Reducing Inequalities Alliance

Core20Plus5 Theory of Change

A supporting narrative for Bradford District and Craven Core20Plus5 programme

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Contents:

- Foreword
- Introduction
    - Context and pre-conditions
        - Population
        - Policy
        - Funding
        - Operational Context
            - Core20Plus5 delivery infrastructure
            - Acting as One
    - Assumptions
- Core20Plus5 Investment
    - What we will do
        - Core20Plus5
        - Acting as one
    - Why we will do it
    - How we will do it
    - What will change
- Maternity
    - What we will do
        - Core20Plus5
        - Acting As One
    - Why we will do it
    - How we will do it
    - What will change

- Smoking
  - What we will do
    - Core20Plus5
    - Acting As One
  - Why we will do it
  - How we will do it
  - What will change
  -
- Serious Mental Illness
  - What we will do
    - Core20Plus5
    - Acting As One
  - Why we will do it
  - How we will do it
  - What will change
  -
- Respiratory Disease
  - What we will do
    - Core20Plus5
    - Acting As One
  - Why we will do it
  - How we will do it
  - What will change
  -
- Cancer
  - What we will do

        - Core20Plus5
        - Acting As One
    - Why we will do it
    - How we will do it
    - What will change
    -
- Cardiovascular Disease
    - What we will do
        - Core20Plus5
        - Acting As One
    - Why we will do it
    - How we will do it
    - What will change
    -
- Adversity, Trauma and Resilience
    - What we will do
        - Core20Plus5
        - Acting As One
    - Why we will do it
    - How we will do it
    - What will change

Further Information

Related Documents

Core20Plus5 ‘What we will do’

‘What works’ evidence packs

Community Partnership Profile Data Sets

Core20Plus5 in Bradford District and Craven Logic Model

Core20Plus5 in Bradford District and Craven Evaluation Plan

Foreword

Core20Plus5 is a national inequalities framework that covers the 20% most deprived population, "plus" groups (those often marginalised from mainstream services), and 5 clinical priorities (maternity, severe mental illness, chronic respiratory disease, cancer, and hypertension). The Core20Plus5 programme is being delivered locally by the Reducing Inequalities Alliance and the Healthy Communities programme, with its partners in the NHS, voluntary and community sector (VCS) and Bradford local authority.

This document describes the way that the Core20Plus5 programme will achieve its aims in Bradford District and Craven, it is for staff working in roles or organisations that contribute towards reducing health inequalities locally including VCS organisations, Bradford Local Authority, Community Partnerships, and organisations working in partnership with the Bradford District and Craven Health and Care Partnership. It outlines the activities that are already underway as part of the Core20Plus5 programme and the evidence underpinning this approach.

The report complements wider Core20Plus5 planning documents that includes a logic model, evaluation plan, supporting evidence and data packs. We hope it will support the case for continuation of investment to prevent ill-health and reduce inequalities locally, and to grow the Core20Plus5 approach beyond its current boundaries. In addition, it is intended to be a useful reference point to support future strategies, funding bids, service developments and transformation.

The structure of this document covers:

- The context within which the Core20Plus5 programme is being delivered.
- What actions and activities the Core20Plus5 programme will take to address the priorities (with local major strategies and via Core20Plus5 funded interventions).

- Why the Core20Plus5 programme is taking the approach described for each clinical priority.
- How the Core20Plus5 programme will deliver change against the clinical priorities and the underpinning evidence that supports this approach.
- The change that is expected
- The appendices summarise how you can access supporting documents covering data, intelligence, further evidence, and the evaluation plan.

To learn more about the local approach we're taking with Core20Plus5 visit www.bdcpartnershp.co.uk/ria or contact us directly at ria@bradford.nhs.uk

Introduction

The Core20Plus5 programme in Bradford District and Craven seeks to bring about positive change in health outcomes and reduce health inequalities for the communities and population groups that experience the biggest disparities in healthy life expectancy and life expectancy. It will do this through the devolvement of Core20Plus5 funding to community partnerships and enabling them to make data led decisions regarding their own health priorities and support the development and implementation of prevention focused interventions in the community.

The initial national Core20Plus5 programme and local funding focussed on adults, before a Core20Plus5 framework for Children and Yong People was published by NHS England. Most of this document focusses on adults although in the Maternity and Adversity Trauma and Resilience we reference CYP outcomes. A separate piece of Core20Plus5 work with a CYP focus has been established.

The approach described here has been developed for a defined population within the current national, regional, and local policy context, it should therefore be noted that whilst the approaches are likely to remain constant the activities may change. Please contact ria.@bradford.nhs.uk for more information.

This document forms part of a suite of programme documents and is intended to be read alongside:

- Core20Plus5 Prevention Intervention Summary (Appendix A)
- Evidence of “what works for Core20Plus5” packs. (Appendix B)
- Community Partnership Data Packs (Appendix C)
- The Core20Plus5 logic model (Appendix D)
- Core20Plus5 evaluation Plan (Appendix E)

Context and pre-conditions

Population:

Bradford District and Craven stretches from Bradford city centre, past Keighley in the Aire Valley, through the large market towns of Ilkley and Skipton, to Ingleton in the Craven basin. As a partnership we serve a GP-registered population of over 657,579 people in this mixed urban and rural area covering 597 square miles (of which Craven is 454 square miles). Craven GP practices, serve around 7.5% of our population (c50,000). Bradford District and Craven represents around 25% of the population of West Yorkshire of 2.6 million people.

Bradford District is an ethnically diverse area, with the largest proportion of people of Pakistani ethnic origin in England. One in four people describe themselves as Asian/Asian British compared to one in ten for England and there is a high proportion of our population in Bradford City and Keighley who identify as being from a Black, Asian or Ethnic Minority background. Conversely, the wards of Ilkley, Wharfedale and Craven are predominantly White British.

More than a third of our population live in poverty. Whilst wards around central Bradford and Keighley appear in the 10% most deprived wards in the country, wards in the Wharfe Valley are in the 10% least deprived nationally.

We currently have a young population, with the fourth highest proportion of under 16-year-olds in England and a higher proportion of babies, infants, children, and young people than the average for England. The proportion of the working age population is lower in Bradford than the average for England. However, the largest increase in our population has been in older people, and this is predicted to further grow, bringing with it the challenges associated with managing increasing long term conditions and the potential impact on the social care sector.

Bradford District and Craven has significant populations represented in the Inclusion Health groups. Emerging findings from the Bradford District and Craven inclusion health needs assessment indicate that there are:

- 2,740 people assessed as homeless every year.
- 1,400 Asylum Seekers housed in Bradford (December 2023)
- 1,150 Gypsies and Travellers (Census 2021)
- 1,613 Roma (Census 2021)
- 85 Street based sex workers (Lotus project service users)

- 142 offences related to modern slavery a year.
- 3,855 people in contact with criminal justice system (Nov 2023)
- More than 10,000 people in Bradford experiencing drug and alcohol dependency.

NB. Most of these statistics are underestimates e.g., actual Roma population in Bradford District is likely to be 10 times higher than the official Census figure.

Policy

Closing the gap in healthy life expectancy between the least and most deprived parts of Bradford District and Craven will be challenging when the historical rise in life expectancy has stalled, and both the West Yorkshire ICB and Bradford Council are experiencing a severe financial crisis. We therefore need realism, as closing this gap even in a generation is ambitious. Stopping the gap widening should be our priority and we have various national and local policy drivers that help focus this aim.

National Policy

NHS England: Our Approach to reducing healthcare inequalities[1]
In the first half of 2021/22, systems were asked to focus on five priority areas outlined in the NHSE priorities and operational planning guidance:

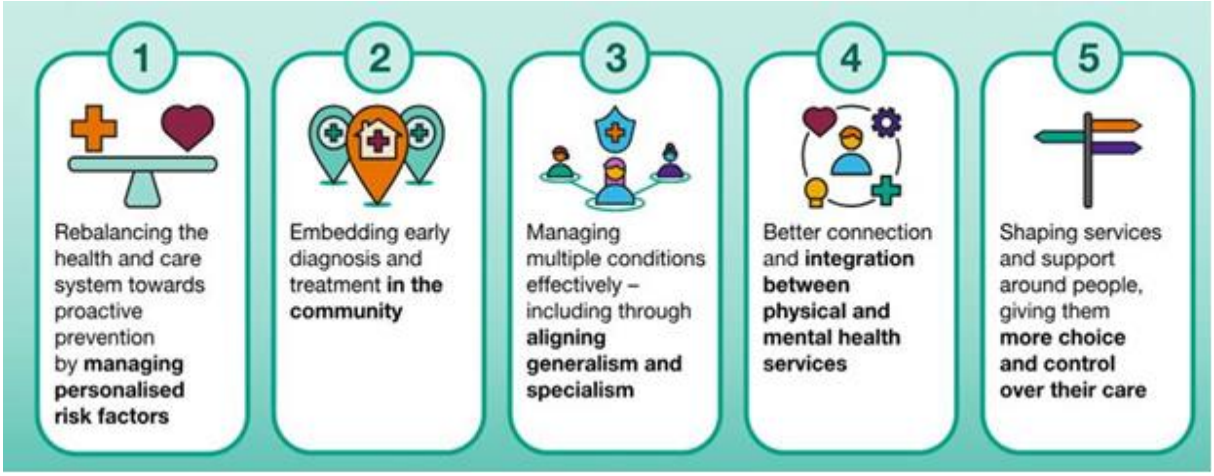
1. Restoring NHS services inclusively
2. Mitigating against digital exclusion
3. Ensuring datasets are complete and timely.
4. Accelerating preventative programmes
5. Strengthening leadership and accountability

The 2023/24 operational planning guidance states that ICBs and system partners should continue to address health inequalities and deliver on the Core20Plus5 approach which informs action to reduce healthcare inequalities at both national and system level.

Chapter 2 of the NHS long term plan[2] focuses on addressing health inequalities describing the need to improve upstream prevention of avoidable illness and its exacerbations through preventative action to reduce health inequalities by focussing on the biggest risk factors for poor health (smoking, poor diet, high blood pressure, obesity, alcohol and drug use, and anti-microbial resistance).

[1] NHS England » Our approach to reducing healthcare inequalities
[2] NHS Long Term Plan » Chapter 2: More NHS action on prevention and health inequalities

NHS Major conditions strategy: The major conditions strategy proposal provides a framework within which to anchor an approach to reducing health inequalities, specifically the Core20Plus5 programme in Bradford District and Craven will both align with and support the delivery of the strategy. It prioritises six groups of conditions that account for 60% of ill health in the UK (cancers, cardiovascular disease (CVD) including stroke and diabetes, musculoskeletal disorders, mental ill health, dementia, chronic respiratory disease) and five priority areas to make the greatest impact[3].



Further recent national policies and frameworks that are referenced within this document and highly relevant to strategic work to reduce inequalities are:

- The NHS England (NHSE) inclusion health framework, published setting out action on inclusion health across the system
- The NHSE digital inclusion framework identifying groups as being at higher risk of digital exclusion and actions to mitigate this.
- The equality delivery system (EDS) to help NHS organisations improve the services they provide for their local communities and provide better working environments, and
- The NHSE statement on information on health inequalities setting out powers available to ICBs and trusts on reporting and using inequalities data.

West Yorkshire ICB Policy

The West Yorkshire Health and Care Partnership 5-year plan contains ten big ambitions the first of which was to reduce the gap in life expectancy between the people living in our most deprived communities compared with the least deprived

[3] Major conditions strategy: case for change and our strategic framework - GOV.UK (www.gov.uk)

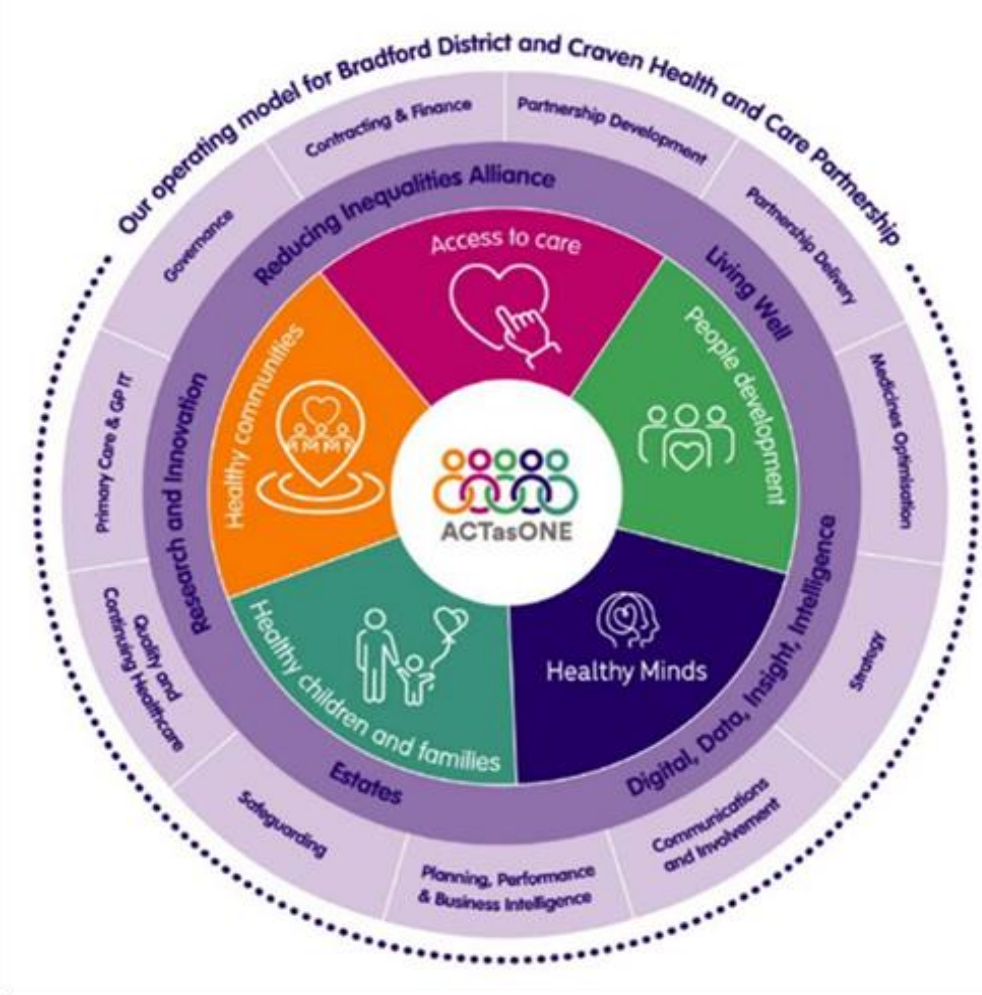
communities by 2024 (currently being refreshed). The ambitions go on to prioritise groups of people often experiencing the starkest inequalities (including those with mental health conditions, learning disabilities and/or autism; children and young people (CYP) living in poverty; and groups with poor maternal outcomes)[4].

District and Place Based Policy

The Bradford District and Craven Health and Care Partnership Strategy sets out the strategic ambition to reduce health inequalities and improve population health via the quadruple aim:

- Improving outcomes in population health, healthcare, and wellbeing.
- **Tackling inequalities in outcomes, experience, and access.**
- Enhancing productivity and value for money; and
- Supporting broader social and economic development

[4] Better_Health_and_Wellbeing_for_Everyone.pdf (wypartnership.co.uk)



The Reducing Inequalities Alliance coordinates some of this work as one of the five enabler programmes (below) although work to reduce inequalities happens across the health and care partnership, Bradford Council, the VCSEE sector and in our research institutions[5].

This work contributes to the Bradford District Plan[6] (2021-2025), directly via service delivery to the first and second strategic outcomes (Children have the best start in life; Residents achieve good health) and more indirectly to the further three outcomes (Sustainable economic growth; Safe, sustainable, and inclusive communities and Action to address climate & environmental change).

[5] Reducing Inequalities Alliance - call to action by Reducing Inequalities - Issuu

[6] Bradford District Plan 2021-2025

The work also contributes directly to the North Yorkshire Council Plan 2024-2028[7] priority for Health and Wellbeing and indirectly to the other priorities (Place and Environment, Economy, People, organisation)

Local policy and strategy

- Bradford District and Craven Health and Care Partnership Joint Forward Plan[8]
- Healthy Minds: our strategic plan for mental health, learning disability, neurodiversity, and substance use.
- NHS Vaccination Strategy
- ACEs Trauma & Resilience Strategy
- Every Baby Matters
- Bradford District Digital Strategy 2022-2027
- Bradford District Prevention and Early Help Strategy 2022 – 2025
- Improving physical health and reducing premature mortality for people with severe mental illness, learning disabilities and autism spectrum condition: An action plan for Bradford District and Craven 2023 - 2026

Funding

[7] North Yorkshire Council: Our plan for the future of North Yorkshire

[8] Bradford District and Craven Health and Care Partnership Joint Forward Plan

The Core20Plus 5 programme will be delivered in the context of significant budget constraints and the revised operating model across the NHS West Yorkshire Integrated Care Board (WYICB).
NHSE Funding to support Core20Plus5 funding has been allocated to the WYICB to deliver the programme and apportioned at both ICB and place levels. A proportion of the funding available will be retained by WYICB to support ICB wide interventions to address inequalities in Inclusion Health and other strategic approaches best delivered at a WYICB level that support the reduction in health inequalities at scale. Funding allocated to Bradford District and Craven place to support the delivery of the framework has been apportioned as follows:

- A proportionate allocation to the 13 Community Partnerships (CPs)within Bradford District and Craven who will deliver the programme of interventions in line with their local priorities.
- Funding to support the commission of two district wide programmes of work focused on developing resilience in children and promoting sleep hygiene in children.
- Funding to enhance local VCSE funding strategies that will support the reduction of health inequalities (Harnessing the Power of Communities) and support the integration of previously successful health inequalities interventions into wider Bradford District and Craven work programmes (Reducing Inequalities in Communities)
- Funding to support the Core20Plus5 delivery infrastructure.

Funding for Core20Plus5 is included in current budget cycles until 2026 and assurance is being sought beyond that period.

Operational Context

Core20Plus5 Delivery Infrastructure:
A robust infrastructure exists to ensure the effective delivery of the Core20Plus5 programme across the Bradford District and Craven area comprising:

- A place based Core20Plus5 steering group that reports to the Reducing Inequalities Alliance and the WY Core20Plus5 group.
- A dedicated support team located within the Reducing Inequalities Alliance to provide leadership, strategic and operational oversight.
- Core20 Reducing Inequalities Manager roles working within locality teams. who are adding capacity to the Healthy Communities team and community

partnerships to ensure effective delivery of interventions to address local health inequality priorities.
- Community partnerships with a devolved Core20 budget aligned with wider local authority led work.
- Place based commissioned services to address Adversity, Trauma and Resilience, Children and Young People and Inclusion Health.

This delivery infrastructure will be essential to the success of the programme, but it should be recognised that it exists within a broader context of significant austerity which may threaten the existing infrastructure and impact negatively on wider partners, particularly the VCSE.

Acting as one

Despite funding challenges, Bradford's diverse communities should be viewed as an asset that bring valuable new perspectives and new approaches to old problems. Our vibrant young population provides an opportunity for the future as does Bradford's city regeneration and City of Culture 2025. Networks of community partnerships and locality teams are working with VCSE anchor organisations across the Bradford District and Craven area.

Multi agency boards are working together to tackle mental health, access to care, children and young people, healthier communities and workforce issues and deliver the Bradford District and Craven HCP Forward Plan, with much of this work underpinned by key strategies focussing on issues such as poverty, digital inclusion, and tobacco control.

The Core20Plus5 programme in Bradford District and Craven will be delivered through partnership and collaboration with colleagues across the partnership and ICB, and wider partners including the voluntary and community sector organisations and local authority.

The programme is sited within the broader operationalisation of the BDCHP strategy as set out in the Joint Forward Plan 2023 and will support wider delivery plans through direct intervention and the support and development of the community-based decision making and delivery infrastructures.

Broadly the programme will support the delivery of work being taken forward by:

- Access to Care Programme
- Healthy Communities programme
- Healthy Minds board

- Healthy Children and Families Partnership Board
- Living Well

This will be achieved by implementing prevention interventions that focus on:

- Earlier diagnosis and treatment for major conditions
- Preventing the development of poor health and wellbeing
- Supporting the management of long-term conditions (LTC)
- Support for developing CP infrastructure and delivery of changes that matter to local people to address health inequalities.
- Interventions that deliver lifestyle and wellbeing information and support that add value to the Living Well offer.
- Connection to Living Well services.

Assumptions

The following assumptions have been made in developing this theory of change and underpin the outcomes that are expected from the programme.

- Poverty and deprivation will continue to be issues that we must factor into the way we deliver healthcare services (what we do but also how we do it)
- There will be no major changes to the strategic or policy landscape.
- Funding context prior to March 2026 does not change.
- The community partnership and VCSE infrastructure will remain a key component to delivering the health inequalities agenda.
- The community partnership priorities do not change significantly.
- The reducing inequalities managers remain available to support the implementation of the prevention interventions.
- That should there be a major shift in policy or new emerging priorities then the programme will need to flex to accommodate these which may result in a change to outcomes and a revision to this theory of change.

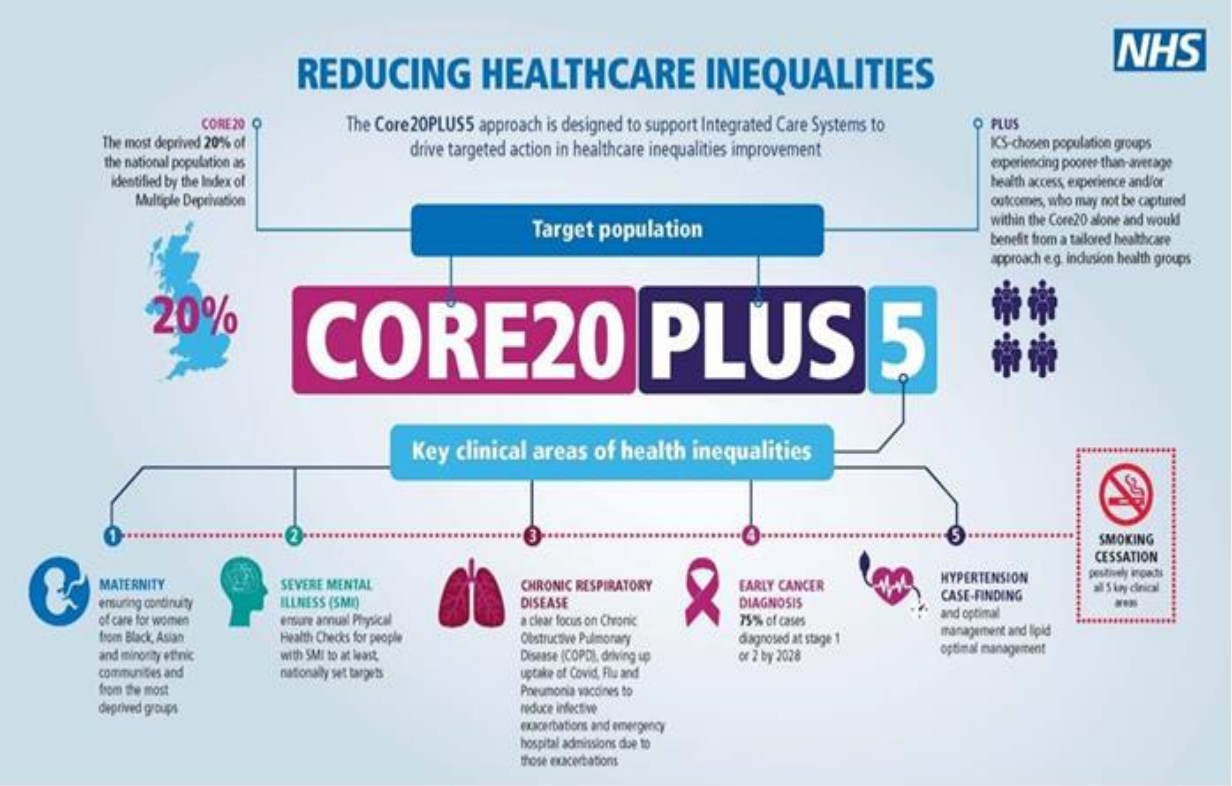
Core20Plus5 Investment

Key Short-Term Outcome:
Improvement in health behaviour and outcomes through more people accessing screening and interventions to promote health improvement.

What we will do

Core20Plus5
We will utilise the funding made available to implement the Core20Plus5 programme across Bradford District and Craven in line with the principles agreed by the WY System Leadership Group.

The Core20Plus5 framework provides an overarching approach to addressing health inequalities by focusing on key population groups that experience the greatest inequalities in health care and the clinical priorities that contribute the most to premature mortality. The national Core20Plus5 approach defines a target population – the 'Core20Plus' – and identifies '5' focus clinical areas requiring accelerated improvement.



Locally we have also prioritised ***'Prevention and early help for children and young people to reduce Adverse Childhood Experiences'.***

The Core20 refers to the most deprived 20% of the national population (which is 50% of the population of Bradford District) where we need to concentrate our efforts and work in a more targeted way.

The PLUS are population groups that are not geographically bounded but who experience health inequalities and social exclusion, such as some ethnic minority communities, people with a learning disability and inclusion health groups.

Core20Plus5Core20Plus5 funding has been made available and will support the delivery of the framework alongside equitable recovery from the pandemic. In May 2022, the WY System Leadership Group (SLEG) approved an approach that is underpinned by four key principles:

- Needs and equity based.
- Have proportionate universalism & subsidiarity at its core.
- Integrate rather than duplicate services and,
- Be evaluated for impact on morbidity and premature mortality.

Acting as one

Bradford District and Craven will implement the framework in line with these key principles through:

- The proportionate allocation of Core20Plus5 funding across thirteen Community Partnerships
- The devolvement of decision making to Community Partnerships to ensure health inequalities priorities are locally determined.
- The provision of data, intelligence, and evidence to support local decision-making.
- Targeted support through RI Managers makes data informed decisions re: priorities.
- Implementation of data led interventions focused on tackling inequalities in the community (Core20Plus5 'what we will do')
- Building relationships/connectivity at hyper local level,
- Building trust and increasing the maturity of Community Partnership network.

Cutting across the programme and delivered through the preventative interventions there will be a focus on mitigating against the effects of poverty and deprivation and the key risk factors of:

- Poor access to health
- Loneliness and isolation
- Low levels of health literacy and health awareness

Why we will do it.

Health inequalities are caused by the conditions that people are born into affecting how they live, work, and grow. The Reducing Inequalities Alliance call to action for Bradford District and Craven sets out clearly the challenges that Core20Plus5 can help to address. Across Bradford District and Craven place there are significant inequalities in both life expectancy and healthy life expectancy between our most and least deprived areas and different groups in society that are systemic, unfair, and avoidable and that have been further exacerbated and exposed because of the Covid19 pandemic.

Before COVID-19 health inequalities were estimated to cost the NHS an extra £4.8 billion a year, and society around £31 billion in lost productivity, reduced taxes, higher welfare benefits and responding to social issues.

Wider determinants of health

Across the communities targeted within the Core20Plus5 framework there are significant disparities in social, economic, and environmental conditions that all impact on health, particularly differences in income and deprivation, with 18.9% of the population experiencing income deprivation (compared to 12.9% in England and almost half of the population living in the worst quintile of deprivation.

Living in absolute or relative poverty is the single most important factor impacting on health and the data across the thirteen community partnerships tells us that there are significant differences between populations in the prevalence of conditions that contribute the most to premature mortality and reduced healthy life. In addition, people living in areas of greatest deprivation are more likely to be living with more than one condition (multi-morbidity) with young and middle-aged adults living in the most deprived areas and/or belonging to Inclusion Health groups having rates of multimorbidity equivalent to those aged 10–15 years older in the most affluent areas. In deprived areas people are twice as likely to suffer from multi-morbidity.

Underlying social determinants can both be caused by or exacerbate inequalities in deprivation and health. People living in areas of greatest deprivation are more likely to lead unhealthy lifestyles and have poorer access to healthcare services and support and a key risk factor for this is poor health literacy. Health literacy /education refers to people having the appropriate skills, knowledge, understanding and confidence to access, understand, evaluate, use, and navigate health and social care information and services. People living in deprived communities are more likely to experience poorer health literacy[9].

Loneliness and social connectedness are key determinants of health.
Loneliness increases the likelihood of premature mortality by 26% and evidence shows that weak social networks and a lack of social support can be particularly associated with coronary heart disease and stroke[10].

It is estimated that the prevalence of loneliness within the population is somewhere between 6%-9% and that there are key populations groups that are at risk of experiencing loneliness including those living in the top 20 % of deprivation and plus populations defined by protected characteristics and inclusion health groups[11].

Both the quality and quantity of social relationships affect mental health, health behaviour, physical health, and mortality risk. Sociologists have played a central role in establishing the

[9] Health disparities and health inequalities: applying All Our health (2022)
[10] Social Relationships and mortality risk: a meta-analytic review
Loneliness and social isolation as risk factors for coronary heart disease and stroke: systematic review and meta-analysis of longitudinal observational studies
[11] Investigating factors associated with loneliness in adults in England (2022)

link between social relationships and health outcomes, identifying explanations for this link, and discovering social variation (e.g., by gender and race) at the population level[12].

In addition, there is growing evidence that suggests that *perceived* social isolation (loneliness) can impact negatively on emotional wellbeing and physical health across the life-course. Outcomes include depression, poor sleep quality, impaired executive function, accelerated cognitive decline, unfavourable cardiovascular function, and earlier mortality[13].

Inclusion Health ("PLUS" groups)

Inclusion health is an umbrella term to describe people who are socially excluded who typically experience multiple interacting risk factors for poor health, such as stigma, discrimination, poverty, violence, and complex trauma. People in inclusion health groups tend to have poor experiences of healthcare services and are least likely to receive healthcare despite having the highest need. This can result in significantly poorer health outcomes and earlier death among people in inclusion health groups compared with the general population[14].

Inclusion Health groups are recognised as part of the 'PLUS' groups to be prioritised nationally within Core20Plus5 and are more likely to live in areas with the greatest deprivation resulting in multiple disadvantages. These groups include:

- People experiencing homelessness and rough sleeping.
- Vulnerable migrants
- Gypsy Roma and Traveller communities
- Sex workers
- Victims of modern slavery and human trafficking
- People in contact with the criminal justice system
- People experiencing alcohol and/or drugs dependency.

Emerging findings from the Bradford District & Craven Inclusion Health Needs Assessment has found that:

- Life expectancy of the homeless population is more than 30 years less than that of the general population largely due to tri-morbidity od physical and mental health and substance misuse.

[12] Social Relationships and health: A Flashpoint for health Policy - PMC (nih.gov).

[13] Perceived social Isolation, evolutionary fitness, and health outcomes: a lifespan approach

[14] A national framework for NHS - action on inclusion health

- Asylum seekers and refugees' health needs relate to untreated communicable diseases, poor mental health, poorly controlled chronic conditions, and maternity care.
- People identifying as Gypsies or Irish Travellers self-report the highest levels of 'bad or very bad health' compared to people of other ethnic backgrounds.
- Lack of knowledge of the UK healthcare system is a common theme for Asylum Seekers and Refugees as well as Vulnerable Migrants such as Roma.

(Professor) Michael Marmot has noted that to reduce health inequalities it is not sufficient to only target the worse off. Health inequalities follow a social gradient and to reduce the steepness of that gradient actions must be proportionate to levels of disadvantage but remain universal (proportionate universalism). Aligned with this if policy objectives are to be delivered effectively at a local level there is a need to empower individuals and communities to engage in effective participatory decision making[15][16]
There remains a continuing need to deliver universal policies to reduce health inequalities on a proportionate basis and for continued efforts to work in collaboration with local communities to do this to best effect.

How we will do it

Working with community partnerships has been and will continue to be central to the development of this Core20Plus5 approach with ongoing provision of data, evidence and targeted support made available to support the identification of local priorities. Community partnerships are seeking to be inclusive in the design of interventions and recognise the need for ongoing community engagement to understand needs at community and individual levels. Whilst some community partnerships have chosen to invest directly in this approach through the recruitment of community development/engagement roles for others it is embedded in the design of their interventions.

Community centred practice and engagement underpins the implementation of this Core20Plus5 programme. Community centred approaches are essential in reducing health inequalities within a local area or community and there is increasing recognition that reducing health disparities requires a complex system approach that puts communities at the heart of everything we do and central to this is understanding the needs of communities.

[15] Fair society, healthy lives: the Marmot Review: strategic review of health inequalities in England post 2010
[16] Health Equity in England: The Marmot Review 10 Years On

Evidence also shows that community engagement interventions have a positive impact on a range of health outcomes across various conditions and NICE guidance signals the importance of working in partnership with local communities to plan, design, deliver and evaluate health and wellbeing initiatives[17].

What will change?

Through taking this approach:

- Communities will be supported and engaged to identify and deliver against their own health inequality priorities.
- Health behaviours and outcomes will improve as more people access the screening and health interventions available to them.
- Local decision making will be driven by data, evidence and understanding of local needs.

Long Term Outcome:
Data and intelligence are consistently used to make well informed decisions on supporting access, experience, and outcomes for residents in Bradford.

[17] Community-centred practice: applying All Our Health (2022)Community engagement: improving health and wellbeing and reducing health inequalities

Maternity

Key Short-Term Outcome
Of those women attending preventative interventions in the community more women will access their antenatal support.

What we will do

Core20Plus5
The Core20Plus5 programme will include geographically targeted preventative interventions (Core20Plus5 'what we will do') in areas where Black and Asian women are underserved and will provide social models of support that enable women to access the information, care, and parent education that they need through:

- Supporting the development of peer-led support networks.
- Increased opportunities for pregnant women to receive relationship-based support.
- Provision of face-to-face antenatal education where it will add value to the district offer.
- Connecting pregnant women and families to information, guidance, and services.
- Community engagement to understand the needs and barrier to accessing services.

The preventative interventions delivered through the Core20Plus5 programme will address the risk factors associated with accessing antenatal support through the provision of supportive networks to address isolation and protect against poor maternal mental health and provision of the information and guidance needed to support women to accept services.

Acting as one
This work will directly support the ambitions of the Health Children and Families programme to improve the outcomes for maternal care across Bradford District and Craven and reduce disparities in experiences by working as a whole system. Specifically, the Core20 Programme will support the 1,001 days agenda through:

- Additional delivery of the maternity circles social model of support
- Promotion of breastfeeding
- Health messaging
- Connection to services including peri-natal mental health support and smoking cessation.

Why we will do it.

Black and Asian women from the most deprived communities are more likely to experience poorer pregnancy outcomes than others.

Women from the most deprived quintile as measured by Children in Low Income Families Local Measures, are more likely to experience stillbirth or neonatal death. There was a widening of inequalities in stillbirth rates by deprivation between 2020 and 2021.

Black and Asian women are also more likely to experience stillbirth/neonatal death than White British women. Wide ethnic inequalities in perinatal mortality continue, but stillbirth and neonatal mortality rates for babies of Black ethnicity increased at a higher rate than for babies of Asian and White ethnicity. Babies of Black ethnicity now have the highest rates of both stillbirth and neonatal death[18].

Black and Asian women and women living in the most deprived communities are:

- Less likely to book early with their midwife and thereby missing essential and access to information and support. Black/Black British women are the least likely to book early with 65.5% booking after ten weeks of pregnancy and 20.4 % booking after 18 weeks. Whilst 52% of Asian/Asian British women will book after ten weeks and 49% of White British women, for both these cohorts the % not booked by eighteen weeks drops significantly to 6.3% and 6.2% respectively.
- Less likely to access antenatal education/support programmes.
- More likely to experience complications in labour Black/Black British women are significantly more likely to suffer complications in their pregnancy and delivery with 22% of pregnancies resulting in an emergency c-section compared with only 11% in White British women. Black women are also more likely to suffer post-partum haemorrhage with 4.8% compared to only 2.2% of White British women.
- More likely to have a lower birth weight baby which has been linked to alcohol/substance misuses, poor diet, and smoking in pregnancy. Asian/Asian British women are more likely to have a low-birth-weight baby with 6% of babies being born below 2500g compared to only 3.5% of white British babies being this small.

Risk factors associated with poor birth outcomes may include:

- poor lifestyle behaviours such as a lack of exercise,
- poor nutrition,
- smoking or

[18] MBRRACE-UK Perinatal Mortality Surveillance: UK perinatal deaths for births from 1 January 2021 to 31 December 2021

- alcohol consumption
- missed essential care and checks because of late booking and engagement with midwifery services.

Risk Factors associated with accessing Antenatal support include:

- Financial hardship – a review of maternity incidents carried out in Bradford in 2023 concluded that" the current financial crisis is impacting on the ability of some women to attend essential antenatal appointments" and that the cost-of-living crisis was a significant factor in still births[19]. Loneliness and Isolation/lack of social connectedness.
- Maternal mental health/wellbeing -can both lead to and be a result of social isolation.
- Lack of awareness of availability of support
- Poor literacy skills related to education and language barriers.

How we will do it

The Core20Plus5 framework suggests continuity of carer models provide a solution to poor birth outcomes however previous pilots for these models have shown that they are challenging to enact locally. Solutions that recognise the need for relationship-based models of care have therefore been sought.

Evidence suggests that access to antenatal support and education (including antenatal classes and social /peer support models) in addition to routine antenatal midwifery services can impact positively on birth outcomes, the Core20Plus 5 programme is working with the local 1,001 days programme to support wider district wide objectives.,

There are many ways in which pregnant women may access antenatal care; through their GP, self-referral, early pregnancy assessment unit, A&E, community midwife, health, and social care professionals. Early access to antenatal care is important for the identification of risk factors that may lead to foetal and infant deaths up to 1 year. It is particularly important that women from disadvantaged backgrounds (or: experiencing multiple disadvantage) and women with poor literacy should be able to access care through places that are familiar to them[20].

Peer support can be beneficial during pregnancy, and it is recommended that women be advised of this. An evidence review undertaken by NICE found that women valued peer

[19] Exclusive: 'Cost of living crisis' contributing to stillbirths, research finds | News | Health Service Journal (hsj.co.uk)

[20] NICE Guideline NG201 Evidence Review [F] Antenatal care

support related to several themes including interpersonal sharing, feeling socially connected, attachment both to peers and their babies and having access to information and practical support[21].

Pregnant women are receptive to receiving information in pregnancy which can support the preparation for parenthood and reduce anxiety however there can be many sources for that information. It is important that women receive consistent and evidence-based information and know the sources for additional support available to them that is specific to their needs and local area. Local support groups in the community are important in meeting this requirement[22].

A local recent survey of participants in maternity circles indicated that the service was positively received and that information on pregnancy and birth, support for mental health and social connections was cited as being important.

What will change?

Of the people who access Core20Plus5 programme interventions:

- Antenatal provision will be better understood in the community.
- More Black and Asian women will be aware of the services and wider support and education available to them.
- More Black and Asian women will feel supported to access provision.
- More women will take up antenatal support.

Long term Outcome:

Fewer ethnically diverse women will experience complications in labour and there will be fewer lower birth weight babies from these communities.

[21] NICE Guideline NG201 Evidence Review [D] Peer Support
[22] NICE Guideline NG201 Evidence Review[B]Approaches to information provision

Smoking

Key Short-Term Outcome:
Services will be proportionate to need with more access to smoking cessation in communities identified as higher risk.

What we will do

Core20Plus5
Core20Plus5 preventative interventions (Core20Plus5 ‘what we will do’) will deliver:

- Provision of support to access cessation services.
- Health messaging about the harms of smoking

- Promotion of healthy life choices - smoking cessation services, increased physical activity, good diet choices.

Acting as one
We will work with public health to support the development and implementation of the Tobacco Control Strategy helping to realise the ambition for smoking cessation services to meet the needs of the target populations at highest risk.

Core20Plus5 preventative interventions will provide additionality and support the implementation of the Bradford Tobacco Control Strategy

This work will also compliment and support place-based activities to deliver the ambitions of the Long-Term Plan to reducing smoking in acute inpatient settings, maternity services, and mental health settings. We will do this through:

- Connecting people to smoking cessation support
- Health messaging on the harms of smoking
- Provision of support to access cessation services

Why we will do it.

Smoking is the UK's biggest preventable killer – causing around one in four cancer deaths and 64,000 in England alone costing the economy £17 billion each year. It puts huge pressures on the NHS in terms of hospital admissions and GP appointments and is one of the biggest drivers of health inequalities, whether one smokes or not is a bigger determinant on life expectancy than social position. Smokers loose on average ten years of life or around one year for every four years of smoking after the age of thirty.

Smoking is the single biggest modifiable risk factor across all the five clinical priority areas within the Core20Plus5 framework and is the biggest modifiable risk factor contributing to preventable disease, disability, and premature death in England.

- Smoking is the leading modifiable risk factor for poor birth outcomes.
- Smoking is the leading cause of 10–20-year reduction in life expectancy for people with serious mental illness.
- Around 86% of all Chronic obstructive pulmonary disease deaths are caused by smoking.
- Smoking is the leading preventable cause of cancer responsible for 27% of cancer deaths.
- Smokers CVD risk is double that of non-smokers.

Smoking is a principal driver of health inequalities helping to sustain deprivation as households are driven into poverty because of smoking. Approximately a third of all households with a smoker live under the poverty line and long-term smokers are 7.5% less likely to be employed than non-smokers.

In NHS West Yorkshire ICB there are 239,000 smokers and 28% of people in routine and manual occupations smoke. It is estimated that smoking costs the ICB £81.8 m a year (2024) and results in 19,278 hospital admissions and 2,957 premature deaths a year (Jan 2024).

In Bradford smoking is most prevalent among White British and Asian British ethnicities. People in routine and manual occupations are nearly three times more likely to smoke as those in other occupations resulting in worse health and premature mortality. Current smokers are two and a half times more likely to require social services approximately ten years sooner than a non-smoker accounting for 8% of the local Authority budget. Prevalence can be mapped to areas of deprivation. In Bradford disadvantaged smokers are least likely to quit and less likely to succeed when they do however and there is a need to ensure smoking cessation services are matched to the populations identified at higher risk.

The risk factors preventing people for stopping smoking include:
Availability of cheap illegal tobacco – the availability of cheap illicit or counterfeit tobacco undermines strategies to reduce smoking and exacerbates health inequalities through increased health risks. People who attempt to give up smoking find it harder to stop if they can source low-cost products making the governments ambitions to be smoke free by 2030 extremely challenging. HMRC estimates that in 2019/20 10% of cigarettes and 38% of hand rolled tobacco in the UK market was illicit with total loss of revenue of £2.3billion.

In Bradford disadvantaged smokers (or: smokers experiencing multiple disadvantage) are least likely to quit and less likely to succeed when they do however, we know that availability of smoking cessation services is not matched to the populations identified at higher risk. Overall smoking rates mask the fact that smoking prevalence is higher in areas of deprivation and some population groups including manual workers, social renters and people living with severe mental illness (SMI).

How we will do it

Reducing smoking across the population will reduce inequality and the burden on preventable mortality and morbidity on the whole system. Nationally there is a commitment to a smokefree society by 2030 with funding to support smoking cessation programmes.

The WY Tobacco Alliance will oversee smoking cessation across West Yorkshire and aims to pool knowledge, experience, resources, and budgets to support and give agency to our communities in improving health and well-being. The Alliance will add value to work happening at place and broker action at a county-wide level where it makes sense to do so.

In Bradford, the Tobacco Control Alliance aims to reduce smoking prevalence within the district setting the vision and strategic direction and advocating for the tobacco control agenda through the Tobacco Control Strategy and Action Plan which aims to reduce the harms and inequalities associated with tobacco.
Addressing inequalities and working with young people to prevent take up are central to the strategy and objectives include:

- To understand youth vaping and address emerging patterns of tobacco/nicotine use among young people.
- Targeting smoking cessation services on the priority groups and areas that need them and using our community networks and levers such as Core20Plus5 funding to support cessation and networking and continuity with NHS programmes.
- Target people who work in routine and manual occupations who are more likely to smoke and their employers who need to be supported to help their employees quit.
- Supporting work to tackle the availability of illicit tobacco which has the greatest impact on our poorest communities and significantly undermines all other strategies.

What will change?

Of the people who access Core20Plus5 programme interventions:

- More people will understand the harms of smoking.
- More people will know how to access smoking cessation services and,
- More people will be supported to access services and stop smoking.

Through adding the additional support outlined above that is proportionate in the communities that are highest risk from smoking the Core20Plus5 programme will contribute towards a decreasing prevalence of smoking in deprived communities.

Long Term Outcome:
Smoking prevalence in deprived communities is decreasing.

Serious Mental Illness

Short Term Outcome:
Those people with SMI who access preventative support in their community to undertake their annual health check will be aware of and understand how to access support to manage physical health conditions diagnosed.

What we will do

Core20Plus5

Core20Plus5 Prevention interventions (Core20Plus5 'what we will do') will aim to address the risk factors associated with SMI and poor physical health and its management through:

- Provision of support for people with low/moderate mental health issues
- Supporting people to adopt healthy lifestyle behaviours.
- Supporting people to connect to the provision available to them through befriending and/or social prescribing.
- Support to address socio-economic determinants and consequences of mental health.
- Activities that aim to increase diagnosis of physical health conditions in the community.

Acting as one

This work will support the ambitions of the Healthy Minds Partnership Board and the Health Minds strategy priorities to:

- Promote better lives: to support everyone with the opportunities to live an independent, fulfilling, healthier and longer life.
- Respect rights: involve people so they are informed to make choices and receive equitable access to opportunities.
- Improve support: support people with high quality, accessible, personalised care that promotes wellbeing.

This work will also support the delivery of the' Improving physical health and reducing premature mortality for people with severe mental illness, learning disabilities and autism spectrum condition – An action plan for Bradford District and Craven 2023-2026.

These strategies will be supported through:

- A focus on wellbeing, early intervention, and healthy lifestyles
- Preventing the escalation of mental health issues
- Connection to mental health services
- Support for people with/seeking diagnosis of dementia.

Why we will do it.

Serious Mental Illness (SMI) refers to people with psychological problems that are often so debilitating that their ability to engage in functional and occupational activities is severely impaired. There are inequalities in the prevalence of SMI across populations with a slightly higher prevalence in men than women and almost double the prevalence in the 35-74 age range when compared to those in the 15 to 34 range. People living in the most deprived areas are over three times more likely to be living with SMI than those living in the less deprived areas.

There are also significant inequalities in life expectancy and premature mortality, people living with SMI die on average 15-20 years sooner than the general population and it is estimated that for people with SMI two in three deaths are from physical illnesses that can be prevented.

Compared to the general population people with SMI aged under seventy-five in contact with health services in England have death rates that are significantly higher for liver disease, respiratory disease, cardiovascular disease, and cancer.
People with SMI aged 15-34 are five times more likely to have three or more physical health conditions and people living with SMI in more deprived areas have a higher prevalence of physical health conditions than those living in the least deprived. In addition, people with SMI are more likely to present with risk factors associated with physical health conditions being more likely to be obese, diabetic, have high blood pressure and smoke.

The risk factors that contribute to these outcomes include:

- Health behaviours such as smoking, poor diet, lack of evidence and substance misuse
- Multiple risk behaviours
- Side effects of medication
- Difficulties in accessing treatment i.e., lack of intervention following diagnosis.

- Disconnected and irregular approach to health and care provisions
- Non-compliance with the care process
- The effect of SMI on poor management of conditions
- Socio-economic determinants and consequences of suffering from mental health conditions such as poverty, poor housing, reduced social networks, lack of employment and social stigma[23].

Socioeconomic deprivation is both a cause and consequence of severe mental illness leading to stress, anxiety and depression that can act as triggers for people without a diagnosis who are at risk of developing a serious mental illness.

How we will do it

The Core20Plus5 programme will aim to support improvements in the physical health of people with SMI through addressing and reducing the impact of:

- Health behaviours such as smoking, poor diet, lack of evidence and substance misuse
- Non-compliance with the care process
- Stress, anxiety, depression, and wider socioeconomic deprivation.
- Isolation and lack of social connectedness.

The Core20Plus5 programme will use community assets to support those with mental health issues in their local area providing community-based support and raising awareness of the importance of those with poor mental health to look after their physical health by accessing their regular NHS health checks. With a focus on reaching those in the community with serious mental illness the programme will reach wider than this target group whilst offering bespoke provision to those that need it.

Latest evidence supports the effectiveness of community-based interventions that support mental health and wellbeing. Although these interventions may not be consistently defined, they include a broad range of non-clinical programme generally targeting both individuals and the communities in which they live. This support may include practical assistance as well as mobilising community connections and resources[24].

Locally developments in offering support that is culturally sensitive have seen an increase in uptake and recovery in Muslim communities[25]. Adapting behavioural activation was found to be acceptable to patients and therapists and feasible in improving talking therapies settings.

[23] Severe mental illness (SMI) and physical health inequalities: briefing
[24] Community interventions for improving adult mental health: mapping local policy and practice in England - PMC (nih.gov)
[25] Delivering a culturally adapted therapy for Muslim clients with depression | the Cognitive Behaviour Therapist | Cambridge Core

Providing bespoke interventions is key to supporting those with SMI through the prevention work in the Core20Plus5 programme.

What will change?

For the Community Partnership areas that have identified SMI as a priority, the prevention interventions will support:

- More people to lead healthier lifestyles protecting against developing/worsening physical health conditions.
- More people will be supported to manage their low/moderate levels of mental health issues protecting against developing SMI (for those at risk) and equipping them to access the support that is available to them when needed.
- More people will be connected to wider support to help with everyday stressors, protecting against depression and anxiety.
- More people will be aware of the services available to them and the importance of taking them up and will be supported to take up those services protecting against undiagnosed physical health conditions that go unmanaged over the longer term.

In the short-term people who access Core20Plus5 interventions will know how to manage their own physical health and wellbeing and where they can go for support to do so preventing or improving physical health conditions. People who access interventions with SMI will be supported to take up physical health checks and the support available to them leading to a reduction in undiagnosed health conditions.

Long Term Outcome:
More of those with SMI will receive their annual health check and a reduction in un-diagnosed conditions including improved access and support for long term conditions.

Respiratory disease

Key Short-Term Outcome:
More of those from deprived areas will be able to get a Flu/COVID19 vaccine in a community venue.

What we will do

Core20Plus5

The prevention interventions (Core20Plus5 'what we will do') within the Core20Plus5 programme will aim to address the risk factors associated with poor management of COPD and acute exacerbations by:

- Working with partners to develop and deliver a community-based model to increase access to Flu and Covid19 vaccinations in the community as described in the Covid19 and Flu Inequalities plan.
- Supporting people with COPD to manage their condition and reduce the incidence of exacerbations and hospital admissions.
- Health messaging and education in the community through community centre based health projects, community champions and community development workers.
- Connecting to wider services to support with socio-economic determinants of health.

Acting as one

This work will support the Access to Care Programme Board in its ambitions to diagnose and treat major health conditions earlier, preventing people from developing a long- term condition and support people to manage their conditions through:

- Direct interventions to support people to take up vaccinations and access smoking cessation services.
- Health messaging.
- Support to manage COPD.

Why we will do it.

Chronic respiratory disease is the fourth biggest cause of the life expectancy gap between the most and least deprived groups contributing 11.8% to the gap for men and 14.1% of the gap for women. In 2020 the rate of premature mortality due to respiratory disease among people

living in the most deprived quintile of areas was at least twice the average for England and in 2022 this gap had increased.

Key risk factors for developing COPD include:

- Smoking is the most common risk factor for COPD with about 90% of cases associated with cigarette smoking.
- Occupational exposures to dusts account for 20% of cases.
- Other risk factors include air pollution, genetics, lung development and asthma[26].

Acute exacerbations of chronic obstructive pulmonary disease account for approximately one in eight emergency admissions in England and research suggests that there is a clear association between COPD, increased emergency health care use, health care costs and mortality. The key risk factors associated with acute exacerbations and increased hospital admissions for those with COPD include[27]:

- viral infections
- smoking,
- a lack of effective self-management,
- stress and anxiety and
- mental health problems
- Environmental factors (air quality, housing conditions)

In Bradford District and Craven there are significant inequalities in the take up of vaccines that could reduce the incidence of acute exacerbations. These inequalities exist between the most and least deprived areas and between different cohorts of the population. There are many factors that may be driving this inequality including misinformation, mistrust, and access to vaccination clinics.

How we will do it

Through the Core20Plus5 programme Community partnerships will use trusted relationships and work with VCSE and community pharmacy partners to engage their local populations to take up locally delivered vaccinations in the community.

[26] NICE Clinical Knowledge Summary Chronic Obstructive pulmonary disease

[27] NICE Guideline NG115 Chronic obstructive pulmonary disease in over 16s: diagnosis and management Evidence Review [E] Predicting and preventing exacerbations

Latest NHSE vaccination guidance suggests that approaches to vaccination delivery should be focused on whole family approaches delivered in a range of venues accessible by the community[28].

Locally, examples of good practice indicate that approaches that are proactive, using trusted relationships and that are delivered in accessible locations within a targeted community can be effective in driving up vaccine uptake for deprived communities and populations with traditionally low uptake of vaccinations[29].

Evidence suggests that by reducing exposure to risk factors such as smoking, viral infections, anxiety and stress and poor mental health and by increasing protective factors, such as improved self- management and increasing the uptake of vaccinations the chance of COPD exacerbations occurring may be reduced[30].

What will change?

For the community partnerships that have identified respiratory disease as a priority the prevention interventions will support:

- More people to be aware of the risk factors associated with COPD and be equipped to manage their condition protecting against acute exacerbations and emergency hospital admissions.

- More people with COPD to be connected to smoking cessation services.

- More young people will be aware of the risks associated with COPD and be more active.

- More people will be aware of the benefits of taking up vaccinations.

- More people will be connected to support to address the wider socio-economic determinants of health as a protective factor against stress, anxiety, and depression.

[28] NHS Vaccination Strategy Dec 2023
[29] Actionable Insights Tackling inequalities in healthcare access, experience, and outcomes Case Study 1 Increasing Vaccine Uptake
[30] NICE Guideline NG115 Chronic obstructive pulmonary disease in over 16s: diagnosis and management Evidence Review [C] self-management interventions, education, and telehealth monitoring

Through the delivery of the Covid19 and Flu Vaccination Inequalities plan more people will be aware of the benefits of taking up vaccines and have more opportunities to take them up in the community.

In the short term these combined activities will enable more people from deprived areas to be able to get a vaccine in a community venue, supporting the longer-term outcome of increasing vaccine uptake in deprived communities increases and for those with increased risk from additional vulnerability e.g., COPD and chronic respiratory disease.

Long Term Outcome: [should the long-term outcome be about reduction of prevalence of COPD among those that take up vaccinations?]
Vaccine uptake in deprived communities increases and for those with increased risk from additional vulnerability e.g., COPD and chronic respiratory disease.

Cancer

Key Short-Term Outcome
Attendance at routine cancer screening and lung health checks in primary care will improve for those target communities not currently attending.

What we will do

Core20Plus5

The prevention interventions (Core20Plus5 ‘what we will do’) within the Core20Plus5 programme aim to address the low uptake of screening and early diagnosis of Cancer by:

- Working with partners to develop and delivery community messaging through community-based health work.
- Delivering culturally sensitive messaging relating to cancer screening through local health champions
- Providing support and awareness of wider health and wellbeing opportunities through mini wellbeing hubs

Acting as one
The interventions delivered through the Core20Plus5 programme will aim to add value to and compliment place based and WYICB led interventions to deliver the priorities within the Long-Term Plan and Bradford District and Craven Joint Forward Plan to:

- diagnose all cancers at an early stage and,
- prevent people from developing long term conditions.

The prevention interventions in the programme will support place-based activities to:

- Deliver targeted Lung health checks through GP practices.
- Enhancing cancer screenings to increase uptake.
- Work with LD communities and cancer screen programmes.
- Support people to be as healthy as possible through Prehab and increase patient physical and lifestyle outcomes, linking in with Living Well.

We will do this through:

- Removing barriers that create inequalities in accessing care through culturally sensitive health messaging.
- Promoting healthy lifestyles as protective factor against developing long term conditions.
- Community development /engagement to understand needs and barriers to accessing screening services.
- Connecting people to support they need locally.
- Raising awareness of health conditions and support available.
- Community centred screening.

Why we will do it.

Cancer is one of the biggest contributors to inequalities in life expectancy with people from the most deprived communities more likely to get cancer, be diagnosed at a late stage for certain types of cancer and to die from the disease.

In England cancer overall can be attributed to 18.1% of the 8.6-year gap in male life expectancy between the most and least deprived quintiles and 19.4% of the gap for women. The two biggest risk factors associated with cancer are smoking and obesity both of which are more prevalent in areas of greatest deprivation.

Smoking is the biggest cause of cancer in the UK responsible for three in twenty cases with smoking prevalence rates far higher in the most deprived populations. Overweight and obesity is the second largest preventable risk factor for cancer after smoking with around 23,000 cases of cancer in the UK each year caused by excess weight. In England adults from the most deprived populations are more likely to be obese and rates of obesity in children are up to twice as high for the most deprived neighbourhoods. Other risk factors include alcohol which is a particular risk factor for colon and rectum cancers.
Cancer awareness and health education is disproportionately lower in minority groups with Black women disproportionately affected by late diagnosis of cancer compared to their white British counterparts. Women from minority groups have lower levels of attendance at both breast and cervical screening with suggestions this is due to a combination of cultural and language barriers. For many women from minority groups Cancer is not talked about and screening is seen as invasive and culturally inappropriate, there is a lack of tailored interventions for this group of the population. In 2019 the national cancer patient survey for England reported that women with breast cancer from minority groups rated their overall care lower than white women.

In Bradford's most deprived communities as few as 51% of 60–74-year-olds have completed their bowel cancer screening compared to 79% in the most affluent areas. This is mirrored in both cervical and breast cancer screening with only 36% attending for breast screening and 56% for cervical screening in central Bradford compared to 67% and 82% in the most affluent areas.

Key risk factors associated with the contribution to premature mortality include:

- Low take up of screenings and late diagnosis.
- Lack of awareness of the signs and symptoms of cancer
- Lack of awareness of the importance of screening and how to access it.
- Lack of understanding regarding preventative health
- Barriers to accessing screening/seeking help.

People living in deprived areas are also less likely to take up screening and less likely to recognise the signs and symptoms of cancer or seek help when they do[31].

Black, South Asian, and other minority ethnic communities are less likely to be aware of the signs and symptoms of cancer and women from these communities are less likely to access breast and cervical screening compared to white women and are more likely to present late when the disease is advanced. This is reflected in higher morbidity and mortality rates[32].

Research suggests there may be multiple reasons why people do not take up cancer screening opportunities, this may be linked to; stigma/taboo associated with cancer, stigma associated with behaviour (and with the types of intervention), practical barriers, and fear[33].

Black and Asian women may face many barriers to accessing breast and cervical cancer screening, they may lack knowledge of cancer and how to reduce their risk of developing cancer and may lack understanding of the idea of preventative health, the importance of screening and how to access it which may be exacerbated by language barriers[34].

How we will do it

Through the Core20Plus5 programme community partnerships will work alongside the VCSE to deliver health and wellbeing messaging; provide information on screening and early recognition of symptoms; deliver awareness raising campaigns and messaging and support the provision of culturally sensitive interventions for those in underrepresented groups.

The Long-Term Plan sets out an ambition for 75% of cancers to be diagnosed at stage one or two by 2028 through raising awareness of the symptoms of cancer, lowering thresholds for referral by GPs, accelerating diagnosis and treatment and maximising the number of cancers identified through screening including the testing of family members where they are at increased risk of cancer.

In West Yorkshire it is one of the ten big ambitions to increase early diagnosis rates for cancer. West Yorkshire Cancer Alliance has set out its ambition to bring local partners together to deliver better outcomes including a focus on the cancer workforce with an emphasis on being informed by the experiences of people using cancer services.

[31] Cancer in the UK 2020: Socio-economic deprivation
[32] Wise Up to Cancer Bradford
[33] Cancer Research UK: Health Inequalities: Breaking down barriers to cancer screening

[34] Wise Up to Cancer Bradford

Locally, examples of good practice indicate that there are approaches using trusted relationships and conversation that improved the understanding and uptake of screening and cancer treatment[35][36]. A targeted extension of the cervical screening campaign was designed to inspire more women in Bradford to take up the offer of cervical screening. With a primary audience of women aged 24-55 years the campaign targeted women where English may not be their first language, the use of face-to-face engagement provided the pilot project with lessons relating to the language used as well as the value of translated materials.

Funding has also been given by NHSE for a pilot of the multi-generational home visiting programme which includes cancer screening as part of the offer from the outreach team identifying families where there are multiple missed contacts for screening and vaccinations. This pilot will inform longer term plans on reaching those that currently don't access Primary Care.

What will change?

For the community partnerships that have identified cancer as a priority the prevention interventions will support:

- More people to lead healthier lifestyles protecting against developing/worsening health conditions.
- More people to access routine screening and understand the importance of uptake.
- More people will be connected to wider services available to protect against undiagnosed health conditions.

In the short-term attendance at routine cancer screening and lung health checks in Primary care will improve for those target communities not currently attending supporting an increase in the early diagnosis of cancer in deprived communities.

Long term outcomes:
Early diagnosis of cancer is increasing in deprived communities and lung cancer screening is more readily available in target areas.

[35] Bowel Cancer Screening | Cancer Research UK
[36] Cervical screening: ideas for improving access and uptake - GOV.UK (www.gov.uk)

Cardiovascular disease

Key Short-Term Outcomes:
More of those with hypertension will be aware of the need to attend primary care and will be taking anti hypertensives. More of those identified as high risk for CVD will access lifestyle support.

What we will do

Core20Plus5
The Core20Plus5 Interventions (Core20Plus5 'what we will do') will support more people to be aware of their hypertension and the need to attend primary care through:

- Provision of health coaching, messaging and awareness and linking people to the support and services available to them to support healthy lifestyle choices.
- Provision of health checks and health activities in the community focusing on hypertension case finding.
- Support to improve their physical health as a protective factor against CVD or help in the management of long-term CVD conditions.
- Connection to wider support to tackle the socio-economic determinants of health.

Acting as one
This work will support the Access to Care Programme Board in its ambitions to diagnose and treat major health conditions earlier, preventing people from developing a long- term condition and support people to manage their conditions through:

- Earlier diagnosis and treatment for Hypertension
- Health messaging
- Connection to wider support services
- Direct interventions to promote healthier lifestyles.
- Direct intervention to tackle diabetes.

Why we will do it.

Cardiovascular disease (CVD) which includes heart attack, heart failure, stroke, and many cases of dementia is the third largest contributor to premature mortality and the life expectancy gap between the most and least deprived populations in England.

Individuals with common high-risk conditions of hypertension (high blood pressure), Hypercholesterolaemia (high cholesterol) and atrial fibrillation (AF) are more at risk of developing CVD and premature mortality from CVD is twice as high in the most deprived areas of England compared to the most affluent areas.

Premature mortality attributed to CVD is however highly preventable through diagnosis and optimal treatment of high-risk conditions such as atrial fibrillation, high blood pressure and raised cholesterol yet a sizeable proportion of those living with these conditions are undiagnosed and of those with a diagnosis a substantial number are not receiving optimal treatment. This may be due to these conditions having no symptoms or because treatment decisions are complex[37].

Other modifiable risk factors associated with cardiovascular disease include, smoking, diabetes (often undiagnosed), obesity, lack of exercise, poor diet, Poor uptake of NHS health checks, lack of awareness regarding the impact of lifestyle factors and socio-economic determinants of health (e.g. poverty) leading to stress, anxiety, and depression.

Stroke is the sudden death of some brain cells due to a lack of oxygen when blood flow to the brain is impaired by blockage or rupture of an artery. Mortality and morbidity statistics along with analysis of risk factors show that stroke in the UK is a significant but largely preventable disease and is a marker of health inequality. Data for Bradford shows that there are significantly higher rates of premature mortality attributed to stroke than the WY and England average for all persons and for men specifically. there is a social gradient for stroke admissions that shows more people are admitted to hospital if they live in areas of highest deprivation.

The modifiable risk factors for stroke include high blood pressure, obesity, physical inactivity, poor diet, smoking, alcohol consumption, high cholesterol, diabetes, and atrial fibrillation.

Dementia is a term used to describe a collection of symptoms including memory loss, problems with reasoning, perception, and communication skills. There are many different types of dementia, Alzheimer's disease being the most common followed by vascular dementia (caused by problems with blood supply to the brain). In England in 2022/2023 432,753 people over 65 had a recorded diagnosis of dementia - Of which 4659 were in Bradford.

[37] Cardiovascular disease prevention: applying All Our Health

Nationally it is estimated that the prevalence of dementia in the over sixty-five age group is 6.5%, applying that percentage to the Bradford population of over sixty-five provides an estimated prevalence of 5000 across Bradford District of which approximately 3000 will be diagnosed.

Dementia has a significant emotional and psychological impact on both the individual and family and carers, for the newly diagnosed it can be difficult to know what services are available for support and how to access information on how to live well with dementia. In addition, it is estimated that there will be significant numbers of people across Bradford District and Craven that are pre-diagnosis who are unable to access support without a diagnosis including access to financial support.

Key risk factors for dementia include lifestyle factors such as physical inactivity, smoking, excessive alcohol consumption, obesity, and infrequent social contact.

The under diagnosis of key conditions associated with cardio-vascular disease remains a significant problem, data suggests that hypertension is significantly underdiagnosed in the population and when it is diagnosed not always managed optimally. Prevalence rates across Bradford and Craven vary greatly with the highest rates in the more affluent areas with older populations- as might be expected- however there is a significant risk that these rates mask underlying rates of low diagnosis in younger populations and all rates are under the estimated prevalence of approx. 26% in the general population. There are also differences across some ethnic groups in the diagnosis of some conditions for example diabetes is a significant risk factor for heart disease and stroke and is likely to be under-diagnosed but of those that have a diagnosis over 50% are of South Asian or ethnic minority heritage.

A review of NHS Health Check undertaken in 2021 found that the check had been effective in meeting many of its objectives, but that uptake could be improved particularly in areas of deprivation and for ethnic minority populations[38].

Wider socio-economic determinants of health are likely to impact on both hypertension and diabetes prevalence. We know that there is a strong correlation between poverty and deprivation and unhealthy behaviours regarding diet, exercise, and smoking, it is therefore likely that these conditions will be more prevalent in communities experiencing poverty and among ethnic minority groups yet recorded prevalence does not reflect this.

[38] Preventing illness and improving health for all: a review of the NHS Health Check programme and recommendations

How we will do it

Prevention is at the heart of the NHS Long Term Plan. In addition to substantial commitments to tackle obesity, alcohol and smoking, the plan includes a major ambition to prevent 150,000 strokes and heart attacks over the next ten years by improving the treatment of the high-risk conditions – hypertension (high blood pressure), hypercholesterolaemia (high cholesterol) and atrial fibrillation (AF).

The NHS Health Check was introduced in 2009 to encourage health professionals to measure and manage the cardiovascular risk burden in the apparently healthy population. People aged 40-75 with no known pre-existing CVD are eligible for an NHS Health Check every 5 years. The health check estimates the risk of having a heart attack in the next ten years and of developing type 2 diabetes and includes an assessment of major factors that drive early death, disability, and health inequalities.

There is a growing body of evidence from work undertaken locally in Bradford that delivering health checks in community settings is effective in identifying undiagnosed conditions such as hypertension and diabetes. Of the 180 patients attending a local mobile 'Heart Bus' screening event approximately 25% had potential abnormalities and were referred for further cardiac testing and a community health check event in one of Bradford's most deprived areas identified individuals with abnormal blood pressure and blood sugar levels resulting in new diagnosis for hypertension and Type 2 Diabetes.

At a system level the Core20Plus5 programme is supporting the development of a consistent care pathway for community NHS health checks that will identify more people in the community that have hypertension, high cholesterol and diabetes coupled with wider information on lifestyle and support.

Community partnerships that have identified CVD as a priority and that wish to deliver health checks in the community will be supported to implement this standard approach to delivering health checks. In addition to making health checks to identify key conditions more accessible, the provision of information, health messaging and awareness raising in local communities and with targeted populations is likely to be beneficial in supporting people to live healthier lives, understand the importance of earlier diagnosis and manage their conditions.

There is compelling evidence that demonstrates that health coaching approaches have a positive impact on the outcomes of patients with chronic diseases such as diabetes, hypertension, obesity, and heart disease and is associated with high patient and practitioner satisfaction. Health coaching has been found to reduce demand on healthcare services. In

Sweden, a large-scale randomised control trial (RCT) demonstrated that the implementation of health coaching reduced hospitalisation rates by 12%. Another study of health coaching on a rehabilitation ward in Hampshire estimated and indicative cost saving of £3million[39].

Other studies have demonstrated that health coaching within specific communities can be effective in managing blood pressure. An American based Randomised Control Trial showed that the provision of health coaching for South Asian populations can be effective in supporting them to manage their blood pressure[40].

What will change?

Through supporting wider system change and implementation of Core20Plus5 interventions outlined above

- More people will have access to activities that will improve their physical health.
- More people will understand the importance of healthy lifestyle choices.
- More people will have access to health checks in their community.
- More people will be aware of the importance of monitoring for hypertension and diabetes and be made aware if they need to take medication for hypertension.
- More people will be connected to support to address the wider socio-economic determinants of health as a protective factor against stress, anxiety, and depression.

In the short term more of those with hypertension will be aware of the need to attend primary care and will be taking hypertensives and more of those identified as high risk for CVD will access lifestyle support contributing towards more people with high blood pressure in deprived communities being diagnosed decreasing the risk from CVD.

Long Term Outcome:
More people with high blood pressure will be diagnosed in deprived communities decreasing the risks from CVD.

[39] Supported self-management: health coaching guide
[40] Integrating Community Health Workers into community based Primary Care Practice Settings to improve blood pressure control among South Asian immigrants in New York City

Adversity trauma and resilience

Key Short-Term Outcome
Children, young people, and their families living in IMD1 &2 will be equipped with skills to support their wellbeing.

What we will do

Core20Plus5
The Core20Plus5 interventions (Core20Plus5 'what we will do') will support the development of resilience and protective factors through:
A district wide programme (targeted to areas of greatest deprivation) focusing on the importance of sleep as a protective factor against poor social and emotional/physical health and educational outcomes.

Community partnership led interventions that will target specific cohorts of young people or areas with an identified need that will add value to the district wide commissions. These programmes will focus on:

- Resources focused on health messaging and connection to universal health and wellbeing services delivered in the community or in the home will support improved take up of maternity, health and educational services including increased access to stop smoking services.

- The provision of practical support for families in crisis will help to avert the worst impacts of extreme poverty for those families at crisis point helping to protect against the trauma that this can bring about for children.

Acting as one

This work will support the Healthy Children and Families Partnership Board in its ambition that all babies, children, and families are able to live a healthy, happy life and when they do need additional help, they receive the information and support they need easily and as early as possible. Specifically, this work will support the achievement of the board's strategic objectives and connects with its three key principles; every child has the best start in life, every child thrives, and every child gets the support they need.

It will also support the Healthy Minds Partnership Board in their ambition to work as a whole system to promote, protect and improve children and young people's mental wellbeing to enable them to lead a full, happy, and healthy life.
Through:

- Connection to services and provision of clinical support for children and young people
- A focus on building resilience in children
- A focus on childhood wellbeing including good sleep hygiene.

Why we will do it.

Adversity and trauma are known to significantly impact on the health of children and young people lasting into adulthood. We know that babies, children, and young people who experience adversity and trauma are at higher risk of poor health and wellbeing.

Adverse Childhood Experiences (ACEs) are stressful or traumatic events that happen in childhood and can affect people as adults. They include events that affect a child or young person directly such as abuse or neglect or indirectly such as the function of the household they are living in which may be impacted on by mental illness, domestic abuse, substance misuse, divorce, or an incarcerated relative. Other risk factors for adversity and trauma include wider environmental factors such as poverty, housing insecurity, racism, and neighbourhood violence.
The prevalence of ACEs in Bradford is likely to be high[41]. A health needs assessment undertaken in 2019 looking at the prevalence of ACES in Bradford found that:

- Bradford has a young population.
- Bradford has a high level of deprivation and growing extreme poverty. The cost-of-living crisis is putting increased pressure on family life, and we know that this can be a significant source of toxic stress for children and families.

[41] Bradford District Aces, Trauma & Resilience Strategy 2011 - 2024

These risk factors can manifest themselves in several ways related to a young person's social, emotional, or mental health and are a significant contribution to disease burden. There is a wealth of research that identifies the harmful effects that adverse childhood experiences have on lifelong physical and mental health with estimates that they can lower life expectancy by twenty years[42].

To have multiple ACEs is a major risk factor for many health conditions. The outcomes most strongly associated with multiple ACEs represent ACE risks for the next generation e.g., violence, mental illness, and substance misuse. Multiple ACEs can be associated with poorer health outcomes related to physical activity, overweight, obesity, diabetes, smoking, alcohol, poor regulated self-care, cancer, heart disease and respiratory disease[43].

The Covid19 pandemic represented a significant source of trauma, stress and adversity for children and families who had already experienced prior trauma compounding the effect of certain traumatic experiences. The pandemic highlighted and exacerbated systemic inequalities and disparities regarding access to physical and mental health care and necessary supports including resources to meet basis needs.

Childhood trauma can have a significant impact on sleep patterns in children and adolescents and evidence suggests that poor sleep has a negative impact on social and emotional development and readiness for school in the short term., This can impact longer term on mental wellbeing, school attainment and physical health in terms of weight and lifestyle choices[44].[45]

In addition, there is growing evidence of the dangers of sleep deprivation for heart health. Lack of sleep can impair metabolism, cause inflammation, raise blood pressure and increase your risk of cardiovascular diseases. The quality and quantity of sleep including fragmented sleep can be linked to heart problems.
and associated conditions including high blood pressure, high cholesterol, heart attack, obesity, diabetes, and stroke.[46]

[42] Health Needs Assessment of Adverse Childhood Experiences in Bradford
[43] The effect of multiple adverse childhood experiences on health
[44] Early Years: promoting health and wellbeing in under fives
Social and emotional wellbeing: early years [PH40]
Social emotional and mental wellbeing in primary and secondary education
Children's attachment
[45] Sleep problems in children and adolescents following traumatic life events
[46] How Sleep Deprivation Affects Your Heart (sleepfoundation.org)

How we will do it

The Core20Plus5 programme will support young people experiencing social, emotional, and mental health issues because of adversity and trauma through:

- Development of protective factors – resilience and good sleep
- Provision of training, guidance, information, and support for practitioners
- Provision of guidance, information, and support for parents
- Networking, connections, and peer support to increase the mitigation of the impact of adversity for children.
- Provision of practical support to alleviate stressors associated with the wider socio-economic determinants of health.

Good sleep hygiene can serve as a foundation for better sleep, creating habits that make it easier to get both the quality and quantity of sleep which in turn acts as a protective factor against poor heart health in adults[47]. By working to improve sleep in children, parents will have less interrupted sleep, better quality and quantity of sleep and a reduced risk of cardiovascular disease.

Research shows that some individuals do not experience the negative outcomes often associated with ACEs, the capacity to overcome and adjust to the challenges of significant adversity is referred to as resilience which is a complex and dynamic development process that helps to buffer against the impacts of stress associated with ACEs[48]

By supporting families and children to understand and manage poor sleep through a tiered approach to provision, families can receive the help they need which will contribute to improved social and emotional wellbeing for the child and the parents, improved school readiness and school attainment providing the future for good educational outcomes.

[47] How sleep deprivation affects your heart (www.sleepfoundation.org)
[48] Resilience under conditions of extreme stress: a multilevel perspective.

What will change?

Through taking a layered and targeted approach the Core20Plus5 programme will help to ensure that:

- more children, young people, and families at risk of the impact of deprivation will be accessing local support when needed, living in improved home conditions.

- More children and young people in Bradford will be equipped with skills to support their wellbeing.

Long Term Outcomes:
CYP and families at risk of the impact of deprivation will be accessing local support when needed and living in improved home conditions sustaining improved wellbeing over the longer term and into adulthood.

Further Information

Any queries regarding this document of to find out more about the Core20Plus5 programme in Bradford District and Craven please contact:

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For more information regarding The Reducing Inequalities Alliance and how we can support you to reduce health inequalities please see:
Reducing Inequalities – our call to action for Bradford District and Craven

Reducing Inequalities Alliance webpage: www.bdcpartnership.co.uk/ria/
Email: ria@bradford.nhs.uk