing up by 5.22%

Delivery costs totalled £201,193, with one quarter of the budget allocated to voluntary sector community engagement.

Support for patients was improved by providing

- An assertive, empowering and persistent approach to engaging patients
- Accessible communication in a range of formats
- Longer appointments at different times (including out of hours)
- Blood pressure monitor loan and support to complete home monitoring
- Community based interventions to increase patient knowledge and confidence

High engagement was achieved with positive feedback from patients via PCNs and TDC

Resources and learning can be used for future projects.

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1. Background and Aims

In January 2024, NHS Sussex were successfully awarded NHSE funding to reduce health inequalities around hypertension and lipid management, for two Brighton and Hove Primary Care Networks, East and Central Brighton PCN (ECB) and Deans and Central Brighton PCN (D&CB). There are 14 practices with a registered list of 111,646 patients, across the two PCNs. Eleven of the wards within the geography are in the top 10% most deprived nationally. PCN profile data shows significantly more middle-aged men than the Sussex and national average are registered in E&CB, with fewer people aged 65 plus. D&CB has a slightly younger age profile with more than average people aged between 20 and 44 years and men and women aged 75 plus who tend to live along the coastal communities.

Informed by Place based health inequalities data from CVDPREVENT, and population health management data from SHAPE and Fingertips, the two PCNs identified showed practice profiles which most closely align with target populations in terms of higher relative deprivation, greater ethnic diversity, and higher proportions of both adults aged 18 – 64 years, and more men of middle age than the Sussex and national average. One of these practices is a specialist homeless surgery in Central Brighton which offers the homeless health engagement service.

Practices from both PCNs are positioned across the Integrated Community Team of East Brighton, which contain some of the most deprived areas of the city, more people of working age, and the most ethnically diverse populations of the city.

In the 2021 census, Brighton & Hove (B&H) had 276,300 residents, 72% of whom were aged between 16 to 66 years, and a population profile younger than the South East and England. A quarter of residents were from an ethnically diverse group and 10% identified with an LGB+ orientation. 20% of its residents were born outside of the UK, with 17% of the population living in the most deprived quintile. The highest concentration of deprivation is to the East, Central and North of the city. Key health inequalities for B&H include homelessness and rough sleeping, multiple long term physical and mental health conditions, heart disease and stroke, with lifestyle behaviours such as smoking, alcohol and drug misuse all being significant issues for the city. Brighton and Hove have the highest smoking rates in the South East.

With regards to the management of hypertension, the following groups are less likely to be treated to target: men, those living in the second most deprived quintile, those whose ethnicity is mixed, not stated or missing, and those aged between 18 - 39 and 40-59 years. Women, and those who live in the least deprived quintiles, are less likely to be prescribed lipid lowering therapy (LLT) when identified to be at high risk of CVD in B&H.

£171,000 of funding was split across the two PCNs for clinical (pharmacist) support, Voluntary Sector Community Engagement (VSCE) input, administrative and patient engagement work. The project was directly managed by the PCNs, led by pharmacists, with support from managers, data analysts, healthcare assistants, pharmacy technicians, care co-ordinators, patient engagement and administrative staff. Planning for the project started in April 2024. Deans and Central Brighton PCN's delivery was focused between June and February 2025 while East and Central Brighton's focused delivery was from August 2024 to June 2025. VCSE partners delivered outreach events between September 2024 and April 2025. The project closed in June 2025.

The work centred on the identification and support of patients with high blood pressure (BP) and high risk of cardiovascular disease. This project focused on improving hypertension management and prescription of lipid-lowering therapy (LLT) for patient groups identified by CVD prevent data as likely to be underserved by the accessible healthcare and information needed to reduce their cardiovascular risk. A funding requirement to include partnership via a local voluntary sector organisation provided a unique opportunity for partnership between the two PCNs and the local

voluntary sector. Expressions of interest were invited and the Trust for Developing Communities (TDC) was awarded this project. TDC was a known and respected organisation within Brighton, already working on reducing health inequalities and increasing access to health and social care, with links in place with specific and relevant local groups and communities. Both PCNs had previous experience working in partnership with TDC.

To reflect the different aspects of this project, clinical processes and outcomes are described in sections 2 and 3 and community delivery and outcomes are described in sections 4 and 5. Please see section 8, Appendix A for baseline data.

2. Clinical Process

2.1 Clinical Planning

The planning stage started in April 2024, using data from CVDPREVENT to agree a focused patient cohort known to experience CVD-related health inequalities, or who are less likely to engage with GP practices for the management of hypertension /or those at risk of hypertension.

Lists were created for each practice, of patients with high risk of cardiovascular disease and two or more of the following characteristics

- Females aged 40-59
- Anyone aged 18-59
- Medical records ethnicity listed as BAME or unspecified
- Postcode indicating areas of deprivation (IMD1)

2.2 Clinical Delivery

The overall goal was to make it as easy as possible for patients to engage in appointments and take part in self-care, including home blood pressure monitoring and healthy lifestyle changes. This was delivered through a programme of patient engagement, BP monitoring, and medication reviews. The first step was to triage patients to ensure they were offered the most appropriate starting point in their cardiovascular care journey. The project officer and care co-ordinators worked intensively with pharmacy teams across the PCNs to support patients to engage and remain engaged with CVD prevention healthcare. This extensive additional resource offered patients responsive support via a direct number and named person. Communication methods were adapted to meet patient's differing needs and all written communications were checked for readability. In addition, easy read and translated versions of letters and information sheets were provided.

Patients were invited to health care assistant clinics for blood tests, blood pressure monitoring, BMI checks, and discussions about lifestyle and family history. These 30-minute appointments provided sufficient time to address concerns, explain the need for home blood pressure monitoring, and prepare patients for medication review appointments. Follow-up appointments were booked, and where necessary, patients were given BP monitors on loan and provided with diaries to record readings. For those unable to attend clinics, extended hours or home visits were arranged. Care coordinators and project officers supported this work by contacting patients directly, helping them gather blood pressure readings, and booking review appointments. Many patients received personalised phone support to help them complete and share home BP monitoring, often for the first time in years. Referrals to healthy lifestyle and wellbeing services were made as appropriate.

Pharmacy technicians supported the identification and triage of patients using pre-defined search criteria. They prepared patient lists and helped plan appropriate interventions based on clinical need. Pharmacy technicians also managed the loan of BP monitors and the collection of home readings,

supporting patients and ensuring clinicians had access to the data needed for review. Their coordination helped streamline clinic preparation and supported the wider team in delivering patient-centred care.

Pharmacists provided structured hypertension clinics across practices on a rotating basis to ensure equitable access and workload distribution. Clinics included both telephone and face-to-face appointments and focused on structured medication reviews. Each appointment allowed time for in-depth discussions with patients, especially those anxious or uncertain about starting or adjusting antihypertensive medication. Pharmacists also offered lifestyle advice and referred patients to services such as smoking cessation and weight management. Direct follow-up was arranged where needed, ensuring continuity of care. The collaborative model involving pharmacists, pharmacy technicians, care coordinators, and project officers supported effective, responsive service delivery throughout the project. Concerted efforts were made by all involved to gather ethnicity data. Patients were offered the opportunity to share their ethnicity during in person and telephone appointments and via Accurx link.

The diagrams below illustrate the contrast between the standard QOF hypertension pathway followed by practices and the additional support provided through this project.

Diagram 1: QOF hypertension process

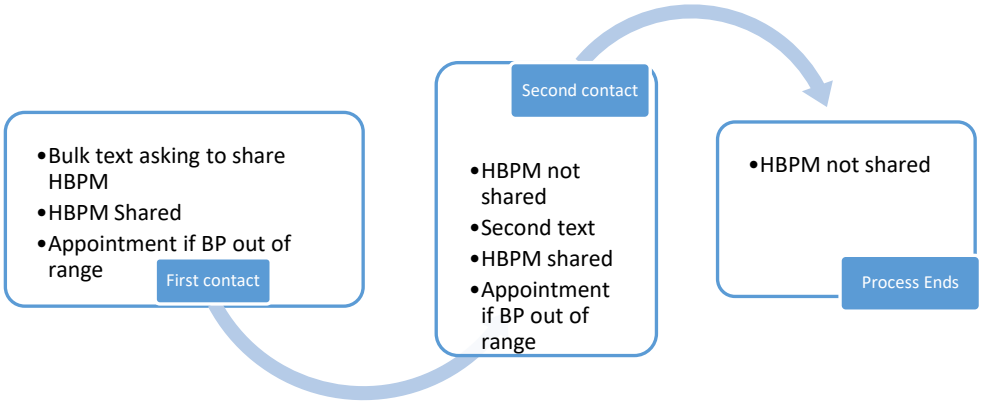


Diagram 2: Additional support the CVD project provided to engage patients

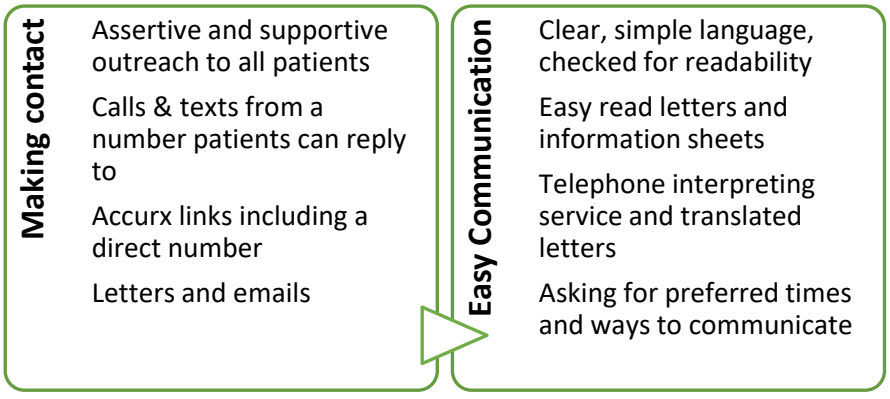
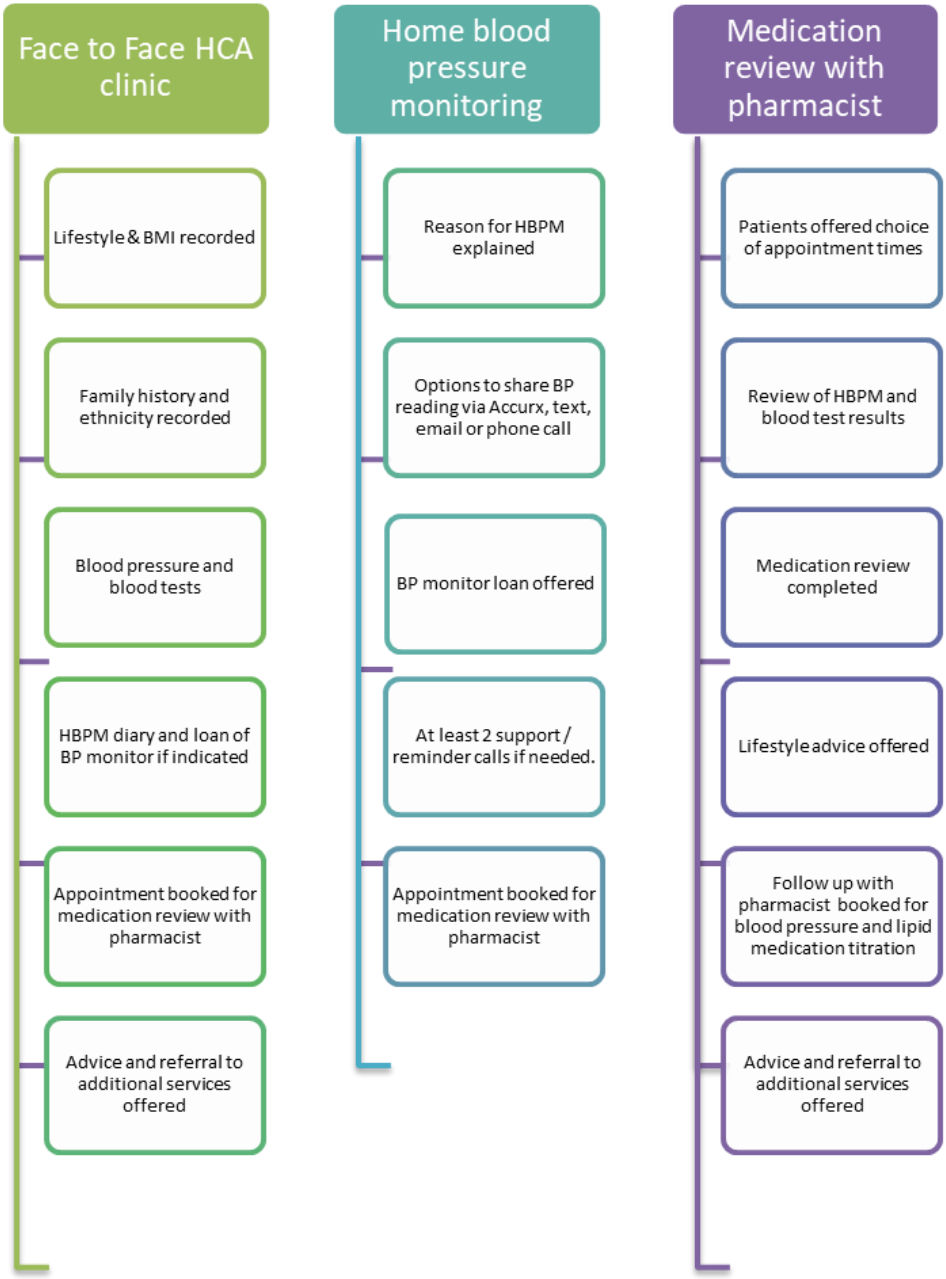


Diagram 3: CVD project patient pathway



The additional support made possible by this project is further highlighted in the case studies below. Please note all names and details have been changed to ensure anonymity.

Case Study 1: Felix and Femi

Femi and Felix are 40 year old men who have been on the on the hypertension register for several years. Every year they receive texts from their GP practice asking for a blood pressure reading. This year Femi's GP practice is part of the CVD project, but Felix's is not.

Felix has been struggling with anxiety but hasn't felt able to talk to anyone about it. He gets a text from his GP asking him to share a blood pressure reading. Felix knows it's important, as he has stopped taking his blood pressure medication. Felix decides to check his blood pressure but doesn't manage to do this before the link expires.

Felix receives a reminder text about sharing a blood pressure reading. Unfortunately, by now he is too overwhelmed to even think about checking his blood pressure. Felix missed the chance for a hypertension

review for another year. His anxiety and low mood continue and he manages this as best he can by comfort eating during the day and drinking once the kids are in bed.

Femi has also been struggling with anxiety, and hasn't talked to anyone. He receives a text asking for blood pressure reading. Like Felix, he knew it was important, but doesn't manage to do any readings before the link expires. Two weeks later Femi gets a text inviting him to book an appointment for a heart health check-up. It sounds like a good idea but Femi doesn't get round to booking. A week later, Femi gets a phone call and is supported to book an appointment.

Femi attends an HCA clinic and has blood tests and blood pressure checks. Femi's blood pressure is high so he takes away a blood pressure diary and a follow up telephone appointment is booked with the pharmacist. The HCA asks him how he is and, Femi feels able to speak about his anxiety. He gratefully accepts an offer to refer him to the PCN mental health team.

The mental health team accept Femi's referral and let him know that they will be able to offer him some support within 8 weeks. Femi feels glad support is on the way.

Femi doesn't complete his home BP diary but is keen to talk to the pharmacist. He tells the pharmacist he has stopped taking antihypertensive medication and wants to try lifestyle changes before starting medication again. The pharmacist explains the benefits of medication and shares information about local healthy lifestyle support. Femi agrees to monitor his BP at home and have a review appointment in a month's time.

Femi's BP monitor is broken so a monitor loan is arranged and Femi shares a 4 day BP diary. This showed his blood pressure is above target. Femi has a second appointment with the pharmacist and decides to restart his medication and try a drop in exercise group he found in the information shared by the pharmacist.

3 months later, Femi is finding life a little easier. He still struggles with anxiety but has started receiving support from the PCN mental health team which is very helpful. He exercises regularly and takes his medication every day. He completes another 4 day HBPM and which shows his BP is now treated to target.

Case study two highlights the work of pharmacy technicians.

Case Study 2: Sofia

Sofia is 55 and has been on the hypertension register since 2007. She was triaged by the pharmacy technician who found that she had not requested her antihypertensive medication for over a year and both blood tests and BP checks were overdue.

It wasn't possible to contact Sofia initially as her phone number was not working. An email was sent explaining that she was due for a heart health check-up with a direct number to contact.

Sofia called a few days after receiving the email. She was happy to monitor her blood pressure at home and agreed to start 4 day monitoring. Sofia was anxious about how to arrange a blood test around her working hours. Support and information were given so she could book a blood test.

Sofia called after her blood tests to share her home BP readings. She was concerned that these were high and said that she had not been taking her BP medication for some time. Sofia was grateful to have an appointment booked with the clinical pharmacist. She agreed to restart antihypertensive medication and redo home BP checks in 6 weeks.

After a reminder to share her HBPM readings 6 weeks later, Sofia was delighted to share readings that showed that her blood pressure was now in range.

Case study three highlights the work done by care coordinators

Case Study 3: Lucas

Lucas is a 60 year old man who has been on the hypertension register since 2010. He has a learning disability and lives in supported accommodation.

Lucas was not taking his medication and had been unwilling to complete home blood pressure checks. Recent clinic blood pressure checks at showed that his blood pressure was significantly out of range. The next step would usually be to arrange a telephone appointment with the clinical pharmacist. This was not appropriate for Lucas who did not like talking on the phone.

The PCN learning disability care co-ordinator suggested a face to face pharmacist appointment in a community setting. Lucas's support worker helped arrange this. Meeting the pharmacist in a familiar place Lucas felt able to say what he found difficult about taking medication and checking his blood pressure.

- It was too difficult for him to swallow his tablets as there were so many to take. The pharmacist was able to reduce the number of Lucas's medications and show Lucas and his support worker how pills could be cut in half or crushed to make them easier to swallow.

- Lucas didn't like checking his blood pressure because the cuff hurt his arm. Having checked the size needed, the PCN loaned Lucas a larger cuff so BP checks were more comfortable.

A month after his appointment Lucas and his support worker reported that he was now taking his medication every day and had happily completed home blood pressure checks. They shared home blood pressure readings that showed his blood pressure was now treated to target.

3. Clinical Outcomes

Following the implementation of the targeted cardiovascular interventions across the two PCNs and the community engagement work, global improvements were observed in three core clinical indicators: lipid-lowering therapy (LLT) prescribing, blood pressure (BP) monitoring, and hypertension treatment to target (TTT). Global improvements refer to changes in PCN registers such as QOF Hypertension registers or all patients with elevated QRISK (QRISK2/3>20%). Following on from the global reports, changes were also tracked within the specific cohort of patients directly engaged by the project.

3.1 Global data outcomes

For the full global results report see the end of this section. The results show that the use of LLT in patients with raised QRISK increased by 6.62%, with DCB improving by 6.73% and ECB by 6.56%. The most substantial gains were seen at Brighton Station and Ship Street surgeries, each with rises of over 14%. In parallel, improvements were also observed in blood pressure measurement, with the proportion of patients on the hypertension register having an up-to-date BP reading increasing by 1.96% overall. DCB showed the largest improvement in this category (+4.61%), with Ship Street demonstrating a notable 12.95% gain. Further improvements were evident among patients on the QOF hypertension register aged under 80, where the proportion achieving target to treatment (TTT) increased by 2.90% overall. Pavilion Surgery and Ship Street saw the highest improvements, recording (+11.24% and +13.11%, respectively).

Category	Overall change
LLT use **Patients with raised Q risk**	+6.62%
Up to date BP readings **Patients on hypertension register**	+1.96%
Treatment to target (TTT) **Patients <80 years old**	+2.9%

All ethnic groups saw increases in LLT prescribing. DCB showed large improvements for Black (+23.48%), Mixed, and Other groups, while ECB showed particularly strong gains for Asian (+11.71%) and other (+13.64%) groups. Similarly blood pressure monitoring at DCB saw significant increase in Black, Mixed, and Other groups (up to +14.95%), but a decrease in Asian patients (-10.62%). In contrast, ECB made small improvements across most groups but showed a -2.94% reduction in Black patient monitoring. Performance in blood pressure TTT also varied by ethnicity. At DCB outcomes improved for Black (+7.56%) and Other (+6.84%) ethnicities but showed declines in Asian, Mixed, and Unspecified groups. At ECB improvements across all ethnicities except Black were experienced (-6.29%), with the highest gain seen in the Mixed group (+8.53%). It's important to note that some of these groups had relatively small absolute numbers and data should be interpreted with this context in mind. Gender based trends in LLT prescribing showed differences across the PCNs. At DCB males improved by 15.24% vs. 6.77% for females. ECB showed stronger improvements for females (+16.27%) than males (+10.71%). In terms of BP monitoring for both genders in DCB improved by around 6.7%. In ECB, females saw a modest improvement (+3.25%), while male performance remained static. TTT performance among younger females declined in DCB but improved among males. It is worth noting that in ECB, females outperformed males in all indicators.

Finally, the data was explored in accordance with UCLP hypertension risk stratification levels. This data shows that the number of patients at very high risk (Last recorded clinic BP, ≥180/120mmHg OR HBPM ≥170/115 mmHg) increased slightly (+8 total), while those at high risk (Last recorded clinic BP, ≥ 160/100 – 179/119mmHg OR HBPM ≥150/95 - 169/114mmHg) decreased substantially (-114 total), mainly driven by DCB. The cohort (ethnic minority patients with elevated BP) increased by 25 patients, suggesting improved identification or persistent disparities. Successful case finding is one reason for increased the numbers in this cohort. It is also worth noting that these patients engaged in medication reviews and lifestyle support that reduced their risk. Those not yet treated to target are receiving ongoing support.

3.2 CVD project cohort outcomes

While the global data reflects changes to CVD for the PCN populations as a whole, the following data reflects changes within the project specific cohort (n = 1524). It is important to note, that this data required appropriate use of clinical codes or template across two PCN's and as such may underrepresent the true size of the cohort. However, this data summary is at least indicative of some of the changes that occurred across the PCNs in terms of new medications and changes in treatment to target rates.

The results of the medication analysis revealed that target patients were prescribed 392 new LLT or hypertensive medications. The total number of unique patients in this cohort was 302, indicating that some patients were prescribed a combination of medications. Divided by PCN, ECB issued 348 new LLT or hypertensive medication to 271 unique patients which was around 22% of the total cohort. In contrast, DCB issued 44 new LLT or hypertensive medications to 31 unique patients at around 12%. The most commonly prescribed new hypertensive medications across the PCN's were Amlodipine, Ramipril and Doxazosin at 23, 20, and 12% respectively. The most commonly prescribed Lipid Lowering Therapy was Atorvastatin by a large margin of 66%, followed by Ezetimibe at 15%. There was however

some evidence of newer LLTs emerging such as Bempedoic Acid and Inclisiran (only for hypertensive patients with co-existent CVD) at 2.59% and 1.72% respectively. It should be noted, that these medications only reflect changes in the target cohort and do not represent all new LLT or hypertensive medication prescriptions across the PCN.

There was also a notable change in TTT rates, when comparing the latest BP readings before and after intervention. Across the PCN's 2735 numerical blood pressures had been recorded for 948 patients, an average of 2.88 new recordings per patient. Moreover, around 62% of the total cohort managed to have new BP readings recorded. It should be noted than in many instances readings will be entered as text, with only the average reading being reported. As such, the actual number of readings could be substantially higher. There was a substantial percentage increase in the percentage of patients treated to target in both PCN's. For the ECB cohort of 772 patients, TTT rates increased from around 18% to 43%, an increase of around 25%. In contrast DCB cohort of 176 patients increased from 7% to around 57%, an increase of 50% TTT rates.

An unexpected finding that emerged when exploring the time between recorded BP dates, was that many of the previous measures were taken several years prior to the intervention. The average time between most recent BP's pre/post intervention was as long as 6.7 years, however this mean value was skewed by outliers such as the max duration of 34.16 years. Further descriptive statistics such as the mode (1.48 years), and median (4.42 years) reveal less extreme, yet surprisingly long gaps in monitoring. Two possible explanations for this finding are data entry issues (e.g. adding BP as text) or that a large portion of the cohort had a one off high blood pressure reading in the past but did not return to general practice for a follow up. This finding means that improvements in TTT rates are not entirely attributed to newly controlled blood pressure, whilst highlighting both the case finding element of the project and the success in engaging patients who have been historically underserved by health care providers.

Taken together the global and cohort data demonstrates the impact of the project. It showed meaningful improvements in lipid-lowering therapy (LLT) prescribing and blood pressure monitoring across the population, with all ethnic groups seeing increased LLT uptake. While gender and ethnicity-specific variations in outcomes were observed, the overall trend indicated progress in addressing gaps in care. Within the targeted cohort, substantial numbers of new LLT and antihypertensive medications were prescribed, and treatment to target (TTT) rates for blood pressure improved significantly. The project also highlighted longstanding delays in routine monitoring for many patients, reinforcing the importance of proactive case-finding and engagement strategies to reach those who have not been adequately supported to regularly access care.

Link to full PCN reports below

Global Data Summary .pdf

Cohort Data Summary .pdf

4. Community Delivery

4.1 TDC work, impact and learning

The Trust for Developing Communities, (TDC) provided invaluable support delivering the community engagement element. TDC acted as a lead provider for a host of VCSE providers to ensure support was offered to those in underserved communities. This included partnership with local community groups such as Brighton and Hove LGBT Switchboard, Bridging Change and Brighton Unemployed Centre Families Project. Objectives were identified by TDC in partnership with the PCNs. These were: to reach target communities; increase awareness of hypertension; support access to clinical treatment and healthy lifestyle support; develop community-led offers and capture insight on barriers to engagement. The PCNs provided training to 16 VCSE staff and volunteers covering information about

what hypertension is, the causes and risks, why and how to check blood pressure as well as teaching staff about specific pathways relating to elevated BPs.

The PCNs' partnership with TDC provided an innovative opportunity to develop stronger links between GPs, VCSE and community pharmacies. ECB and DCB PCNs were the first PCNs to sign up to the community pharmacy GP authority letter. A pathway to use this letter was developed collaboratively by the PCNS and TDC so that patients with moderately elevated BP readings could be referred for community pharmacy support. This was then successfully trialled at community events by TDC and their VCSE partners and the approach is now being used in community events outside this project.

TDC and partners provided hypertension information and BP monitoring at 31 community events including The Inclusive Job Fair, Tarner Family Hub, LGBTQIA+ HOP Group and Community Voices. All events included a market stall with a BP monitor, information sheets on hypertension and local resources supported by at least one trained staff member. Some events were also supported by community navigators and others included facilitated focus group discussions. 782 people attended events where TDC or their partners provided hypertension input. 420 people took part in discussions or had information provided about hypertension. 299 people had their blood pressure checked.

Feedback from TDC staff, volunteers, and VSCE partners

"For some it was the only time they had accessed a reading e.g. a van dweller (no regular GP service)." - TDC staff

"It was a great opportunity for people to access health in an inclusive, safe and non-clinical space." - LGBT Switchboard staff

"People need more opportunities in community settings to take their BP or information about healthy lifestyle choices." - Bridging Change staff

"The training was good, it encouraged me to have conversations in my family and in the community around checking blood pressure." – Community volunteer

Barriers identified to accessing CVD healthcare

- Knowledge - lack of clear, or consistent information.
- Fear - of judgement, or lack of family/peer support.
- Motivation and lifestyle - lack of self-care, routine or poor mental health.
- Conflicting need - limiting conditions, care responsibilities.
- Cost - of monitors, healthy food and activities.
- Language barriers.
- Digital divide.

Learning and recommendations

- Community groups are keen to continue providing health check outreach
- Sufficient staffing, equipment, expertise and space is essential
- PCN training and support increased staff and volunteer confidence
- Signposting or referring was sometimes difficult especially for patients outside the PCNs.
- VCSE partner capacity varies, so back up resources were sometimes needed
- Many people lack the time or confidence to complete evaluation surveys
- A longer project (including more set up time) would build confidence and capacity
- Co-produce consistent information resources in different languages and formats
- Provide a range of options to share BP readings (to avoid the digital divide)
- Check communication needs, provide longer appointments and onward referral if needed.

4.2 PCN Community engagement

Deans and Central Brighton PCN worked with TDC to make hypertension and cardiovascular health the focus of their September and March patient participation group meetings (PPGs). In September, patients were able to check their blood pressure and take part in facilitated discussion about the importance of regular BP checks. Information was provided about the free BP checks available at community pharmacies. At the March PPG patients took part in a Q and A session on how the PCN supported patients with frailty including managing anti-hypertensive medications. This was led by Deans and Central Brighton PCN lead pharmacist, Sarah Trust. Feedback from 25 patients at these events showed that 91% found the sessions useful and informative and 82% said they now felt more likely to make a change to look after their blood pressure.

East and Central Brighton PCN delivered healthy heart sessions at East Brighton Health Hub and Wellsbourne Cafe. 41 people attended the session at the Health Hub and were able to get their BP checked and talk through concerns with HCAs, pharmacy technicians and nursing associates. Medication advice and information was provided by PCN pharmacists, and interactive support offered by local services BHCC Healthy Lifestyles team and Gloji. 86% of attendees said it was a useful and interesting event and 59% said they were now more likely to make a change to improve their heart health. 13 people took part in a facilitated discussion about hypertension at the Wellsbourne Café. 100% said they found the session useful and 89% said they felt likely to make a change to look after their blood pressure.

5. Community Outcomes:

5.1 Healthwatch Review

Healthwatch Brighton and Hove led an evaluation of the community element of the project by surveying 91 people to select 21 people to interview following community interventions. 57% were female and 43% were male. Their age ranged from 38 to 88 years, 57% had a disability, 19 identified as heterosexual and two as gay or lesbian. 11 of the interviewees were 'White – British', five were 'Indian', four were 'Black or Black British African' and one was 'Arab'. English was not the first language for seven of the interviewees.

Healthwatch obtained feedback that the project had a clear positive impact on communities that are at higher risk for hypertension and also likely to experience health inequalities. People interviewed were overwhelmingly positive and receptive to BP monitoring testing in the community. Those who had a previous known history of high BP had received varying levels of support and engagement. A lack of previous lifestyle advice from GPs was a common theme, believed to be because of time constraints.

- Of the 91 survey respondents, 74% stated that they found the session extremely helpful or very helpful. This was reflected in the interview feedback, where all participants took some action following the event.
- Of the 21 interviewees, 16 took new action (e.g. sought GP appointments; started monitoring blood pressure; made lifestyle changes) and the remaining 5 said they would continue monitoring and/or engaging with their GP.
- Most of the survey respondents (64%) believed they knew more about what can cause high blood pressure after the session. Similarly, most interviewees (62%) said they learned something new.

There was significant variation in how much information was shared and how much was learned, depending on the type of event. The key barriers to regular checks identified were forgetfulness; cost and confidence around using at-home monitors; difficulties getting GP appointment; loss of faith in

GPs and the healthcare system; comorbidities and willingness to engage with healthcare; and lack of awareness. The key enabling factors for regular checks identified were convenience; peer support; familiarity of outreach workers and building trust; more relaxed and comfortable in a community space compared to a medical setting; and more accurate readings in community spaces.

The key barriers to improving blood pressure were identified as difficulties accessing their GP; not enough time with the GP to talk about lifestyle; difficulties accessing or knowing what community lifestyle support is available; cost of food/exercise; difficulties with behaviour change; and comorbidities that make regular exercise/eating well more challenging. The key enabling factors for improving blood pressure were identified as access to in-person knowledge sharing and peer support; and access to communal exercising.

5.2 Links to TDC and Healthwatch Reports

Hypertension Evaluation Report - H

TDC Hypertension Outreach Report Apri

6. Learning and Feedback

There was learning from all elements of the project, drawn from staff and patient feedback, examples of which are provided at the end of this section. It was noted that future projects could benefit from focusing on fewer health inequality cohorts at a time, with the aim of improving one factor, for example LLT prescribing for ethnic minority females. A rolling programme of focused support may lead to greater success in improving outcomes for all health inequality groups. One issue when focusing on multiple variables with a very large sample, effects could be lost in respect of data presentation. Despite the importance of case finding, this was seen to actually be counter-productive when trying to demonstrate impact. Case-finding efforts increased practice patient list sizes, but did allow for increased intervention for these patients. Furthermore, the project was only funded for a year, which limited the impact possible from the project, by both the clinical and VSCE elements. Some time and budget was allocated to planning and preparation, which would not be needed if the project was to be extended into a second year, or more.

The budget was limited compared to actual costs for this project. This meant, although the project was a year-long, focused reviews and clinics were only able to be carried out by Deans and Central Brighton PCN pharmacists for six months, and the VSCE partner events did not start until September 2025. Vital support provided by PCN care co-ordinators and pharmacy technicians was worked as business as usual for the PCNs and practices. Additional funding would have allowed more focused time and support from these members of staff. Costs are detailed at Section 11, Appendix D.

Analysis of the data also revealed limitations in the data available on the clinical systems. A high rate of un-coded ethnicity data made it difficult to draw more precise conclusions around equity of access and impact. This is despite concerted efforts to gather ethnicity information and highlights the importance and the difficulty in obtaining ethnicity data. The project also highlighted the importance of consistently coding all hypertension and CVD intervention and results. Development of sustainable processes to maintain high quality coding will be a lasting legacy.

An important next step will be to increase understanding of the structural and practical challenges that make it harder for some patients, particularly Black patients and males aged under the age of 50, to gain access to healthcare. Taking steps to reduce these barriers may include the need for more accessible appointments outside of working hours.

It was not possible to make contact with all patients and a significant number required multiple, different communication attempts to become engaged in a CVD healthcare process. A range of appointment times, were needed particularly for those with work or caring responsibilities. Many patients needed several medication review appointments and required extensive support to remain engaged and complete repeat home blood pressure monitoring, before they were treated to target.

Both PCNS and the TDC gained valuable experience from this opportunity for partnership working. Collaborative planning supported shared insight into the work needed to reduce barriers to healthcare. VCSE partners' understanding of hypertension and safe patient pathways for those with elevated BP readings were developed through a PCN training session. Shared understanding was further developed by PCN colleagues attending community events. Regular reporting and meetings allowed partners to discuss the learning points outlined below.

Building trusting relationships with patients, was a key learning point of this project. This was achieved through community interventions, and extensive patient engagement support alongside focused clinics and review appointments. It was important to understand the barriers for these cohorts to accessing health and social care, or to understanding hypertension. The project identified and recognised barriers such as lack of information, fear of judgement, lack of family support, cost of BP monitors, healthy food or activities, language barriers, and lack of digital access to information. By helping to identify these barriers, and produce solutions, the project increased learning and helped these patients to access the support and information needed. Continuing efforts to build patient trust and confidence in healthcare is necessary for further improvement in outcomes.

Accessible Information and guidance, particularly within the community, saw a significant improvement in patients understanding their blood pressure. This led to patients engaging more proactively with healthcare reviews and taking steps to manage their hypertension. TDC recommends further translations, interpreting, and a variety of methods for communicating home BP readings to break down barriers to healthcare. Ongoing work is needed to follow these recommendations and build on project achievements to sustainably increase access to CVD healthcare, information and lifestyle support.

Alongside the areas to improve, there were also several key factors that improved the overall outcomes of the project:

- Communications in a range of formats including creating or sourcing translations of information into different languages and easy read formats shared with the patient cohort according to need. This is in contrast to the standard text messages sent prior to this project.
- Patients appreciated the option to reply by text with preferred times for a call.
- Longer and easily accessible medication review appointments, including capacity to offer follow up appointments and support to maintain engagement.
- Explaining the need for information on hypertension and BP monitoring in easy, judgement free situations so that patients were able to understand and accept this without fear, confusion, or stigma.
- Information on where to access free or cheap activities around healthy lifestyles provided to patients in clinical settings by pharmacists and HCAs and to all attending community settings by VCSE staff and volunteers.
- Increasing access to BP monitors at community events and via PCN loan of monitors so patients wouldn't have to travel to their GP practice or purchase a BP monitoring machine.
- Information about BP monitoring in their local community pharmacy.

6.1 Staff Feedback and Learning

This section includes learning from staff and volunteers involved in this project.

The PCN pharmacists and pharmacy technicians evaluated the project, with their feedback included at Appendix B.

- **Q1: What were your expectations of the project at the start?**
    - Working with and reviewing patients with risk of CVD and health inequalities.
    - Community engagement.
- **Q2: What do you feel were the positive outcomes for patients?**
    - Extra time given to hypertensive patients.
    - Reaching broader range of patients.
    - Sign-posting to, and advice on, CVD risk, BP monitoring, healthy lifestyle and referral to healthy lifestyle teams.
    - Focus on holistic care.
    - Hypertension medication reviews, BP monitoring, obtaining treatment to target.
    - Reaching patients who may not have engaged otherwise.
    - Higher patient engagement through education and shared decision-making.
- **Q3: What do you feel were the positive outcomes for practices pharmacy team?**
    - Able to engage with patients who have historically not been reached.
    - Supported practice-based Quality and Outcomes Framework (QoF) work on CVD.
    - Proactive and preventative care.
    - Adding additional time and support to these patients via hypertension clinics and focused follow-up.
    - More interaction and engagement within the PCN pharmacy team.
    - Development of pharmacy skills.
    - People patients treated to target, increased awareness of health/health literacy around CVD.
    - Increased case-finding and additions to practice hypertension registers.
- **Q4: What learning have you obtained through and from the project?**
    - Project provided valuable learning opportunities, particularly in managing more complex hypertensive patients and understanding cardiovascular risks.
    - Learning how to calculate QRISK scores and interpret them meaningfully, how to guide patients through home blood pressure monitoring and averaging, and how to escalate very high blood pressure readings appropriately.
    - Practical, hands-on experiences that helped build clinical confidence.
    - Team work. MDT working.
    - Understanding of patient engagement and barriers to people accessing health and social care.
- **Q5: Is there anything you would have done differently?**
    - Surprised to learn the amount of people who don't really know why they should be taking lipid lowering or blood pressure lowering medications.
    - Understanding how to make future projects even more effective by refining strategies, thinking about how we might do this again. We could have improved on regular data collection and reporting against KPIs.

A significant piece of staff and volunteer feedback was the need to understand that this was a piloted, limited time project, and that this had an impact on how much could be achieved and how many people could be engaged with. It was noted by all that a longer-term project would more likely result in continued and sustained improved health outcomes and reduced health inequalities in these patient cohorts.

6.2 Examples of Patient feedback

This patient feedback was obtained by the PCN pharmacists and the project officer. Themes included thanks for the call, additional help, and especially, for listening and increasing their understanding. The feedback reflects patients' appreciation of the additional support provided by the CVD project.

"Thank you for helping me arrange a blood test – I knew it was overdue, but felt overwhelmed about organising it."

"It's a relief to have help with my blood pressure readings – I get really muddled with the links and text messages."

"Thank you for booking me a telephone appointment – that's so much better for me."

"Thank you for listening. I find it difficult, but I will try and check my blood pressure."

"I'm glad you rang. I know my blood pressure is bad but can't get round to doing anything about it."

"The pharmacist helped me understand why I need to take my medicines regularly."

"Thank you for asking about best times to call me."

"Thank you for sending my Dad the letter in Arabic. He has been to the surgery to check his blood pressure and is really happy that it is healthy."

7. Conclusion

Hypertension remains a national and local priority for primary care and community based health and social care. This project demonstrated the positive impact of integrating community outreach with targeted primary care interventions, for patients who are less likely to engage in traditional healthcare. Through a combination of primary care and voluntary sector engagement, both PCNs improved lipid-lowering therapy prescribing, blood pressure monitoring and treatment to target rates. ECB demonstrated higher overall patient engagement and clinical contact rates, while DCB recorded more substantial improvements in BP monitoring and lipid management in certain subgroups: variation which may reflect differences in local practice infrastructure, community need, or data recording processes. The interventions also resulted in 392 new prescriptions for LLT and hypertensive medications and reactivated care for many patients who had not been reviewed in several years, highlighted both the success of the case-finding approach and the longstanding challenges of engaging with high-risk patients. The use of evidence-based guidelines (NICE NG136 and NG238) and targeted pharmacist-led care helped streamline treatment pathways and enhanced safety netting practices.

Importantly, the project left a legacy of learning that will help inform future initiatives. This includes the strong partnership that developed between the two PCNs and TDC. It also offered valuable insights into other areas for improvement, such as extending the length of review appointments, delivering blood pressure monitoring in community settings, and sharing information in multiple languages and accessible formats. The project also required the development of new data recording tools and improved the PCNs' awareness of clinical data issues particularly around ethnicity coding and historical BP. Learning from this pilot suggests that future interventions may benefit from focusing on more tightly defined cohorts with a fewer outcome metrics. Costs are another factor to be considered as project delivery for both PCNs relied on resources already in place, such as the engagement team, pharmacy technicians, and care co-ordinators. Longer-term funding would make more impactful, positive outcomes possible.

In conclusion, the CVD project successfully contributed to health improvement among patients with known inequalities in Brighton. It highlights the importance of tailored engagement, clinical collaboration, and data-driven monitoring in achieving equitable healthcare delivery. However, persistent data quality issues and demographic engagement gaps underscore the need for continued refinement and investment in primary care outreach and infrastructure.

6. Appendix A: Baseline Data Positions

(On Hypertension, Lipid Management and HI Groups)

PCN	Practice	March 2024	PCA rate	No. to treat to target
DCPCN	Brighton Station Health Centre	62.69%	16.93%	46
DCPCN	Saltdean and Rottingdean	65.81%	4.85%	275
DCPCN	School House Surgery	62.27%	6.38%	95
DCPCN	Ship Street Surgery	55.56%	15.07%	55
DCPCN	The Avenue Surgery	63.11%	12.34%	125
ECPCN	Arch Healthcare	47.11%	23.26%	40
ECPCN	Ardingly Court Surgery	57.49%	10.23%	177
ECPCN	Broadway Surgery	59.05%	1.04%	97
ECPCN	Park Crescent	71.60%	5.89%	104
ECPCN	Pavilion Surgery	55.05%	18.70%	321
ECPCN	Regency Surgery	65.82%	18.05%	78
ECPCN	St Peter's Medical Centre	63.63%	14.85%	311
ECPCN	Wellsbourne Healthcare CIC	71.14%	11.70%	87
ECPCN	Woodingdean Medical Centre	70.93%	13.53%	138

Data from CVDPREVENT shows the percentage of patients with GP recorded QRISK of 20% or more, on LLT for December 2023.

PCN	Practice	December 2023
DCPCN	Brighton Station Health Centre	73.5%
DCPCN	Saltdean and Rottingdean	54.6%
DCPCN	School House Surgery	69.7%
DCPCN	Ship Street Surgery	61.4%
DCPCN	The Avenue Surgery	58.3%
ECPCN	Arch Healthcare	47.2%
ECPCN	Ardingly Court Surgery	65.6%
ECPCN	Broadway Surgery	60%

ECPCN	Park Crescent	55.3%
ECPCN	Pavilion Surgery	53.7%
ECPCN	Regency Surgery	49.3%
ECPCN	St Peter's Medical Centre	55.4%
ECPCN	Wellsbourne Healthcare CIC	59.8%
ECPCN	Woodingdean Medical Centre	51.1%

Data from CVDPREVENT indicated where inequalities in hypertension management for the two PCNs existed.

December 2023	Deans and Central Brighton PCN				East and Central Brighton PCN			
Inequality Breakdown	Numerator	Denominator	No. to TTT	Value	Numerator	Denominator	No. to TTT	Value
Sex: Persons	1,820	2,885	1,065	63.1%	4,505	7270	2,765	62.1%
Sex: Male	900	1420	520	61.4%	2,330	3830	1,500	60.7%
Sex: Female	925	1465	540	64.9%	2,175	3440	1,265	63.5%
Ethnicity: White	950	1490	540	63.7%	3290	5220	1,930	63.04%
Ethnicity: Other	15	35	20	41.7%	65	115	50	58.77%
Ethnicity: Not stated	650	1020	370	63.6%	370	620	250	60.03%
Ethnicity: Mixed	15	30	15	50.0%	65	115	50	57.52%
Ethnicity: Missing	135	210	75	63.7%	505	845	340	59.62%
Ethnicity: Black	25	50	25	52.1%	70	120	50	56.67%
Ethnicity: Asian	35	55	20	66.0%	155	240	85	64.85%
Age group: 80+	480	655	175	73.2%	905	1240	335	72.2%
Age group: 60-79	960	1475	515	65.2%	2,420	3820	1,400	64.0%
Age group: 40-59	340	675	335	50.6%	1,080	2015	935	53.5%
Age group: 18-39	40	85	45	48.8%	95	195	100	48.5%
(M) Age group: 80+	185	250	65	74.2%	380	485	105	77.6%
(M) Age group: 60-79	515	780	265	66.1%	1315	2070	755	63.5%
(M)Age group: 40-59	175	385	210	45.6%	590	1165	575	50.7%
(M)Age group: 18-39	25	50	25	45.1%	50	105	55	45.7%
(F)Age group: 80+	295	405	110	72.7%	525	750	225	69.6%
(F)Age group: 60-79	445	690	245	64.1%	1150	1750	600	65.8%
(F)Age group: 40-59	165	290	125	57.2%	475	850	375	55.7%
(F)Age group: 18-39	20	35	15	54.3%	40	90	50	44.9%

9. Appendix B: Pharmacy Team Project Evaluation

This was collated from evaluations by pharmacists and pharmacy technicians in both PCNs.

1. What were your expectations of the project at the start?

- I initially expected to be working with groups of patients who are at high risk of cardiovascular disease (CVD), such as women and individuals from Black, Asian, and Minority Ethnic (BAME) backgrounds. I hoped this would be an opportunity to learn more about CVD in ethnic groups and to engage directly with these patients face to face. I also anticipated working with individuals who had not previously engaged with healthcare services, making the project feel particularly rewarding.
- The aim, as I understood it, was to review patients at highest risk of health inequalities and optimise their CVD risk reduction by managing blood pressure and lipid levels. The project offered a chance to have meaningful conversations with patients from more deprived or under-treated populations and contribute to achieving positive health outcomes.
- I saw the CVD project as an opportunity for the pharmacy team to apply their existing clinical skills while also developing new ones. By focusing on patients at high risk—particularly those in deprived areas—we could help prevent some of the poorest and most unwell individuals in our PCN from falling through the cracks of the healthcare system. Ultimately, the goal was to lower CVD risk in those suffering the greatest health inequalities.
- I was expecting to speak to patients who may have otherwise not had a conversation with a clinician about either their cholesterol, blood pressure, or both.
- At the beginning of the project, I have to admit I felt quite nervous. It was my first time being involved in a project like this, and it initially felt a bit overwhelming with all the new information and unfamiliar processes. I wasn't entirely sure what to expect, and the idea of doing something outside of my usual day-to-day role seemed a little daunting. However, I was also curious and open to learning, and I saw it as a valuable opportunity to step outside my comfort zone and grow professionally.
- The project successfully identified and treated patients within the surgery, which was rewarding.
- To meet the national target aligned with the NICE guidelines for hypertension and lipids:
    - 80% of people with hypertension treated to target
    - 65% of patients with QRISK>=20 prescribed lipid lowering therapy
- Steps to be carried out were identification and diagnosis (first 80%). Expectations were robust screening programs across primary care, community pharmacies, and outreach services; systematic blood pressure checks in high-risk populations (e.g. people aged 40+, those with diabetes, cardiovascular disease, or obesity); use of validated BP monitoring devices, including home and ambulatory BP monitoring; use of data tracking systems (using clinical system searches) to identify undiagnosed individuals with raised BP.
- Outcome Goal:
    - At least 80% of the estimated hypertensive population is diagnosed.
    - Treatment Initiation (second 80%) expectations were for 80% of patients with hypertension diagnosis to be on appropriate treatment (lifestyle and pharmacological) and treated to target; to ensure timely follow-up after diagnosis to assess treatment initiation and adherence. Use of NICE treatment thresholds and stepwise protocols (e.g. starting with ACE inhibitors or calcium channel blockers depending on age/ethnicity). Support through medication reviews, patient education, and behaviour change strategies. Implementation of clinical audits to monitor treatment rates across practices.
- Project Implementation - Expectations were clear governance structure with local clinical leaders; workforce training to improve BP measurement and NICE-compliant care delivery. Community outreach to reduce health inequalities and engage underserved groups. Integration of digital tools (e.g., Accurx BP monitoring forms). Regular data collection and reporting against KPIs.

- Patient-centred care: Shared decision-making and culturally sensitive interventions, to help achieve health inequalities goals.

2. What do you feel were the positive outcomes for patients?

- One of the standout aspects of the project was the extra time patients were given to talk about their health and lifestyle — typically 20-minute appointments, compared to the standard 10 minutes with a GP. This allowed for more in-depth conversations and meaningful interventions. We referred many patients to services such as the Weight Management Hub and Smoking Cessation, and offered follow-up appointments to review how they were getting on with new medications.
- Many patients we contacted would not have otherwise been reached, and we had numerous instances of identifying and treating individuals with high-risk blood pressures. I feel we successfully reached a broad range of patients and made positive strides in optimising various aspects of their cardiovascular risk.
- The vast majority of patients, after speaking with a clinician, were either motivated to make lifestyle changes in an effort to avoid medication or were more appropriately treated with pharmacological interventions to reduce their cardiovascular risk. Patients were offered up-to-date blood tests and blood pressure checks, and were treated in a holistic manner. If clinic blood pressure readings were elevated, patients were asked to carry out home BP monitoring, and then given dedicated one-to-one time with a pharmacist to discuss concerns and ask questions — an opportunity many may not otherwise have had.
- For patients with raised lipid levels who were not yet on a statin, appropriate treatment was initiated where necessary, offering long-term health benefits. When the team focused on targeting the most deprived patients, the additional effort truly made a difference. This is exactly the kind of impact the PCN outreach team is meant to have.
- I would say that every patient will have come away with more knowledge around CVD risk reduction and the majority of patients would have had positive medication changes to reduce that risk.
- I believe the project made a real difference by reaching patients who may not have engaged otherwise. Particularly those who might not have responded to formal invitations. It created a more accessible and relaxed environment where patients had the opportunity to speak directly with healthcare professionals, complete health questionnaires, and in some cases, discover underlying health concerns like high blood pressure that they may have been unaware of.
- I feel that, as a team, we contributed to preventing potentially serious health issues and possibly even saved lives. From my perspective, one of the most meaningful outcomes was that patients felt listened to. They had space to ask questions, be heard, and receive personalised support in person/over the phone which I believe had a real impact on their experience.
- Patients achieved brilliant outcomes by understanding their numbers and the importance of hypertension treatment. Building engagement with the community and outreach teams was also a rewarding qualitative success.
- Higher patient engagement through education and shared decision-making. Improved medication adherence, especially with regular follow-up and reviews. Better understanding of CVD risk factors and lifestyle interventions. Reduction in health inequalities, with proactive targeting of deprived or ethnically diverse groups. Improved patient satisfaction with more accessible, holistic care models (e.g. integrated lipid/hypertension clinics).

3. What do you feel were the positive outcomes for practices pharmacy team?

- We were able to engage with patients who historically have not been reached, and we also supported the completion of their Quality and Outcomes Framework (QoF) work. Personally, I had the opportunity to speak with patients at the Health Hub, deepen my understanding of background calculations, and experience the strength of collaborative working — our team functioned really well together.

- This project allowed us to support workload that is often left behind due to the overwhelming demand for GP appointments, where surgeries must prioritise urgent care. It felt rewarding to contribute to proactive, preventative patient care.
- Pharmacy teams within the surgeries were also integrated into the project to some extent. They were able to identify and case-find their own patients, using the project time to hold clinical conversations — something that likely saved their teams considerable time. Pharmacists developed and applied their clinical skills specifically in cardiovascular care, working with a cohort of patients who may not have been targeted otherwise.
- For East and Central Brighton PCN pharmacy team the key positives were working together towards a shared goal, solving problems collaboratively to improve outcomes, and focusing on reducing CVD risk and health inequalities in some of the most deprived patients in our community.
- I personally think that this project helped to bridge that gap by identifying and engaging with patients who may have otherwise slipped through the net. I hope that from the practices' perspective, this additional layer of support felt beneficial and not just in terms of workload, but also in contributing to improved patient outcomes and earlier intervention. It was a collaborative effort that I believe complemented their ongoing work.
- Improved Patient Outcomes – More patients treated to target, better hypertension control, and increased awareness of their health.
- Enhanced Team Performance – A more proactive, skilled, and engaged team benefiting from a focus on hypertension.
- Stronger Collaboration – Improved relationships with community pharmacies, outreach teams, and external agencies, leading to better patient reach.
- Efficient Systems – Optimised searches, workflows, and processes to identify and treat more patients effectively.
- Recognition and Growth – My leadership in improving care could set an example, potentially leading to more opportunities within the PCN or beyond.

Clinical Outcomes:

- Increased diagnosis rates for hypertension and hyperlipidaemia, especially in high-risk and underserved populations. This was achieved by proactively using computer search systems to identify undiagnosed individuals with raised BP and treat as appropriate.
- Improved treatment initiation rates, aligned with NICE guidelines. Using QOF data, we managed to achieve the 80% of patients treated to target, both in patients over and under 80yrs.
- Better blood pressure and lipid control, reflected in higher percentage of patients achieving BP <140/90 mmHg and more patients reaching target LDL-C or non-HDL-C levels.
- Reduction in cardiovascular risk scores (e.g. QRISK3) among project participants.
- Fewer cardiovascular events over time (e.g. strokes, heart attacks).

System-Level Outcomes:

- Improved primary care performance against QOF indicators and national CVD targets.
- Enhanced use of digital tools (e.g. remote BP monitoring, clinical dashboards).
- Greater alignment with NICE pathways and standardisation of care.
- Reduction in healthcare variation across practices, networks or ICSs.
- Efficient workforce use through task-sharing using pharmacy-led reviews.

4. What learning have you obtained through and from the project?

- This project provided valuable learning opportunities, particularly in managing more complex hypertensive patients and understanding the cardiovascular risks associated with chronic kidney disease. I developed a much stronger understanding of CKD itself and its implications. I also expanded my knowledge of lipid-lowering therapies beyond statins — such as ezetimibe — and came to better appreciate their long-term benefits.

- Through the project, I learned how to calculate QRISK scores and interpret them meaningfully, how to guide patients through home blood pressure monitoring and averaging, and how to escalate very high blood pressure readings appropriately. These were practical, hands-on experiences that helped build my clinical confidence.
- I now feel much more comfortable optimising blood pressure and lipid-lowering therapy for patients. My understanding of non-pharmacological interventions has also improved, and I've become more confident in having conversations around lifestyle and cardiovascular risk reduction. This project has really allowed me to embed a person-centred approach in my consultations, encouraging shared decision making with every patient.
- While clinically the content may not have been entirely new for everyone, it was surprising to see how many patients lacked awareness of their own cardiovascular risk factors and how to manage them. This highlighted the importance of the work we were doing.
- I've learned how to carry out a QRISK3 assessment from start to finish and have gained a better grasp of blood test interpretation, particularly around lipid profiles. I now feel more confident recognising when BP readings — either clinic or home — are out of range or concerning, and I know the appropriate steps to take.
- Beyond clinical skills, I've also grown in my ability to work as part of a multidisciplinary team and to engage meaningfully with patients. The PCN pharmacy team has a long-standing focus on cardiovascular disease, and this project has complemented that perfectly. Three pharmacists in the team are currently undertaking their non-medical prescribing (NMP) training — two of them focused on CVD medications — so this has been excellent real-world experience to support that learning.
- I was surprised to learn the amount of people who don't really know why they should be taking lipid lowering or blood pressure lowering medications.
- This project has been an incredibly valuable learning experience for me, both professionally and personally. At the beginning, there were areas I had never worked with before. For example, I had no prior experience with QRISK scoring. Through this project, I was taught how to assess cardiovascular risk, interpret scores, and understand how those figures influence clinical decisions.
- I also had the opportunity to work closely with different pharmacists, which gave me great insight into their way of thinking, how they make decisions, what they prioritise, and how they approach each patient holistically. Being able to observe this up close taught me a lot about risk criteria, guideline-based interventions, and when it's appropriate to escalate, ask for more readings, or simply offer lifestyle advice.
- Beyond clinical knowledge, I also made new connections and friendships. It taught me how to make better judgments, ask the right questions, and trust in my ability to contribute meaningfully within a multidisciplinary team.
- Early identification of hypertension:
    - Routine checks (e.g. annual reviews, health checks) are key.
    - Many high-risk patients remain undiagnosed — case-finding and audits are essential.
    - Community pharmacies and outreach boost detection in underserved groups.
- Data and Digital Tools:
    - Accurate coding and up-to-date registers are foundational.
    - Clinical tools (e.g. Ardens, UCL Partners) support better targeting.
    - Remote BP monitoring is effective, but digital inclusion needs support.
- Treatment Gaps and Optimisation:
    - Diagnosed does not equal treated — action often delayed due to clinical inertia or patient hesitation.
    - Clear protocols and pharmacist-led reviews drive improvement.
    - NICE-aligned prescribing needs reinforcing across the team.

- Multidisciplinary Approach Works:
    - Pharmacists, pharmacy technicians, admin, HCAs, and nurses add real value when empowered.

    - Task-sharing relieves GP pressure and increases reach.
    - Training and clear roles support sustainability.
- Tackling Health Inequalities:
    - Engagement is lower in ethnic minorities, deprived groups, and working adults.
    - Flexible services (virtual reviews) improve access.
    - Cultural competency and tailored messaging build trust.
- Quality Improvement in Action:
    - Small, focused changes (e.g. PDSA cycles) bring measurable impact.
    - Regular data reviews (BP/lipid targets) keep momentum.
    - Celebrating team wins boosts morale and motivation.
    - Patient empowerment.
    - Many patients still unaware of their cardiovascular risks.
    - Lifestyle advice is under-delivered but powerful.
    - Home monitoring and education improves self-management and outcomes.
- Clinical and Patient Engagement:
    - Understanding patient barriers – I gained insights into why some patients remain untreated or struggle to reach targets. Improved patient communication – helping patients understand their numbers and treatment rationale strengthened engagement with us and the surgery.
- System and Process Improvement:
    - Workflow optimisation – lessons on how to better streamline patient identification, follow-ups, and interventions were learnt in surgery, GIRFT objectives embedded, and medication review focused on.
- Collaboration and Leadership:
    - Engaging external partners – working with community outreach and pharmacies provided insights into better integration of care across the system.
- Strategic Thinking:
    - Balancing proactive vs. reactive care – recognising whether resources were best used within the practice or through wider community engagement. If we had more time to unpack this I might have wanted more time in the community engagement but this is a time sensitive project.

5. Is there anything you would have done differently?

- No, I was really happy with how the project was run and how we worked together as a team. It was a truly positive experience from start to finish. I'm very grateful for the opportunity to be part of such a dedicated and supportive team, and I've learned so much along the way.
- Understanding how to make future projects even more effective by refining strategies, thinking about how we might do this again. As I say, massive benefits to patients in the surgery but they are known knowns and I would like to target more unknown patients ideally if this was done again.
- I feel we could have improved on regular data collection and reporting against KPIs.

10. Appendix C: Patient Case Studies

Case Study 4 - January 2025:
J, 35 year old male. Ethnicity listed as White British. On the hypertension register since 2022. Major active problems include anxiety, depression, ADHD and PTSD.

J booked an appointment at a PCN CVD clinic via an Accurx text, but did not attend. He responded to a text message offering support to rebook and requested a call in the afternoon. He answered an afternoon phone call and a new appointment was booked. J was very late for his clinic appointment but the HCA was still able to see him that day. He had blood tests and his BP checked. As his blood pressure was high, J agreed to complete a home BP diary via text link. An appointment with a PCN pharmacist was booked. J didn't complete his blood pressure diary in time for his appointment with the pharmacist. The pharmacist talked with J about his difficulties monitoring his blood pressure and remembering to take his meds. J felt a bit better knowing he was not the only person to find these things difficult and was able to recognise the importance of monitoring and managing his blood pressure. He agreed to complete four days of home blood pressure checks via text link and have a follow up appointment in three weeks. The PCN texted J after the link expired. He explained that he had completed four days of BP readings but had not managed to share them before the link expired. J shared his readings via a phone call before his next pharmacist appointment. In this telephone appointment J agreed to a change in hypertensive treatment and talked with the pharmacist about strategies to help him remember to take his medications every day. A month later, J completed another four day home BP diary to review the impact of new medicines, and has asked to share his BP readings in a phone call.

Case Study 5 - January 2025:
A, 40-year old female. Ethnicity listed as Mixed British. On the hypertension register since 2021. She is dyslexic. Major active problems include asthma, migraines, and intrusive thoughts and self-harm. A was supported to book an appointment in a PCN CVD clinic. She had blood tests and a BP check showed raised blood pressure. She talked about her difficulty losing weight and was referred to the PCN Weight Management Hub. A explained that she found text links very difficult to use. She was given a four day home blood pressure diary to complete and post back before an appointment with a PCN pharmacist. A found it difficult to record her home blood pressure, so her pharmacist appointment was rescheduled and she was given support via phone and text to get her diary completed. She told the pharmacist that she had not been taking her medications regularly. She had not yet engaged with the weight management service. She agreed as a first step to make sure she took her current blood pressure medicine every day and to follow up on the support from the Weight Management Hub. A new HBPM diary was sent to A to complete before her next appointment. A lost this before she had a chance to complete it. Again the PCN offered calls and texts to support her to record her BP over four days. She was very proud to share over the phone that her blood pressure was now in range. A had a final appointment with the pharmacist. She said she felt great knowing her blood pressure was so much improved. She has been taking her medicines every day and engaging with weight management support. The CVD project support helped her stay focused on managing her health and as a result she said feels much better about herself.

Case Study 6 – April 2025
D, 40 year old male. Ethnicity listed as Mixed British. Major active problems include hypercholesterolemia. No history of hypertension. D's hypercholesterolemia medication was reviewed by a PCN pharmacist as part of the CVD project. The pharmacist noted that there were no

recent blood pressure readings on record for this patient. D said he didn't have time to monitor his blood pressure at home or get a reading at the GP or pharmacist. The patient engagement team were asked to offer D support to share up to date BP readings.

D didn't answer the first BP support call, so a text was sent offering support with blood pressure monitoring and giving some information about why it was important. D answered the second call. He said he had just bought himself a blood pressure monitor because 'you guys seem to think it is such a good idea.' He went on to say he still felt reluctant to check his blood pressure and was definitely not happy to use a text link to share any readings. After talking through his concerns D decided to complete a 4 days of BP diary. Another phone call was planned so D could easily share his readings.

D called back less than an hour later. He had done two reading and thought that these seemed to be rather high. The first was 208/119, the second 210/120. After the call, D understood he would need to see a doctor that day, possibly at A &E. The pharmacy team arranged a same day GP appointment. The GP started Daniel on anti-hypertensive medication straight away and he was seen in hospital the following day.

D called 2 weeks later to share his recent home blood pressure readings – the average was 130/85. D also wanted to say thank you to the team – "I think you guys saved my life." He had since found out that two of his grandparents died young from stroke and heart attacks. "It made such a difference to have people reaching out, caring about my wellbeing. I'm definitely going to keep checking my blood pressure and make sure I have regular appointments."

11. Appendix D: Project Costs

East and Central Brighton PCN

Adjusted population January 2025: 81,124	
Costs	**£108,572**
% of total cost	54%
Breakdown of costs	
Set up and reporting	
IT and printing	£3,134
Data and reporting	£4,250
Planning and liaison	£17,034
Sub Total	**£23,944**
Delivery	
Pharmacist team hours including project management	£57,979.
HCA clinics and visits	£6,219.
Admin and outreach	£15,417
Sub total	**£84,628**

Deans and Central Brighton PCN

Adjusted population January 2025: 36,026	
Costs	**£47,162**
Percentage of total cost	23%
Breakdown of costs	
Pharmacist team & admin	£36,355.00
Data, reporting and project management	£10,806.49

Trust for Developing Communities

Costs	£45,459
% of total cost	23%
Breakdown of costs	
TDC	£20,459
Bridging Change	£5,000
BUFCP	£5,000
Community Groups	£5,000
Healthwatch	£5,000
Switchboard	£5,000
Total	**£45,459**

12. Appendix E: Resources

HEALTHY HABITS

HOW CAN YOU LOOK AFTER YOUR HEART HEALTH?

Smoking can increase your heart rate and blood pressure. It makes blood vessels narrower than normal which can lead to heart disease

Stopping smoking can be tough and it is normal to experience some of these symptoms: cravings, feeling restless or irritable, trouble concentrating or sleeping, anxiety and an increase in appetite

We know that this sounds worrying, however many people find that these symptoms disappear completely within four weeks and you will feel better in the long term

Did you know?

Within six hours of stopping smoking your heart rate will slow down and your blood pressure will become more stable

Within one day of stopping smoking your blood stream will almost be nicotine free, the level of carbon monoxide in your blood will have dropped, and oxygen will be reaching your heart and muscles more easily

Within one week of stopping smoking your sense of taste and smell may be better

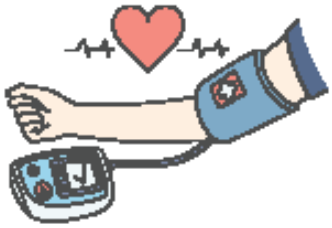
Within three months of stopping smoking you will be coughing and wheezing less, your immune system will be better, circulation to your hands and feet will have improved and your lungs will be working better

Within six months of stopping smoking your stress levels are likely to have dropped, and you are less likely to be coughing up phlegm

After one year of not smoking your lungs will be healthier and breathing will be easier than if you'd kept smoking

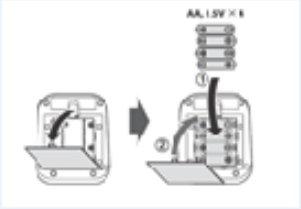
Ask us for more information on quitting smoking!

TAKING YOUR BLOOD PRESSURE AT HOME



1) Setting up the blood pressure machine

If you are using the blood pressure machine for the first time you will need to put the batteries into the machine:



You now need to connect the cuff to the machine.

This is by connecting the small plug at the end of the tube (which is attached to the cuff) into the blood pressure machine:

2) Taking a reading

It is helpful if you can rest for a few minutes before taking a reading.

Put the cuff on your left arm (if possible) and always try to use the same arm. The tube should be above the inside of your elbow:

3) Tips for taking a reading

- Sit upright with your back supported (1), feet flat on the floor and legs uncrossed (3)
- Rest your left arm on a flat surface with the top of your arm level with your heart (2)
- Don't talk whilst doing a reading
- If you can, please take 3 readings, 1 minute apart

4) Reading the result

When you press the START/STOP button, the reading will start and the machine will make a noise.

When the machine has finished taking the reading, it will show the blood pressure measurement and pulse on the screen:

This reading is 140/88 and the pulse rate is 86.

Example of Easy Read CVD Invitation letter

NHS

Dear *Patient Name*,

	You are invited to book a Heart Health appointment
	At St. Peter's Health Centre
	Please call to book an appointment. 07869 684074

NHS

	You had a High Blood Pressure Reading
	Your appointment is to help you stay healthy
	We will check your Blood Pressure
	We will take a Blood Test
	Tell us if you are worried about blood tests

NHS

	We will check your weight
	We will ask you about your health
	We will ask you about your family's health
	You can ask a family member, carer or friend to come with you.

The Cardiovascular Project Team

Example of 4 day home blood pressure diary

Home Blood Pressure Diary

How to take your blood pressure

- Sit still with your arm resting on a table.
- Try not to talk when taking your blood pressure.

- Put the cuff around your arm.
- Press the button on the machine to start.
- The cuff will tighten around your arm.
- It will take one or two minutes.
- The cuff will loosen when it is finished.

- Look at the numbers on the machine.
- The numbers circled in red are your blood pressure.
- They would be written as **118/78** in your chart.

Home Blood Pressure Diary

- Please check your blood pressure for **4 days**
- Take **2 readings,** in the **morning** and **evening**.
- **Write** your readings in the blood pressure chart
- Please take your medication as normal, unless you have been told not to.

If two or more blood pressure readings are over 170/115
- **Contact your Doctor or call 111 straight away.**
- **You need an urgent same day appointment**

At the end of the 4 days please

- **keep your blood pressure chart**
- text 07869 684074 to share your readings
- **or** email a copy to sxicb-bh.ecb-pcn-team@nhs.net

If you need help contact **Kathy** on **07869 684074**
(Between 9am & 4:30pm, Monday -Thursday)

Home Blood Pressure Diary

Patient Name:

GP Practice:

Blood Pressure Chart

	Morning			Evening		
	1st	2nd	pulse	1st	2nd	pulse
Example: 29/06/22	*118/78*	*118/78*	*70*	*118/78*	*118/78*	*70*
Day 1 Date:						
Day 2 Date:						
Day 3 Date:						
Day 4 Date:						

Please keep this chart