Final

British Heart Foundation

Blood Pressure Award Programme Evaluation – Phase 2 report

October 2021

CordisBright

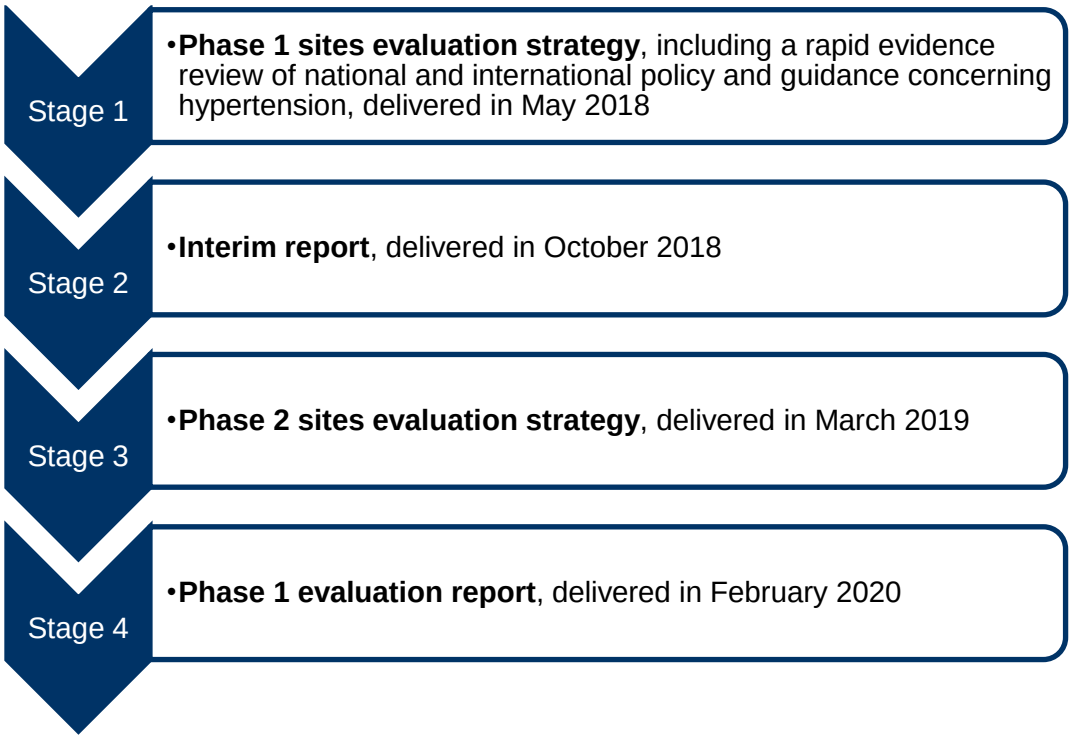
Table of contents

1 Introduction and Methodology

1.1 Introduction

The British Heart Foundation (BHF) commissioned Cordis Bright and Cobic to conduct an independent evaluation of its Blood Pressure (BP) Award Programme.

The evaluation began in September 2017, and up until the beginning of the Covid-19 pandemic in March 2020, had delivered the following outputs:



These outputs are available from the BHF on request.

From March 2020, programme sites were largely unable to deliver funded activity as a result of the Covid-19 pandemic. As a result, the BHF asked for evaluation activity to be paused.

In April 2021, the BHF took the difficult decision to cease the programme due to the challenges faced by the BHF and programme sites as a result of the pandemic. Following this decision, it was agreed with the BHF that a final evaluation report would be produced based on the following criteria:

- A desire to capture relevant learning in relation to the implementation and delivery of the programme prior to March 2020.
- An approach that builds on evaluation work done to date, including that presented in the Phase 1 sites final report.

- An additional focus on capturing learning from sites' responses to the pandemic, including where blood pressure awareness-raising activity has continued in alternative forms.

- A focus on qualitative consultation and minimising the research burden on sites and steering group members.

This is the Phase 2 evaluation report, which presents a summary of the process and delivery of the Blood Pressure Award Programme, the sustainability and future plans of Phase 2 sites, outcomes and impacts achieved by the programme, and key learnings and recommendations for the BHF and programme sites.

1.2 About the BHF Blood Pressure Award Programme

1.2.1 Overview

This section provides an overview of the BHF Blood Pressure Award Programme, including a summary of the funded sites, and the programme's theory of change.

1.2.2 About the programme

The BHF Blood Pressure Award Programme provided funding to individual sites across the UK to develop, test and implement into practice approaches to detecting people with high blood pressure. The aims of the programme[1] were to:

- Increase the detection and management of people who have undiagnosed hypertension.

- Increase accessibility to blood pressure testing in wider community settings.

- Increase support for patient self-management and self-testing of blood pressure in the population to become routine practice.

- Add to the evidence base on effective detection and management of high blood pressure and demonstrate the impact of the interventions through external evaluation.

The programme had three key objectives:

- To develop and test innovative approaches to detecting people with high blood pressure and ensure a pathway to facilitate medical and behaviour change support is in place.

[1] Source: BHF Briefing Document: Blood Pressure Award Programme – Round 2

- To target areas of high social and health inequality, with high prevalence of cardiovascular disease (CVD) and higher than average CVD and premature mortality rates.

- To disseminate best practice and promote widespread adoption of the models to increase the number of people tested and treated for high blood pressure.

Sites could apply for funding of up to £100,000 across two years. There are also two phases of funding across two time periods as summarised below.

Phase 1 sites (launched from October 2017)	Phase 2 sites (launched from April 2019)
• Bradford • Cheshire & Merseyside • Haringey & Islington • Lambeth[2] • Leeds • Royal Borough of Greenwich • NHS 24/Lothian/Lanarkshire/Western Isles (WI)	• Cheshire and Merseyside (this site was awarded funding for both Phase 1 and Phase 2) • Hertfordshire and West Essex CCG • East Riding of Yorkshire • Gloucestershire • Lancashire • Newcastle Gateshead • Northern Ireland's Old Library Trust • Telford and Wrekin

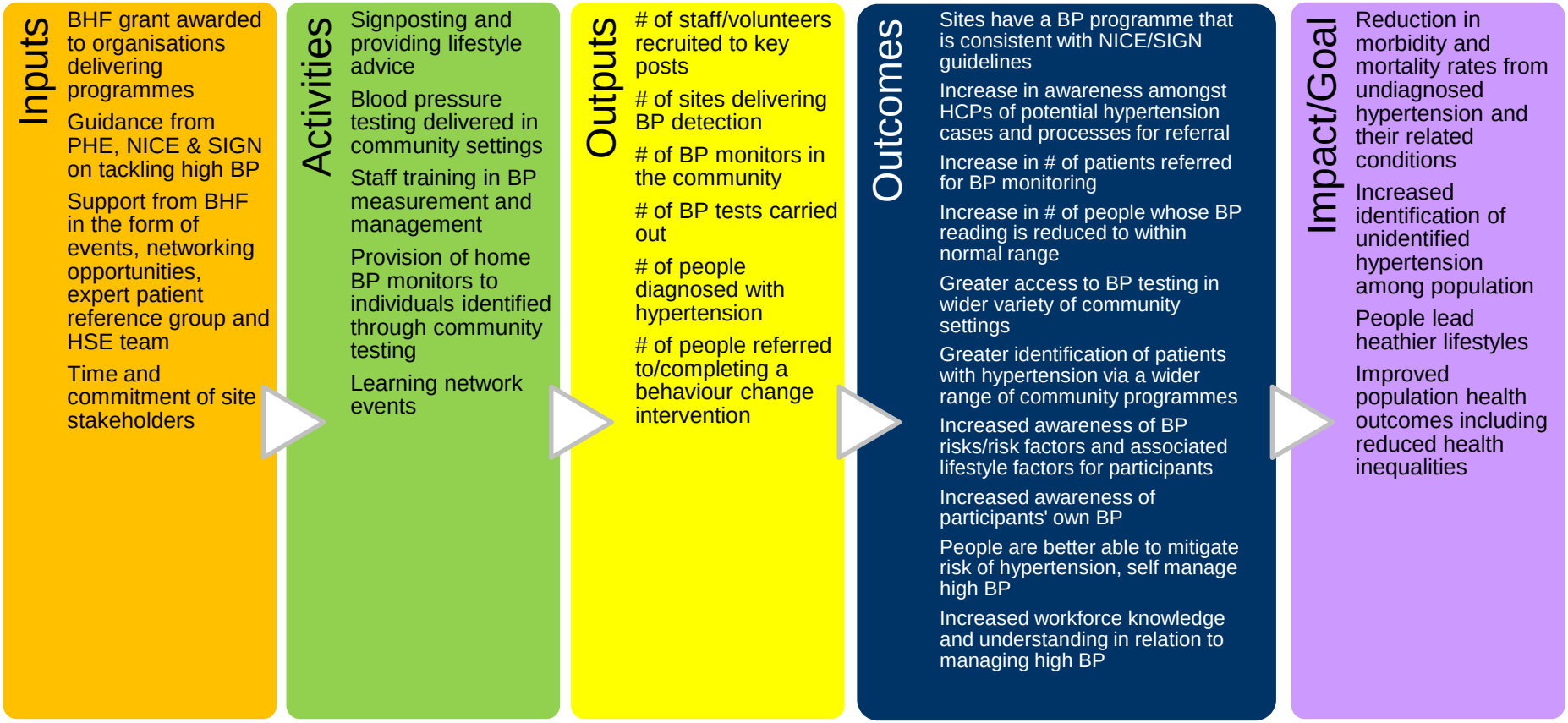
Details of the intended delivery models for each site, alongside logic models and evaluation frameworks for each site, are provided in the evaluation strategy documents (see section 1.1).

1.2.3 Theory of change

A revised theory of change for the Blood Pressure Award Programme, summarised as a logic model, was produced by the evaluation and is shown in Figure 1. This was developed following workshops with individual sites and reflects the intended outcomes of projects as reported by site stakeholders

[2] The Lambeth site experienced a number of delays in establishing its testing activity, and testing activity only began in late 2019, i.e. over two years after funding was awarded. As a result, the Lambeth site has been treated as a Phase 2 site for the purpose of the evaluation.

Figure 1: Programme theory of change



1.3 About the evaluation

The Blood Pressure Award Programme ended early due to the Covid-19 pandemic. As a result it was agreed that rather than focusing on impact and outcomes achieved by the phase 2 sites, the final evaluation should focus on capturing relevant learning in relation to the implementation and delivery of the programme, including sites' responses to the pandemic.

The impacts and outcomes achieved by the BHF BP Award programme overall are outlined in the Phase 1 Evaluation report.

We hope that these findings will help to inform future funding programmes and community-based public health initiatives.

1.4 Methodology

This evaluation report is based on the following methods, as agreed with BHF colleagues.

Site lead consultation

To capture qualitative data regarding the implementation of the programme and site activity during the Covid-19 pandemic, we conducted in-depth interviews with Phase 2 site leads.

These interviews were conducted using a topic guide agreed in collaboration with BHF colleagues. Interviews focused on:

- The application and approval process for Blood Pressure Award Programme funding.
- Challenges faced during implementation and delivery, and how these were overcome.
- Approaches to delivering community-based public health initiatives, including during the pandemic.
- Plans for the future and how these have been shaped by their experiences of the Blood Pressure Award Programme.

12 individuals from nine sites were invited to participate in an interview by email, with follow-up emails sent where necessary. In total, ten individuals from eight sites were interviewed. Unfortunately, site leads from the Lambeth site was unable to participate in an interview.

Steering group consultation

We also conducted in-depth interviews with members of the programme steering group. Again, the topic guide for these interviews was agreed upon in collaboration with BHF colleagues. Interviews focused on:

- Steering group members' views on the implementation, delivery and impact of the programme.
- Identifying key challenges faced by the programme, and how these may be overcome.
- Wider approaches to delivering community-based public health initiatives and how these may provide insights for future funding programmes.

We aimed to speak with four steering group members in total. The BHF identified five potential interviewees from the steering group, and in total three interviews were conducted.

A note on terminology

Throughout this report, the following terms are used to refer to interviewees:

Site leads refers to the eight site leads from seven Phase 2 sites who were interviewed as part of the final evaluation.

Steering group stakeholders refers to the threesteering group members interviewed as part of the final evaluation.

Stakeholders include both site leads and steering group stakeholders.

Previous evaluation activity

As well as the qualitative evidence captured by interviews with site leads and steering group members, this evaluation report draws on the wide range of evidence captured as part of previous evaluation activity. This is detailed in the evaluation strategy documents and the Phase 1 sites final report and includes site visits and observation, consultation with stakeholders and programme participants, reviews of programme and site documentation, learning network events, and a rapid evidence review of national and international policy and guidance concerning hypertension.

Learning Network event

The findings from the draft evaluation report were presented at a virtual Learning Network event in September 2021. Further learning from programme sites regarding their experiences of being involved in the Blood Pressure Award Programme shared prior to and during this event, as well as feedback from participants on the key lessons, has been incorporated into the final version of this report.

1.5 Challenges and limitations

There are a number of challenges and limitations for the evaluation that should be taken into account when considering the findings presented in this evaluation report:

- **Comparing different approaches between sites:** Each site is based on a unique delivery model, working with a unique group of delivery partners and providing testing to a unique group of participants. Whilst there are similar characteristics shared across sites, due to the differences between delivery models, it is not possible to draw direct comparisons between sites.

- **The impact of the Covid-19 pandemic:** As detailed in sections 1.1 and 1.3, the Covid-19 pandemic has significantly impacted the implementation and delivery of the programme, and subsequently the evaluation. Phase 2 sites were not able to fully deliver their models as intended, and as such any findings about their process and impact must be consider in this context.

- **Stakeholder consultation sample size:** As detailed in section 1.4, it was not possible to interview site leads from Lambeth and only three out of the intended four steering group members were available for interview. Therefore, the qualitative findings in this evaluation report do not reflect operation in Lambeth and do not reflect the views of all stakeholders involved in the delivery.

1.6 Structure of this report

This report is structured as follows:

- **Section 2** explores the implementation, process and delivery of Phase 2 sites.

- **Section 3** discusses the sustainability and future plans for blood pressure community testing.

- **Section 4** examines the outcomes and impacts achieved by the Blood Pressure Award Programme.

- **Section 5** summarises the key lessons learned for the BHF and local sites.

- **Section 6** presents a series of recommendations for the BHF and local sites to consider when delivering future programmes related to blood pressure and/or community testing initiatives.

2 Process and delivery

2.1 Overview

This chapter explores the implementation, process and delivery of the BHF BP Award Programme in seven Phase 2 sites. It covers delivery until March 2020, at which point the COVID-19 pandemic halted delivery in all sites. The impact of the pandemic and subsequent lockdowns is examined in section 2.8

2.2 Programme inputs

The Phase 2 Evaluation Strategy outlines the programme inputs for each of the local sites. Common inputs across each site included:

- **Funding:** funding from the BHF over two years.
- **Equipment:** BP testing equipment.
- **Training:** training and education events.
- **Development:** pathways for referrals following high BP readings; Information governance/info-sharing agreements.
- **Time in-kind** from all partner organisations for project set-up, monitoring, steering group, etc.

Examples of other inputs in at least two or more sites include:

- Additional funding from other sources.
- Marketing/public awareness campaign and information documents (including cards to record BP).
- Payments to providers for testing.
- Data collection software.
- Engagement and support from Primary Care colleagues.

2.3 Site delivery models

When applying for funding from the BP Award Programme, sites were expected to detail a delivery model for detecting high BP in their area, with a target of 10,000 BP tests to be delivered over the two-year funded period. Sites were expected to demonstrate commitment to developing delivery models consistent with national guidelines (e.g. NICE/SIGN). These guidelines are explored in the hypertension rapid evidence assessment provided alongside the evaluation strategy (see section 1.1).

Figure 2 below draws out the common characteristics between the models for the seven Phase 2 sites. This shows that across Phase 2, sites commonly intended to deliver opportunistic BP testing in community settings, provide BP and lifestyle

advice to participants, and train staff to support this. Site models differed in the partners with whom they worked with to deliver testing, split between either voluntary and community sector (VCS) partners and/or local pharmacies.

Sites used a mixture of referral pathways following a high BP test reading. These included signposting to community pharmacies for further testing, referral to a BP Advisor, referral to primary care, and referrals to lifestyle intervention services (in some cases these referrals followed the provision of home BP monitors). In many sites, this pathway ended with an onward referral or signposting to a GP. One steering group member suggested that there may be further opportunity to explore the development of effective community-based pathways for diagnosing and managing high BP (i.e., where a high BP test results in a referral to community-based services rather than directly referring to a GP for diagnosis). This could help ensure there are always appropriate pathways for onward referral. In all cases, the GP would lead ongoing management and support of the patient following diagnosis.

Further details of individual site delivery models are provided in the Phase 2 Evaluation Strategy (see section 1.1).

Figure 2: Characteristics of site models

Sites ➔ Characteristics ⬇	Cheshire and Mersevside	Gloucester	Hertfordshire and West Essex	Hull and East Ridina	Lancashire	Lambeth	Newcastle Gateshead	Northern Ireland	Telford and Wrekin
Funding to provide new BP monitors	✓	✓	✓	✓	✓	✓	✓	✓	✓
Delivering opportunistic BP testing in community settings	✓	✓	✓	✓	✓	✓	✓	✓	✓
Working with VCS partners to deliver BP testing	✓	✓	✓		✓			✓	
Working with local pharmacies to deliver BP testing	✓	✓	✓	✓	✓	✓	✓		
Working with local statutory partners to deliver BP testing	✓		✓		✓	✓			
Providing BP management and lifestyle advice to participants	✓	✓	✓	✓	✓	✓	✓	✓	✓
Training staff to deliver BP testing and provide lifestyle advice	✓	✓	✓	✓	✓	✓	✓	✓	✓
Developing a diagnosis pathway for people identified as having high BP	✓	✓	✓	✓	✓	✓	✓	✓	✓

2.4 Target cohorts

The target cohort of the BHF BP Award Programme was those with undetected high blood pressure, especially those at risk and from disadvantaged groups. At risk people are likely to be people who do not normally engage with healthcare and/or live in areas of high social and health deprivation, where there is a high prevalence of cardiovascular disease (CVD) and higher than average CVD and premature mortality rates.

Local sites were able to decide which criteria to set to reach these target cohorts. For many sites, the main criterion was simply anyone who had not had a BP test in the last 12 months.

Within this cohort, most site leads reported that they hoped to capture specifically males aged 40-60 and people from deprived areas, as these people are less likely to have received a BP test in recent years. In order to ensure that BP testing was made available to as wide a range of people at risk of undiagnosed hypertension as possible, sites did not have firm eligibility criteria, but rather targeted various cohorts through the design of their testing models.

Some sites offered more targeted testing based on demographic factors that put the cohort at higher risk of hypertension.

Good practice example: targeted testing

All local sites were required to deliver testing in areas with higher than national average rates of CVD and premature mortality rates. As part of this targeting, Gloucestershire used data to identify an area with a higher prevalence of inequalities that might lead to high BP (such as obesity, BAME communities, material deprivation, and smoking). A pre-programme audit further revealed a gap in this area between observed hypertension (gathered via the Quality and Outcomes Framework database) and expected numbers of people with diagnosed hypertension.

In Cheshire and Merseyside, project leads aimed to target working-age males under the assumption that this group may not be able to access traditional models of testing with primary care due to work and time commitments. They therefore focused on delivering tests in the workplace.

As a result of the criteria for testing being so broad in many sites, a large number of tests needed to be administered in order to detect each case of high BP. Some site leads felt that more targeted testing of high-risk groups might have been a more effective use of resources. In contrast, others felt that it was appropriate to target a large number of people to spread awareness of prevention and healthy lifestyles. For example, one site lead said:

> *We kept a very broad approach to finding people, as there is a recognition from everyone we speak to that when you're testing people for BP, it isn't just about identifying hypertension…prevention and detection go hand in hand. A lot of the services we've seen*

> *designed in the past have been too strict on inclusion criteria, because they probably thought it was mainly about detection…By being restrictive in your inclusion criteria, you're missing out on the value you could bring by having conversations with 30-year olds about CVD prevention."*
>
> Phase 2 site lead

2.5 Programme management

2.5.1 BHF national management of BP Award Programme

At a national level, stakeholders considered the BP Award Programme to be very well-managed by the BHF. They reported that the national team were supportive, organised and proactive in problem-solving. They also felt that the BHF's response to the COVID-19 pandemic was appropriate (please see section 2.8 for more detail).

In particular, site leads highlighted that having a named BHF regional representative was particularly useful in terms of:

- **Acting as a critical friend**. One site lead commented that this helped ensure they articulated value for money and evidenced and explained decision-making and programme activity.
- **Providing local knowledge and support while** also having a fresh, expert perspective slightly removed from the politics and process of the systems in which local site leads were working.
- **Brokering connections** with partners from other organisations that the programme team could liaise with to deliver testing.

This relationship was also considered an asset for the BP Award Programme and as a point of contact for any future activity relating to BP. One site lead reported that the relationship with the BHF and the BP Award Programme had already provided a foundation for spin-off BP projects:

> *"Huge credit goes to what the BHF has enabled us to do. We have all these spin-offs now which wouldn't have happened without the foundations laid by the project. [We are] incredibly grateful for their support…[we] consider them a core partner in what we are doing here. I would say that if they are not at the table, it is a real gap."*
>
> Phase 2 site lead

The learning networks that were organised and facilitated by the BHF were also highlighted as supportive by stakeholders in building relationships and sharing learning among the sites.

One challenge identified by site leads with the BHF programme management was that the funding application, reporting and data collection/submission

process was often time-consuming, with some site leads querying whether it was proportionate to the size of the resource available through the bid. However, other site leads reported that although these processes were demanding on their time, they were effective in helping clarify thinking around the project and outlining expectations with data collection.

2.5.2 Programme management in local Phase 2 sites

Figure 3 outlines the programme management structures in each of the Phase 2 sites. The most common organisation to be given the remit of managing the programme were Clinical Commissioning Groups (CCGs) or Public Health Teams.

Although it is difficult to draw correlations between management structures and outcomes (due to the short lifespan of the project and its disruption by the COVID-19 pandemic limiting the value of outcomes data), site leads within Public Health Teams generally reported better relationships with community pharmacy partners than those based in CCGs. This is discussed in more detail in section 2.6.

Figure 3: Programme management structures in Phase 2 sites

Area	Programme Manager	Organisation
Cheshire and Mersey Side	Public Health Consultant and BP lead	Champs Public Health Collaborative (CHAMPs) Support Team
Gloucester	Senior Improvement Manager in the Circulatory Diseases Group	NHS Gloucestershire CCG
Hertfordshire and West Essex	Cardiovascular Programme Manager and Project Manager within Project Manager Office	East and North Herts CCG
Hull and East Riding	Commissioning manager within the Planned and Primary Care team	East Riding CCG
Lancashire	Senior Public Health Practitioner	Lancashire County Council
Newcastle Gateshead	NHS Health Check and LTC Programme Lead and LA advisor	Newcastle Public Health Team Gateshead Public Health Team

Area	Programme Manager	Organisation
Telford and Wrekin	Project Manager	Telford and Wrekin Public Health Team

Site leads reported that a dedicated project team was important in ensuring sufficient resources and capacity to drive the service. Locating site leads in well-established teams with existing relationships with organisations in the community was also valuable in mobilising the projects. In particular, the project management and administration support provided to some site leads by their wider team was highlighted as a key enabling factor to successful implementation. In sites without a specific project team, leads reported that there wasn't sufficient resource or capacity to drive the service as effectively as possible, which at times lead to delays with implementation and delivery.

Good practice example: CHAMPs support team

In CHAMPs, the BP Award Programme was placed within the remit of the CHAMPs support team. Site leads reported excellent programme and project support from this team with administration, project management, and processes. They suggested that this was "incredibly helpful", and a key factor in the successful mobilisation of the project, as was the recruitment of project leads with previous experience of delivering similar initiatives.

They also reported that the CHAMPS Public Health Collaborative has been actively engaged with Public Health activity (including CVD-related activity) and relevant partners for 15 years, and so there were existing infrastructure and relationships in place that the programme was able to tap into.

Other aspects of programme management highlighted as useful by site leads included:

- Clarity around expectations and co-production with delivery partners to get partners on board.
- A dedicated steering group (with skilled representatives from a range of partners) to help foster positive partnership working. Including GPs and health professionals in this steering group can also help encourage engagement from primary care (see 2.6.3).
- Dedicated project management for the duration of the project, not only for initial set-up.
- Establishing key stakeholders and partners, and corresponding roles and responsibilities, early on.
- Use of community partners with a larger team who are able to designate responsibility for running testing to a single staff member.

2.6 Partnership working

2.6.1 Working with community pharmacies

There were mixed experiences of working with community pharmacies both across and within the different sites. Some site leads in areas where payment was attached to the number of tests delivered reported challenges in convincing some community pharmacies that the model was financially sustainable in terms of remuneration. Community pharmacies were often reluctant to commit staff and capacity without reassurance of how much they would be paid.

This challenge was enhanced in Newcastle Gateshead, where one funding pot was available for all positive tests, meaning that it was not clear from the beginning of the project how much money was attached to each test. This also disincentivised community pharmacy staff from recording a normal BP reading in PharmOutcomes, which may have caused over-reporting in the percentage of patients who were identified as having elevated BP readings in Newcastle and Gateshead. Members of the BHF BP Award Programme steering group suggested that relationships and buy-in from community pharmacies could have been improved by:

- **Tailored, operational support from the BHF** at an earlier stage of the process for community pharmacies. This could take the form of individual conversations or visits to community pharmacies from a BHF representative.

- **Regular meetings, updates and dialogues** between the BHF and community pharmacies.

However, other sites reported that community pharmacies were engaged, well-equipped to deliver community testing, and could do so with relatively little support. This was partly due to existing links they had with the local population. In these sites, engaged Local Pharmaceutical Committees (LPCs) were important in encouraging and facilitating the engagement of community pharmacies with the project. There were examples of LPCs supporting with recruiting community pharmacies, acquiring contracts, and delivering training. Site leads reported that LPCs were better placed to liaise with community pharmacies than site leads because of their existing relationships with community pharmacies.

For example, one site lead reported:

> *"We have a brilliant LPC… they are very innovative, they want to be engaged in the agenda. It fitted their Healthy Living pharmacy philosophy and fitted into their remuneration model. They were very open and very fast-moving in terms of translating an idea into a reality. This was down to some key individuals who are just very good at that. They were a joy to work with."*

Phase 2 site lead pre-existing links in the steering group/project team also supported sites to engage well with community pharmacies.

Project team members with pre-existing links with pharmacies, and the development and sharing of promotional materials were also identified as helpful in engaging pharmacies.

2.6.2 Working with other delivery partners

There were mixed experiences of partnership working with delivery partners across the Phase 2 sites. Some site leads were able to give positive examples of partnership working, including working with local community groups and convening a multi-agency steering group to monitor project performance, identify challenges, and make improvements.

Good practice example: Partnership working with community groups

In Gloucester, community volunteers worked closely with local community groups, community and religious leaders, sports clubs, and social enterprises (among others) to deliver BP testing in the community. In particular, they worked with a 'Friendship Café' to offer testing, which works with over 40 community organisations, allowing testing to be delivered to a wide cohort of people.

Site leads reported that engagement from these groups was important in delivering the project, and that the new relationships formed with these partners was one of the main positive outcomes from the programme.

Across other sites, two main challenges to partnership working were identified, which limited the number of tests administered:

- **The limited capacity of staff** to administer tests (exacerbated during flu season and the beginning of the COVID-19 pandemic when other priorities took precedence.)

- **The confidence of staff/volunteers** in administering tests. Despite receiving training, some assistants in community pharmacies and some community volunteers were not comfortable administering BP tests, engaging the patients, or answering their questions. High turnover of staff and limited resources to re-run training also meant that knowledge was sometimes lost, and new starters were less confident in administering tests. Some sites suggested further support from the BHF with ongoing training and tools as something that would be helpful in supporting sites to increase confidence. This is discussed further in Chapter 6.

Some site leads also suggested that uncertainty around long-term funding of VCS organisations limited the extent to which longer term planning for delivery could take place with these partners.

2.6.3 Primary care data collection

Site leads reported that PharmOutcomes was effective and useful in recording testing data internally and with testing partners but collecting data from primary

care that captures the pathway of the patient after testing was an ongoing challenge in almost all sites. This makes it challenging to ascertain to what extent the programme identified undiagnosed, “at-risk” groups, and therefore whether inequalities are being addressed effectively.

This was because GPs had limited capacity to collect and share data, and some demonstrated resistance to having outside input into patient records. Site leads also suggested that even when GPs are willing to share data, this requires a large amount of resource, trust, and goodwill from GPs, which is not always readily available.

Furthermore, some site leads suggested that even if GPs were able to provide primary outcomes data, the coding of this varies across practices, so additional quality assurance would be required to ensure it was consistent and useful It is also important to recognise that a participant’s full journey from initial testing to receiving a formal hypertension diagnosis may have extended beyond the timescales of the programme, and so would not have been captured in programme monitoring data. Steering group stakeholders also reported that often information governance issues limited data-sharing capabilities.

It should be noted that based on stakeholders’ and evaluators’ experience, these technical, financial and motivational challenges are systemic across the sector, and are common for most projects attempting to collect primary care data. As such, there is limited influence that the BHF or individual sites can extend to address these challenges.

Having said this, stakeholders suggested some possible methods sites and the BHF could use to support data sharing, including asking the CCG to quality assure and standardise variable coding systems across the system, providing ring-fenced funding to support GP data collection, embedding data collection expectations and processes as early as possible. Using locally trusted organisations with existing relationships with primary care (such as Public Health teams –see section 2.5.2) to explain the importance of the project to GPs and build on existing relationships may also support engagement. This had been successful in some sites, such as Northern Ireland, where the project team had existing good relationships with GPs due to social prescribing partnerships.

One site in Phase 1 of the evaluation also overcame the issue of sharing data with GPs by using the SystmOne, a clinical software system. However, primary care software systems vary even within local authority areas, and so there is unlikely to be a single solution to this challenge.

2.7 Public engagement

Site leads and stakeholders reported mixed success in engaging with their target cohorts. Some examples of effective methods of engaging with the public and less effective methods are outlined in Figure 4. These mainly focus on implementation and delivery factors; for more information about best practice and public engagement around diagnosing hypertension, drug treatment, lifestyle

interventions and patient education, please see the Hypertension Rapid Evidence Review provided in the Phase 1 Evaluation Strategy Report (see section 1.1).

Figure 4: Examples of methods used to engage the public in community testing

Effective methods	Less effective methods
• Translating a full range of materials into all locally used languages. • Utilising BHF branded marketing and communication. This gave the programme legitimacy as the BHF is a well-known organisation, separate from statutory or government organisations. that people trust. • When testing is taking place at an event, advertising the fact that testing will be available in advance. • Workplace testing at sites such as offices where people are already on-site for extended periods of time. • Digital and hard-copy promotional materials, such as photos and 'top tips' for delivery partners to increase uptake . • Testing in areas with high footfall • Using delivery partners that are well-known and respected by the public, and have experience of delivering similar initiatives. • Working in partnership with a range of other organisations. This can also increase resilience of the programme in case challenges are encountered with specific delivery partners.	• Testing at sites where people might feel time- pressurised, such as factories where it is not possible for employees to take extended breaks or at football matches. • Testing at outdoor events where electronic data recording of participants' details and test result may be less reliable due to connectivity issues. • Testing for multiple conditions at the same time as BP, as this can take longer and deter the public from engaging (and staff from delivering testing). However, there are also likely to be benefits to taking a holistic approach to risk assessment and intervention.

2.8 The impact of COVID-19

All site leads reported that the COVID-19 pandemic and subsequent lockdowns ultimately resulted in all activity relating to the BP Award Programme being ceased. This was generally because:

- Face-to-face contact with the public was not permitted due to lockdown measures.
- Resources were redirected into the COVID-19 response.
- For delivery models based on testing at community events or workplaces, venues and offices were closed and events cancelled.

When lockdown restrictions eased and testing was permitted to continue, the projects continued to experience challenges because many staff members who had previously been delivering testing or working on the project being made redundant, seconded, or re-routed into COVID-19 response work.

The momentum lost by the pausing of the programme also made it difficult to re-engage partners and resume testing, particularly during flu season (when administering flu vaccines was a particular priority). Staff and public safety considerations, such as sufficient use of Personal Protective Equipment (PPE), cleaning protocols, and avoiding creating footfall and crowds, also meant that the decision was made not to resume testing following the easing of restrictions in some sites.

Due to the extent and pervasiveness of these challenges, in general, few changes were made to delivery models during the pandemic. However, some examples of continued activity include:

- Redistributing BP monitors/kiosks to primary care or staff wellbeing areas
- Following up with members of the public who had been lent monitors and taking them through the end of their process with their GP.
- The steering group in one area continued meeting virtually once a quarter to ensure momentum was sustained and activity could resume after the pandemic.
- Continued BP awareness-raising community online (particularly through social media) and in the community.
- ‘Rent-a-cuff’ initiative, whereby people were invited to take a monitor home to measure their BP.

Rent a cuff initiative.

In Northern Ireland, the BHF BP Award programme was delivered through Healthy Living Centres. During lockdown, staff at one of the centres

conducted phone call check-ins with regular visitors. If during this call someone mentioned concerns around BP, the staff passed the referral and information to the BP Award programme coordinator. The coordinator would call them back to discuss their BP, offer advice and guidance, and tell them about the rent-a-cuff initiative. The participant could then arrange an appointment or drop into the centre to collect a machine to keep track of their BP at home.

The 'rent-a-cuff' initiative was also advertised through flyers, leaflets, posters, and in a Healthy Heart online session provided by one of the Healthy Living Centres.

Having said this, the take-up of the rent-a-cuff initiative was not as high as had been hoped, with site leads suggesting this is because people generally prefer to have their BP taken to face where they can receive immediate information and guidance around the result.

Good practice example: BP awareness-raising activity during the COVID-19 pandemic.

One site lead described how the project team continued promoting the key messages around BP prevention through the Public Health team and updating the materials/website relating to the programme.

They reported that generally, these messages focused on home BP testing and social media campaigns launched from an NHS Facebook and Instagram Account. They reported that linking up with NHS social media pages gave the campaign credibility.

All site leads reported that they felt the BHF's approach to the pandemic was appropriate. One lead commented that they appreciated that the BHF did not place pressure on sites to continue with delivery, considering the other priorities that were taking precedence for many of the project teams during this time.

3 Sustainability and Future plans

3.1 Overview

This chapter discusses the sustainability and future plans for BP community testing for both the BHF nationally and in Phase 2 sites specifically. Please note that these plans have not yet been formalised or signed-off and should be considered as representative of the thinking of site leads and Steering Group stakeholders as of July and August 2021.

3.2 Nationally: BHF and NHS England

Despite the ending of the BP Award Programme, steering group stakeholders reported that the BHF is still focused on the prevention agenda and working closely with communities. They also suggested that future work with communities should include exploration of some of the challenges of working with diverse communities (including looking at the BHF's cultural competency as an organisation) and consider the importance of effective messaging around health care.

Nationally, NHS England work is heavily influenced by BHF-led work. As such, BP testing and management is also an ongoing priority for NHS England, and for the National Clinical Director (NCD) for CVD prevention. Steering group members suggested that overlapping priorities between NHS England and the BHF include developing a pathway for hypertension diagnosis before a referral to GPs, and improving access and medicalising the testing and diagnosis of raised BP. The intention is that this will lead to a reduction in mortality and health inequalities.

This is reflected in the new community pharmacy contract, which includes payment for BP testing and diagnoses. The BHF BP Award Programme has directly influenced this new policy. The establishment of the NHS England Blood Pressure @ Home initiative, which has seen over 220,000 home BP monitors distributed since October 2020, has also been delivered in close collaboration with the BHF[3]. In Scotland, the use of remote monitoring to manage blood pressure is being scaled up, drawing on the successes of the Phase 1 NHS24 site[4].

The emergence of these national initiatives reflects the impact of the Blood Pressure Award Programme, and of the BHF's work more widely. It highlights the importance of the pilot projects delivered by the programme, and suggests that the programme has succeeded in bringing blood pressure monitoring onto the national agenda. In this context, the end of the programme and sharing of

[3] See https://www.england.nhs.uk/ourwork/clinical-policy/cvd/home-blood-pressure-monitoring/

[4] See https://tec.scot/programme-areas/remote-health-pathways/blood-pressure

learning appears timely, as blood pressure testing becomes embedded as a national priority.

3.3 Phase 2 sites

Almost all sites reported intentions to continue community testing of BP in some form following the end of the BHF BP award programme, with site leads suggesting that the programme had been really valuable in highlighting the potential of community-testing, both for BP and other health needs. Many also reported that continuing with community-based public health approaches was especially important in light of the COVID-19 pandemic, which has highlighted health inequalities and the role of the community in addressing these.

Many sites also reported plans to continue building on the skills, experiences and relationships developed as part of the BP Award Programme.

Specific future plans for each site are outlined below in sections 3.3.1 to 3.3.8.

3.3.1 Cheshire and Merseyside

There are plans to upgrade the kiosk model used in Cheshire and Merseyside with updated technology and antimicrobial materials. It is intended that this model will be available in community pharmacies across three local authorities. In one of these local authorities, the kiosk will form part of a digital pilot for NHS health checks in community settings. The kiosks will be implemented for another nine to 12 months using some match funding from the local Integrated Care System.

There are also plans to resume opportunistic testing in pharmacies and workplaces using the skills developed as part of the programme.

3.3.2 Gloucestershire

There are no plans in Gloucestershire currently to continue community testing of BP, but the 40 community volunteers trained through the BP Award Programme will continue to spread blood-pressure awareness.

3.3.3 Hertfordshire and West Essex

In Hertfordshire and West Essex, a session was held with stakeholders to review the project, how the landscape has changed because of COVID-19, and what it could look like going forward. A proposal was put forward that focused largely on opportunistic testing in community pharmacies and community pharmacies, supporting GPs with monitoring and diagnostics. This proposal is currently under consideration as part of a review of a wider cardio-vascular prevention programme.

3.3.4 Hull and East Riding of Yorkshire

In East Riding of Yorkshire, the project team are keen for the programme to continue in some form and are planning to continue contracts with delivery partners.

They are also planning a pilot to test BP in dental surgeries using the equipment from one pharmacy that is cancelling their current contract. As part of this, they are working with Primary Care Networks (PCNs) to produce a list of patients who have not been seen by a GP practice in the last two to three years and are aged between 40-60 years old. The team will then ask dental surgeries if they have those patients on their registers and are likely to see them. They will then test the BP of those patients and refer them to the community pharmacies if their BP is raised for seven days of monitoring. At this point, they will be referred to the GP if their BP is still raised.

3.3.5 Lancashire

Lancashire is hoping to use the existing equipment to sustain the project while sourcing funding for delivery from elsewhere. There are plans to use some of the Health Checks budget to continue programme delivery within a smaller model. It is intended the programme will continue to be delivered by existing delivery partners, as it is felt that these partners are well-placed to target deprived areas where the population is at higher risk of hypertension.

3.3.6 Newcastle and Gateshead

Although there are no firm plans for continued community BP testing in Newcastle and Gateshead, there is an appetite for using the learning from the programme to inform future cardio-vascular prevention and other public health priorities. The team is hoping to link in with the CVD Prevention Network in the North East to share findings from the project and suggested that the CVD Primary Care Network specification coming out nationally later in the year could be useful as a lever to disseminate this learning.

3.3.7 Northern Ireland

Northern Ireland are planning to continue community testing, and have reconvened the steering group and begun to identify potential sites. This will continue to be delivered though the Health Living Centre alliance.

3.3.8 Telford and Wrekin

There are no current plans for continued community testing in Telford and Wrekin due to a continued focus on the COVID-19 response. However, the site lead hoped that eventually community testing will resume with the current BP monitors and would welcome support from the BHF about the recalibration or replacement of the monitors.

4 Outcomes and impacts

4.1 Overview

This section explores the outcomes and impacts that the BP Award Programme may have achieved. It is important to note that for Phase 2 sites, due to the changes to programme activity and subsequently to the evaluation as a result of the COVID-19 pandemic, the evaluation has not explored outcomes and impacts in detail, nor should Phase 2 sites be expected to have delivered against intended outcomes and impacts.

However, Phase 1 of the evaluation found that the BP Award Programme had a positive impact on:

- Awareness and confidence of people who had participated in BP testing relating to their BP and how to manage it
- Behaviour change for participants concerning healthy lifestyles and managing BP
- Staff awareness of the signs of potential hypertension cases, referral processes, and knowledge and understanding in relation to high BP
- Improved access to BP testing for participants and communities
- Reduced burden on General Practice, as participants have their blood pressure tested elsewhere

More information can be found in the Phase 1 Evaluation Report (see section 1.1).

Whilst evaluating outcomes and impacts was not within the scope of this Phase 2 sites evaluation, findings from consultation with stakeholders suggest that similar outcomes have been achieved in the Phase 2 sites, albeit at a more limited scale due to the reduced time for which sites were able to operate.

In addition to these, stakeholders also reported that the programme has resulted in more and better working relationships with multi-agency delivery staff, increasing detection of hypertension, and has enabled operational learning that can be used to inform future community-based testing programmes.

4.2 Influencing national policy

As discussed in section 3.2, steering group members reported that the BHF BP Award programme has directly influenced national policy and action, as reflected in the new community pharmacy contract, which now includes payment for BP testing and diagnosis delivered to those over 40 (please see NHS England Hypertension Case-Finding Pilot and Hypertension case-finding service for more detail).

4.3 Relationships with multi-agency partners

One key outcome of the programme identified by site leads was the development of new and better relationships with multi-agency delivery partners. Stakeholders hope that these relationships will enable stronger partnership working relating to community-based approaches to public health in the future. Steering group stakeholders also suggested that nationally there will be more opportunity for such approaches in the future as integrated care systems become more established across the country.

Many site leads cited these relationships as key to future plans for such work (see Chapter 3 for more detail).

4.4 Raising awareness of BP

Some site leads suggested that the project had raised awareness of the importance of monitoring BP and healthy lifestyles for participants in BP testing, even for those not identified as at-risk or who declined testing. For example, one reported:

> *"[The project] has pushed forward the previous campaign of … really giving people the awareness and encouragement to take control of their own healthcare. That message was sent out to whoever we tested. They were given advice on how to diet, exercise, and how to maintain or reduce BP. Being able to do that outside of a healthcare setting is a main positive. That needs to be a continued, ongoing thing to see any shift in culture around that."*
>
> Phase 2 site lead

Another lead reported:

> *"All people were hungry for information. They don't realise the implication of things like alcohol intake and low levels of physical activity on their BP. These were useful conversations."*
>
> Phase 2 site lead

Steering group stakeholders felt this awareness has also been heightened by an increasing focus on hypertension as part of the national Prevention agenda.

Good practice example: Raising awareness of BP and partnership working in CHAMPs

In one site, during the COVID-19 pandemic and subsequent lockdowns, one of the delivery partners (the Fire and Rescue Service (FRS)) contacted the project lead to ask if they could continue spreading awareness of BP by giving out information as they dropped off shopping or prescriptions for vulnerable people.

The project lead co-developed some resources for the FRS with key messages and simple action-orientated messages around BP prevention to distribute on their visits. These were developed with CHAMPs Public Health Collaborative, Cheshire and Merseyside Health and Care Partnership, and Kaleidoscope. These resources are available in Appendix 1.

This is an example of how the project has raised awareness of the importance of BP monitoring among delivery partners and built upon positive relationships with these partners, resulting in increased awareness among the wider community.

Site leads also reported that awareness-raising around how to manage high BP was also useful for people who had already been diagnosed with high BP or hypertension, but were not confident in managing the condition.

4.5 Detecting hypertension

Stakeholders reported early indications that the programme has been successful in identifying people who are eligible for further monitoring of hypertension through improved access to testing in communities. For example, one site lead reported that data shows they are doing better with BP detection and control than the national average and felt confident that the BP programme had resulted in changes in practice relating to increased community testing and diagnoses (although further evidence is needed to test this theory).

Stakeholders suggested that successes in engaging with target cohorts (see section 5.3.2) and completing onward referrals to GPs had been instrumental in detecting undiagnosed hypertension.

Although primary care outcomes data to evidence the impact of onward referrals to GP and other services is limited, other data can be used to demonstrate this impact. For example, one stakeholder reported:

> *Routinely available data is our friend. We looked at how we are performing against national ambitions for BP detection and control…the data show us that we are doing better than the national average, which is a particular strength given our demographics compared to the national averages. Looking at this data, I am certain that the BP programme has been translated into changes in practice, increases in diagnoses, and creating a culture of community testing.*
>
> Phase 2 site lead

4.6 Upskilling/recruitment of staff and volunteers

Almost all areas reported that a key positive impact of the programme has been the training and involvement of community volunteers and the recruitment of a skilled team. Site leads hoped that this would result in knowledge around BP testing and awareness-raising continuing to be spread among the health care system, VCS partners, and within the wider community.

However, maintaining this confidence and these skills was an ongoing challenge for many sites (see section 2.6.2). Ongoing training and the use of centralised resources may therefore be important in any future work with partners to continue to effectively spread skills and knowledge relation to BP testing and awareness-raising.

4.7 Operational learning to inform the development of future community-testing initiatives

Stakeholders also suggested that their experience of the programme had resulted in learning about what works and does not work within community testing that they could build upon when commissioning, designing, and delivering future initiatives.

For example, one steering group member reported:

> *"The experience gained, not just in this programme but elsewhere, is leading to the acceleration of the design and implementation of new models of care that are consistent with the ideas underpinning this programme."*
>
> Steering group member

One site lead also suggested that their improved understanding of how much it costs to detect and refer a case of hypertension would be particularly useful when considering incentives and payments for future programmes.

5 Lessons learned

5.1 Overview

Over the course of the BP Award Programme, a series of lessons have been learned for both the BHF and local sites regarding the effective delivery of community-based testing initiatives.

Key lessons include:

For the BHF

- The BHF brand is well-respected and trusted by the public. Using BHF branded marketing and communication can therefore be helpful to encourage engagement from the public.

- Learning network events run by BHF are valuable forums to share learning and good practice. The BHF are also influential nationally, which can help further disseminate this learning and convey messages from localities more widely.

- The BHF can support effective project delivery through clearly articulating reporting and data collection requirements, a rigorous application process, and the role of BHF regional leads. This could include support with developing evaluation frameworks early on to help projects measure impact.

- Establishing a clear Theory of Change prior to implementation can support projects to understand by what mechanisms they are expecting to create outcomes and impacts. This ensures that:

    a. Sites are clear that their intended activity may be expected to lead to their intended outcomes and impacts. This process can also involve drawing on previous experience and external evidence of effective practice elsewhere.
    b. Appropriate sources of monitoring data are identified to enable sites to monitor their progress against intended outcomes and impacts. Identifying these sources early is key as putting in place appropriate data collection systems can take time. This is especially important for projects where primary care data may be needed to demonstrate impacts.

- Focusing on sites or projects with pre-existing infrastructures and relationships with community-based organisations is key for effective delivery. This is of particular importance when timescales for implementation and delivery are relatively short.

- Awareness-raising activity around the importance of managing BP and healthy lifestyles has been extremely valuable. It may therefore be appropriate to focus more on awareness-raising as a primary impact of the programme

instead of detection and diagnosis of hypertension, particularly considering the pervasive challenges in collecting primary care data that would demonstrate impacts on detection rates.

- Community pharmacies play an important role in local health promotion, treatment, and reducing health inequalities. Regular contact and training around systemising delivering approaches may support continued engagement from community pharmacies. .

For local sites

- A dedicated project management team with the capacity for both project management and administration for the project's duration is key to driving the service.
- Using data is key to understanding local need, to help target testing and to use available resource in the most efficient ways. Dedicated project support for data collection can also support ongoing monitoring and ensure a responsive and flexible approach.
- Developing an evaluation framework early on enables projects to measure impact, capture learning, and ensures appropriate data collection mechanisms are put in place which can be used for evaluation and monitoring.
- The potential of community-based health interventions in engaging with the public and giving people a sense of ownership over their health.
- The need for effective and well-resourced advertising and messaging to encourage public engagement that draws upon well-known and respected resources (such as the BHF brand and BHF online resources) where possible.
- Translation of materials and a diverse delivery team can help ensure that people of all backgrounds can access services.
- For sites without pre-existing links with key partner organisations, time for relationship-building should be built into planning and timescales.
- A cross-system commitment to addressing hypertension (including persistent prioritisation of hypertension and accompanying support networks) is important for effective delivery and engagement from all partners.

5.2 BHF

5.2.1 Project management

Consultation in Phase 2 suggests that the BHF's regional leads were particularly useful in offering support to sites and brokering relationships with VCS organisations, which is key to driving engagement and supporting implementation.

Phase 2 stakeholders also suggested that time spent upfront by the BHF in ensuring reporting and data collection requirements are clearly understood and that sufficient systems are in place to capture accurate and reliable data are key to the effective delivery of projects such as this.

Linked to this, the BHF worked with sites through Learning Network events to collaboratively identify common barriers and solutions to accessing primary care data. In addition to this support, some site leads suggested that ring-fenced resources to support primary care data collection would be particularly helpful for projects with such requirements. Further support from the BHF with information governance issues may also be helpful to address any challenges with primary care data collection.

Findings from both evaluation phases indicate that by requiring a high level of clarification and detail from projects, particularly during the application stage, the BHF can support projects to drive change, clarify their thinking, and understand expectations. A focus on local data within the application process can also make sure projects have a good understanding of local need and how to respond to it. A clear Theory of Change at the beginning of implementation can support projects to understand by what mechanisms they are expecting to create outcomes and impacts.

Findings also suggest that when providing funding for future community-based initiatives, the BHF would benefit from encouraging sites to invest in infrastructures and relationships with community-based organisations, as this appears to be valuable in supporting effective delivery.

5.2.2 Design of community-testing initiatives

Initially, the primary objective of the BHF BP Award programme was identifying and treating hypertension. However, throughout the programme it has become clear that awareness-raising activity around the importance of managing BP and healthy lifestyles (particularly in relation to alcohol intake and levels of physical activity) has also been extremely valuable, and that this can be achieved by testing wide cohorts and offering testing in a wide range of settings.

The programme may therefore have benefited from being less focused on detection as the primary outcome and instead looking at the potential impacts and outcomes of community-based testing activity more broadly. This also would reduce the reliance on primary care data to measure outcomes, which might be helpful considering the challenges associated with collecting primary care data, which are pervasive across the sector.

One site lead suggested that a solid Theory of Change and Logic Model is important in giving programme leads the confidence to do this; if the Theory of Change is well-designed, leads can be more confident that testing and awareness-raising are an adequate proxy measure for primary care data that might not be available.

However, if a focus on detecting hypertension is the primary measure on which such programmes are based, and on which relative success is to be measured, a

more targeted cohort, based on demographics and factors that put certain populations at risk of hypertension, can be a more efficient use of the resource.

5.2.3 Partnership working

Steering group members discussed how the pandemic has highlighted the potential role of community pharmacies in delivering health promotion, treating conditions in the community, and working as part of the community pharmacy networks to reach out to people in need of their services. They suggested that community pharmacies are particularly well-placed to do more tailored work within this field which is targeted at the needs of local communities and has the potential to reduce health inequalities.

Having said this, there have been challenges in some sites across the lifespan of the programme in engaging with community pharmacies. Limited capacity and confidence of community pharmacy practitioners in administering tests were key challenges; high staff turnover can also mean that knowledge and engagement can be lost when staff members trained in BP testing move on.

There were also some reported challenges around convincing community pharmacies that the model was financially sustainable in terms of remuneration. This may be partly resolved by the new community pharmacy contract, which, partly due to learning from the BHF project, will include payments to community pharmacies for BP testing and advice provision.

Close and regular contact between the BHF, site leads and community pharmacies at an early stage of the programme and training and support that focuses on systematising delivery approaches can help foster engagement from community pharmacies and ensure that confidence and skills are maintained and not held by individuals. E-learning is a possible format of training that might increase take-up by providing flexibility.

The programme has also highlighted how the engagement of VCS organisations can be key to driving engagement and supporting implementation. The BHF can support the engagement of local VCS organisations by providing community representatives who can provide local knowledge and support and broker connections. VCS organisations have enabled sites to better access certain local communities by drawing on their existing links with community leaders and community settings. This local knowledge is a key enabler for supporting the engagement of local communities.

5.2.4 Sharing learning

Over the course of the evaluation, the learning network events run by the BHF have consistently been reported by stakeholders as a valuable forum to share resources, identify challenges and develop potential solutions.

5.3 Local sites

5.3.1 Project management

A number of key enabling factors for effective project management were identified across both phases of the evaluation. These included:

- **A dedicated project team** and well-resourced project management is important to get community testing up and running.
- **Dedicated project support for data** can support monitoring and evaluation.
- **Pharma-outcomes** is a useful data collection system for collecting primary care data.
- **Public Health Teams** generally have positive pre-existing relationships with community providers, which can support with community testing, including in community pharmacies.
- Using **local data to understand the population needs** can help target testing and use the available resource in the most efficient ways.
- **Developing an evaluation framework** at the beginning of the project is important to measure impact, capture learning, and ensure appropriate data collection mechanisms are put in place early on. This could also include mechanisms for measuring the impact of any onward referrals to other services, which was identified by site leads as an ongoing challenge.

5.3.2 Engaging with the public

The BHF BP Award Programme has highlighted the potential of community-based health interventions, including those delivered by people without a clinical background, in engaging with the public and giving people a sense of ownership over their health. In particular, sites where BP testing was delivered by non-clinical staff and volunteers reported that they were better able to support members of the public who may otherwise have been reluctant to engage with healthcare settings and services.

To capitalise on this potential, effective advertising and messaging (along with sufficient resources dedicated to this) is needed to extend the reach of community-based testing or other community-based health initiatives. This should include wide translation of materials to ensure that people of all backgrounds can access such services. Similarly, a diverse delivery team can help with engagement with a range of clients.

5.3.3 Partnership working

As mentioned in section 5.2.2, existing relationships and links with key partner organisations (such as pharmacy networks) are important to ensure that community-based initiatives are successful. For sites without pre-existing links, time for relationship-building should be built into planning and timescales.

Findings from both phases of the evaluation also suggest that a cross-system commitment to addressing hypertension is important for effective delivery and

engagement from all partners. This can be heavily affected by staff turnover, so ongoing training and awareness-raising can also be useful.

6 Recommendations

6.1 Overview

This chapter outlines eight recommendations for the BHF and local sites to consider when delivering future programmes related to BP and other community-based public health testing initiatives.

They may also be useful for other organisations considering implementing similar programmes in the future and for pharmacies and PCNs delivering free blood pressure checks to those over 40 as part of the new Hypertension case-finding service (also see NHS England Hypertension Case-Finding Pilot for more detail).

Figure 5 outlines f the recommendations which are based on the evidence presented in this evaluation report and previous evaluation outputs.

We recognise that not all stakeholders are likely to agree with all recommendations. However, we hope that they will support future delivery. We would welcome an opportunity to discuss and refine these recommendations with the BHF and consider the approach to disseminating the findings of this evaluation report.

Figure 5: Recommendations for the BHF, local sites, and other organisations when considering similar community-based public health testing initiatives in the future

Recommendation	Evidence	Section in report
1. When developing similar programmes, applicants should be encouraged to use a logic model approach to outline their proposed delivery model.	Site leads were clear that the BHF's application process, whilst relatively time-intensive, was helpful in supporting them to understand the mechanisms by which their model intends to achieve outcomes and impacts. Across both Phase 1 and Phase 2, the evaluation also found that sites were not always able to collect robust data in relation to their project's inputs, activities, outputs, outcomes and impacts, particularly when this involved accessing primary care data (this is an ongoing challenge across the sector). The process of developing a clearly articulated Theory of Change and Logic Model early on in the project can provide more confidence that project activity is achieving the desired impact when it is not possible to collect the data to evidence this. This is because it can help ensure there is a clear rationale for why activities are taking place and how they will contribute to outcomes and impacts, identify required inputs, and support data collection processes to be built into the project early on, linked to expected outputs, outcomes and impacts. Examples of logic models for all Phase 1 and Phase 2 sites are provided in the evaluation strategy documents (see section 1.1) This builds on a recommendation made in the Phase 1 sites evaluation report.	Phase 1 report: 1.2.2, 1.2.3. Phase 2 report: 2.5.1, 5.2.2.

Recommendation	Evidence	Section in report
2. Linked to this, future programmes should establish clear data collection expectations and processes as early as possible to ensure consistency in reporting. This should include working collaboratively with delivery partners to ensure that reporting requirements are fully understood from the outset of projects and that sufficient systems are in place to ensure data will be available. This may also include providing dedicated funding to support the collection and reporting of monitoring data.	Collecting data relating to the programmes' activities, outputs, outcomes, and impacts was an ongoing challenge in almost all sites across both phases of the evaluation. In particular, collecting data from primary care that captures the pathway of the patient after testing was identified as a key challenge. Site leads suggested that this was due to limited capacity within general practice to collect and share data amongst GPs and technical challenges with ensuring a consistent approach to codifying programme participants. Clarifying and embedding data collection expectations (including establishing clear Key Performance Indicators) and processes as early as possible can help identify any challenges early on, which can then be addressed as far as possible by sites. Linking these data collection processes to an evaluation framework can also help ensure that data is linked to the projects' intended outcomes and impacts, and that GP's limited time and capacity is being used in the most efficient way to evidence this. Ring-fencing funding to support with data collection and asking for support from local partners such as CCGs and ICSs to quality assure and standardise coding systems may also help ensure data is reliable and accurate.	Phase 1 report: 1.4.1, 1.5, 2, 2.6.14.4. Phase 2 report: 2.5.1, 2.6.3, 5.2.1., 5.3.1,
3. Although detection and diagnosis rates of hypertension should be the primary focus of future BP testing	Findings from both phases of the evaluation suggest that sites delivered a substantial level of awareness-raising information to participants who currently have normal BP (particularly around the	Phase 1 report: 1.2.2, 2.5.2.

Recommendation	Evidence	Section in report
programmes, awareness-raisingof hypertension and promoting appropriate long-term preventative action amongst local populations could also be included as a secondary aim . This would also apply to other similar community-based public health testing initiatives.	impact of lifestyle on BP, such as through alcohol intake and physical activity levels). This awareness-raising activity is considered particularly valuable in the context of prevention and can be achieved by testing wide cohorts and delivering testing in a wide range of community settings. Expanding the aims of the programme to include this aim would formally recognise this aspect of sites' activity and promote the potential benefits the programme may be having at a local population level. This would also support programmes to demonstrate impact more easily than if the focus is solely on detection and diagnoses, as monitoring of impact on awareness could be embedded from the start of a project. However, if future programmes do not include a secondary aim of awareness-raising, and are only seeking to increase detection and diagnosis rates, , then targeting a more specific cohort may be a more efficient use of resource.	Phase 2 report: 2.4, 5.2.2.
4. When identifying and developing potential delivery models for future community-based testing initiatives, consider emphasising the use of local knowledge in the design and delivery of models. This may include involving BHF colleagues in supporting design and	The BP Award Programme allowed funded sites to design and deliver blood pressure testing to groups which were locally identified as being at risk of having undetected hypertension, rather than being overly prescriptive with the programme's target cohort. Site leads reported that this flexibility enabled them to use their local data and intelligence to appropriately target testing activities in the areas and communities where it was most likely to have the greatest impact.	Phase 1 report: 2.5.3, 2.6.2, 4.5, 4.6. Phase 2 report: 2.5.1, 2.5.2, 2.6.1, 2.8, 5.2.1, 5.3.1.

Recommendation	Evidence	Section in report
implementation, working with organisations where existing working relationships are in place, and giving delivery sites the scope to use local data and intelligence to identify areas, sites and communities which may most benefit from initiatives.	Across both phases of the evaluation, there was also evidence to suggest that sites which used a diverse delivery team reflecting local communities, and sites working with delivery partners with which there were strong existing relationships, were better able to implement their model at pace, and to engage with their target cohorts. Phase 2 site leads highlighted that having BHF colleagues acting as critical friends helped ensure the projects were articulating value for money and evidencing and explaining decision-making and programme activity. They were also useful in providing local knowledge and support balanced with an expert, fresh perspective slightly removed from the politics and process of the systems in which local site leads were working. Regional leads also helped broker relationships with partners from other organisations that the programme team could liaise with to deliver testing. The relationship between site leads and regional representatives was considered an asset not only for the BP Award Programme but as a point of contact for any future activity relating to BP. One site lead reported that the relationship with the BHF and the BP Award Programme had already provided a foundation for future follow-on BP projects.	

Recommendation	Evidence	Section in report
Future programmes should consider dedicating resource to (a) project management capacity, (b) developing relationships with community partners, and (c) establishing a cross-system commitment to programme priorities (where these enablers do not exist already). The BHF should encourage potential sites for future programmes to consider these factors and offer support in developing them where needed.	The evaluation found evidence that those sites which have had the greatest success at delivering blood pressure testing in community settings are those where delivering partners had previous experience of delivering community outreach services, and as a result had structures in place to support delivery of blood pressure testing. It was also emphasised by a range of stakeholders that a dedicated project management team was important in ensuring sufficient resources and capacity to drive the project (and that delivery was negatively impacted in sites that did not have a dedicated team). Ring-fenced funding to support this function should also be considered for future funding programmes. In addition, successful sites also had a cross-system commitment to delivering the programme priorities regarding the detection and management of hypertension.	Phase 1 report: 2.6.2, 4.6. Phase 2 report: 2.5.2, 2.6, 5.3.1, 5.3.3.
5. Future programmes and initiatives for delivering community-based public health testing should consider embedding ongoing training in delivery models and consider how centralised resources can be used to support and promote this.	Findings from both phases of the evaluation suggest that continuous training for practitioners and volunteers who are delivering testing is important to help support their confidence in administering tests and to mitigate the risk of knowledge being lost when individual practitioners/volunteers change roles (which can result in delivery partners subsequently disengaging with the project). This is especially important considering the high levels of staff or volunteer turnover found amongst many delivery partner organisations in the local sites.	Phase 1 report: 2.5.1, 2.5.3, 2.5.4, 4.7, 5.3. Phase 2 report: 2.6.2, 4.6, 5.2.3, 5.3.3.

Recommendation	Evidence	Section in report
	Such training should also include supporting pharmacies to systemise testing pharmacies and embed them in their 'business as usual' to help support engagement with the project and reduce the burden on practitioners. This support should be considered alongside recent changes to the community pharmacy contract funding which provides financial incentives for delivering blood pressure testing. These changes have been informed by the experiences of the BHF in delivering the BP Award Programme[5]. Ongoing awareness-raising around the importance of BP testing can also ensure that knowledge is spread among the health care system, VCS partners, and within the wider community, potentially having a sustained impact on their work in future, and giving them increased knowledge, understanding and confidence in relation to managing blood pressure and associated lifestyle factors. It can also help foster a cross-system commitment to addressing hypertension. Repeated training and awareness-raising however is resource-intensive. Sites may therefore wish to consider e-learning opportunities to reduce ongoing training costs and increase the flexibility of delivery.	

[5] Source: BHF.

Recommendation	Evidence	Section in report
6. Future community-based programmes and initiatives should consider using messaging and advertising materials that draw upon well-known and respected resources.	Stakeholders suggested that effective advertising and messaging (along with sufficient resource dedicated to this) is needed to extend the reach of community-based testing or other community-based health initiatives. They also reported that translating materials into a broad range of languages is key to ensure that that people of all backgrounds can access such services. Site leads also reported that using the BHF brand as part of their marketing and communication strategies gave the projects legitimacy, as the BHF is a well-known and trusted organisation.	Phase 2 report: 2.7, 5.3.2.
7. For future multi-site programmes, ensure a clear and well-established network for learning at an early stage. This should include coordination and support for developing and sharing training tools to ensure sites are supported with this while also allowing some flexibility depending on local context.	Stakeholders reported that the learning networks that were organised and facilitated by the BHF were supportive in building relationships and sharing learning among sites. Phase 1 site leads also reported that the Yammer sharing platform established by the BHF had been beneficial for sharing resources between sites and discussing common challenges. In particular, events that focused on particular common challenges and facilitating a solution-focused approach to addressing these were found to have been valuable. The BHF should consider emphasising the sharing of resources such as testing protocols, data capture templates and communication and engagement materials between sites, as site leads reported that these resources have the most cross-over between projects and the greatest potential for sharing examples of successful materials based on their use elsewhere.	Phase 1 evaluation report: 2.6.1. Phase 2 evaluation report: 2.5.1, 2.6.2 5.2.4.

Appendices

Appendix 1: Resources from CHAMPs

Happy Hearts poster_final.pdf

HH_A5_Leaflet_Generic final.pdf

CordisBright Limited

23/24 Smithfield Street, London EC1A 9LF

Telephone 020 7330 9170
Email info@cordisbright.co.uk
Internet www.cordisbright.co.uk