healthwatch
in Bath & North East Somerset, Swindon & Wiltshire

Empowering the patient

How to increase the understanding and testing of high blood pressure among Asian and deprived populations.

Contents

Commissioning

This project was commissioned by the Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board (ICB). The research was conducted between May and September 2025. The report was published in October 2025.

Acknowledgements

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- Bath City Farm (Bath)
- BEMSCA at Fairfield House (Bath)
- Oasis Hub (Bath)

Summary

Key findings

Many people, especially those from Asian heritage and socioeconomically disadvantaged communities, face systemic barriers to accessing blood pressure care. Our key theme is that health services should empower patients to take responsibility for their own blood pressure health.

Patient journeys

When invited to a clinic, most people come forward to have their blood pressure taken. However, it is rare that they enquire about blood pressure health or proactively ask for a test.

Knowledge and attitudes

Understanding of blood pressure readings, risks, and treatments remains low across all groups. Fear, confusion, and lack of culturally relevant information contribute to disengagement.

Trusted information

The people we spoke to trust authoritative sources of information. Messaging from the NHS/Public Health about blood pressure has a low profile on social media.

Barriers and enablers

Barriers include limited access to testing; cultural and language obstacles; and the misconception that symptoms must be present to warrant concern. Enablers include convenience, education, and community-based approaches.

Recommendations

To improve outcomes, health partners must focus not only on the availability of services but also on motivating and empowering individuals to use them.

About Healthwatch

Healthwatch is your independent, health and social care champion. We listen to people's experiences, amplify their voices, and make sure decision-makers understand what matters to communities. Our role is to ensure that the design and delivery of health and care reflects the needs of the people it serves.

About this report

Purpose and research objectives

The purpose of this report is to recommend practical measures to increase the understanding and testing of high blood pressure. Our focus will be on people who are from deprived areas and Asian heritage.

The research objectives are to:

1. Analyse the patient journey — how people experience the blood pressure 'system'.
2. Assess knowledge and attitudes — what people know, believe, and feel about high blood pressure.
3. Identify trusted sources — where people go for information and which voices they rely on.
4. Explore barriers and enablers — practical, cultural, and emotional factors that shape engagement with blood pressure health.
5. Review existing messaging — how current communication about blood pressure is delivered and perceived.

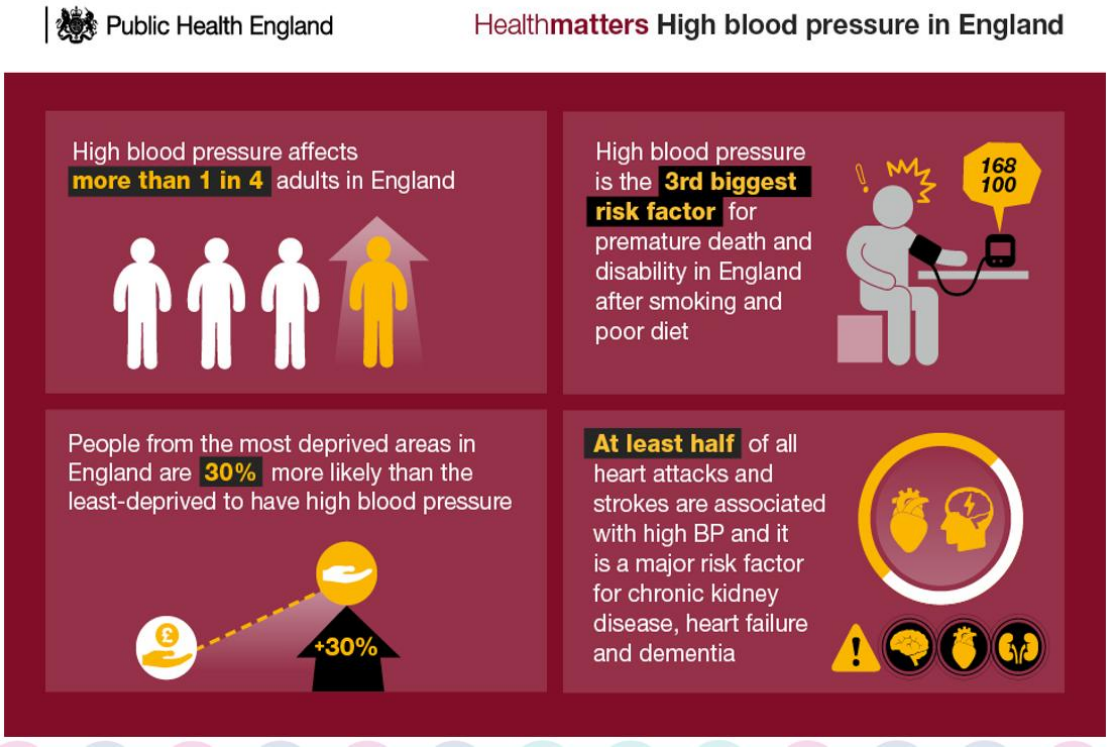
Methodology

We used a mixture of surveys and conversations, involving a total of 486 people. In this report 'participants' refers to people who took part in focus groups and one-to-one interviews. 'Respondents' refers to those who completed our online survey.

Context

Context

In its '10 Year Health Plan for England', published in July 2025, the government called for a shift from treating sickness to promoting prevention. Identifying people with high blood pressure (also known as 'hypertension') is a significant enabler of preventative care. If blood pressure is monitored and managed well, then cases of heart attack, stroke and other serious diseases will fall.

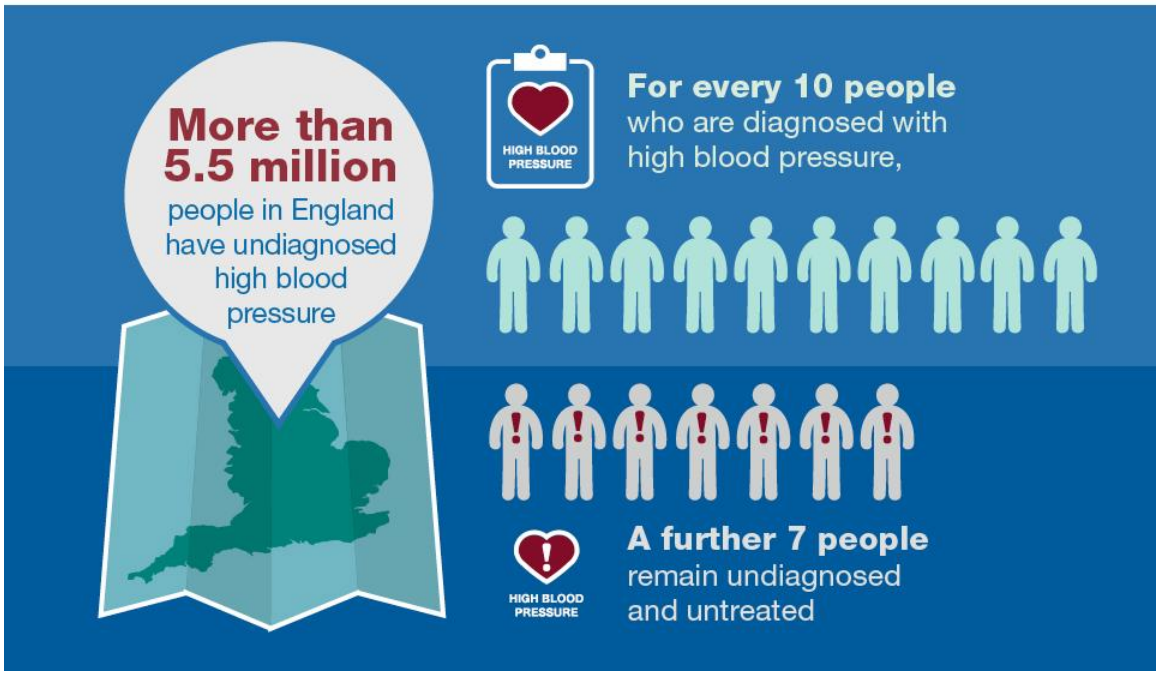


Data indicates that people from most deprived areas (known as Core20 populations) and Asian communities are more likely to have hypertension. Reasons include health literacy, healthcare access, dietary habits and lifestyle choices.[1]

The challenge

Public health uses a wide variety of techniques to identify and treat people with hypertension. Strategies include targeting those at most risk, public awareness campaigns, community-based outreach, population screening and making it easier to get tested. Yet over 5.5 million people in England remain undiagnosed.

1 For socioeconomic influences, see: Liu, S., et al. (2025). Associations of socioeconomic status and healthy lifestyle with incident early-onset and late-onset hypertension: A nationwide prospective cohort study in the UK. Population Health Metrics, 23(1), Article 392. https://doi.org/10.1186/s12963-025-00392-y


More than 5.5 million
people in England have undiagnosed high blood pressure
HIGH BLOOD PRESSURE
For every 10 people
who are diagnosed with high blood pressure,
HIGH BLOOD PRESSURE
A further 7 people
remain undiagnosed and untreated

Key findings

1. A disempowering environment

Our research shows that people's experience of blood pressure is often disempowering. As our graphic illustrates, most people don't request a blood pressure check; don't check it themselves; and don't understand its results.

Don't ask

Almost everyone we spoke to had never proactively asked for a blood pressure check, suggested it as a possibility, or even considered it might be a helpful tool.

Don't check

Using a blood pressure machine is more complex than taking your temperature, but it is still a simple, learnable skill. However, only a minority of our respondents tested their own blood pressure.

Don't understand

Most of our respondents have a limited or unclear understanding of blood pressure readings. They are told by a professional whether it's "too high" or "fine" – and that's often the sum total of their knowledge. This reflects a missed opportunity by health professionals to provide meaningful education and support.

Empowering the patient

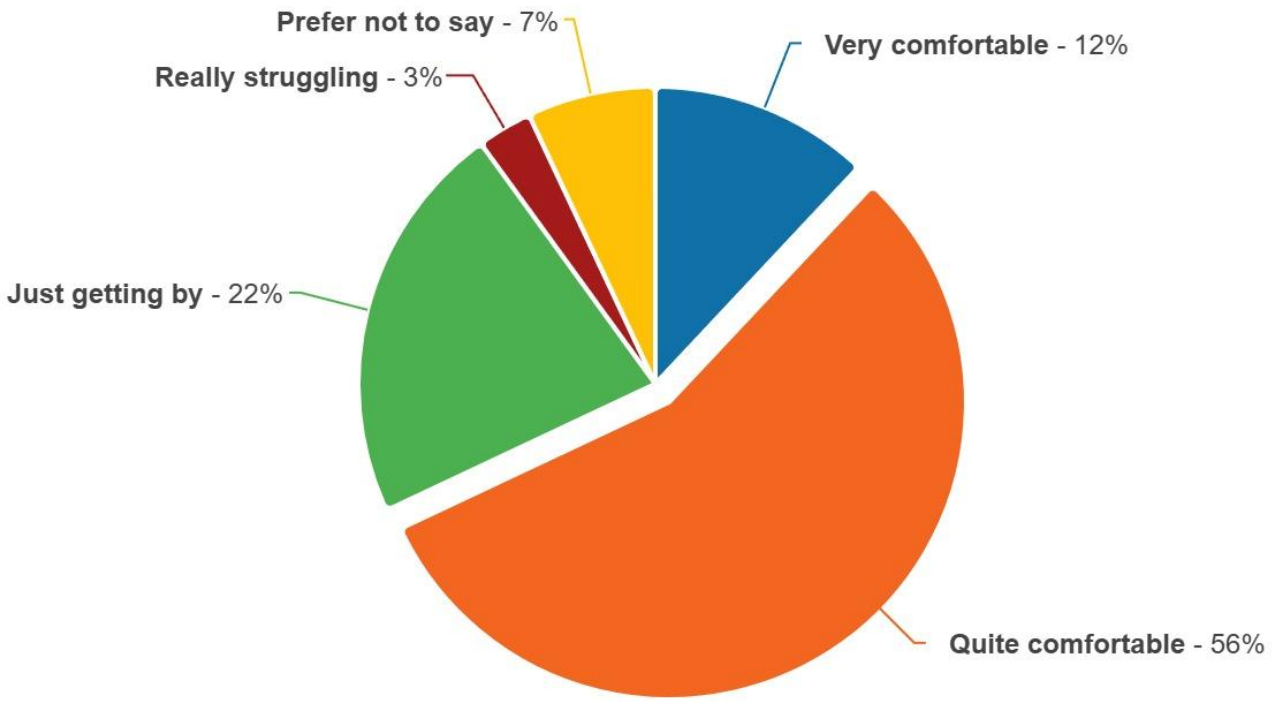
Of course, there are other conditions where patients 'don't ask, check or understand' their condition. But our research into hypertension reveals that tackling this disempowering environment is crucial. This report shows how to empower priority patient groups.

2. Effect of economic status

Our research confirms that a person's economic status makes a significant difference to their understanding of risks, and the regularity of being tested.

Although our conversations targeted those from deprived backgrounds, our survey was publicly available and was completed by respondents from a wide range of financial circumstances.

Which of the following best described your current financial situation?



These were the two key questions that scored differently depending on economic status:

Response	**More affluent** (combining 'very' and 'quite comfortable')	**Less affluent** (combining 'just getting by' and 'really struggling')	**% points difference**
I understand the risks of high blood pressure very well	46%	31%	15% points
My blood pressure was checked in the last 2 years	90%	80%	10 % points

We also found differences in the respondents' characteristics. These were the two key questions.

Response	**More affluent** (combining 'very' and 'quite comfortable')	**Less affluent** (combining 'just getting by' and 'really struggling')	**% points difference**
Answering "Yes" to: do you consider yourself to be overweight?	48%	57%	9%
"I don't smoke"	93%	84%	9%

However:

- These differences in knowledge, access and health are not unique to blood pressure health. They reflect broader inequalities that affect many health conditions.
- For most of the other questions, there is not a significant difference in response between more and less affluent respondents. This highlights that the challenges presented in this report affect people from all economic backgrounds.

Patient journey

We asked our respondents what happened before, during and after they were involved in blood pressure testing.

Invitation for testing

The blood pressure 'journey' usually starts with people being invited to a clinic.

87% of our respondents were tested in the last two years.

72% of blood pressure testing takes place as part of a routine health check.

Other key triggers are pregnancy and an operation. Almost everyone we spoke to took up this offer to be tested. In contrast, none of our respondents had ever asked to be tested.

Anxiety

A significant minority of participants reported that this invitation caused them anxiety. This was caused by fear of the test and its results; as well as concern they were going to be "told off" by the health care professional. This 'white coat effect' is well documented, however we didn't hear about any measures taken to reduce this anxiety.

No explanation

The next milestone is the moment of testing, when the patient and professional are one-to-one, usually in a private space. Although 68% of our respondents said the explanation they received about their result was "clear", it is apparent from our discussions that these explanations have no depth. The patient is usually told that the blood pressure is "too high" or "fine", and if it's too high, they

are directed to the doctor. 25% of respondents said that they did not have a clear explanation.

It's too high / it's fine

Some explanation

When it's a doctor or pharmacist taking blood pressure, the patient is usually given at least a minimal explanation. One respondent told us: "The doctor didn't explain too much, just to cut down on my smoking" (which this patient hasn't done).

Self-testing success

A minority of patients were given blood pressure machines to take tests at home, over a period of one or two weeks. In all cases, we heard that patients successfully worked the machines and provided the doctor with the data required. In a majority of cases, however, patients did not understand the readings.

> You're writing down numbers for a week. But you don't know what they mean.

Self-testing and anxiety

A significant minority of our participants reported becoming fixated on the results of their self-testing. One told us that: "My husband became obsessed with it, worrying about every slight change."

Tablets and trust

A majority of our respondents felt that GPs are too quick to prescribe blood pressure tablets. A significant minority believe that: "doctors just don't care and treat us as numbers".

> I'm annoyed that the doctors throw tablets at people. They only treat the symptoms and that's why people get ill and die".

GP .v. pharmacy

Almost all of our participants who went to a pharmacy for a blood pressure check had a positive experience. People were surprised that this service was available and complimented the 'bed-side manner' of the pharmacist.

Follow up from the doctor

A majority of our participants were concerned that there was little or no follow up to their blood pressure check – particularly when medication was prescribed.

Follow up from patient

Everyone we spoke to who were given tablets took them as prescribed. However, a majority of respondents failed in some way to follow the behavioural change advised by the clinician.

Knowledge

In this section, we explore what people know about blood pressure. 81% of respondents said they knew what hypertension meant. But this was mostly because they simply associated the word with the topic of blood pressure. 22% said they didn't know or were unsure.

1. Where can you get your blood pressure checked?

All participants knew that blood pressure can be taken by the GP. About half of respondents also referenced the pharmacy, though sometimes as a question: "you can also get it done at the pharmacy, right?". A minority mentioned self-testing at home and A&E.

2. Do you know what the readings mean?

A minority said they understood blood pressure readings. Although, when asked, half of these respondents got the numbers wrong. For example, a respondent confidently shared with the group that a 'good' blood pressure is 80/60. However, this is described as a 'low' result by the NHS.

Good or bad?

3. What are the symptoms?

A majority of participants said the key symptom of high blood pressure was dizziness, or "feeling lightheaded". A significant minority knew that hypertension was usually symptomless.

4. What makes it more likely that you will have high blood pressure?

Strength of participant opinion	Risk factor
Almost everyone	Stress
Majority	Unhealthy diet
	Salt
	Smoking
	Lack of exercise
	Being overweight

Significant minority	Drinking alcohol
	Getting older
	Infection
Minority	Depression and anxiety
	Lack of sleep
	Genetics

Stress

According to the majority of our participants, stress is the main risk factor for high blood pressure. As one participant put it: *"The reason I've got it [high blood pressure] is because I'm running around a lot doing things".*

According to our Asian participants, the main cause of stress was caring for family members. For them, this means that carers are likely to have high blood pressure.

An Asian voice on exercise

One of our older, Indian participants explained that he was brought up on a farm. There was lots of physical work. He cycled everywhere because there were no cars. This is why, from his perspective, he never had a concern about high blood pressure.

A Jamaican voice: being overweight

One of our Jamaican participants said that in traditional society (especially in rural areas or among older generations), being overweight can be seen as a positive attribute. Overweight people can be described as "big and fine" – as in healthy-looking.

Smoking & alcohol

Some participants said they had tried to cut down on smoking and alcohol. We were told:

"I continue to smoke the same amount, but I smoke rollies which are a lot better for you".

"We got "blotto" once a week with friends but not anymore."

The Asian voice on diet

Our Asian attendees strongly believe that a 'bad' diet leads to high blood pressure.

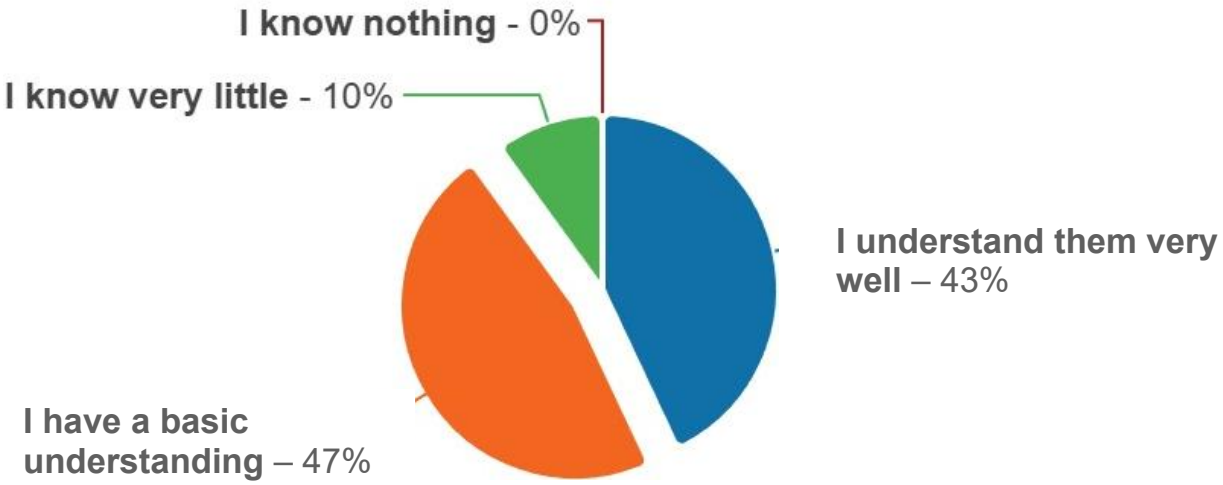
"We must hold onto the healthier aspects of the Asian diet – with lots of vegetables and pulses. And not so many Indian sweets!"

"There's too much salt in the Indian diet."

Genetics

One of our participants, aged over 80, told us that she was diagnosed with hypertension when she was 42. She described it as a genetic condition as *"most of my family suffers from it or have died from heart problems".* She has been very careful with her diet and exercise to reduce her own risk of high blood pressure.

4. How much do you know about the risks of high blood pressure?



90% of respondents felt they had either a 'basic understanding' or 'understand well' the risks of high blood pressure. This usually referred to knowing the risk of heart attacks, strokes and dizziness. One in ten felt they knew little or nothing about risks.

Strength of participant opinion	Risks
Almost everyone	Stroke
	Heart attack

Majority	Dizziness
Significant minority	Kidney damage
	Liver damage
Minority	Vision loss
	Diabetes
	Bleeding on the brain
	Lethargy / tiredness

5. How do you treat high blood pressure?

Strength of participant opinion	Treatment
Almost everyone	Pills
Majority	Diet (reduce salt, fat & caffeine)
	Exercise
	Reduce stress
Significant minority	Reduce alcohol
	Alternative medicine
Minority	Social prescribing

Pills

A significant minority of respondents felt that the primary treatment tool was taking medication. In some ways, they felt, there wasn't much point using any other treatment. *"It's just pills, and that's it".*

Treatment of stress

Because our attendees emphasised the role of stress in hypertension, we asked them how they managed it. Techniques included the common mix of exercise, mindfulness practice, socialising, experiencing nature, listening to music etc.

Better diet

Respondents told us about improvements they had made to their diets, which they classed as healthy and contributing to better blood pressure. These improvements usually meant more fruit and vegetables; and less fast food, caffeine, sugar and salt.

The Asian voice on treatments

Most of the conversation about treatment of high blood pressure centred on tea. Attendees took great pleasure discussing their personal versions. All ingredients should be fresh, they advised, and include: cloves, cardamom, turmeric, lemon, black pepper and fennel. They also advocated yoga and meditations as essential tools.

Asian voices on natural remedies

Our Asian participants explained that a certain amount of 'assimilation' meant that younger members of her community were relying more on the British "addiction" to pills. However, particularly because of a drop in trust in the NHS over Covid, this generation is now returning to natural remedies, alongside medication. There is renewed interest in herbs and spices.

Exercise: don't overdo it!

A significant minority of respondents felt there was a 'right' and 'wrong' type of exercise to treat hypertension. As one put it: "do some exercise, but don't overdo it". Walks, yoga and pilates were deemed as good; gym and other vigorous exercise were described as too vigorous.

Right or wrong?

Learning from experience

The primary reason participants knew about the risks of high blood pressure was because a family member had suffered the condition and its consequences. For example, a significant minority had supported a family member with a stroke.

Learning from Portugal

In one of our focus groups, an attendee was far more knowledgeable than anyone else. We found out that this knowledge came from his school education in Portugal. It was a topic embedded in health education. Everyone else, who were based in the UK, couldn't remember learning about blood pressure at school.

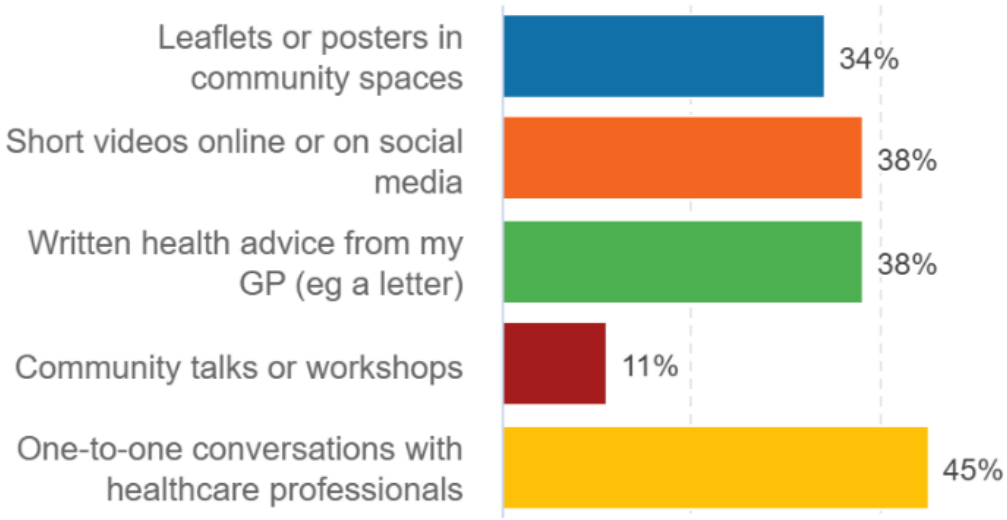
Trusted information

Nothing useful

We asked everyone: have you come across useful information about blood pressure. Everyone said: "no".

Type of information

We asked respondents what type of communication would help them in the future to understand blood pressure better? The top results were as follows:



Trust in authorities

The majority of respondents seek 'official' information. As one put it: "I want proper information, from the authorities". These sources were:

- GP, nurse, pharmacist
- NHS website, app and 111

Lack of trust online

A majority of participants said they are suspicious of online material that does not come from authoritative sources. However, it became clear in our conversations that they still proactively access this information and are influenced by it.

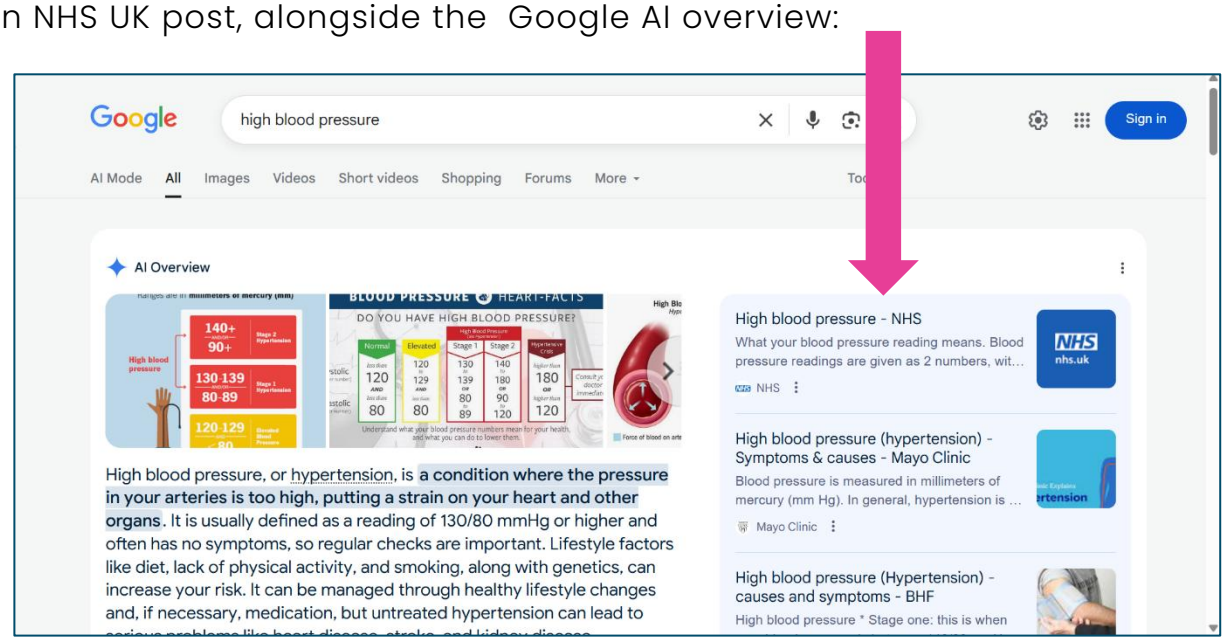
Social media

We tested the availability of 'trusted information' on social media. This test isn't 'scientific' as search results vary depending on personalised algorithms. However, the results can give us an indication. On 1 September 2025, we did two searches on social media using these words: "high blood pressure" and "NHS high blood pressure".

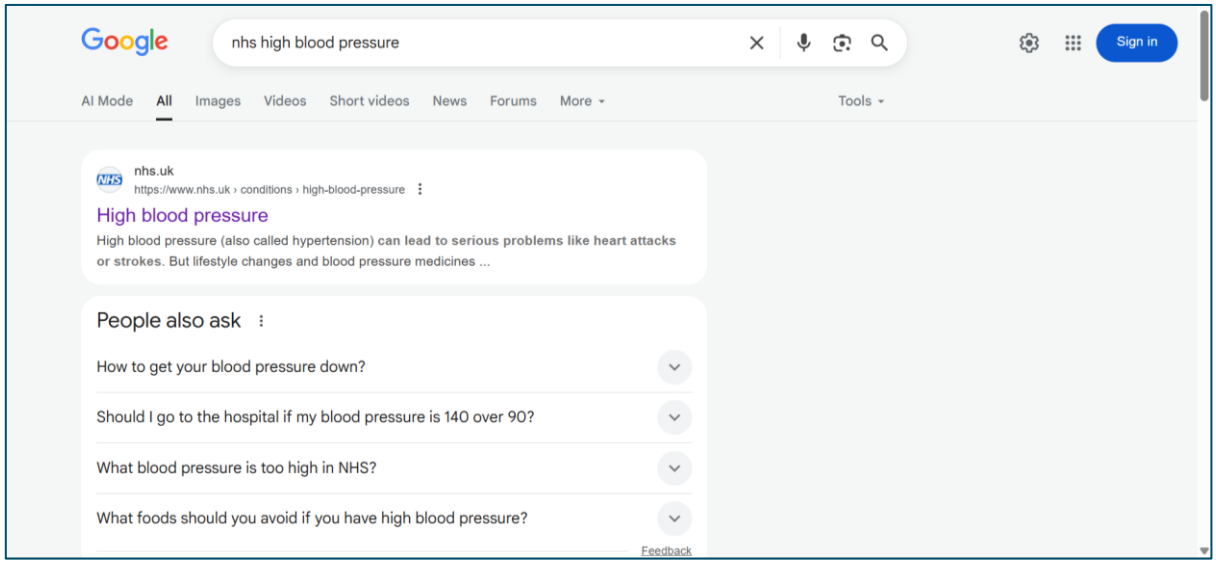
Search terms	YouTube	Facebook	TikTok
"High blood pressure"	No NHS videos (regional or national) in first 50 results	44th post is NHS UK post.	No NHS (regional or national) videos in first 50 results
"NHS high blood pressure"	1st video is from NHS West Suffolk with 788 views. 6th video is from NHS UK with 3.6K views.	1st video is from NHS BANES, Swindon & Wiltshire (likely featured because Healthwatch researcher is based in Bath) 34th video is from NHS UK.	12th video is from Sandwell & West Birmingham Hospitals NHS Trust. No NHS UK videos in first 50 results.

Google

We used the same search terms in a Google search (also on 1 September) and got very different results. The search "high blood pressure" returned a top result for an NHS UK post, alongside the Google AI overview:



The search terms “NHS high blood pressure” produced this top result:



Another quick way to find out information is to type “NHS” into a Google search bar (which takes you to the NHS website) and then enter “high blood pressure” into its search bar.

It may be the case that Google ranks NHS content higher because it comes from a ‘trusted source’. Social media, on the other hand, pushes content that gets attention. Since younger people rely more heavily on social media, they face greater barriers to finding trusted health content.

Leaflets

We asked our respondents for their views on blood pressure leaflets. It was largely positive. “I would browse leaflets or look at the poster in the waiting room if they felt relevant.”

Videos

The majority of respondents wanted information in video format. “I like videos – I take in the letters, images and sounds”.

TV dramas

A majority of respondents told us that they learn about health through TV shows. Respondents are also picking up health messages on podcasts.

> I like watching health programs, like Casualty, 24-7 and Holby City. You see day-to-day hospital wards and you look at what treatments they’re giving, like oxygen. It informs me a lot.

Peer influence

Participants told us that one of the most persuasive source of information, that would encourage them to get their blood pressure checked, was their friends. "If one of my friends said 'I'm worried about you' then I'd go do it [get their blood pressure checked]".

It's more the trust than the channel

A significant minority of respondents made the point that trust in information was more important than its channel. For example, social media content isn't good or bad, it just depends on your level of trust in its creator.

Personally relevant

We were told that there is "a lot of noise" in everyday life, so participants only have the capacity to concentrate on information that seems strongly, personally relevant. "The leaflets are too general. I only want to look at something that's very specifically about me."

Not relevant

A majority of participants explained that they wouldn't engage in new ways of communicating blood pressure – simply because they don't see the subject as relevant. One attendee explained:

> If I wasn't pregnant, or thinking about getting pregnant, I wouldn't read a leaflet about being pregnant.

The Asian voice on trusted information

Our Asian respondents trusted these sources of information:

- Information provided in their community space
- Leaflets in different languages
- Health advice from the leaders of health centres and religious organisations
- Multi-lingual caseworkers
- Men's group at Temple

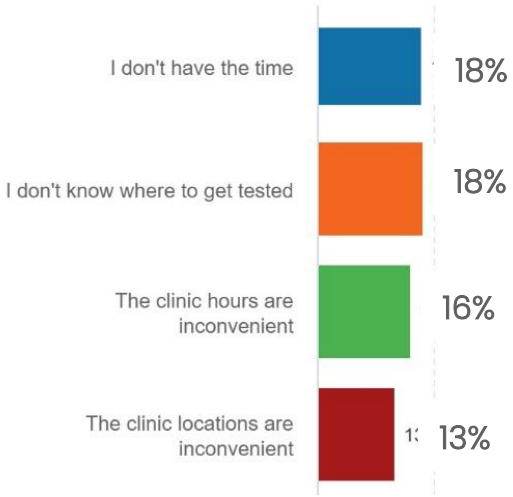
Barriers and enablers

BARRIERS

Access barriers

The biggest practical barriers for our respondents to get tested were:

- Not knowing where to get tested
- Lack of time
- Inconvenient clinic hours
- Inconvenient clinic locations



A minority of our participants told us that:

- Having access to a free machine would be a key enabler, but they didn't know where to hire them.
- A blood pressure check is very uncomfortable or painful.

Asian voice on cultural barriers

Our Asian participants told us about 3 cultural barriers:

- They feel less trust in GPs because of their singular focus on conventional medicine (ie tablets) and lack of "respect" for alternative approaches.
- Key communications (particularly leaflets) are not translated.
- Blood pressure can be a taboo subject. This isn't helped by some faith leaders avoiding talking about health. Men find it more difficult than women to talk about their health.

Conversation barriers

Other participants also told us that most people don't discuss their blood pressure. This contrasts with frequent mention of other health 'stats', including: baby's weight; step count, pulse and temperature. Reasons provided for this reticence include: it's too personal; difficult to understand; not relevant; and risky to reveal in case it's perceived as a bad result.

Educational barriers

A key barrier for our participants was lack of blood pressure education at school. It wasn't that their schools failed to teach them. It was simply because blood pressure wasn't on the curriculum.

Attitudinal barriers

The top three attitudinal barriers for our respondents to get tested were:

1. No symptoms

- "If I feel well, why go?!"
- This was felt by 33% of respondents

2. Fear the results

"I just don't want to know".

Felt by 15% of respondents.

3. Not urgent

"It's not urgent or important."

"People say they'll do it tomorrow."

Other attitudinal barriers were raised, each felt by a significant minority of our participants:

4. Skepticism	5. Protect NHS	6. Medication
• "It won't change anything"	• I don't want to bother busy doctors" (echoing reticence to ask for care during Covid).	• "I don't want medication."

7. Trust	8. Fatalism	9. Shame
• "People distrust the NHS."	• "Some people just don't care. If they're gonna die, they're gonna die [sic]"	• "I don't want a professional there because I don't want to be told off."

ENABLERS

We asked respondents where would be the most convenient location to get tested. Excluding 'don't knows', these were the top results:

Location	Respondents
GP	46%
Community setting (e.g. supermarket and library)	15%
Home testing	17%
Pharmacy	19%

The result for home testing stands out as high, and fits well with the September 2025 national campaign promoting this approach.

Mobile clinics

A majority of participants strongly approved of having self-service pop-up clinics in city centres, events, community hubs, supermarkets, libraries and gyms.

One participant received excellent feedback from the group for his design:

- Like a photobooth, with a curtain for privacy.
- Prints off your result.
- Watch calming video before test, and then informative one afterwards.
- Provide a traffic light system to indicate seriousness.
- Get a free sweet.

A self -testing BP unit designed by a participant.

Salisbury self-checking machine

For a number of years in Salisbury hospital, there was a self-checking machine on the top floor, for staff to use. It measured weight and blood pressure, and provided a printed readout. We were told it was popular.

Concerns about mobile clinics

There were also concerns about mobile clinics. Participants told us:

- beware of results being skewed by alcohol and late-night activity
- many attendees won't live locally, so it will be more difficult to organise follow-up medical intervention
- the offer of a blood pressure check at these mobile clinics must not feel forced, which would dent trust
- it's important that the 'vibe' of the event isn't spoilt with this clinical intervention.
- because blood pressure checks are so personal, the experience needs to feel safe and secure. If a professional is present to provide advice, the conversation must be private.

At the workplace

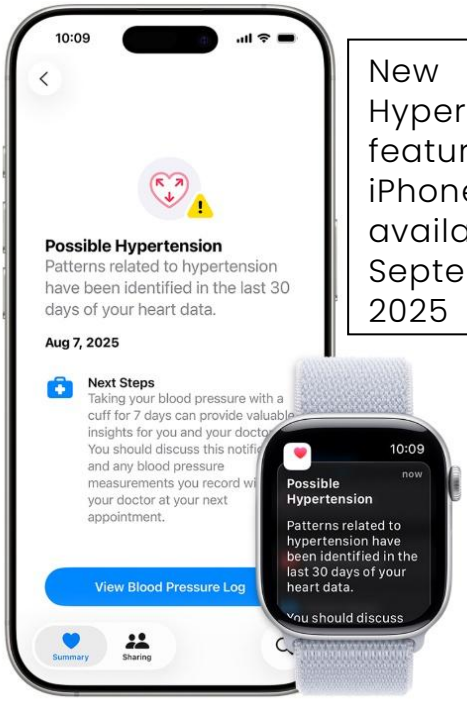
Participants were strongly in favour of blood pressure checks in the workplace, once we raised it as an option. They commented:

- results must be confidential, and purely for employee
- employees can attend in work time – not break time
- the check should be seen as part of wider wellbeing corporate initiatives, e.g. free yoga.

Technology

Participants who were digitally confident emphasised that texts and the NHS app are useful to book appointments, find out test results, and get access to information.

They also looked forward to using more convenient methods to test their blood pressure, for example new mobile phone applications.



New Hypertension feature on iPhones, available September 2025

Dedicated phone line

Our participants wanted the ability to get personalised blood pressure advice whenever they need it. One person suggested having a dedicated NHS or charity phone line to answer their questions.

Embedded in other patient journeys

We were told that more blood pressure checks would be taken if they were embedded in other patient journeys. We heard that pharmacists are offering checks to patients at the moment they collect medication. One respondent described this as “very convenient”.

Messaging

We asked participants what types of messages would encourage them to engage with blood pressure health.

To scare or not to scare

Participants discussed the pros and cons of using 'scare tactics' to boost testing rates. An example of messaging using scare tactics is: "Every day you ignore your blood pressure, you gamble with your life".

For our participants, the pros are that it grabs a person's attention. It adds a sense of urgency and lasts longer in their memory. The cons are that it encourages avoidance. Some people fear a blood pressure check in case "something awful" is revealed. Others may experience a sense of fatalism: "if I'm going to get a heart attack, I may as well enjoy myself in the meantime." These other messages were favourably received by our respondents.

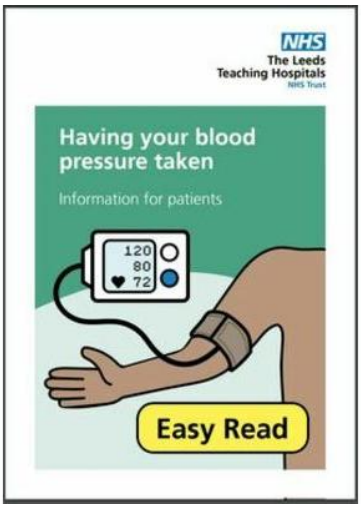
Category	Example
Curiosity	What happens to your blood pressure if you squeeze this stress ball as hard as you can?
Incentive	• Get checked and receive a raffle ticket. • Get free advice about your blood pressure.
Bandwagon	Everyone is finding out their numbers – why not you?
Personal responsibility	• Know your numbers (this is the slogan used by Blood Pressure UK for its national blood pressure awareness campaign) • Has anyone in your family had a heart attack?
Risk	Do you want to take a big risk with your health?
Health gain	Stay healthy for your family.
Authority	The NHS recommends everyone over 40 checks their blood pressure yearly.
Storytelling	I had no symptoms – but my check saved my life.

It's hard to overstate the importance of messaging. One tweak might engage thousands of people. Or it might put them off.

Operational recommendations

The following practical recommendations come directly from our participants and respondents.

Powerful and accessible communications



1. Promote short, authoritative videos, particularly on social media. Include emotive stories of people whose lives were saved/transformed by having their blood pressure checked.
2. Review how accessible blood pressure guidance is for foreign language speakers (particularly for the Asian communities) and publish a plan of action to address concerns.
3. Ensure communication tools are available for those with lower digital or literacy skills.

Community engagement

4. Bring blood pressure information into community and faith centres, rather than expecting its members to go and find it elsewhere.
5. Support the establishment and growth of men's health groups, particularly in Asian communities.
6. Encourage those being tested to stress the importance of testing to other members of their community. Provide them with tools/incentives.

Accessibility

7. Promote pharmacies as a primary, convenient testing point, coordinating with Pharmacy First to manage demand.
8. Develop private, approachable testing kiosks in supermarkets, pharmacies, and community settings for mobile and self-service blood pressure checks. Provide clear follow-up information and use the setting as an opportunity for education — for example, offering a virtual reality experience to explain blood pressure.

9. Increase free-to-borrow blood pressure monitors in community spaces (e.g. libraries) and promote their availability.

Knowledge and skills

10. Pilot a blood pressure educational experience in a local school and workplace, linking it to their wider wellbeing programmes.

11. Develop a basic "blood pressure curriculum", setting expectations of the knowledge and skills different groups need. For example: what should children know aged 16? What blood pressure information should feature in first aid courses?

Technology

12. Use the NHS App and digital reminders to educate people about their blood pressure and prompt them to get tested.

13. Consider providing patients with blood pressure machines that make it easier for them to understand their results. For example, they could colour code the readings and connect with an engaging, educational app.

Trust and patient experience

14. Encourage trained first aiders and community health staff to incorporate a blood pressure check when assisting someone who feels unwell, once any emergency response is undertaken.

15. Provide clear follow-up pathways (pharmacies, wellbeing coaches, or digital tools) so patients get personalised advice about their test results, without needing a GP appointment.

16. Use waiting times—such as in surgeries or helpline queues—as opportunities for short, reassuring education.

Strategic recommendations

Summary

To increase people's engagement with blood pressure, focus is needed on both the 'supply' and 'demand' of services. Examples of 'supply' are walk-in appointments and free loans of blood pressure machines. 'Demand' is the motivation of people to use this supply of services. We would like to work with the Integrated Care Board (ICB) to develop these 'demand side' recommendations.

1. Develop BP (blood pressure) Champions

Many of our participants trusted leaders of religious, ethnic, and community centres. So we recommend a 'community activation' strategy, spearheaded by these leaders. Community leaders would be trained and motivated to become Blood Pressure Champions and own the cascade of blood pressure health through their community.

2. Design Blood Pressure Conversations

Consideration should be given to the development of structured 'Blood Pressure Conversations' to accompany blood pressure checks.

The National Institute for Health and Care Excellence (NICE) advises healthcare professionals to:

- Offer lifestyle advice to people with suspected or diagnosed hypertension,

and continue to offer it periodically (section 1.4.1)[2]

However, participants in this project told us that this educational input is not effective. One of the best opportunities for blood pressure education is when blood pressure is taken. Consider that between 2021 and 2026, 15 million blood pressure screenings are projected to take place in pharmacies alone.[3] This represents 15 million one-to-one opportunities to educate the patient.

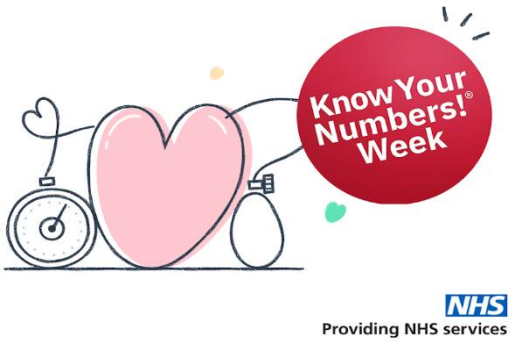
3. Increase workplace testing

Establish a working group to review how to increase blood pressure testing in the workplace. This could include:

- Integrating blood pressure testing in annual staff health checks, health induction programmes and other health or wellbeing events.
- Providing micro-incentives (e.g. a free healthy snack) if employees get their blood pressure checked at work.

4. Refine and segment local messaging

Much of the messaging around blood pressure checking is set at a national level. For example, each September a national campaign called 'Know Your Numbers' is rolled out. However, we feel that there is potential to follow up this national approach with powerful local messaging.



[2] https://www.nice.org.uk/guidance/ng136/chapter/Recommendations#treating-and-monitoring-hypertension

3 https://thecca.org.uk/community-pharmacies-expected-to-deliver-15m-blood-pressure-checks-by-2026/

Approach	Explanation
A/B testing	Trial different types of messaging with the same type of audience, to see which is more effective. This is known as 'A/B testing'.
Segmentation	Segment messaging so that different populations receive messages that mean the most to them. This is particularly important for ethnic minority communities.
Community co-production	Develop the content of community messaging with community leaders, as they know which messages will have the most impact.
Positive messaging	Put more emphasis on messaging which arouses curiosity; offers incentives; triggers a sense of personal responsibility; and stresses health gains. These are positive and empowering messages that have a place alongside more traditional 'scare tactics'.
Storytelling	Invest in storytelling, as patients can often learn more from a person's experience than dry medical explanations.
Patient journey	Plan messaging for each step of the patient journey. For example, the messaging used to persuade someone to get tested will be different from the messaging they receive when they are in the clinic, with a midwife or before an operation.

Last word

Many of the Public Health initiatives we came across in this research focus on the 'supply' side of blood pressure services. The goal is to make testing more accessible and promote this availability to target populations. It's a provider-led service, where the patient is disempowered.

This approach is captured well by the term 'case finding'. This is when doctors metaphorically search around in hard-to-reach places to find suitable candidates to test.

It may be more effective if these candidates proactively come forward because they want to be tested. That's why we emphasise the need to focus more on the 'demand' side of services. This requires people to have greater awareness, stronger motivation and a sense of ownership over their own blood pressure.

The most powerful way to boost blood pressure health is by empowering the patient.

Appendix

Methodology

Research type	Information	Number of people
Focus groups	6 groups across BANES, Swindon & Wiltshire	36
1-2-1 conversations	30-minute conversations	8
Online survey	Takes less than 5 mins to complete	442
	TOTAL	**486**

Participant & respondent profiles

Research method	Socioeconomic status	Ethnicity	Gender
Focus groups	Core 20 (This term refers to populations who live in the 20% most deprived areas of the UK)	47% Asian	39% male 61% female
1-2-1 conversations	Core 20	White British	12% male 88% female
Survey	12% very comfortable 56% quite comfortable 22% just getting by 3% really struggling 7% prefer not to say	80% White British 5% White (any other background) 2.6% Black/Black British: Caribbean Less than 2% for all other categories	28% male 69% female 2% Non-binary /prefer to self-describe / not to say.

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