Reducing Inequalities Alliance

Long Term Conditions and Multimorbidity: A needs assessment from a health inequalities perspective

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A note on the data included in this assessment

This assessment covers adults with long term conditions in Bradford District and Craven.

The Bradford District and Craven area covers two different local authorities: the City of Bradford Metropolitan District Council (CBMDC) and Craven District Council (CDC). We have sought to include data for both areas throughout this assessment. It should be noted that there are some data sets where this is not possible. The data source and area covered is indicated throughout the document.

About this needs assessment

This assessment has been produced by the Reducing Inequalities Alliance (RIA) to inform the design and delivery of services in Bradford District and Craven.

It is intended to provide additional insight and intelligence to our partners on the topic of long term conditions and multimorbidity. It covers, for each long term conditions and multi-morbidity, what our data is telling us about health and inequalities, areas of good practice, and priority areas for action.

It is not intended to replace the condition specific needs assessment created by local public health teams.

We have used a range of data within this assessment, combining nations data sets with locally created bespoke analysis. Data sources are made clear throughout this document.

Who are our partners?

The Bradford District and Craven Health and Care Partnership is made up of the NHS, councils, care providers, and the voluntary, community and social enterprise sector. It makes decisions about the use of health resources across Bradford District and Craven.

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1. Executive summary

This needs assessment has been developed in response to the publication of a number of reports and frameworks which highlight the increasing trends in the development of long term conditions and multimorbidity. The main two documents: *The Major Conditions Strategy: Case for Change and Our Strategic Framework*[1] and *Health in 2040: projected patterns of illness in England*[14] both describe the health burden of long term conditions and multimorbidity on individuals, and the growing health and care needs that this leads to. Nationally, the numbers of people with long term conditions and multimorbidity are increasing, and with this will come increasing demands on the health care system.

We should not be deterred by this prediction. Long term conditions, by their nature, have the potential to be managed, delayed and in some circumstances prevented, if appropriate action is taken at the right time.

The purpose of this needs assessment is to review the current position of long term conditions and multimorbidity within Bradford District and Craven. This document will describe the impact of long term conditions, an overview of each individual condition, before focussing on multimorbidity and shared risk factors, from a health inequalities perspective.

Key findings

Our review of local data shows that inequalities exist across each of the long term conditions, with disparities most evident in areas of deprivation. The data sections of our report pinpoint the areas that diagnoses, hospital admissions and premature mortality are highest for a number of conditions.

The development of long term conditions occurs at a younger age in our most deprived areas, starting when people are in their 40s. We need to take action to delay or prevent disease progression at this point.

The incidence of multimorbidity is also increasing so we need to take action to delay, or reduce, the 51% of the 'healthy' population from developing a long term condition. We also need to delay the onset of multimorbidity in the population that already have one long term condition. In particular the overlap of depression and musculoskeletal conditions with cardiovascular disease and chronic respiratory disease is significant.

The evidence of the effectiveness of primary and secondary prevention interventions is clear. We need to understand the root causes of variation in uptake and delivery of services and then take action to reduce this variation.

Effective self-management (for those who are able) can help people to confidently manage their conditions, and even prevent the use of reactive healthcare. To support people to take greater control over their health, increase treatment adherence and opportunities for effective self-management, we need to understand and recognise the impact of the wider determinants of health. These are extensive, and include:

- Poverty and ability to travel to appointments
- Employment and ability to attend appointments when choice and flexibility is not offered

- Community awareness of symptoms and support offers
- Health literacy and the ability to find, understand and use health information

Taking action to reduce inequalities in long term conditions is not only the right thing to do from a moral perspective, but also necessary from a financial perspective. Unnecessary costs linked to health inequalities can arise in the NHS for a variety of reasons, such as:

- missed appointments due to working patterns or transport availability
- emergency admissions through a lack of preventative care
- inappropriate service usage, for example A&E attendance for minor ailments
- exacerbation of conditions due to poor living standards

This means that whilst people from the most deprived areas have a lower life expectancy compared to those in more affluent areas, their per capita cost of healthcare is still higher. This is due to more to emergency admissions, earlier multimorbidity, and prolonged length of hospital stay. For example if we can take action to reduce the variation in hospital utilisation across our population, so that the cost per head is the same for all areas as it is in the least deprived areas, we could reduce our system spend by an estimated £27 million per year (see table 15).

Key themes for areas of action

The areas for action described throughout the document are grouped together in this section, for ease of reference. At the end of the section there is a high level summary of key themes.

1. **Target inequalities.** The impact of inequalities is seen in long term conditions and multimorbidity – both in terms of distribution and how care is utilised to support these conditions. Focused work on health & healthcare inequalities is a “must do” to achieve system financial stability and sustainability, in the short, medium and long term.
2. **Prioritise and embed prevention into care pathways.** The development and progression of long term conditions can be avoided and/or delayed through effective prevention. Maximising uptake of existing prevention offers, and targeting those who would benefit most, will improve outcomes and help manage future health and care demands.
3. **Design pathways with a greater consideration of health literacy.** Increasing community awareness of long term conditions can improve healthcare inequalities. Simplify and tailor language and messaging to overcome health literacy, cultural barriers and stigma and customise communications to specific groups where needed.
4. **Shift pathways into communities.** Delivering interventions in community settings improves access. Working with partners such as VCSE organisations can help understand community readiness for interventions and tailor delivery accordingly.
5. **Improve our invites and appointment processes.** Having a combination of approaches, and the functionality to tailor messages to specific cohorts of people, improves uptake of services. Recognising that some groups will need reasonable

adjustments to attend appointments is important, as well as taking action to avoid digital exclusion.

6. **Target specific groups and reduce variation.** Tackling variation in care delivery, from screening uptake through to treatment optimisation, and across population groups (i.e. inclusion health groups, people with learning disabilities) will improve experience and outcomes. A data driven approach should be used to identify the parts of population (and conditions) that account for large numbers of unplanned and avoidable admissions. This is where are greatest gains can be made.
7. **Develop holistic and integrated care approaches to multi-morbidity.** Coordinated care approaches are needed for people with complex long term conditions and multimorbidity. Generalist pathways and approaches (with support for single specialty care) using multidisciplinary teams where possible should be used for these cohorts to avoid fragmented care and to integrate mental and physical care needs.
8. **Support self-management.** Increasing the availability of, and access to, support tools will help people to be more actively involved in their care plans and to be more confident in managing symptoms and exacerbations. This includes the use of digital technologies where appropriate. Offers may need to be tailored to meet the needs of individuals, with a range of access options available.
9. **Take a population health approach.** Be clear on the groups and communities we are targeting our interventions on, so we can understand if we are making the expected impact.

2. Introduction

Why?

Healthy life expectancy, or the number of years a person can expect to live in good health, is a key metric in understanding the health and wellbeing of a population. Across Bradford District and Craven this figure varies, with the difference being as much as 20 years between the most deprived and most affluent areas.

Long term conditions are a contributing factor to this health inequality.

A long term condition is a non-communicable disease which cannot be cured but can be managed. The development of these conditions can be:

- delayed (and in some instances avoided) through the uptake of preventative interventions;
- controlled through a combination of treatment and therapies, self-management and medication

The purpose of this assessment is to understand the inequalities that exist within the cohort of people living in Bradford District and Craven and who have at least one long term condition and identify potential interventions to help mitigate these.

In this assessment we have used the six groups of conditions specified within the Major Conditions Strategy: Case for Change and Our Strategic Framework[1]. These are:

- Cancer
- Cardiovascular disease
- Chronic respiratory disease
- Dementia
- Diabetes
- Mental ill health (depression and serious mental illness)
- Musculoskeletal conditions

These have been identified because, collectively, they are the greatest contributors to ill-health and early mortality. Poor health arises from living with at least one of these conditions, but this increases when people live with more than one of these conditions (known as multimorbidity). We are seeing a rising incidence of multimorbidity, so we need to consider the evolving needs of our population, so that we can plan services which best meet their needs.

Long term conditions are not just a health issue – they have a significant impact on a person's ability to work and live a full life.

3. Our 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 Settle in the north. This broad geographical area covers a range of population demographics, with varying healthcare needs.

This section explores some of the key metrics for our population based on 2021 census data. Full population details can be seen in each of our local authority's joint strategic needs assessments: Bradford District[2] and Craven District[3].

These factors are being highlighted as they can influence how our populations access and experience services.

3.1 Current population size

- The current population of Bradford District is 546,600 and the population of Craven District is 56,900.
- The profile of the population varies across our place. In Craven the population is older than the national average – 27.4% are aged 65 years and over compared with the England average of 18.4%. This has increased from 22.8% in 2011.
- In contrast, Bradford District's population profile is younger. 63.4% of the district's population is aged between 15 and 64 and 15.2% is aged 65 and over. However, since the last Census (2011) there has been an increase of nearly 2% in the number of people aged 65 and over, whilst there has been a decrease in the percentage of young and working aged people.

3.2 Projected population changes

- Bradford District: By 2040 the population aged over 65 will increase by over 50%
- Craven: By 2030, the population aged 64-84 years will increase by 22% and the population aged over 85 years will increase by 39%

3.3 Population density

- Bradford District has a population density of 1,491 people per square kilometre (sq. km) – this is an increase of 63 people per sq. km since the 2011 census and the highest rate in West Yorkshire.
- Across Craven District the population density is 48 people per sq. km. Much of the population is concentrated in the towns of Skipton, Bentham and Glusburn and Crosshills.
- The England average is 434 people per sq. km.

3.4 Deprivation

- Bradford District is one of the most deprived local authorities in England and ranks 13th out of 317 Local Authority Districts.
- Deprivation varies greatly across Bradford District, with wards generally around central Bradford and central Keighley appearing in the 10% most deprived wards in the country and wards located in the Wharf Valley appearing in the 10% least deprived wards in the country.

- Whilst most of Craven is defined at ‘least deprived’ there is still variation across the district with some areas experiencing higher levels of deprivation. Skipton South has a higher Index of Multiple Deprivation score than the national average, and the score for Skipton West is just below the national score. (Higher score = more deprived).

3.5 Ethnicity

The ethnicity profile across the two places is different, with a greater diversity evident in the Bradford area:

Bradford District	Craven District
61.1% White	96.9% White
32.1% Asian	1.7% Asian
2.5% Mixed/multiple	1.0% Mixed/ multiple
2.0% Other	0.3% Other
2.0% Black	0.2% Black

Table 1: Ethnicity profile of Bradford District and Craven

Please see our data annex for more detail. Slides in annex:

- Projected population changes for Bradford District and Craven District
- Deprivation profiles of Bradford District and Craven District
- Ethnicity profile of Bradford District and Craven District

4. Impact of long term conditions in our population

In this assessment we have used the six groups of conditions specified within the Major Conditions Strategy: Case for Change and Our Strategic Framework[1]. This approach has been taken in recognition that mental and physical conditions often coexist, and that musculoskeletal conditions are common with other long term conditions such as cardiovascular disease.

4.1 The burden of disease across our population

The disability-adjusted life year (DALY) metric is a single measure used to quantify the burden of diseases, injuries and risk factors[4]. The DALY is based on years of life lost from premature death and years of life lived in less than full health.

DALYs are used within the Global Burden of Diseases, Injuries, and Risk Factors Study 2021 (GBD) to measure the burden of premature mortality and disability for major diseases or disease groups, along with trends worldwide.

This is a useful way of considering the health of a population and the services needed to support them. Mortality and life expectancy estimates to not give a complete picture of the burden of disease borne by individuals in different populations, and their associated health and care needs. In high-income nations such as the UK, non-communicable diseases, which include long-term conditions, account for a large share of the overall burden of disease.

The following charts show which diseases contribute to the DALYs across the life course. As it is not possible to access this data at a District council level, data for North Yorkshire has been used in place of Craven specific data[5]. *It should be noted that the population of Craven District is 9.25% of the entire population of North Yorkshire*.

To aid understanding, the following colour scheme has been used in the GBD charts:

- Blue and purple are used for non-communicable diseases
- Red and orange are used for communicable, maternal, neonatal, and nutritional diseases
- Green is used for injuries

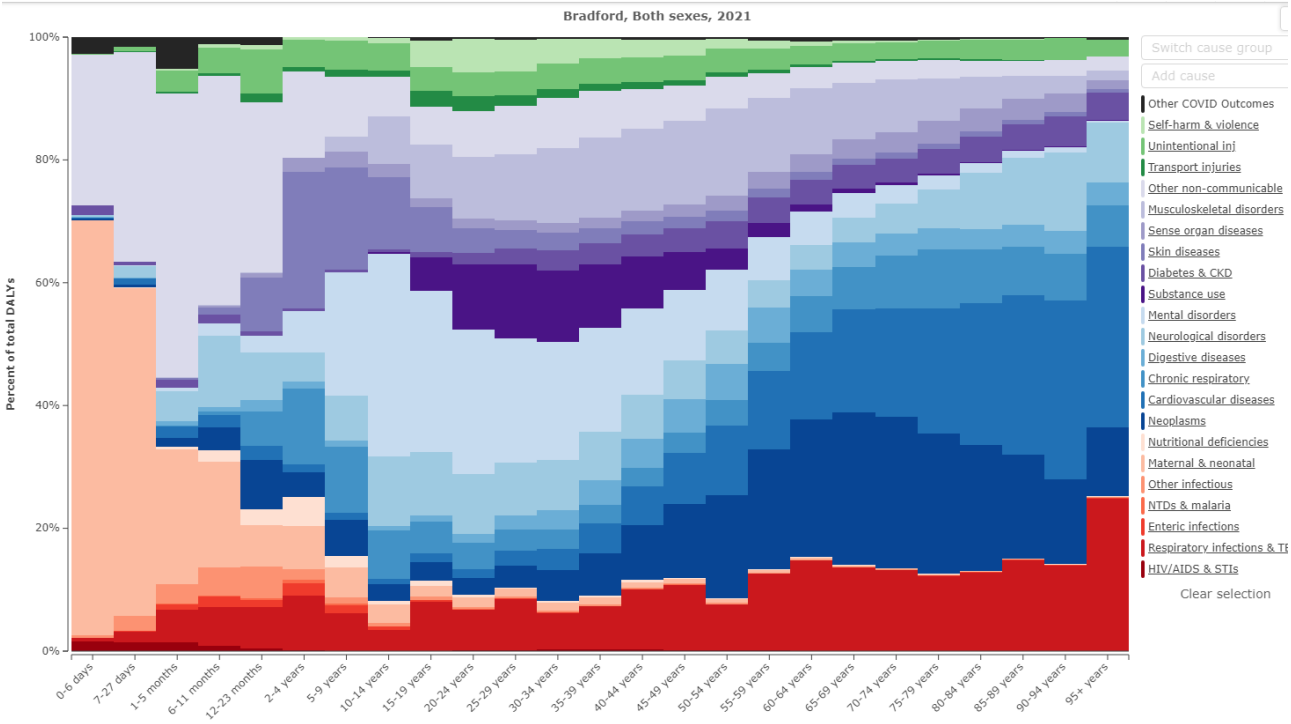

Figure 1: Chart showing patterns in the range of diseases causing DALYs, by age, in Bradford District

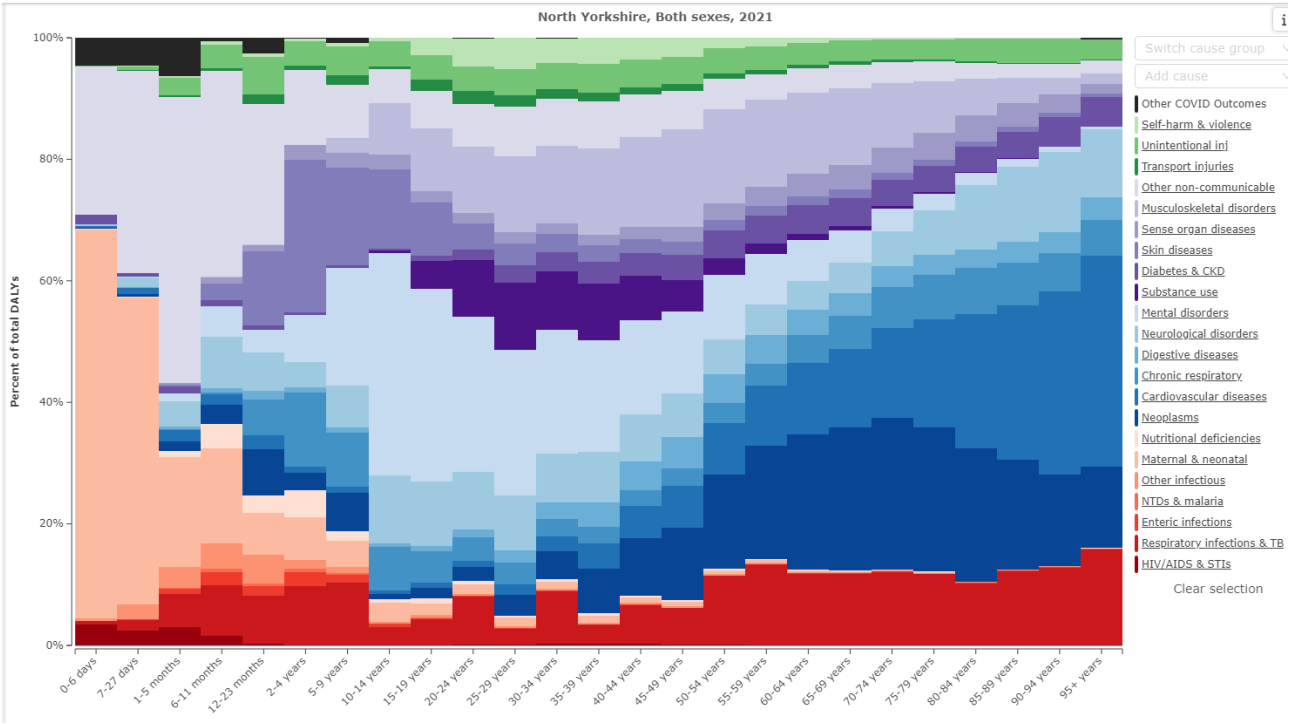

Figure 2: Chart showing patterns in the range of diseases causing DALYs, by age, in North Yorkshire

The distribution of disease type follows similar patterns in each geographical area. For each age group the disease/ illness contributing to the top two highest proportion of DALYs have been reviewed:

From age 0 to 4 years, both areas experience the same pattern with ‘other non-communicable diseases’ featuring as one of the top two causes of DALYs for the age groups. For age 0 to 11 months the other disease type in the top two causes is ‘maternal and neonatal disorders’, for ages 12 month to 4 years the other disease type ‘skin and subcutaneous diseases.’

‘Mental disorders’ cause the highest proportion of DALYs from the age of 5 years to 44 years. The second highest contributing disease or illness varies across the age range and/or place:

- For ages 5 to 14 years it is ‘skin and subcutaneous diseases.’
- For ages 15 to 19 years it is ‘neurological disorders’
- For ages 20 to 44 years in North Yorkshire, the second highest disease grouping is ‘musculoskeletal disorders.’
- ‘Musculoskeletal disorders’ is the second highest grouping in Bradford for the age groups 30 – 44 years. For the group aged 20 to 29 years in Bradford ‘substance use disorders’ are higher than ‘musculoskeletal disorders’.

‘Musculoskeletal disorders’ continue to feature in the top two disease/illness pairings for age 45 to 55 years. This age group features either ‘mental disorders’ or cancer (neoplasms) as the other paring for the top two highest groups.

From age 50 years in Bradford and age 55 in North Yorkshire, cancer (neoplasms) emerges as the disease or illness causing the highest proportion of DALYs, and this is case until age 79. The second highest group in these pairing is usually ‘cardiovascular diseases.’

Cardiovascular diseases cause the highest proportion of DALYs for ages 80 to 95+ years for both places. Cancer and respiratory infections and tuberculosis and the diseases/ illnesses which make the pairings.

Please see our data annex for more detail. Slides in annex:

- Treemap charts showing the distribution of conditions causing DALYs in three different age groups
- Charts showing change in distribution of diseases which cause the most DALYs, comparing 1990 to 2021

4.2 Impact on mortality

Not only do the long term conditions considered in this assessment have a considerable impact on the ill health experienced by our population, but they also contribute to gap in life expectancy between the most and least deprived areas.

The impact of inequalities can be clearly seen in the differences in life expectancy across Bradford and North Yorkshire. The following chart shows the life expectancy between the most and least deprived quintiles, for males and females. Please note that this data was not available for Craven, so data for North Yorkshire was used instead.

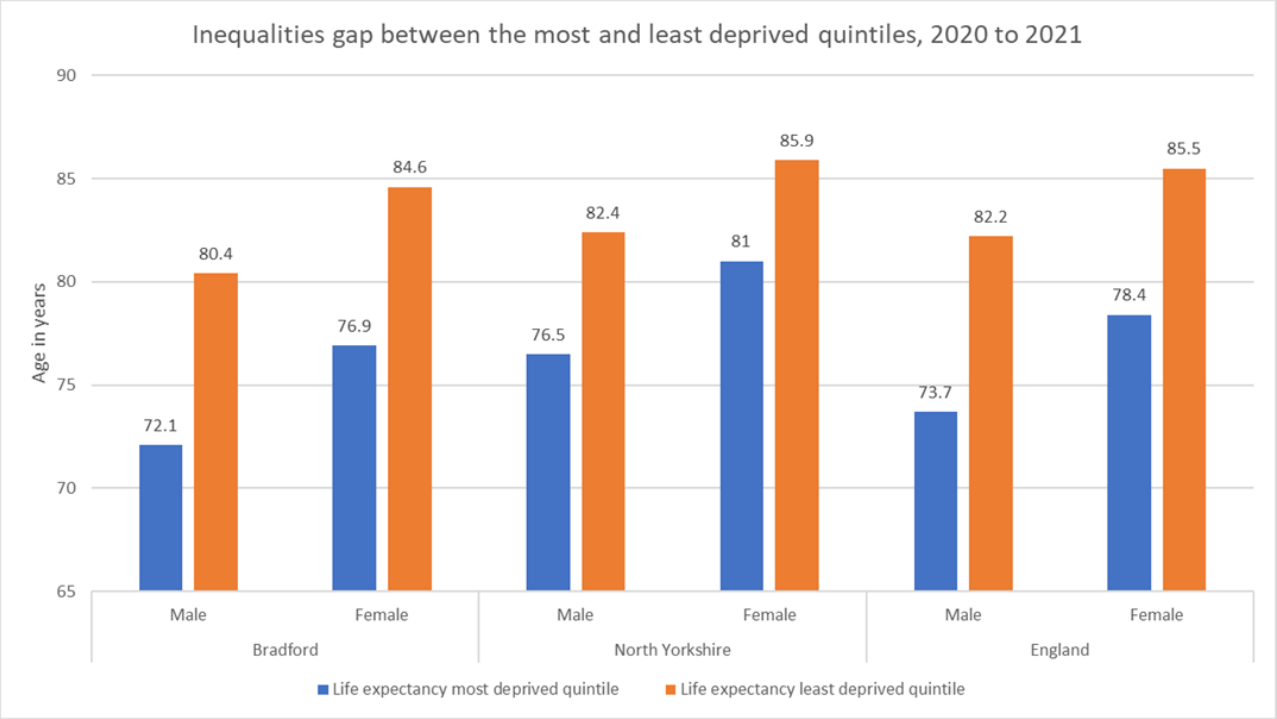

Figure 3: Life expectancy gap between the most and least deprived quintiles, 2020 to 2021[6].

Circulatory (CVD), cancer and respiratory disease account for over half of the life expectancy gap for males and females in both Bradford District and North Yorkshire. The following table shows the breakdowns for each place.

% contribution to the life expectancy gap	Bradford males	Bradford females	North Yorkshire males	North Yorkshire females
Circulatory	26.6%	22.8%	27.6%	22.9%
Cancer	14.5%	17.7%	15.2%	23.0%
Respiratory	13.1%	12.9%	14.5%	11.8%
Total	54.2%	53.4%	57.3%	57.7%

Table 2: Table showing life expectancy gaps in Bradford District and North Yorkshire

4.3 Local data

Within this section we show an overview of the condition profiles across Bradford District and Craven. Most of this data has been specifically created for this needs assessment and comes from either a SystmOne data extract or an extract from our extended primary care data set. Both extracts were taken in October 2023.

The data in these charts is based on primary care records so consideration should be given as to whether or not there is underrepresentation in disease registers or if there are barriers to accessing care for certain groups.

Current numbers

Our primary care data extract shows that in October 2023 the number of people with each of the recorded conditions in Bradford District and Craven is as follows:

- Cancer 20,155
- Cardiovascular 36,393
- Chronic respiratory 59,615

- Dementia 5,183
- Depression 109,897
- Diabetes 49,984
- Musculoskeletal 263,598
- Serious Mental Illness 7,772

Figure 4 below shows the age profile of each of these long term conditions. There are two key points to consider from this profile. Firstly, for a number of these conditions, the highest proportion of people are within the working age group (18-64 years). From an individual perspective, managing these conditions may require time off work, affecting employment stability or reduced work capacity, impacting an individuals' economic well-being. From a service delivery perspective this may impact on an individual's ability to attend appointments.

Secondly, the population profiles produced for both Bradford District and Craven District show that the over 65 years population is expected to grow the most (see section 3.2 above for details). This means that consideration needs to be given now on how we can either prevent or mitigate the impact of this growth.

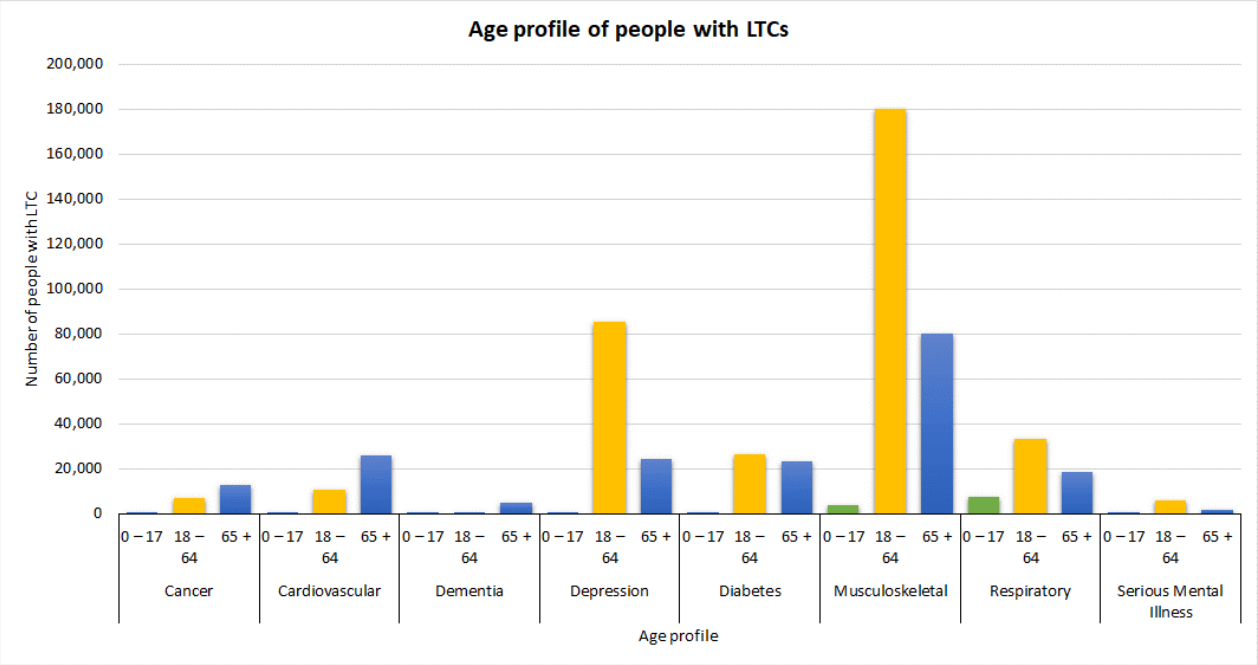

Figure 4: Chart showing the age profile for each of the long term conditions

Trends

QOF prevalence data produced by OHID (Office for Health Improvement and Disparities (OHID) Fingertips data[7]) for the period up to 2022/23 show that the number of people with the long term conditions are either increasing, or broadly remaining the same. The only exception is COPD. The age ranges the data relates to are indicated.

Long term condition	QOF prevalence summary for Bradford District and Craven
Cancer (all ages)	Below England prevalence but shows a similar increasing trend
Coronary heart disease (all ages)	Above England prevalence, showing a similar decreasing trend. However, numbers with CHD have remained fairly level since 2014/15

	and decrease in prevalence rate is due to increase in total population (denominator)
Dementia (all ages)	Diagnosed prevalence is increasing after a fall during 2020-22 (COVID-19 pandemic). Similar to England prevalence in 2022/23
Depression (18+ years)	Increasing prevalence and increasing numbers diagnosed in Bradford and Craven. Prevalence is above England rate
Diabetes (17+ years)	Increasing prevalence and increasing numbers diagnosed in Bradford and Craven. Prevalence is above England rate
Respiratory: Asthma (6+ years)	Both prevalence and numbers of patients with asthma show an increase. Prevalence is above England rate
Respiratory: COPD (all ages)	Decreasing trend but numbers of people not falling as fast as prevalence rate (due to increase in population/ denominator). Prevalence is above England rate
Serious Mental Illness (all ages)	Increasing trend and numbers of people. Prevalence is above England rate

Table 3: Table showing summary of trends in QOF prevalence data

Our local primary care data, extracted in September 2024 (based on all ages), show the same pattern as the OHID trends for all conditions except for dementia, where the number of recorded patients has fallen since September 2023. See figure 5 below.

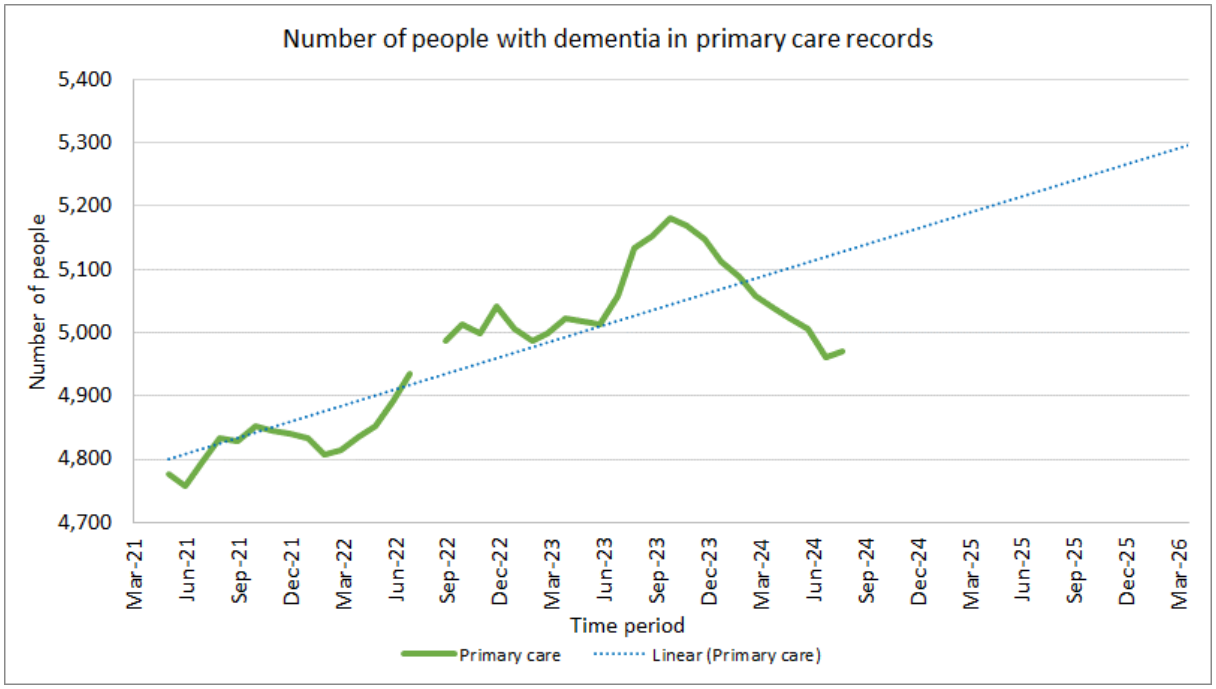

Figure 5: Chart showing trends in the number of people with dementia

All other conditions (excluding COPD) demonstrate increasing trends. See figure 6 below as an example.

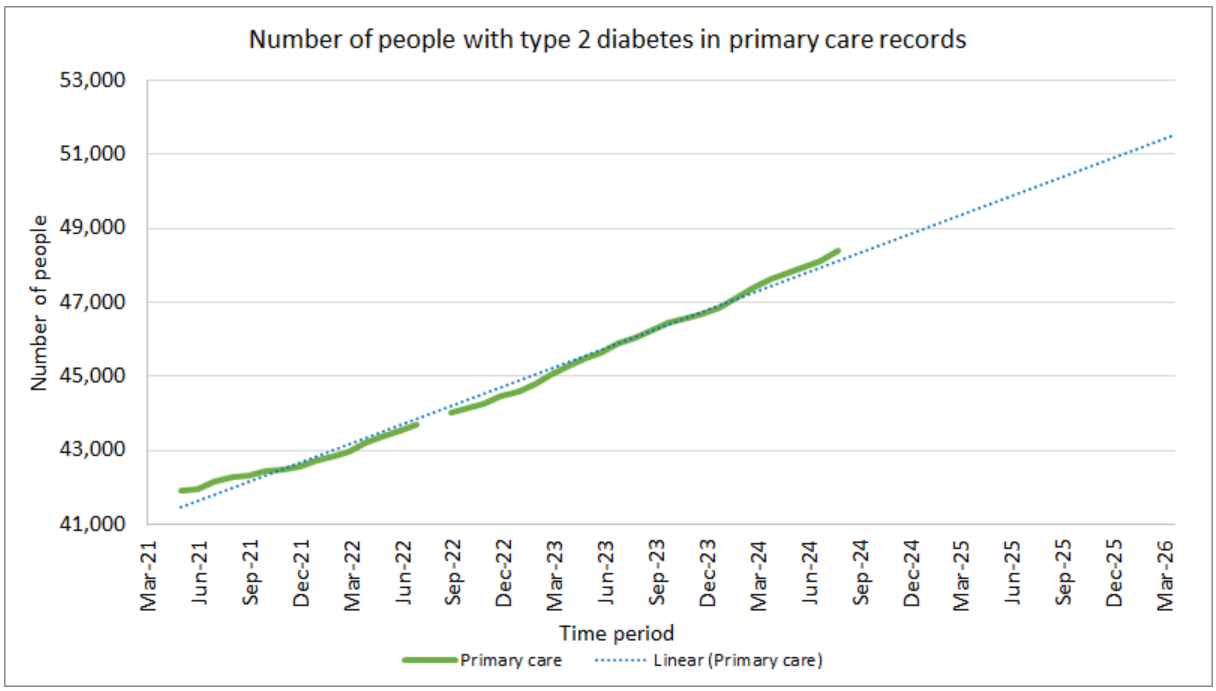

Figure 6: Chart showing trends in the number of people with type 2 diabetes

This table and these charts show the significant number of registered patients with a recorded diagnosis of the specified conditions. This is likely to be less than the actual number of people who have the condition, as there may be people in our communities without a diagnosis.

These conditions are the main causes of disability (see section 4.1 above), so it is important that we have services which are able to prevent or delay the development of these diseases and effectively support people to management them. This is increasingly important when we consider the population projections for Bradford District and Craven District, where we see a sharp increase in the older age groups.

Please see our data annex for more detail. Slides in annex: Trends for long term conditions from our local primary care data

Deprivation

The following diagram shows how each of the long term conditions are distributed across our population from a deprivation perspective.

Figure 7 shows the profile across the deprivation quintiles, where quintile 1 is the most deprived and quintile 5 is the least deprived. Each bar represents the total number of people recorded with that condition, and the shading shows the proportion living in each quintile. It is raw data and not age standardised. It shows that some conditions, such as cancer, are relatively evenly dispersed across the quintiles, other conditions such as serious mental illness and diabetes are more common on the most deprived quintiles.

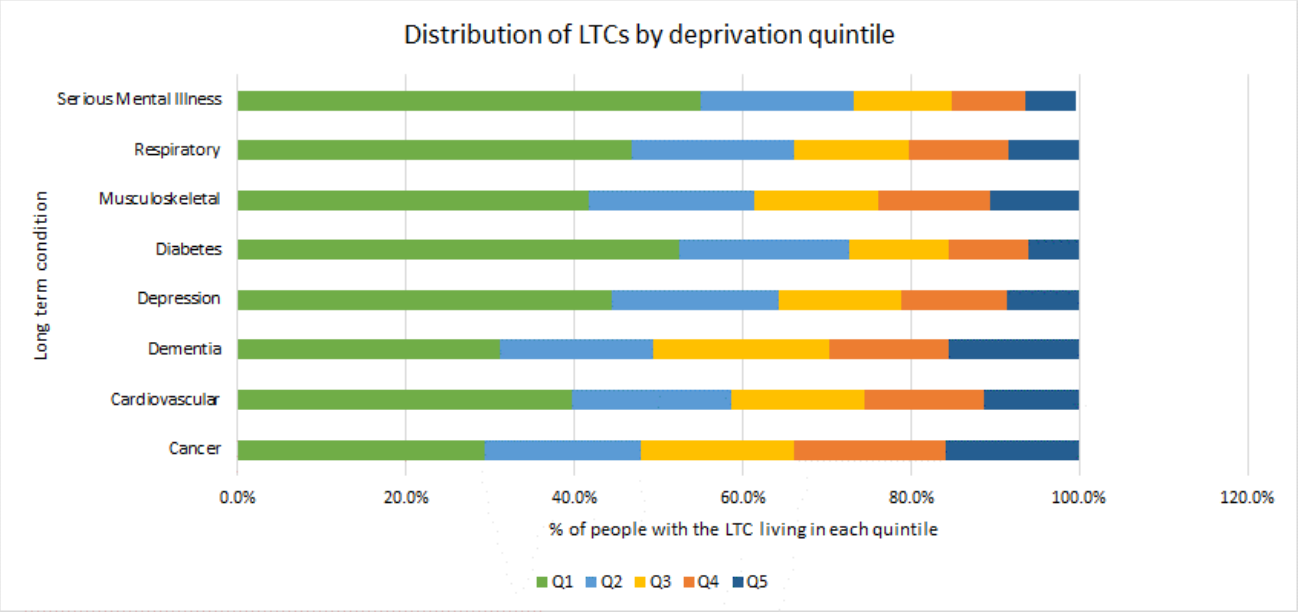

Figure 7: Chart showing distribution of long term conditions by deprivation

Ethnicity

Figure 8 shows the profile across ethnic groups. Each bar represents the total number of people recorded with that condition, and the shading shows the proportion for each ethnic grouping. It is raw data and not age standardised.

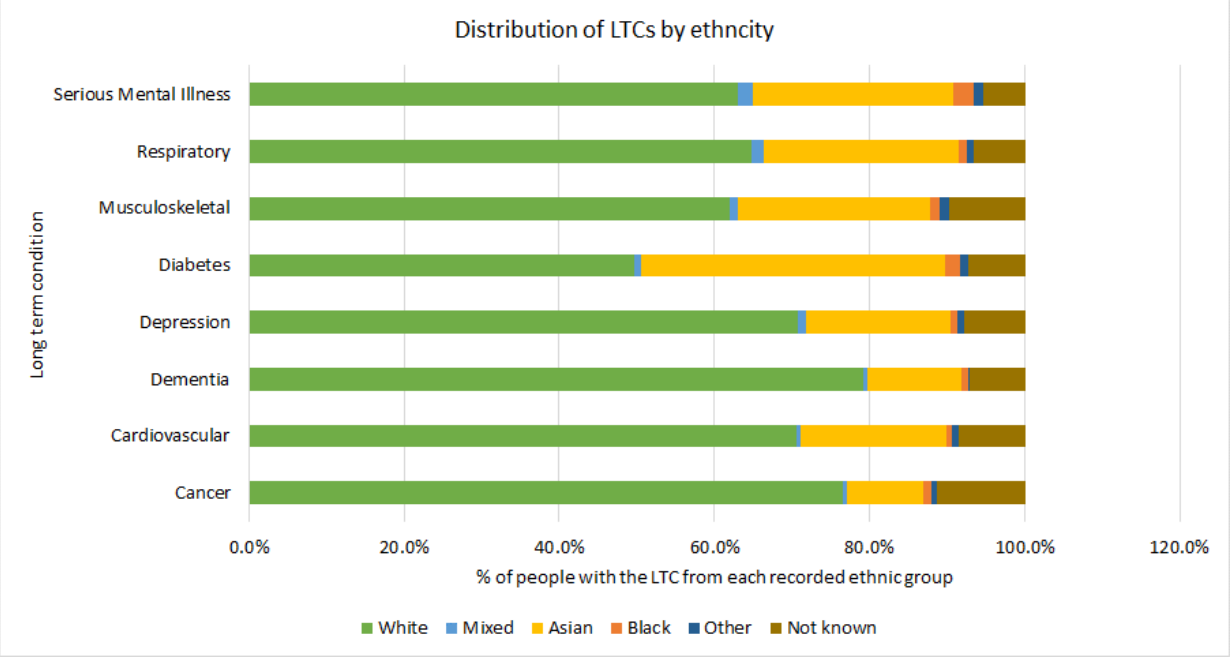

Figure 8: chart showing distribution of long term conditions by ethnicity

It is difficult to draw conclusions due a high proportion of records where ethnicity is not known (this ranges from 5.3% of records for people with serious mental illness to 11.3% for cancer. However, using recent JSNA figures as a simplistic guide, where approximately 65% of the Bradford District and Craven population is White, and approximately 30% are Asian, we can see that the distribution patterns for most of the conditions are different to the overall population profile. However, of the conditions displayed here, there is a high proportion of people with diabetes of Asian ethnicity.

5. Overview of long term conditions in Bradford District and Craven

Within this section we will focus on each of the condition groups, highlight key insights, examples of local best practice and indicate high impact areas for action. A range of data will be used, sources and coverage will be indicated throughout.

It is not the intention of this section to replace existing joint needs assessments – they will be referenced where they exist.

The sections highlighting local best practice and high impact areas for action are based on the local adaptation of the Intervention Decay Model. The Intervention Decay Model is a simple framework developed by Professor Chris Bentley to illustrate how a range of factors can influence an individual's ability to achieve the best health access, experience and outcomes. It provides a framework for considering inequalities across a care pathway, showing how various determinants can contribute to creating healthcare inequalities. Areas for action are grouped into seven key themes in the orange boxes, which are indicated in the orange boxes in the chart below.

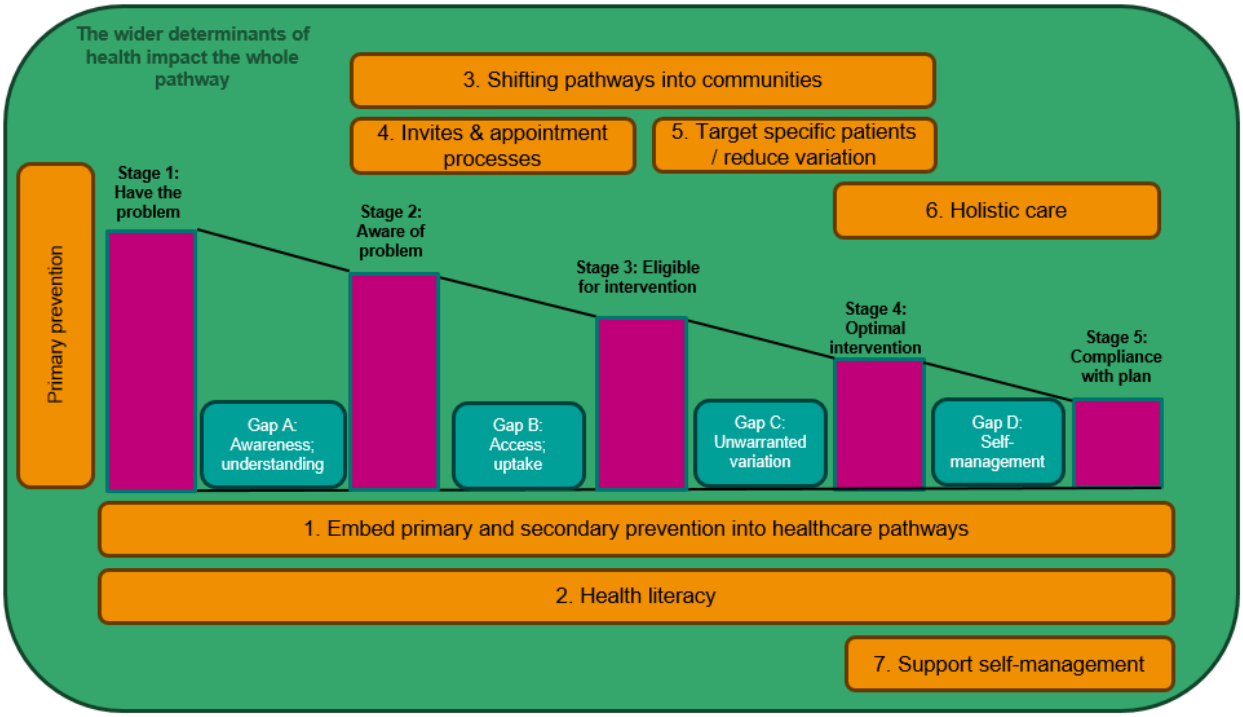

Figure 9: Intervention Decay Model

5.1 Cancer

Overview and key insights from an inequalities perspective:

Cancer has a significant impact on the burden of disease, and in the mortality rates within the population. This impact is not distributed evenly across the population, and there are inequalities which are experienced in a number of ways. For example:

- Socioeconomic factors, including access to healthcare services and lifestyle choices, play a role in cancer incidence and outcomes.
- Different population groups (such as inclusion health groups) may face barriers to early detection and treatment. Data suggests that people from the most deprived

communities are less aware of cancer symptoms and report more barriers to seeking help

- Differences in the uptake of early detection and screening programmes in disadvantaged communities contributes to these disparities. This leads to diagnoses at later stages, poorer outcomes and reduced survival rates.
- People from more deprived communities are 50% more likely to be diagnosed through emergency routes like A&E (when looking at all cancers together).
- Individuals with cancer in deprived areas may experience a lower life expectancy due to delayed diagnosis and limited access to advanced treatments.
- Diverse populations, different cultures and communities are likely to have different views on cancer and the importance of diagnosis and treatment. Healthcare professionals need to understand these differences and customise how they communicate the need for lifestyle changes, tests, symptoms, and care pathways when cancer is diagnosed.
- Cancer can lead to unemployment or reduced work capacity, affecting individuals' economic well-being. Socioeconomic disparities may further impact the ability to take time off work for treatment and recovery.

Data from Cancer Research in 2020 shows that deprivation is a key factor in cancer related inequalities, with 20,000 more cancer cases a year in the most deprived areas[8]. To reduce this and ensure that there continues to be a reduction in the rate of premature mortality from cancer, there needs to be concerted action in both prevention and reducing variation in treatment. 30-50% of cancer is preventable: screening and early detection improves outcomes.

Distribution

The following two charts illustration the distribution of cancer by ethnicity and deprivation.

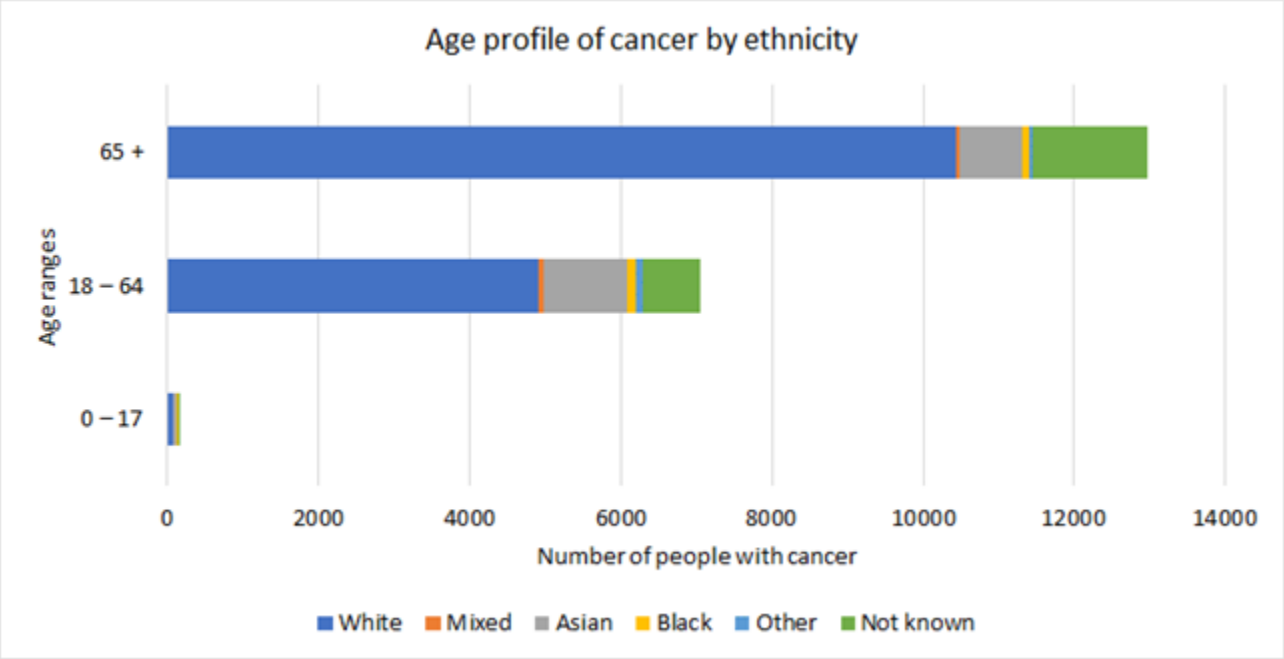

Figure 10: Chart showing age profile of people with cancer, by ethnicity

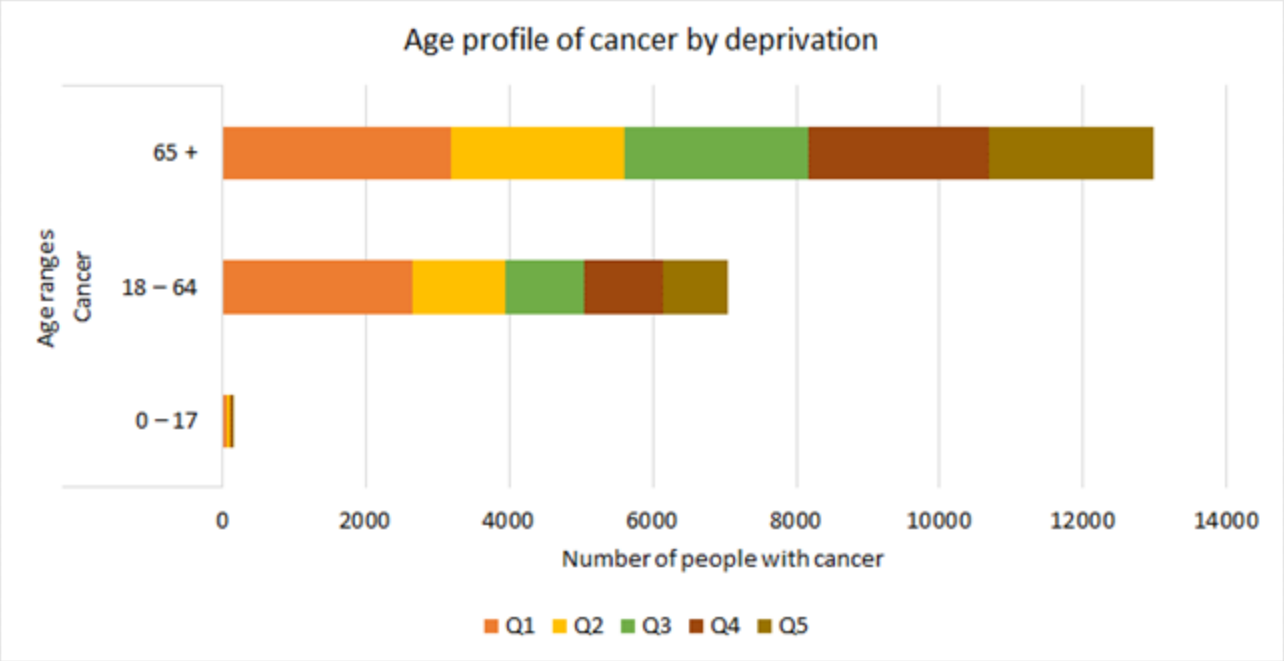

Figure 11: Chart showing age profile of people with cancer, by deprivation

Data

Our local data tells us that:

- 20,155 patients with cancer recorded in primary care records in 2023.
- Our local primary care data, extracted in September 2024 (based on all ages), indicate that the number of people with cancer detected is increasing.
- Cancer was the second highest contributor to the life expectancy gap between the most and least deprived quintiles, 2020 to 2021 (excluding Covid-19).
- In data in key OHID metrics for cancer, North Yorkshire values are better that the England averages. However, the trends for most of these metrics are either decreasing or remaining static (see table 4 below).
- In data in key OHID metrics for cancer, Bradford values are worse that the England averages. However, the trends for most of these metrics are either decreasing or remaining static (see table 4 below).

		Bradford		North Yorkshire		England	
	Period	Value	Trend	Value	Trend	Value	Trend
Cancer screening coverage: bowel cancer	2023	68.9%	Increasing and getting better	78.1%	Increasing and getting better	72.0%	Increasing and getting better
Cancer screening coverage: breast cancer	2023	54.8%	Decreasing and getting worse	73.2%	Decreasing and getting worse	66.2%	Decreasing and getting worse
Cancer screening coverage: cervical cancer (aged 25 – 49 years)	2023	62.2%	Decreasing and getting worse	75.5%	Decreasing and getting worse	65.8%	Decreasing and getting worse
Cancer screening coverage: cervical cancer (aged 50 – 64 years)	2023	73.3%	Decreasing and getting worse	78.6%	Decreasing and getting worse	74.4%	Decreasing and getting worse
Percentage of cancers diagnosed at stages 1 and 2	2021	51.5%	No significant change	53.2%	No significant change	54.5%	No significant change
Under 75 mortality rate from cancer considered preventable (rate per 100,000)	2020-22	58.4	Could not be calculated	43.4	Could not be calculated	50.5	Could not be calculated
Under 75 mortality rate from cancer (rate per 100,000)	2022	133.1	No significant change	104.6	No significant change	122.4	Getting better

Table 4: Table showing trends in key cancer metrics. Please note that data was not available for Craven, so we have used the data for North Yorkshire in place of this.

When data is disaggregated by ethnicity, we can see some variation. For example in the following chart (figure 5) compares the percentages in each ethnic group for people with a record of cancer in primary care (1, bottom bar) and all people living in the Bradford and Craven NHS area (2 – top bar). We can see that in the group of people with South Asian heritage (green) there is less cancer diagnosis at younger ages (under 65).

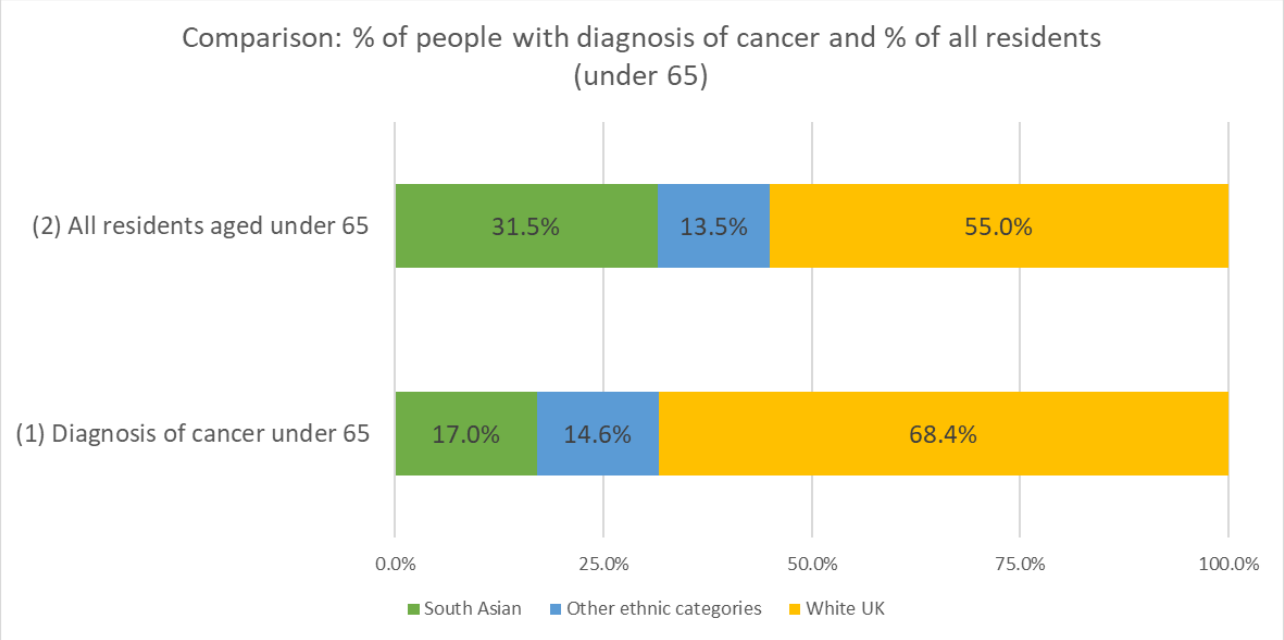

Figure 12: Chart showing % of people under 65 years with a diagnosis of cancer

This is different to the trends we see in the over 65 population, figure 6

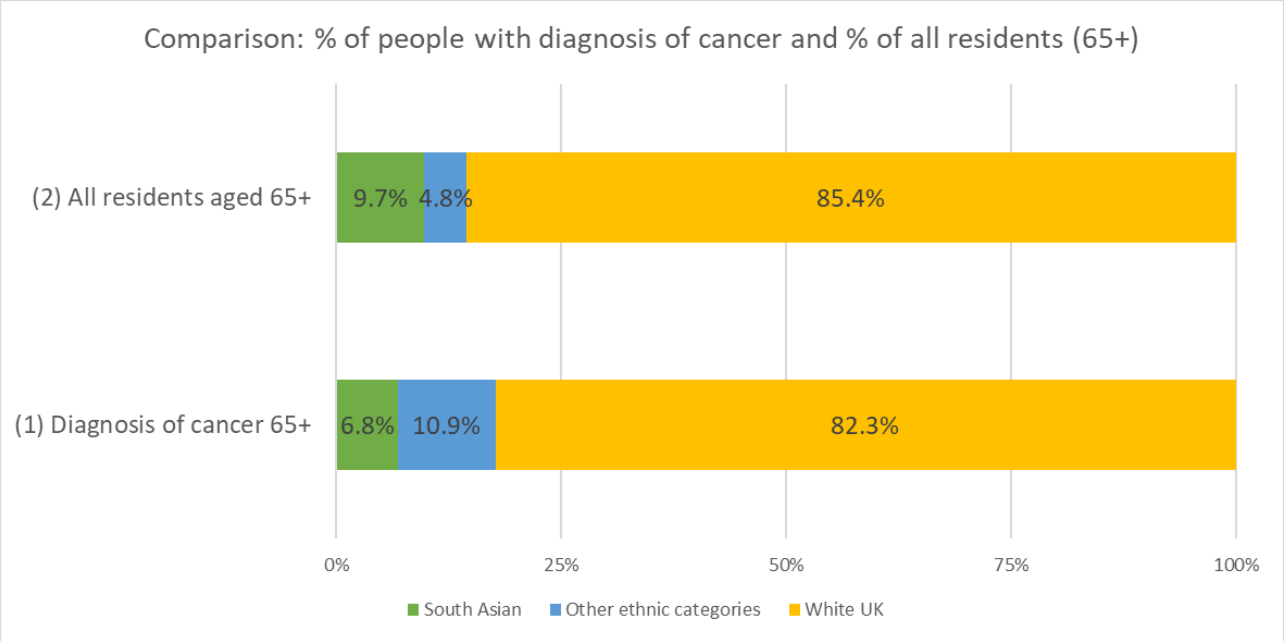

Figure 13: Chart showing % of people aged 65+ with a diagnosis of cancer

Considerations from our data

- Low rates in cancer screening and/or decreasing trends in uptake indicate missed opportunities for early detection of cancer.

- Late presentation continues to be an issue. Advanced disease means there are fewer options for treatment and often results in rapid deterioration.
- South Asian heritage population has less cancer diagnosis at younger ages. Consider the younger age profile of South Asian under 65 population and attitudes to risk factors i.e. smoking, alcohol, other factors.

Examples of local best practice

Health literacy	• Work with people with LD/autism, including myth busting in communities • Working with local partners to ensure consistent messages • Involvement of men in the discussions around women's health (cervical screening engagement with wider South Asian community) • Development of videos for learning disability communities on all three national cancer screen programmes • Introducing a digital marketing project to promote and encourage uptake to all cancer screen programmes
Shifting pathways into communities	• Expansion of targeted lung health checks across all GP Practices in Bradford District and Craven. This includes the implementation of a clinical trial YorQuit for smoking cessation
Invites and appointment processes	• RIC bowel screening project - 'reminder intervention in community languages' increased test completion rate • Cervical Behavioural Science and Nudge Theory programme improved response rate to screening invites. This has now been expanded to all cancer screen programmes including lung.
Target specific patients / reduce variation	• Implementation of a learning disability & autism cancer screen programme which involves the education and upskilling of primary care staff and raising awareness in the respective communities. • Development of an inclusion and cancer pathway programme, from screening through to diagnosis, treatment and 'Living with and Beyond.' Phased approach beginning with the Homelessness community. • Introduction of a cervical self-sample pilot beginning November 2024.
Support self-management	• At diagnosis – offering pre-treatment support e.g. Bradford Encouraging Exercise Programme (BEEP) with team trained in supporting cancer patients. The cancer prehabilitation programme supports people to be as healthy as possible from receiving a cancer diagnosis and before secondary care treatment starts and following treatments and to help to increase patient physical and lifestyle outcomes.

	• Introduced a comprehensive personalised care support package to ensure that people diagnosed with cancer will have access to personalised care, including needs assessment, a care plan and health and wellbeing information and support.

High impact areas for action

The following table summarises areas for action:

Primary and secondary prevention	• Deliver health and wellbeing information including smoking, obesity and harmful drinking
Health literacy	• Provision of information to support the early recognition and referral to specialist services • Delivery of awareness raising campaigns for screening and signs/symptoms • Support to wider health check provision to include signs and symptoms of cancer in community assets • Outreach with culturally competent education about the condition, and interventions (such as screening). Use a combination of tools i.e. written and visual. • Provide all screening information and resources in the full range of accessible formats and languages, not just invite and result letters. Work has begun on this with videos and easy read/ pictorial information) • Work with communities to establish screening as a visible and valuable routine service within underserved groups • Proactively ask groups who do not engage with screening to share their concerns and work to counter any myths or misconceptions • Support to wider health check provision to include signs and symptoms of cancer in community assets
Shifting pathways into communities	• Build on successful programmes which have delivered interventions in community settings i.e. target lung checks and the mobile chemo van. This will reduce inequalities and assist with access issues people may face.
Invites and appointment processes	• Create more flexible ways for people who have been invited to get screened that fit with their lives and responsibilities where advanced booking is not possible or convenient. • Utilise support workers to offer education, appointment scheduling assistance and reminder/follow-up calls to increase compliance with screening

	• Target specific telephone/ mailed reminders and endorsed invitations (i.e. from a named GP) to people who have not attended • Ensure booking processes can capture support needs and reasonable adjustments and share with services ahead of appointments.
Target specific patients / reduce variation	• Focus on reducing variation in uptake in screening – continue to target groups who do not attend e.g. inclusion health groups • Provision of interventions to increase uptake of cancer screening (breast, bowel and cervical) in underrepresented groups or those with repeat 'Did Not Attend' appointment outcomes. • Require robust collection and assessment of equity data by services and use insights to evaluate and capture the value of different interventions.
Holistic care	• Make screening a standard issue for relevant healthcare professionals to routinely raise when they come into contact with someone eligible, with an offer to provide information or assist with booking if needed.

References for this section

- Collated-what-works-evidence-packs-updated-Apr-24-v0.3-JH.3-JH.docx (live.com)
- Consensus Statement on breast screening inequalities - Race Equality Foundation
- What-works-Addressing-inequalities-in-the-uptake-of-cervical-screening.pdf (heec.co.uk)

5.2 Cardiovascular disease, including diabetes

City of Bradford Metropolitan District Council has updated its public health resource packs on the following conditions:

- Cardiovascular Disease in Bradford District (2024) Cardiovascular Disease (bradford.gov.uk)
- Cardiovascular Disease in Bradford District (2024) Diabetes in Bradford District

Overview and key insights from an inequalities perspective

Like cancer, cardiovascular disease (CVD) and diabetes have a significant impact on the burden of disease, and mortality of the population. This impact is not distributed evenly across the population, and there are inequalities which are experienced in a number of ways. For example:

- Heart disease, stroke, and diabetes are closely related and contribute to health inequalities. These diseases significantly contribute to the life expectancy gap between deprived and affluent areas.
- Lifestyle factors, such as diet and physical activity, along with access to healthcare, influence the incidence and management of these conditions.

- People in deprived areas of Bradford and Craven are more likely to have risk factors such as obesity, high blood pressure, and poor nutrition, which increase the risk of heart disease and diabetes.
- Managing these conditions may require time off work, affecting employment stability. Disparities in employment opportunities can exacerbate health inequalities.
- Testing and interventions need to be local to people and accessible for all. People often leave their illness until it is more serious and complex to treat, seeking help late.
- Data suggests that people from the most deprived communities are less aware of CVD symptoms, particularly stroke, and may not seek help as quickly as they should. People from the most deprived also report more barriers to seeking help
- Research suggests that the incidence of high blood pressure within the most deprived communities is roughly double that of the most affluent areas and people living in the most deprived areas are nearly twice as likely to have a stroke.
- Finding people with hypertension allows early intervention to optimise blood pressure and reduce the risk of heart attacks and stroke. It also presents an opportunity to offer preventative measures to those at risk of developing the condition[9].

Distribution

The following two charts illustration the distribution of cardiovascular disease by ethnicity and deprivation.

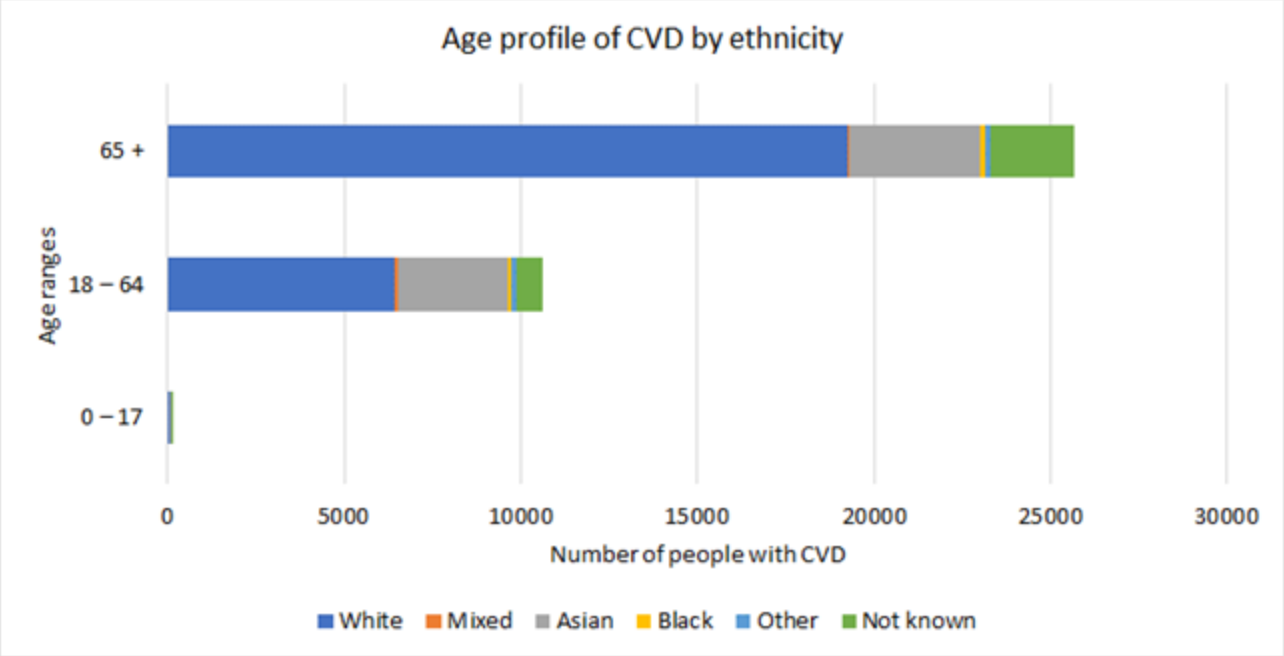

Figure 14: Chart showing age profile of people with CVD, by ethnicity

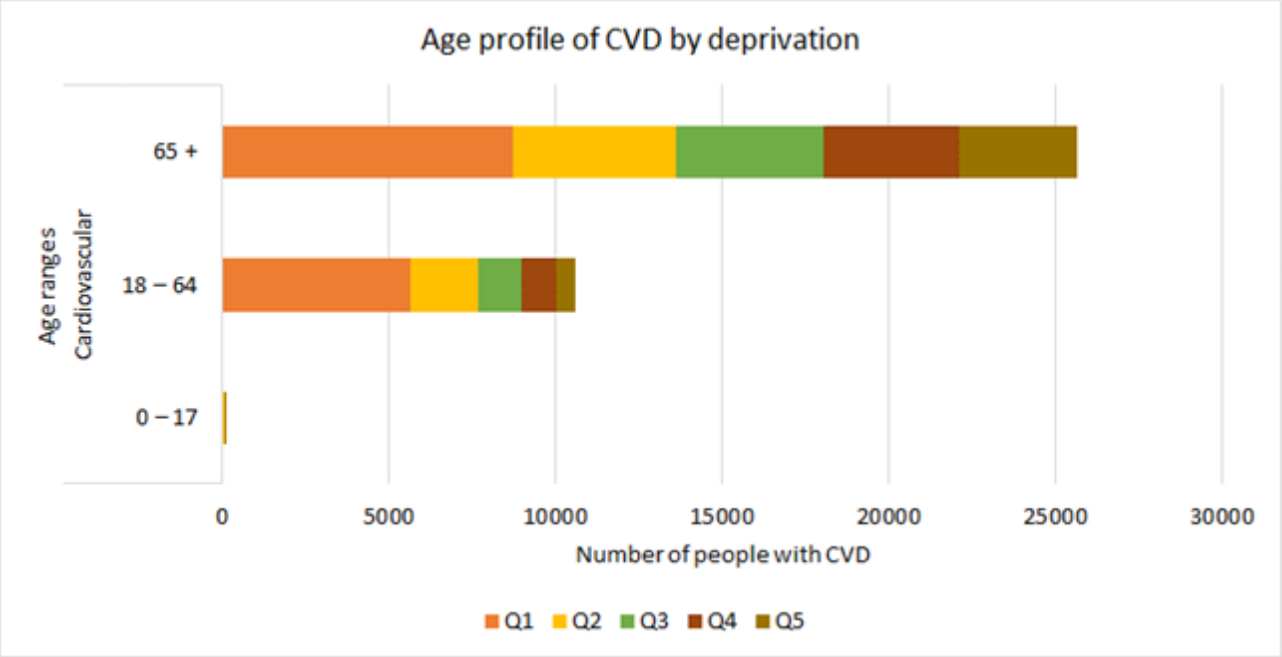

Figure 15: Chart showing age profile of people with CVD, by deprivation

Data

- 36,393 patients with CVD recorded in primary care records in 2023, and 49,984 people with diabetes.
- Our local primary care data, extracted in September 2024 (based on all ages), indicate that the number of people with atrial fibrillation, coronary heart disease, heart failure and diabetes (both type 1 and type 2) is increasing.
- Circulatory disease was the highest contributor to the life expectancy gap between the most and least deprived quintiles, 2020 to 2021 (excluding Covid-19).
- In data in key OHID metrics for conditions relating to CVD, North Yorkshire values are better that the England averages. However, the trends for most of these metrics are either decreasing or remaining static (see table 5 below).
- In data in key OHID metrics for conditions relating to CVD, Bradford values are worse that the England averages. However, the trends for most of these metrics are either decreasing or remaining static (see table 5 below).

	Period	Bradford Value	Bradford Trend	North Yorkshire Value	North Yorkshire Trend	England Value	England Trend
Hypertension: QOF prevalence (all ages)	2022/23	13.9%	Increasing	17.8%	Increasing	14.4%	No significant change
Stroke: QOF prevalence (all ages)	2022/23	1.8%	Increasing	2.6%	Increasing	1.8%	Increasing
CHD: QOF prevalence (all ages)	2022/23	3.1%	No significant change	4.0%	Decreasing	3.0%	Decreasing
CKD: QOF prevalence (18+)	2022/23	3.9%	Increasing	5.6%	Increasing	4.2%	No significant change
Diabetes: QOF prevalence (17+)	2022/23	9.5%	Increasing	7.2%	Increasing	7.5%	Increasing
Cumulative % of the eligible population aged 40 to 74 who received an NHS health check	2019/20 - 23/24	22.4%	Could not be calculated	28.6%	Could not be calculated	28.1%	Could not be calculated
Under 75 mortality rate from all circulatory diseases (rate per 100,000)	2022	114.6	No significant change	70.7	No significant change	77.8	Increasing and getting worse

Table 5: Table showing trends in key CVD metrics. Please note that data was not available for Craven, so we have used the data for North Yorkshire in place of this.

When data is disaggregated by ethnicity, we can see some variation. For example in the following chart (figure 7) compares the percentages in each ethnic group for people with a record of diabetes in primary care (1, bottom bar) and all people living in the Bradford and Craven NHS area (2 – top bar). We can see that people of South Asian and minority ethnic heritage make up over half of adults (18-64yrs) with a diagnosis of diabetes (mainly type II). Most of these people resided in the Bowling and Barkerend, Little Horton, Great Horton, Keighley Central areas.

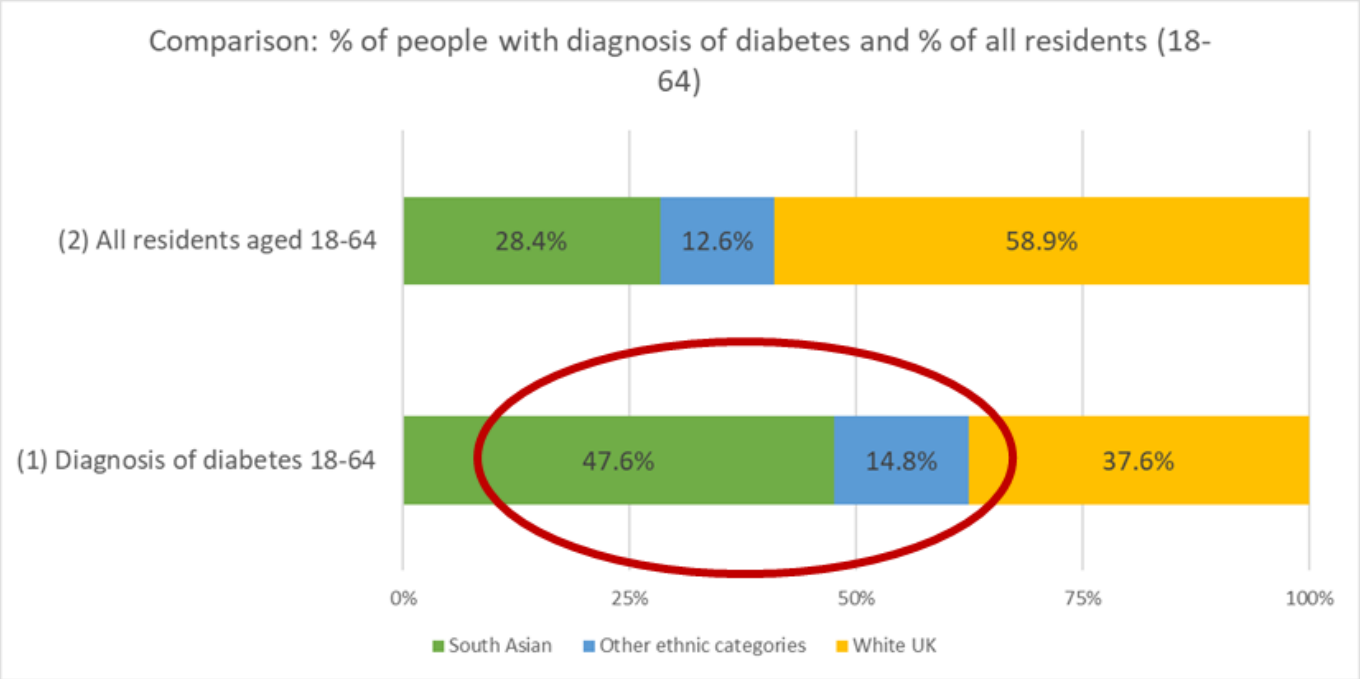

Figure 16: Chart showing % of people under 65 years with a diagnosis of diabetes

Considerations from our data

- Low rates of NHS Health check uptake for 40-74yr olds indicate missed opportunities for early detection of diabetes and cardiovascular disease.
- Increasing trends for hypertension, diabetes and chronic kidney disease
- We have used incentives in the past to encourage lifestyle change, such as the Bradford Beating Diabetes Passports, and Living Well Service

Examples of local best practice

Primary and secondary prevention	• Diabetes prevention promotion events have been held in communities
Health literacy	• KAWACC and Modality PCNs did some work around prediabetes for south Asian women, including some health checks. PCNs in Keighley delivered in multiple community settings
Shifting pathways into communities	• Community partnerships have held health checks for diabetes, hypertension. The health check as developed through the healthy hearts programme and has been rolled out in multiple community venues. This is a first point of contact approach to detect LTC, but also to maximise health messaging and supporting with prevention approaches
Invites and appointment processes	• The community podiatry team successfully tested an opt-in process for patients being able to choose their appointment date/ time and location for their annual diabetes foot check. This reduced the proportion of 'Did Not Attend' appointment outcomes
Target specific patients / reduce variation	• Lipid project helped practices to identify undertreated patients and help them manage their cholesterol.

High impact areas for action

Primary and secondary prevention	• Community pharmacy hypertension case finding • Increase uptake of the NHS Health Check • Provision of health checks for those younger than 40 yrs. • Increase uptake of the NHS Diabetes Prevention Programme • Support PCNs to identify their patients with higher risk of developing heart failure, develop pathways to integrate with social prescribers and VCSEs, implement proactive care with follow-up, embed patient activation measures
Health literacy	• Culturally sensitive education sessions using materials that consider language barriers • Show people how the heart works, the impact of high blood pressure, and examples of little changes we can implement, with a specific focus on self-care, smoking and lifestyle factors. • Empower local community leaders to be more aware of conditions, starting early in mother and toddler groups to the knit and natter groups

Shifting pathways into communities	• Delivering testing and patient education in community venues. Overcoming information sharing barriers between community testing and primary care records • Working with local pharmacies and universities to reduce pressure on primary care staff. • Outreach activity by community health workers such as health trainers
Invites and appointment processes	• Community health sessions/NHS health checks that are flexible, out of hours and target prioritised groups • Support to ensure people who are disadvantaged can attend appointments (for example, this may include help with transport, postal prompts and offering home visits).

Target specific patients / reduce variation	• Cholesterol search and risk stratification
	• Case finding and direct-acting oral anticoagulation) to prevent atrial fibrillation related strokes
	• Optimisation of:
	  ○ hypertension treatment
	  ○ heart failure treatment through annual reviews
	  ○ management post ACS, including lipid management
	  ○ delivery of 9 diabetes care processes
	• Cardiac rehabilitation for patients post ACS and diagnosis of heart failure

Support self-management	• Encouragement and support for people who are disadvantaged to follow the treatment that they have agreed to. For example, encourage them to use self-management techniques (based on an individual assessment) to solve problems and set goals. • Structured education programmes (DAFNE and X-PERT are cited, others are available) • However, recognise that the NHSE education offer does not work for all cohorts. Levels of health literacy vary across population and we need service offers that reflect this • Using digital technologies for Atrial Fibrillation and home blood pressure machines. • Use community venues to promote self-care advice • Provision of education and exercise programmes to patients with or at risk of heart problems e.g. exercise classes designed for those recovering from a heart attack

References for this section

- Collated-what-works-evidence-packs-updated-Apr-24-v0.3-JH.3-JH.docx (live.com)

- https://www.england.nhs.uk/wp-content/uploads/2022/12/B1590-cvd-high-impact-interventions.pdf
- https://www.england.nhs.uk/wp-content/uploads/2022/12/B1590-iv-Diabetes-High-Impact-Interventions.pdf

Please see our data annex for more detail. Slides in annex:

- Comparisons between ethnic groups by age for CVD and diabetes
- Maps showing the distribution of people with a primary care record of diabetes

5.3 Chronic respiratory disease

Overview and key insights from an inequalities perspective

Respiratory has a significant impact on the burden of disease, and in the mortality rates within the population. This impact is not distributed evenly across the population, and there are inequalities which are experienced in a number of ways. For example:

- Chronic respiratory diseases, such as chronic obstructive pulmonary disease (COPD), are influenced by smoking rates, air quality, and access to healthcare.
- Deprived communities in Bradford and Craven may have higher rates of chronic respiratory diseases due to environmental factors and lifestyle choices. This includes higher smoking rates and exposure to environmental pollutants.
- Chronic respiratory diseases can limit an individuals' ability to engage in physically demanding work, affecting employment opportunities.
- Deprivation is linked with increased emergency health care use among people with COPD.
- 70% of COPD is caused by smoking

Distribution

The following two charts illustration the distribution of chronic respiratory disease by ethnicity and deprivation.

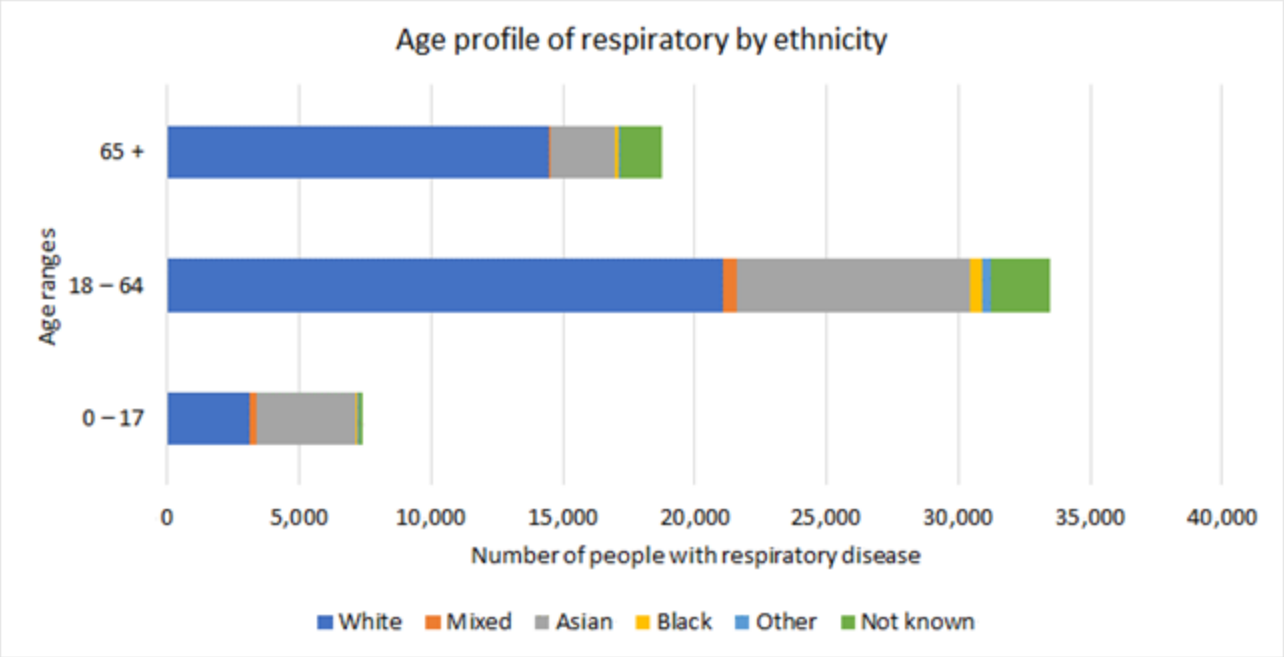

Figure 17: Chart showing age profile of people with chronic respiratory disease, by ethnicity

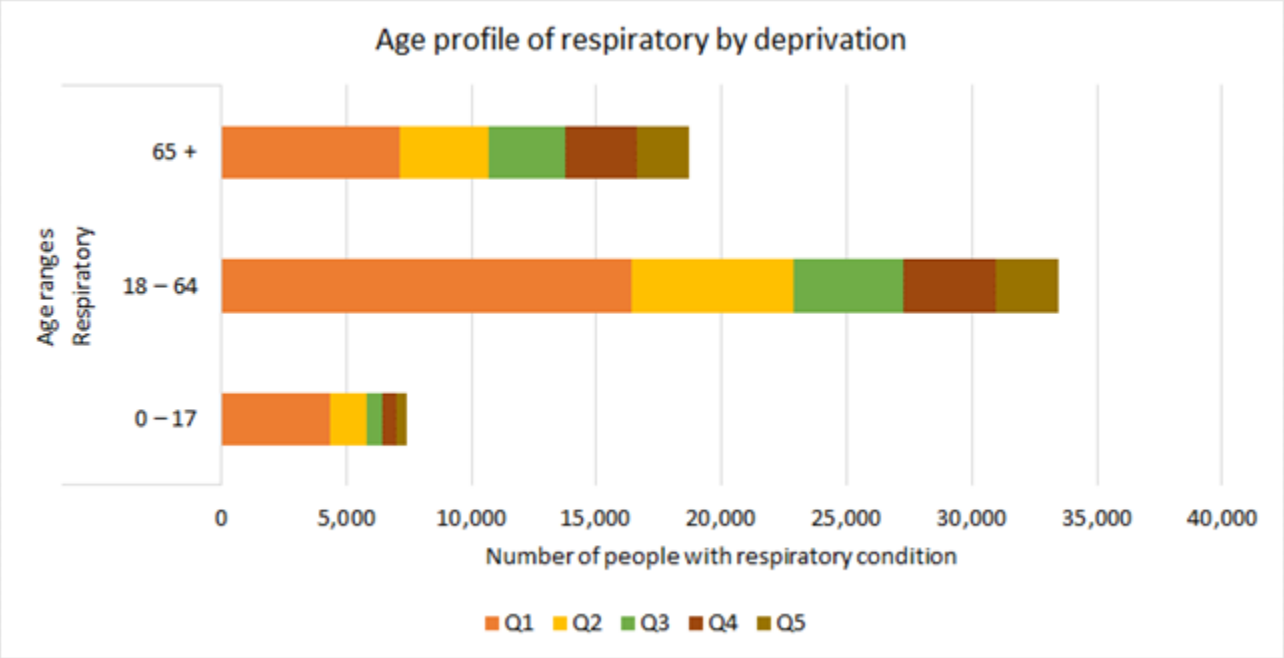

Figure 18: Chart showing age profile of people with chronic respiratory disease, by ethnicity

Data

Our local data tells us that:

- 59,615 patients with chronic respiratory disease are recorded in primary care records in 2023.
- There is more than three times as much asthma as COPD in adults (some adults have both)
- Our local primary care data, extracted in September 2024 (based on all ages), indicate that number of people with asthma is increasing and COPD is decreasing.
- Respiratory diseases were the third highest contributor to the life expectancy gap between the most and least deprived quintiles, 2020 to 2021 (excluding Covid-19).

- In data in key OHID metrics for respiratory disease, North Yorkshire values are better that the England averages. Trends for these metrics vary (see table 6 below).
- In data in key OHID metrics for respiratory disease, Bradford values are worse that the England averages. Trends for these metrics vary (see table 6 below).

	Period	Bradford Value	Bradford Trend	North Yorkshire Value	North Yorkshire Trend	England Value	England Trend
Asthma: QOF prevalence (6+ years)	2022/23	7.5%	Could not be calculated	7.6%	Could not be calculated	6.5%	Could not be calculated
COPD: QOF prevalence (all ages)	2022/23	2.0%	Decreasing	2.0%	Decreasing	1.8%	Decreasing
Population vaccination coverage: Flu (primary school aged children)	2022	30.2%	Could not be calculated	65.7%	Could not be calculated	56.3%	Could not be calculated
Population vaccination coverage: Flu (aged 65 and over)	2022/23	76.9%	Increasing and getting better	85.7%	Increasing and getting better	79.9%	Increasing and getting better
Under 75 mortality rate from all respiratory disease (rate per 100,000)	2022	44.2	No significant change	21.2	No significant change	30.7	Decreasing and getting better

Table 6 – Table showing trends in key respiratory metrics. Please note that data was not available for Craven, so we have used the data for North Yorkshire in place of this

When data is disaggregated by ethnicity, we can see some variation. For example in the following chart (figure 8) compares the percentages in each ethnic group for people with a record of chronic respiratory disease in primary care (1, bottom bar) and all people living in the Bradford and Craven NHS area (2 – top bar). Nearly half people aged 65+ with chronic respiratory disease are of South Asian or diverse ethnic heritage compared with 15% of the general population.

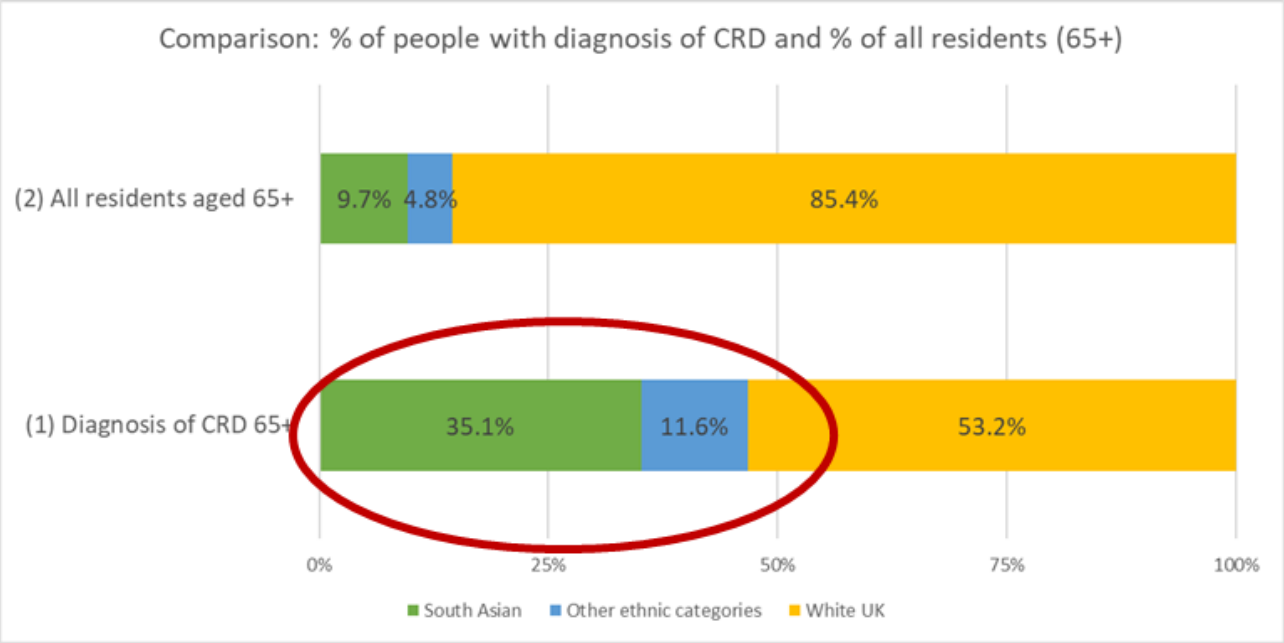

Figure 19: Chart showing % of people aged 65+ years with a diagnosis of CRD

Considerations from our data

- QOF prevalence for asthma and COPD are higher that England average for both Bradford and North Yorkshire.
- Vaccination rates in Bradford are lower than the England average for both primary school aged children and people aged over 65 years. North Yorkshire rates are lower than the England average.

- High rates of chronic respiratory disease in the 65+ years South Asian or diverse ethnic heritage group may be a result of cold housing, air pollution and/ or long term effects of textile industry work.

Examples of best practice

Health literacy	• Bradford District Care NHS Foundation Trust (BDCFT) clinicians, worked in partnership with people with learning disabilities, their families and carers to co-produce a digital resource. The website supports people to manage their respiratory health at home by providing of suite of accessible videos and text guidance available in multiple languages: See the website: Keeping my chest healthy – Bradford District Care NHS Foundation Trust (bdct.nhs.uk)
Shifting pathways into communities	• Local success has been seen when using the "bus" for spirometry (flexible sites) • Working with Modality PCN to develop a spirometry hub model
Target specific patients / reduce variation	• Ongoing implementation of an audit and feedback approach with all of our practices to promoting better quality and greener asthma care through the Campaign to Help Improve Respiratory Prescribing (CHIRP)
Support self-management	• Reviewing the pulmonary rehabilitation offer to increase uptake, including the use of VR headsets to support remote monitoring • Resources to support self-care for respiratory/asthma developed in community languages. These include Inhaler technique A3 Poster (NHS multiple Trusts).pdf (pcrs-uk.org) and Multi-lingual Respiratory Resources (respiratoryfutures.org.uk) • Group consultation model

High impact areas for action

Primary and secondary prevention	• Interventions to increase early diagnosis of COPD to improve quality of life and keep healthy for longer • Provision of quit smoking support for identified groups
Health literacy	• Consider use of peer supporters for nervous/ concerned patients • Increase understanding of the value of vaccines and uptake of COVID-19, Flu and Pneumonia vaccines
Invites and appointment processes	• Ensure key staff can speak community languages
Target specific patients / reduce variation	• Increase use of spirometry in diagnosis of asthma & COPD. See our local campaign to increase this: Equal Breath campaign for GPs in West Yorkshire (vimeo.com) • Inhaler and medicines optimisation

	• Ensure effective prediction and management of exacerbations for people with COPD
Holistic care	• Provision of anticipatory care models
Support self-management	• Self-management interventions, education, telehealth and use of digital solutions. The local West Yorkshire Respiratory Toolkit is supporting the roll out of patient self-management apps which have evidence of impact (Asthmahub and COPDhub). • Community language self-care videos • Increase access to pulmonary rehabilitation to all appropriate people with COPD • Personalised asthma action plan for all children and young people with asthma

References for this section

- Collated-what-works-evidence-packs-updated-Apr-24-v0.3-JH.3-JH.docx (live.com)
- https://www.england.nhs.uk/wp-content/uploads/2022/12/B1590-respiratory-high-impact-interventions.pdf

Please see our data annex for more detail. Slides in annex: Comparisons between ethnic groups by age for chronic respiratory disease

5.4 Dementia

City of Bradford Metropolitan District Council has a Dementia Needs Assessment (2019): Dementia Needs Assessment (bradford.gov.uk)

Overview and key insights from an inequalities perspective:

Dementia has a significant impact on the burden of disease in the older population. This impact is not distributed evenly across the population, and there are inequalities which are experienced in a number of ways. For example:

- Dementia can reduce life expectancy, especially when coupled with other conditions.
- A recent report of the Lancet Commission on dementia prevention, intervention, and care [10] indicates that there are 14 risk factors that could prevent or delay nearly half of dementia cases. These can be seen in figure 20 below

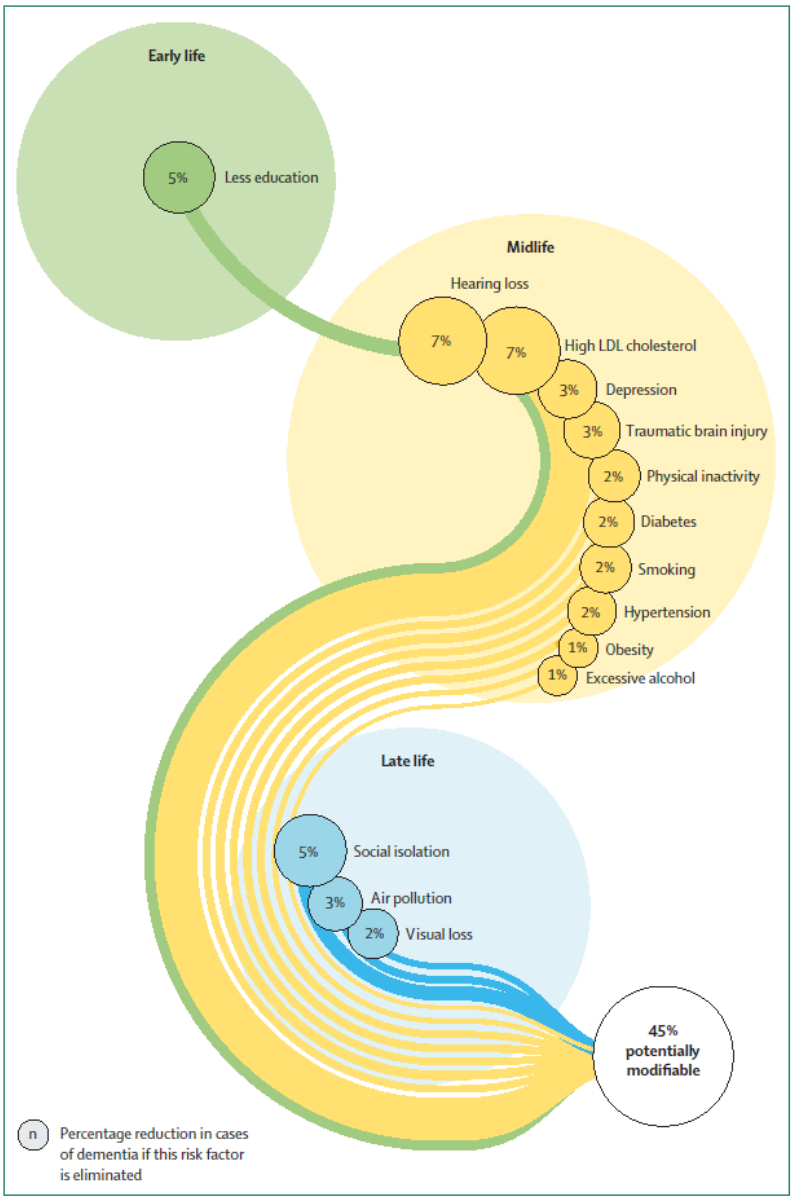

Figure 20: The life-course model of the 14 potentially modifiable risk factors for dementia, taken from the Lancet Commission report on Dementia

- The prevalence of these risk factors is higher in people from socioeconomic groups. Risk factors also cluster within communities and some may impact certain ethnic groups than others. For example, people from Black ethnic backgrounds have higher prevalence of potentially modifiable risk factors.[10]
- An early diagnosis of dementia is essential in accessing post-diagnosis care and support, and also helps to facilitate future care planning. However, stigma and a lack of understanding about dementia can result in people not seeking help.
- A national review on dementia[11] highlighted the need to focus on the needs of rural and deprived communities to reduce variation in dementia diagnosis, and when reviewing the effectiveness of diagnostic pathways.
- There is a need for culturally sensitive and language appropriate services.
- Dementia often leads to caregiving responsibilities, affecting the employment and overall well-being of family members. The City of Bradford Metropolitan District

Council (CBMDC) estimates that 85% of people living with dementia live in their own home.

Distribution

The following two charts illustration the distribution of chronic respiratory disease by ethnicity and deprivation.

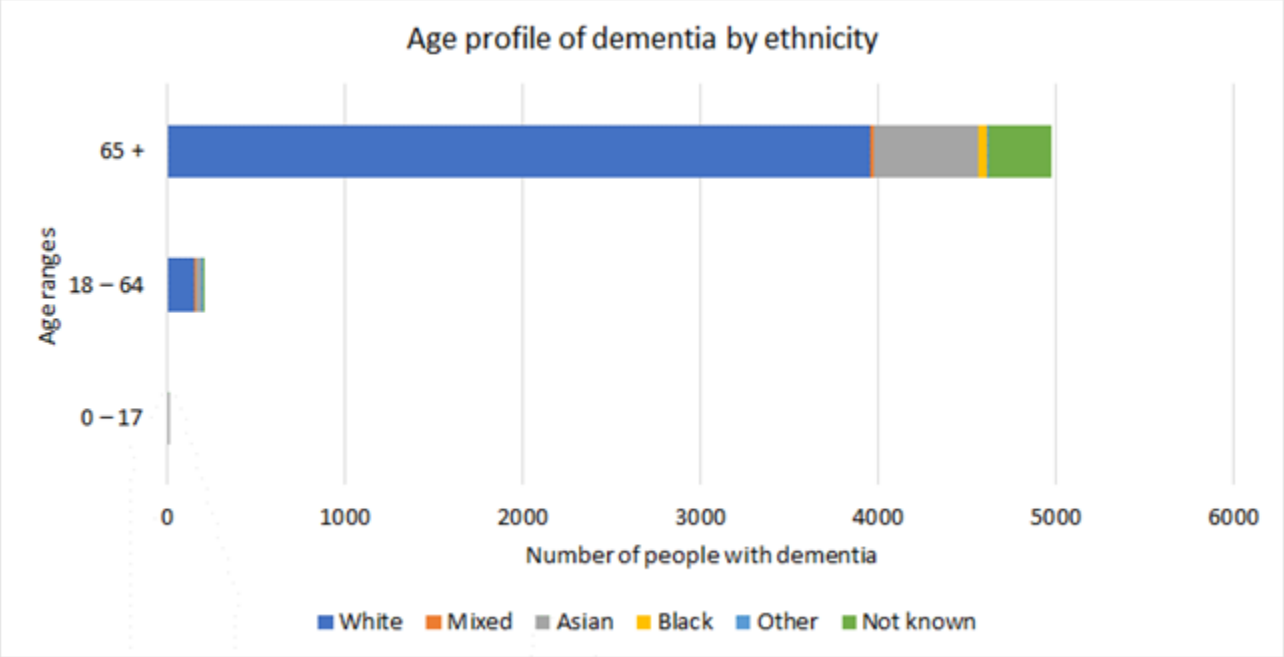

Figure 21: Chart showing age profile of people with dementia, by ethnicity

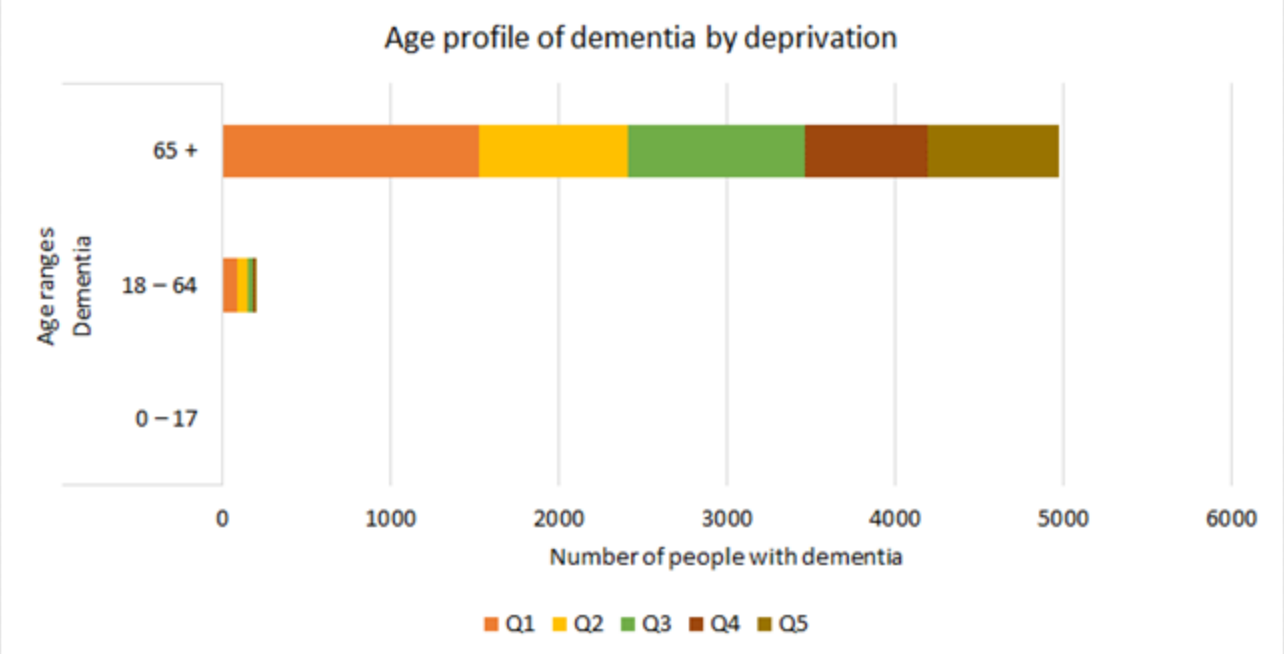

Figure 22: Chart showing age profile of people with dementia, by deprivation

Data

Our local data tells us that:

- 5,183 patients with dementia recorded in primary care records in 2023. CBMDC estimates that there are approximately 6,000 people living with dementia in their area. This includes people without a formal diagnosis.
- Our local primary care data, extracted in September 2024 (based on all ages) indicate that the number of people with dementia is increasing. CBMDC expect this number to increase by 25% in the next decade.
- Bradford District and Craven has significantly higher proportion of people on the dementia register who were prescribed antipsychotic medication than the national average. In August 2022, the local average was 15.2% compared to England average of 9.2% and a West Yorkshire ICB average of 9.7%. There is also significant variation within our place.
- Latest data from the Global Burden of Disease (2021) study shows that 5.66% of the DALYs in 70+ was attributable to Alzheimer's disease and other dementias. In North Yorkshire, this figure is 6.69%. Dementia is a significant cause of disability and dependency among older adults.
- In data in key OHID metrics for dementia, Bradford values are worse that the England average. There was no data for North Yorkshire. (See table 7 below).

		Bradford		North Yorkshire		England	
	Period	Value	Trend	Value	Trend	Value	Trend
Estimated dementia diagnosis rate (65+) - level	2023	74.3%	No significant change	No data	No significant change	63.0%	No significant change

Table 7: Table showing trends in key cancer metrics. Please note that data was not available for Craven, so we have used the data for North Yorkshire in place of this.

When data is disaggregated by ethnicity, we can see some variation. For example in the following chart (figure 10) compares the percentages in each ethnic group for people with a record of cancer in primary care (1, bottom bar) and all people living in the Bradford and Craven NHS area (2 – top bar). We can see that nearly a quarter of those with dementia diagnosis are of diverse ethnicities.

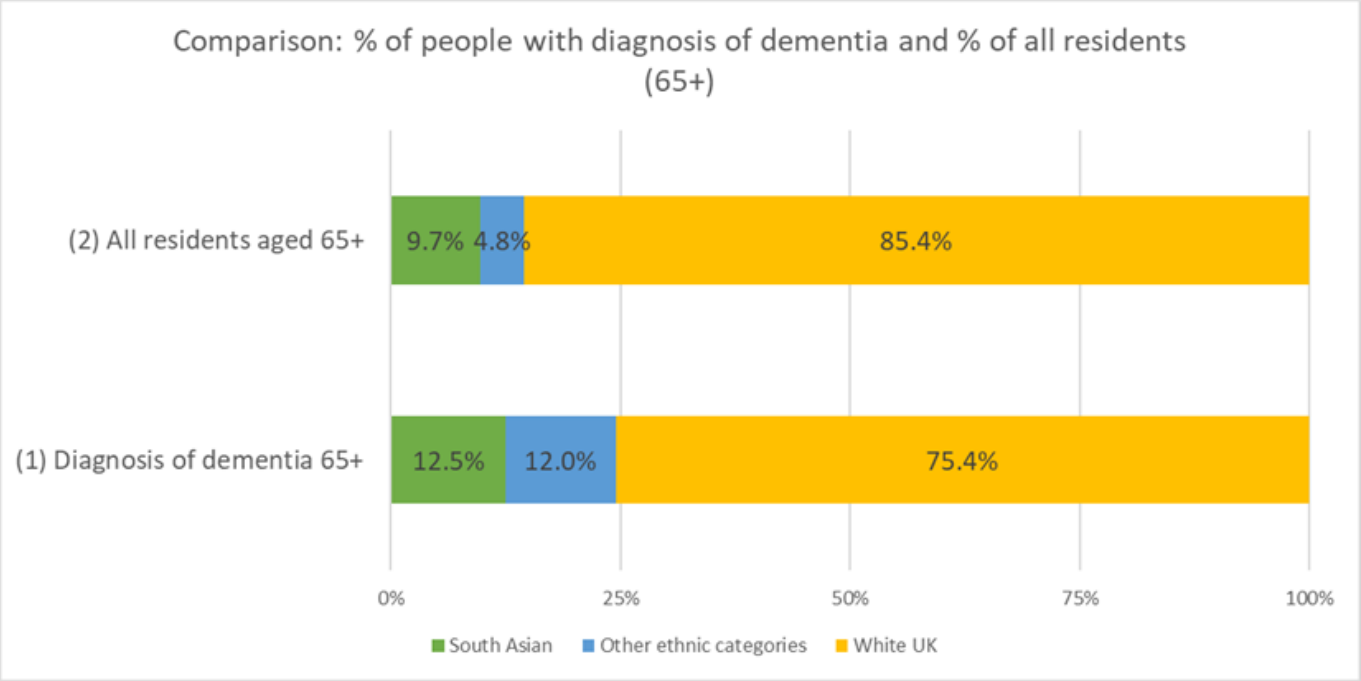

Figure 23: Chart showing % of people aged 65+ years with a diagnosis of dementia

Consideration from our data

- Nearly a quarter of those with dementia diagnosis are of diverse ethnicities, indicating need for culturally competent care including support for family carers.

Examples of local best practice

Health literacy	• Affinity has developed an enhanced dementia friendly project focussing across pathway from awareness to support for carers
Target specific patients / reduce variation	• Antipsychotic audit and supporting resources to reduce variation in prescribing rates and support deprescribing
Holistic care	• RIC Admiral nursing project in central Bradford – this has increased awareness around the importance of diagnosis and provides support for carers. There is evidence of impact on dementia registers and A&E attendances in the RIC area. • Specific training in care homes to support caring for people with distress
Support self-management	• VCSE small grants used to fund various initiatives such as creating dementia friendly spaces, support groups for people with early onset dementia, dementia support groups.

High impact areas for action

Primary and secondary prevention	• Focus on 'brain health' initiatives which target the 14 modifiable risk factors illustrated in figure XX. This should involve highlighting and promoting existing interventions (such as Living

	Well services, NHS Health Checks) and identifying future opportunities.
Health literacy	• Increase awareness of dementia and reduce stigma within community groups • Assessment tools should be culturally appropriate, and should not be dependent on inappropriate literacy and education levels
Target specific patients / reduce variation	• Use a range of communication channels and techniques to improve awareness of/ access to diagnostic services
Holistic care	• Provide continuity of care to support people with dementia, and their carers, through the dementia pathway
Support self-management	• People should be supported to live well with dementia. Interventions after diagnosis can help to maximise physical health, improve quality of life, reduce hospitalisations, and plan for the future. • Multicomponent coping interventions for family carers and managing neuropsychiatric symptoms are important and should be person-centred

5.5 Mental ill health (depression and SMI)

Overview and key insights from an inequalities perspective

Mental ill health has a significant impact on the burden of disease within the population. This impact is not distributed evenly across the population, and there are inequalities which are experienced in a number of ways. For example:

- Mental ill health is strongly influenced by socioeconomic factors, including housing, employment, and access to mental health services.
- Individuals in deprived areas may face more significant stressors and reduced access to mental health support, contributing to higher rates of mental ill health.
- Mental health conditions can lead to reduced life expectancy due to factors such as increased suicide risk and poorer physical health outcomes.
- Mental health conditions can affect employment and productivity, particularly when individuals face stigma or discrimination in the workplace.
- Stigma, discrimination, isolation and exclusion are all factors that can prevent people from seeking help and accessing timely and appropriate physical health care and treatment.
- People with a long-standing mental health problem are twice as likely to smoke, with the highest rates among people with psychosis or bipolar disorder.
- It is estimated that for people with SMI, 2 out of 3 deaths are from physical illnesses that can be prevented. SMI can influence an individual's risk of developing chronic

health conditions and their access to health services. People living with SMI are also likely to have more difficulty in monitoring their own physical health needs

- People with SMI can also experience diagnostic overshadowing.
- Compared with the general patient population, patients with SMI are at substantially higher risk of obesity, asthma, diabetes, chronic obstructive pulmonary disease (COPD) and cardiovascular disease. People with SMI make more use of secondary urgent and emergency care, and experience higher premature mortality rates[12]

Distribution

The following two charts illustration the distribution of chronic respiratory disease by ethnicity and deprivation.

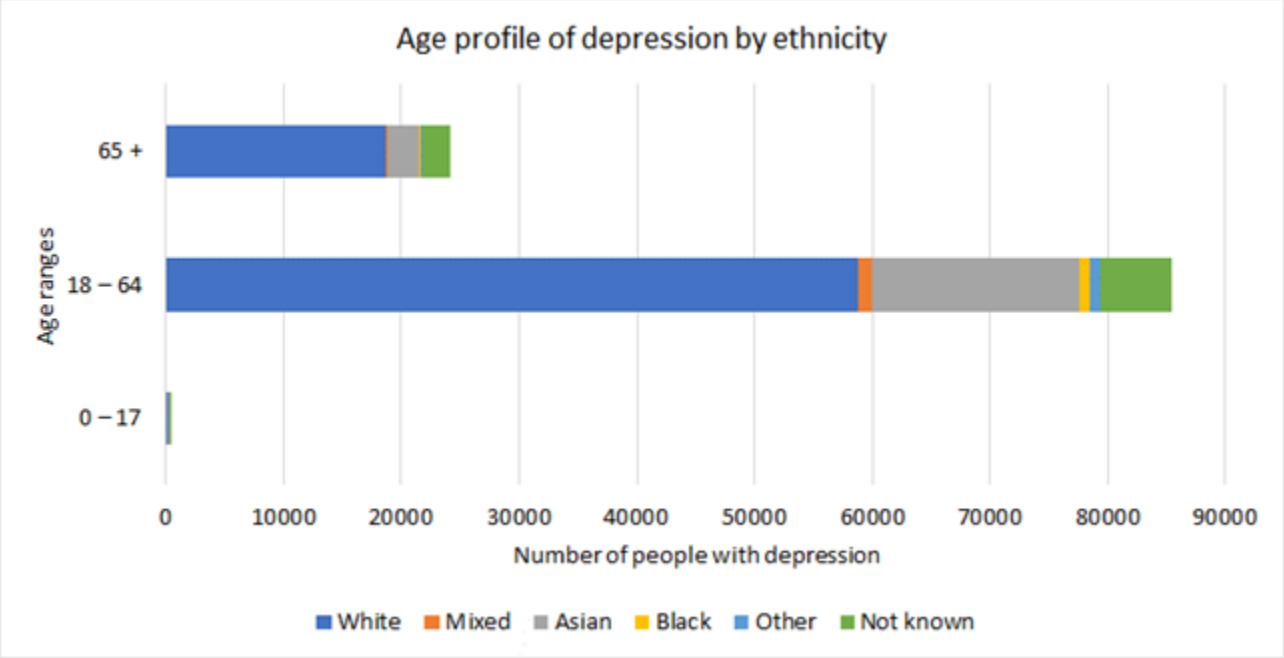

Figure 24: Chart showing age profile of people with depression, by ethnicity

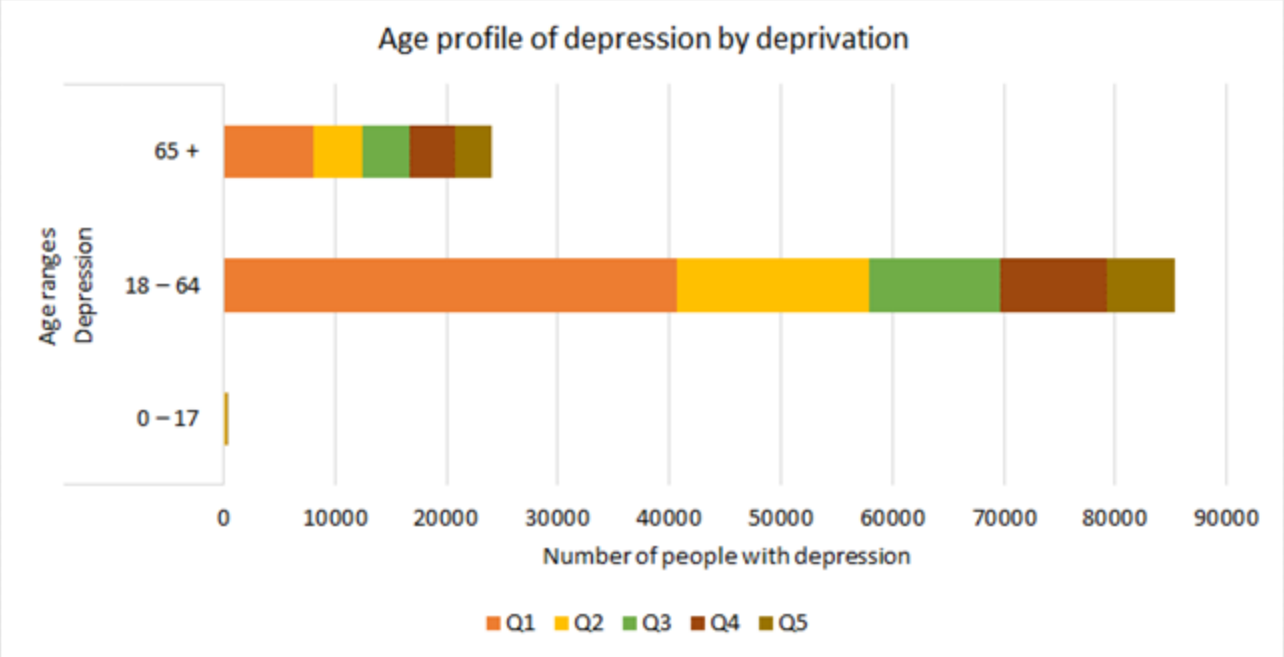

Figure 25: Chart showing age profile of people with depression, by deprivation

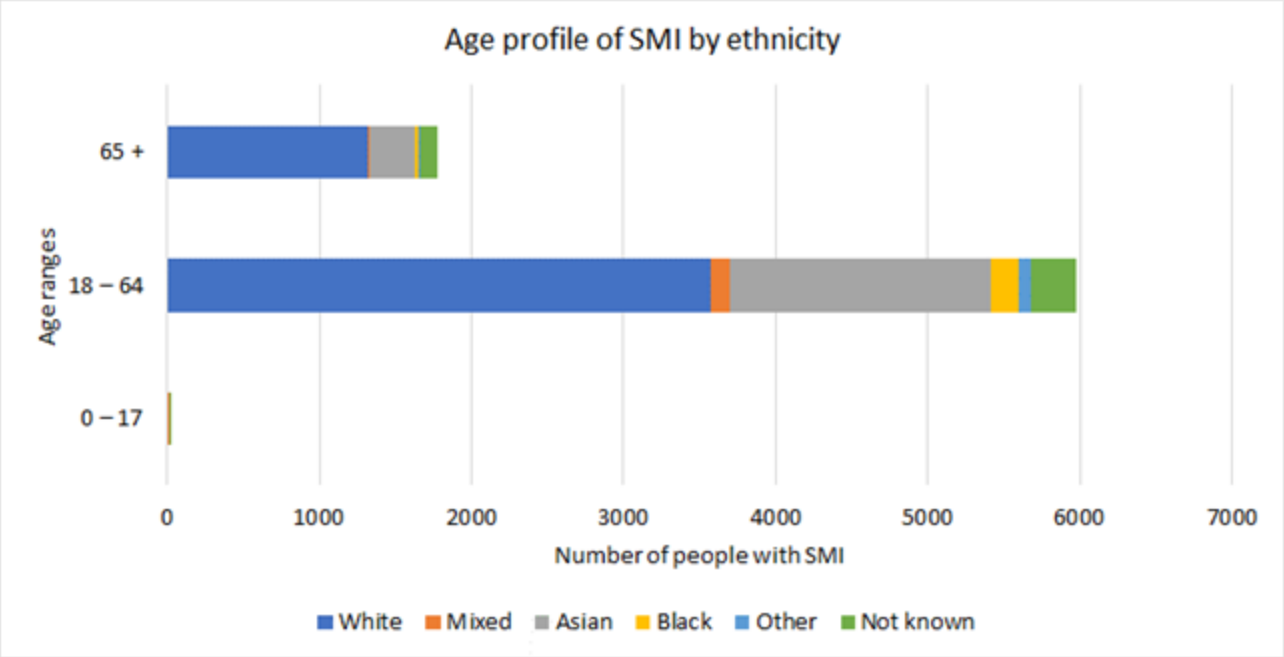

Figure 26: Chart showing age profile of people with serious mental illness, by ethnicity

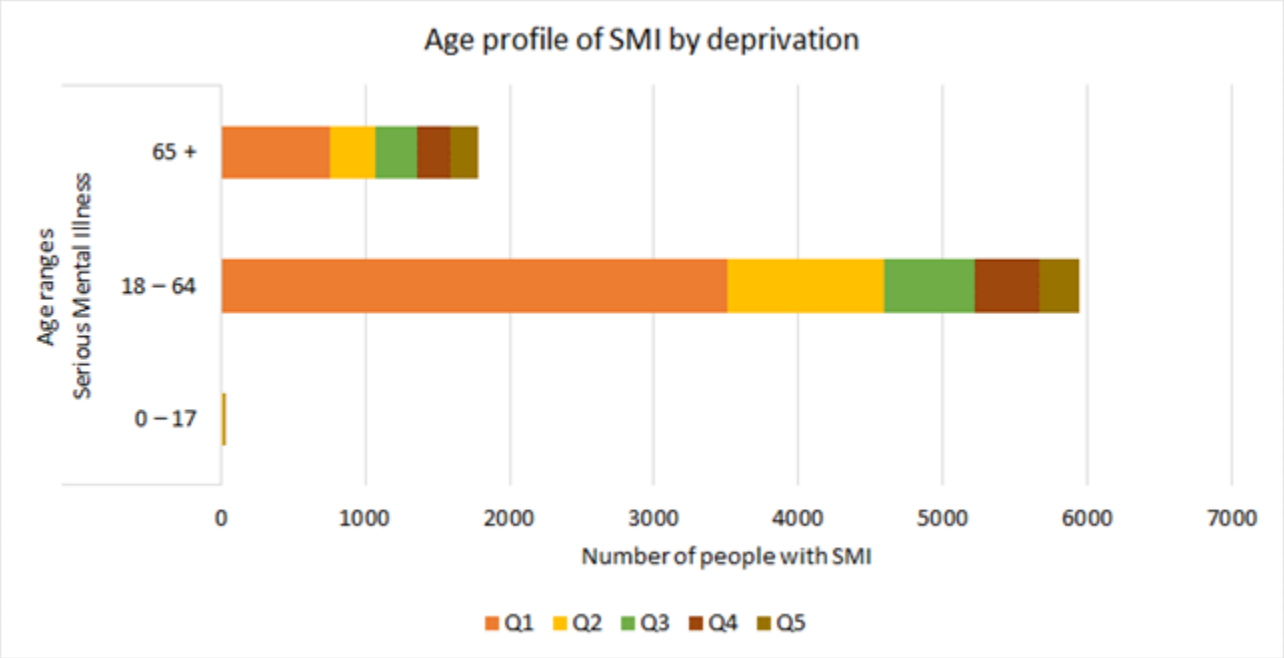

Figure 27: Chart showing age profile of people with serious mental illness, by deprivation

Data

Our local data tells us that:

- 109,897 patients with depression were recorded in primary care records in 2023, and 7,772 patients were recorded with SMI
- Our local primary care data, extracted in September 2024 (based on all ages) indicate that number of people with depression and SMI is increasing.
- ‘Mental disorders’ cause the highest proportion of DALYs from the age of 5 years to 44 years.

- In data in key OHID metrics for SMI, North Yorkshire values are better that the England averages. However, the trends for most of these metrics are either decreasing or remaining static (see table 8 below).
- In data in key OHID metrics for cancer, Bradford values are worse that the England averages. However, the trends for most of these metrics are either decreasing or remaining static (see table 8 below).

		Bradford		North Yorkshire		England	
	Period	Value	Trend	Value	Trend	Value	Trend
Depression: QOF prevalence (18+)	2022/23	13.7%	Increasing	12.6%	Increasing	13.2%	Increasing
Premature mortality in adults with severe mental illness (SMI) (rate per 100,000)	2020-22	121.0	Could not be calculated	No data	Could not be calculated	111.2	Could not be calculated

Table 8: Table showing trends in key mental health metrics. Please note that data was not available for Craven, so we have used the data for North Yorkshire in place of this.

When data is disaggregated by ethnicity, we can see some variation. For example in the following chart (figure 11) compares the percentages in each ethnic group for people with a record of depression under the age of 65 in primary care (1, bottom bar) and all people living in the Bradford and Craven NHS area (2 - top bar). We can see that a relatively low proportion of under 65s with a depression diagnosis are of South Asian heritage.

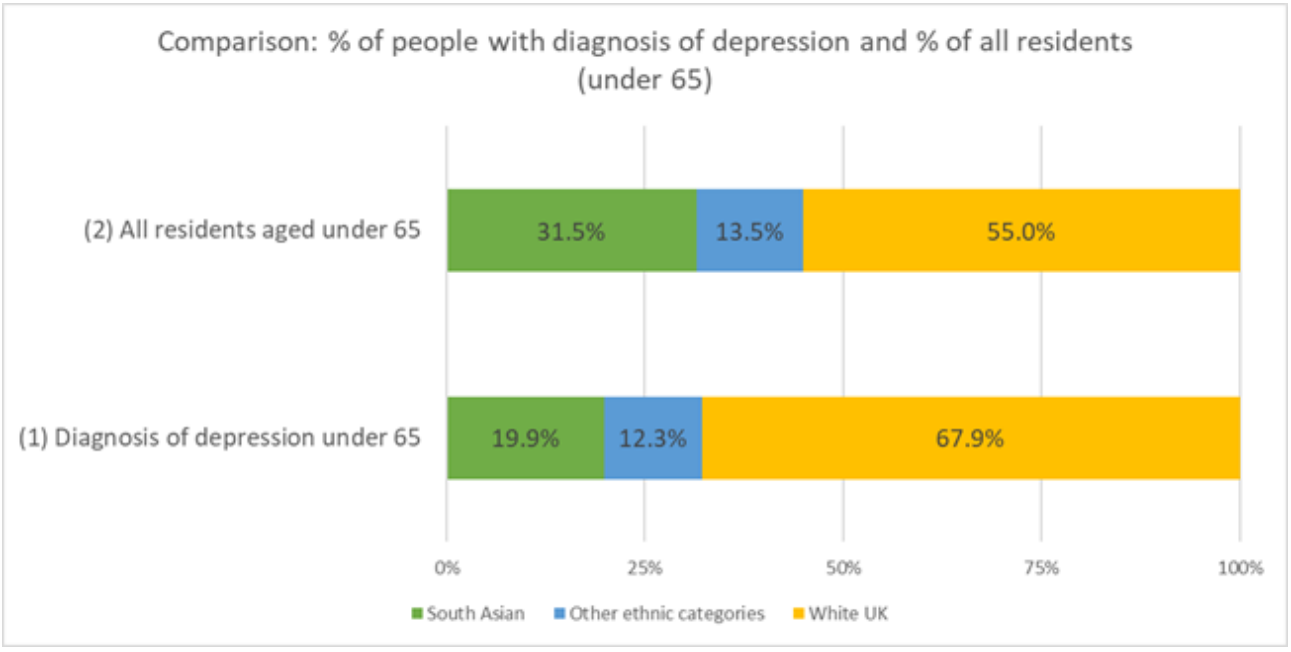

Figure 28: Chart showing % of people under years with a diagnosis of depression

The following chart shows a comparison of people with SMI:

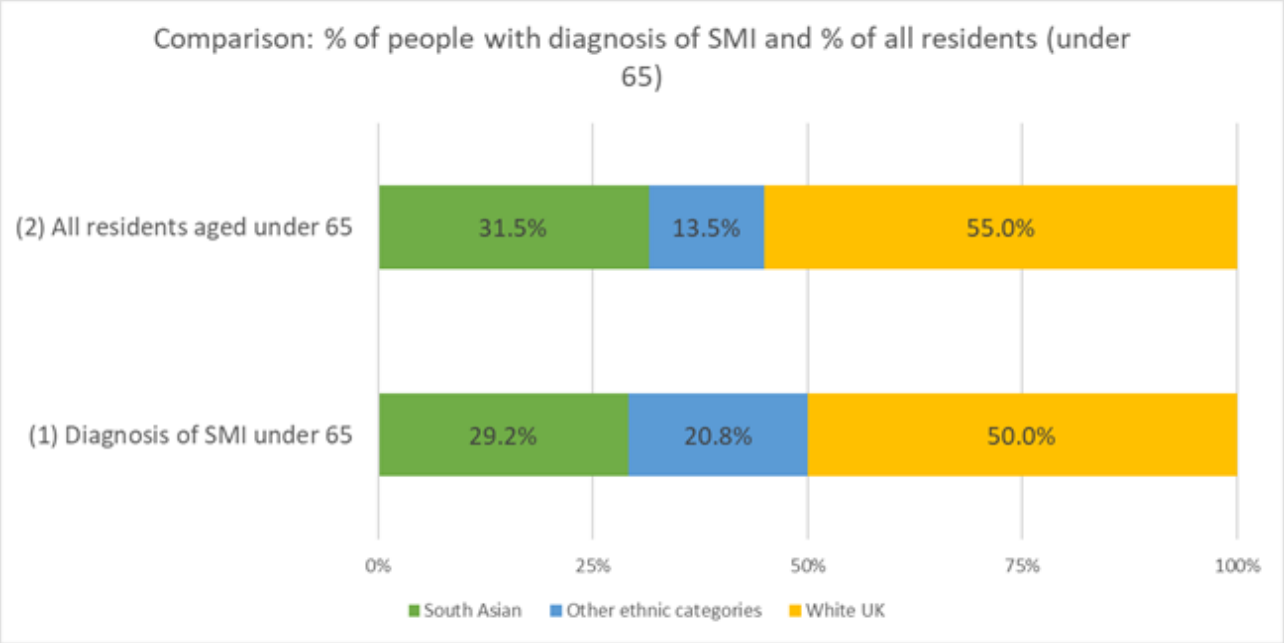

Figure 29: Chart showing % of people under years with a diagnosis of serious mental illness

Considerations from our data

- Trends for depression show numbers are increasing across Bradford and North Yorkshire
- The premature mortality rate for people with SMI for Bradford is higher than the England average
- Relatively low proportion of under 65s with depression diagnosis are of South Asian heritage. More than 20% of those aged 65+ diagnosed with depression are of diverse ethnicities, showing need for culturally competent care.
- Half people with SMI aged under 65 and nearly a third of those aged 65+ are from South Asian and minority ethnicity groups, showing need for culturally competent care
- Within Bradford in the SMI population highest excess premature mortality is from liver disease and respiratory conditions in both males and females.

Examples of best practice

Primary and secondary prevention	• We have developed training to raise awareness of cardiovascular health needs of people with mental health, learning disabilities or neurodiversity needs and have worked with the Cancer Alliance to improve the identification and support of people accessing early diagnostics
Health literacy	• VCSE organisations can play key role in reducing stigma and providing trusted spaces to raise awareness and discuss concerns
Shifting pathways into communities	• VCSE small grants used to fund various initiatives to tackle loneliness and isolation e.g. men's sheds, community garden, hey mamma groups

	• Community partnerships have led a project with Youth Service for targeted teen males with a high level of need in Bingley • RIC project focused on improving uptake of early interventions for people at risk of psychosis in central Bradford area • Established the first Crisis House in Bradford. This opened in May and in the first 12 months 98 people have accessed support with an average length of stay of 5 days, 96 people were not admitted and only 2 people went on to receive a planned admission
Target specific patients / reduce variation	• Introduced the culturally adapted therapies to our Talking Therapies services and improved access, recovery rates, reduced missed appointments and improved completion rates • Some practices used 22/23 health inequalities premium to focus on SMI annual health checks
Support self-management	• Established the personal health budgets (PHBs) scheme for people who are inpatients, and in the first quarter of the project we had 53 inpatient PHB's costing around £8,000, which helped to support early discharge and reduced bed days by 85 days which equates to a saving of circa £61,000

High impact areas for action

Shifting pathways into communities	• Provision of community-based support for those with moderate mental health issues with support to adopt healthy behaviours
Target specific patients / reduce variation	• Therapists and supervisors working in Talking Therapy services may need to adapt therapy delivery models to improve access, retention rates and outcomes for service users from ethnically diverse communities • Provision to raise awareness for workforce of the importance of reaching those with SMI and supporting access to their physical health check • Ensure those with SMI or those on antipsychotic medication are identified and supported to access their physical health checks • Provision for specific target groups within the SMI population (ethnically diverse communities) with bespoke offers of support
Support self-management	• Offer access to bespoke interventions for those with SMI to improve their physical health and self-care • Provide support for those with SMI and their families and carers to access universal support to improve health and wellbeing

References for this section:

- Collated-what-works-evidence-packs-updated-Apr-24-v0.3-JH.3-JH.docx (live.com)
- BABCP | British Association for Behavioural & Cognitive Psychotherapies > Therapists > BAME Positive Practice Guide

Please see our data annex for more detail. Slides in annex: Comparisons between ethnic groups by age for depression and serious mental illness

5.6 Musculoskeletal conditions

Overview and key insights from an inequalities perspective

Mental ill health has a significant impact on the burden of disease within the population. This impact is not distributed evenly across the population, and there are inequalities which are experienced in a number of ways. For example:

- Severe musculoskeletal disorders can limit mobility and overall well-being, potentially reducing life expectancy.
- Musculoskeletal disorders, including arthritis and back pain, can affect people's ability to work and engage in daily activities.
- Access to physical therapy and pain management services varies across communities.
- People in deprived areas may experience higher rates of musculoskeletal disorders due to physical labour, inadequate ergonomic conditions at work, and limited access to rehabilitation services.
- Musculoskeletal disorders can result in work-related limitations, leading to unemployment or underemployment, particularly in manual labour jobs.
- Research by Versus Arthritis in 2021[13] found that MSK affects the following groups more than others: White Gypsy or Irish Traveller, White Irish, White British and Black Caribbean

Distribution

The following two charts illustration the distribution of chronic respiratory disease by ethnicity and deprivation.

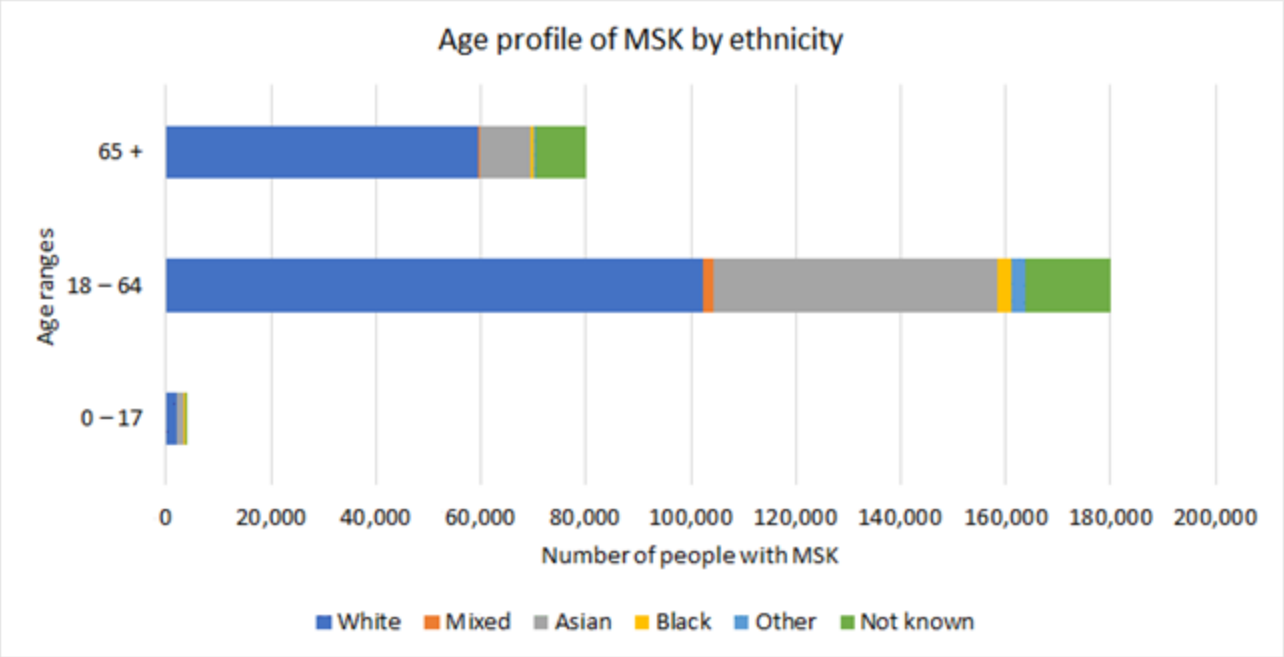

Figure 30: Chart showing age profile of people with MSK, by ethnicity

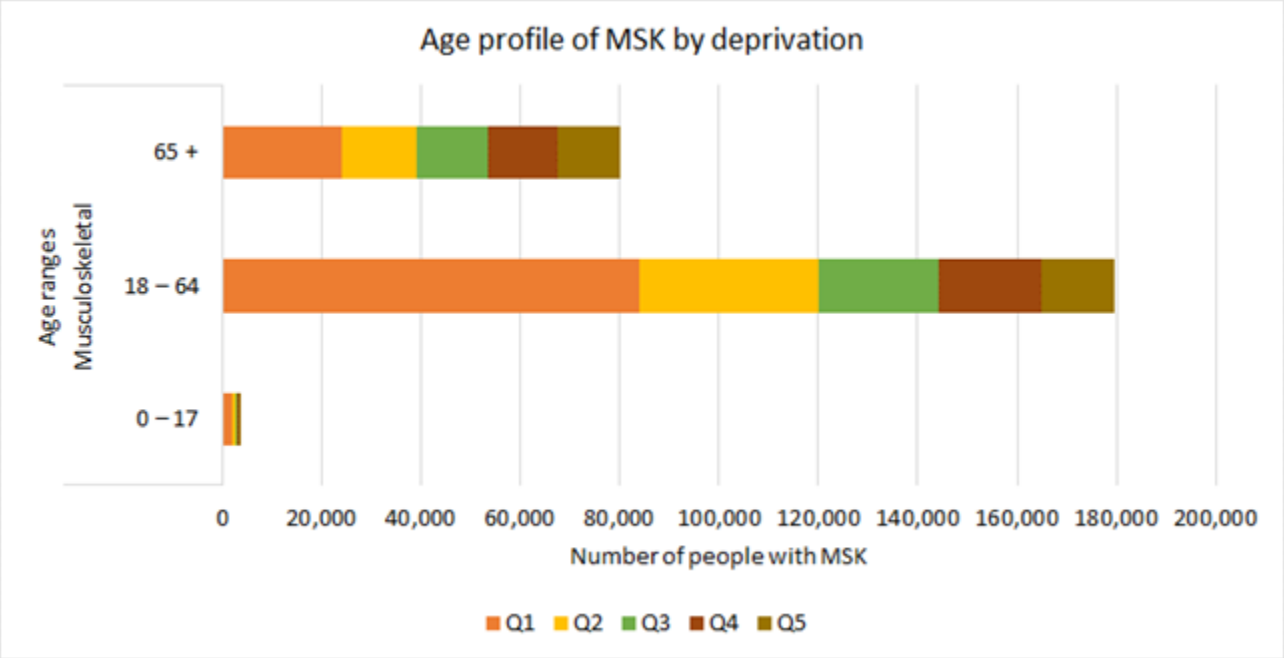

Figure 31: Chart showing age profile of people with MSK, by deprivation

Data

Our local data tells us that:

- Between 212,000 and 263,598 patients with musculoskeletal conditions were recorded in primary care records in 2023. (The upper limit is from primary care records – this may be an overestimate for conditions currently affecting people, so a lower limit has been estimated).
- ‘Musculoskeletal disorders’ cause a significant proportion of DALYs in our population. They feature as a top two cause from the age of 20 to 55 years (see burden of disease section).

- In data in key OHID metrics for musculoskeletal conditions, North Yorkshire values are higher that the England averages. (See table 9 below).
- In data in key OHID metrics for musculoskeletal conditions, Bradford values are mixed. Prevalence data is higher than the England average and is increasing. The proportion of people reporting a long term MSK problem in the GP patient survey is lower than the England average (see table 9 below).

	Period	Bradford		North Yorkshire		England	
		Value	Trend	Value	Trend	Value	Trend
Osteoporosis: QOF prevalence (50+) – level	2022/23	1.1%	Increasing	1.1%	No significant change	1.0%	Increasing
Rheumatoid Arthritis: QOF prevalence (16+ years)	2022/23	0.8%	No significant change	1.0%	No significant change	0.8%	No significant change
Percentage reporting a long-term Musculoskeletal (MSK) problem (GPPS data)	2023	17.3%	Could not be calculated	20.9%	Could not be calculated	18.4%	Could not be calculated

Table 9: Table showing trends in key MSK metrics. Please note that data was not available for Craven, so we have used the data for North Yorkshire in place of this

When data is disaggregated by ethnicity, we can see some variation. For example in the following chart (figure 13) compares the percentages in each ethnic group for people aged 65+ years with a record of MSK disorders in primary care (1, bottom bar) and all people living in the Bradford and Craven NHS area (2 – top bar). We can see that in the group of people with South Asian and other ethnic groups is higher than that of the general population.

Figure 32: Chart showing % of people aged 65+ years with a diagnosis of MSK

Considerations from our data

- Age under 65: proportions of people in different ethnic groups are similar on MSK register and in general population.
- Age 65+: people of diverse ethnicities make up 22% of MSK register (only 15% of general population) – shows need for culturally competent care

- The proportion of people in Bradford reporting a long term MSK problem is lower than the England average. This might not be a true reflection for our population, as research by Versus Arthritis in 2021 shows that people in the most deprived quintile are more likely to report a long term MSK

Examples of local best practice

Holistic care	• New Rethinking Pain service includes education modules and potential referral pathway to cognitive behavioural therapy. It has increased the confidence of participants in being able to deal with their pain and to work. • Keighley Healthy Living delivered on MSK project that has now become a national rollout. Model is that of peer support/ care plan and access to holistic therapy and movement.
Support self-management	• We use our Living Well team to support people to 'wait well.' This includes the opportunity to change their lifestyle (eating, smoking, exercise) and engage in safe activities that would benefit them whilst awaiting a diagnosis and treatment plan

Please see our data annex for more detail. Slides in annex: Comparisons between ethnic groups by age for musculoskeletal disorders

6. Multimorbidity

Having multiple illnesses at a time is known as multimorbidity. This is an important concept when considering the health and wellbeing of a population because it is increasingly common for people to experience more than one long term condition. With this comes a higher need for care and support.

The purpose of this section is to provide an overview of current thinking within multimorbidity, and to summarise key considerations for Bradford District and Craven.

6.1 Overview

Recent national research has been highlighting the need to take action to respond to the increasing numbers of people experiencing multimorbidity. A recent study has indicated that 9.1 million people are projected to be living with major illness by 2040, an increase from almost 1 in 6 to nearly 1 in 5 of the adult population[14]. Much of the projected growth relates to depression, chronic pain and diabetes, conditions predominantly managed in primary care and the community[7].

As the number of people with multiple long term conditions grows, meeting their needs will be one of the biggest challenges facing the NHS. In 2006/7 one in 10 patients admitted to hospital in an emergency had 5+ conditions. In 2015/16 this had increased to one in three[15].

People with multiple conditions have multiple consultations and treatments. In a study it was found that people with 4+ conditions had an average of 8.9 outpatient visits across 2.8 different medical specialties, visited their general practice 24.6 times and were prescribed 20.6 different medications. This compares to 2.8 outpatient visits, 8.8 visits to general practice and 5.6 different medications for patients with one condition[11].

The impact of multimorbidity on health is cumulative. Multiple conditions and deprivation both have an adverse impact on life expectancy and disability-free life expectancy[16]. People in disadvantaged areas are at greater risk of multiple conditions and are likely to have multiple conditions at younger ages. 30% of people with 4+ conditions are under 65 years of age, and this percentage is higher in disadvantaged areas[17]. People with the lowest incomes can be four times more likely to have multiple conditions than those with the highest incomes[13].

The groups at greatest risk of multi-morbidity and inequality also include people from ethnically diverse groups, and those with serious mental illness.

Considerations for care pathways

We need to integrate mental **and** physical health support. Younger people (aged 15 to 34 years) with SMI experience the greatest level of health inequalities. They are 5 times more likely to have 3 or more physical health conditions than the general population[17] .

Our pathways are not designed to support multi-morbidity – people with multiple conditions do not seem to have significantly longer GP consultation times despite their complex needs and clinical strategies to manage care focus on single conditions.[17]

Effective support could be delivered by services structured to deliver care for the whole person, rather than for single conditions. Services need to be tailored to meet the needs of local communities, especially those facing the greatest disadvantage. Bespoke support can help people adopt healthy lifestyles, understand and manage their conditions and reduce inappropriate prescriptions. Professionals need the resources and time to deliver personalised care.[13]

We need to recognise that peoples' experiences of health services differ. The particular needs of disadvantaged groups are often neglected or even made worse by services' responses. They are more likely to face barriers to self-care. These include poor health literacy, a lack of trusting relationships with professionals, and care that does not reflect their individual needs[13].

Finally, we need to recognise that population-based strategies are needed alongside service-level changes to tackle the environmental, social and economic determinants of health[13].

Healthy ageing with multimorbidity

The Chief Medical Officer's annual report 2023: Health in An Ageing Society[18] reminds us that multimorbidity does not necessarily mean frailty, and that good health in an ageing society is possible.

The recommendations in the report include:

- Directing resources towards greatest need. Services should be planned on the basis of where the population will age in the future, rather than where demand was in the past.
- Support system partner to increase environmental factors which can delay or prevent the probability of early ageing (primary prevention). An example is making it easy and attractive for people to exercise throughout their lives, which is one of the most effective ways of maintaining independence into older age.
- Prioritise secondary prevention and screening services so we can delay disease to the greatest possible extent and delay the period of disability people will experience as they age.
- Recommit to supporting and maintaining the development of generalist skills within the workforce, particularly as doctors specialise. NHS organisations need to minimise the probability that the same person has to attend multiple clinics for a predictable cluster of diseases.

6.2 Data

Our local data shows that we have a significant number of people with two or more long term conditions recorded in primary care (the following numbers are based on our SystmOne extract from October 2023):

- 2 conditions = 99,390
- 3 conditions = 37,145
- 4 conditions = 11,301

- 5 conditions = 2,446
- 6 conditions = 312
- 7 conditions = 31

However, the distribution of these people across our population is not equal. The population within our most deprived areas experience multimorbidity at a much younger age. The following chart shows the distribution of multimorbidity by deprivation and age:

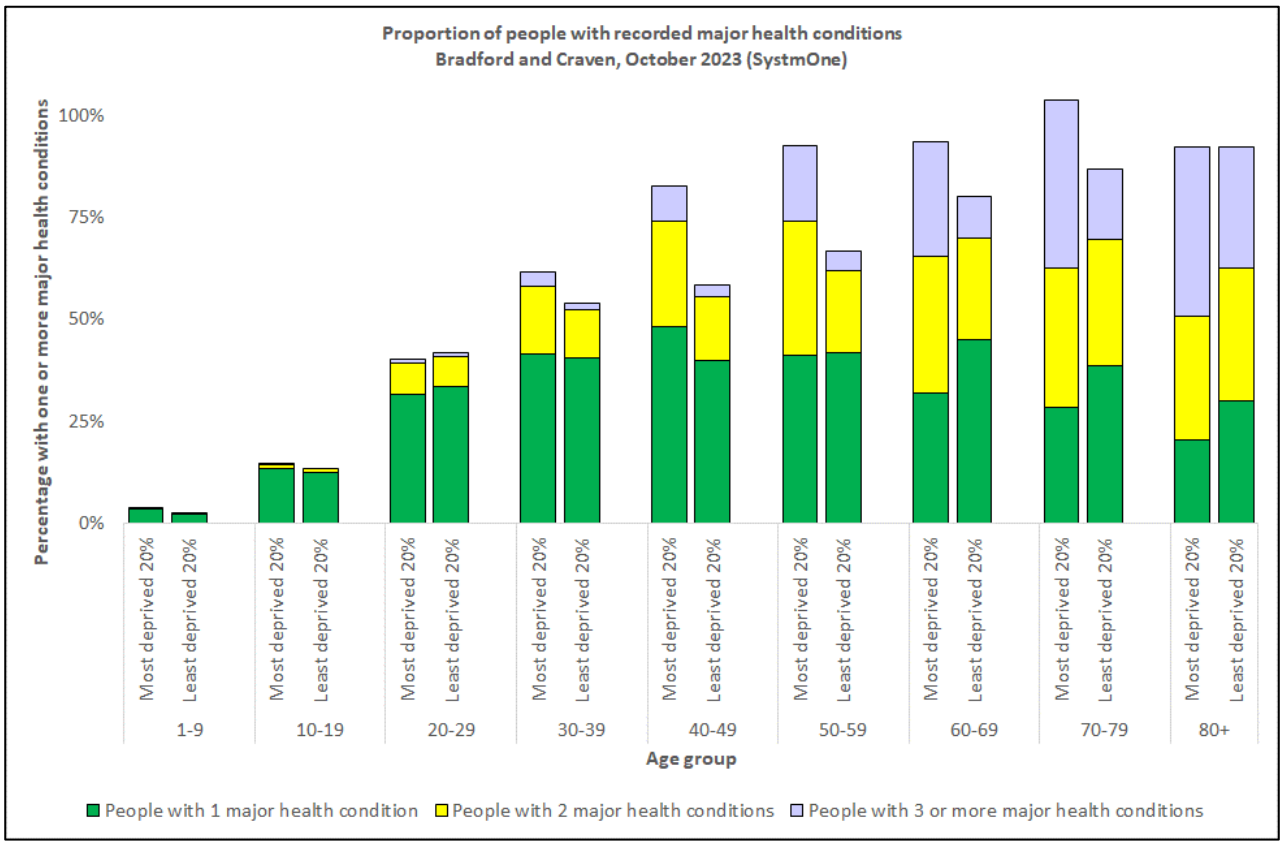

Figure 33: Chart showing % of people one or more long term (major health) conditions

From this data we can see that:

- The inequality gap is starkest at age 40 – 49 years. Within this age group 1 in 33 people in the least deprived areas have 3 or more long term conditions, but in the most deprived 20% of areas this number is much higher at 1 in 11.
- The impact of deprivation is also high for 50 – 59 years (1 in 20 in the least deprived areas have 3 or more long term conditions compared to 1 in 6 in the most deprived) and in the group aged 60 – 69 years (where 1 in 10 in the least deprived areas have 3 or more long term conditions compared to 1 in 4 in the most deprived.
- The likelihood of having 3 or more major health conditions is higher for someone aged 50-59 in the most deprived 20% of areas (18%) than for someone aged 70-79 in the least deprived 20% of areas (17%)

In common with the national trends, people in Bradford District and Craven with multiple long term conditions also require a greater number of care interventions. The following table shows how the number interactions increases with the number of conditions a person has:

Number of LTCs	GP attendance	Outpatient attendance	A&E attendance	Elective inpatient stay	Emergency inpatient stay	Other inpatient stay
0	3.01	0.63	0.25	0.05	0.07	0.05
1	6.45	1.27	0.30	0.16	0.09	0.05
2	10.91	2.03	0.43	0.32	0.15	0.04
3+	17.74	3.30	0.74	0.54	0.34	0.02

Table 10: Table showing health care usage of people with long term conditions

The following charts show the geographical distribution of people with three or more long term conditions across our area, and their median age. It is based on the SystmOne data extracted in October 2023.

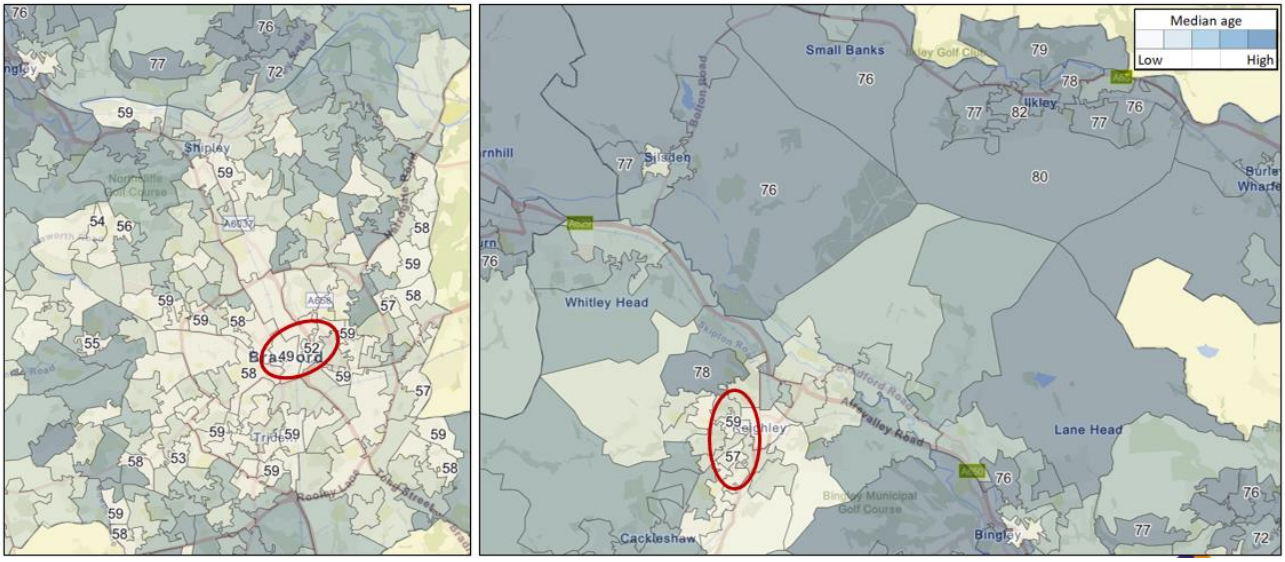

Figure 34: Map showing median ages of adults with 3+ major health conditions and their geographical location

The median age of people with three or more long term conditions varies between 49 (central Bradford) and 82 (Ilkley). The median age of people with three or more long term conditions is under 65 in 40% of areas (LSOAs) in Bradford District and Craven.

This demonstrated that the median ages of this cohort largely reflect median age of general population and show that not everyone with multiple comorbidities is in the older (65+) age range.

6.3 Common combinations of long term conditions

In this section we are highlighting common combinations of long term conditions within Bradford District and Craven so that we can take this into consideration when planning and reviewing services.

This is important because:

- Interventions promoting healthy lifestyles and improved management of risk factors can benefit a range of long term conditions.
- Conditions may exacerbate each other. For example, chronic pain can lead to increased stress and depression, while mental distress may worsen perceptions of pain and disability. Chronic pain and mental distress can create a cycle of reduced productivity and well-being.

- Heart disease, stroke, and diabetes often share common risk factors, including obesity, high blood pressure, and poor dietary choices. These risk factors contribute to the development and progression of both cardiometabolic conditions.
- Dementia and mental ill-health, such as depression and anxiety, can share overlapping symptoms like cognitive impairment and mood disturbances. They may also have common risk factors, including social isolation and limited access to mental healthcare.

The next chart shows common pairings in long term conditions, and the number of people recorded as having both. It is based on the SystmOne extract showing Bradford and Craven patients with diagnosis recorded in primary care (October 2023).

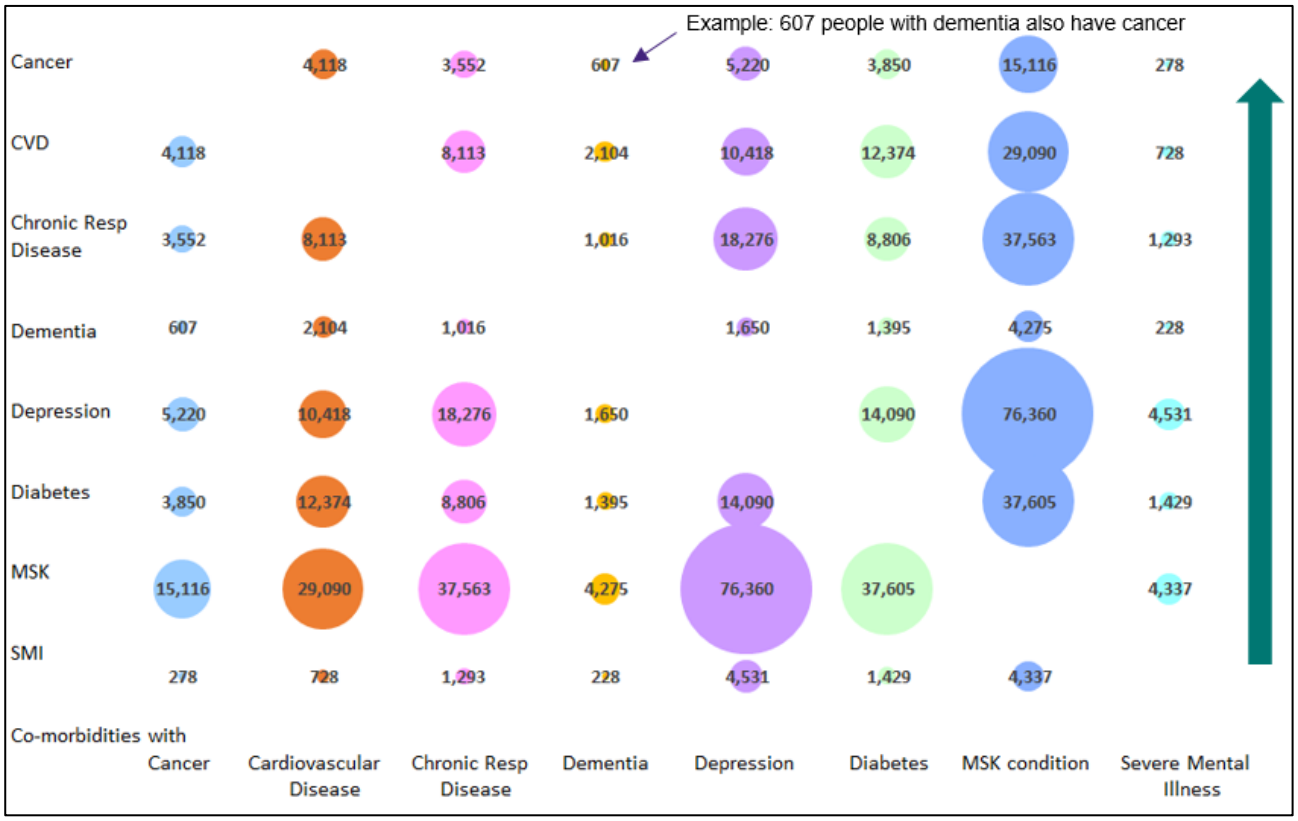

Figure 35: Chart showing common parings of long term conditions

Within this chart we can see that depression is a common pairing with other long term conditions, with significant number of people experiencing this. Musculoskeletal conditions also feature as a common comorbidity, due to the high proportion of people with this.

The same SystmOne extract was used to demonstrate the most frequently occurring comorbidity triads. This is shown in the chart below:

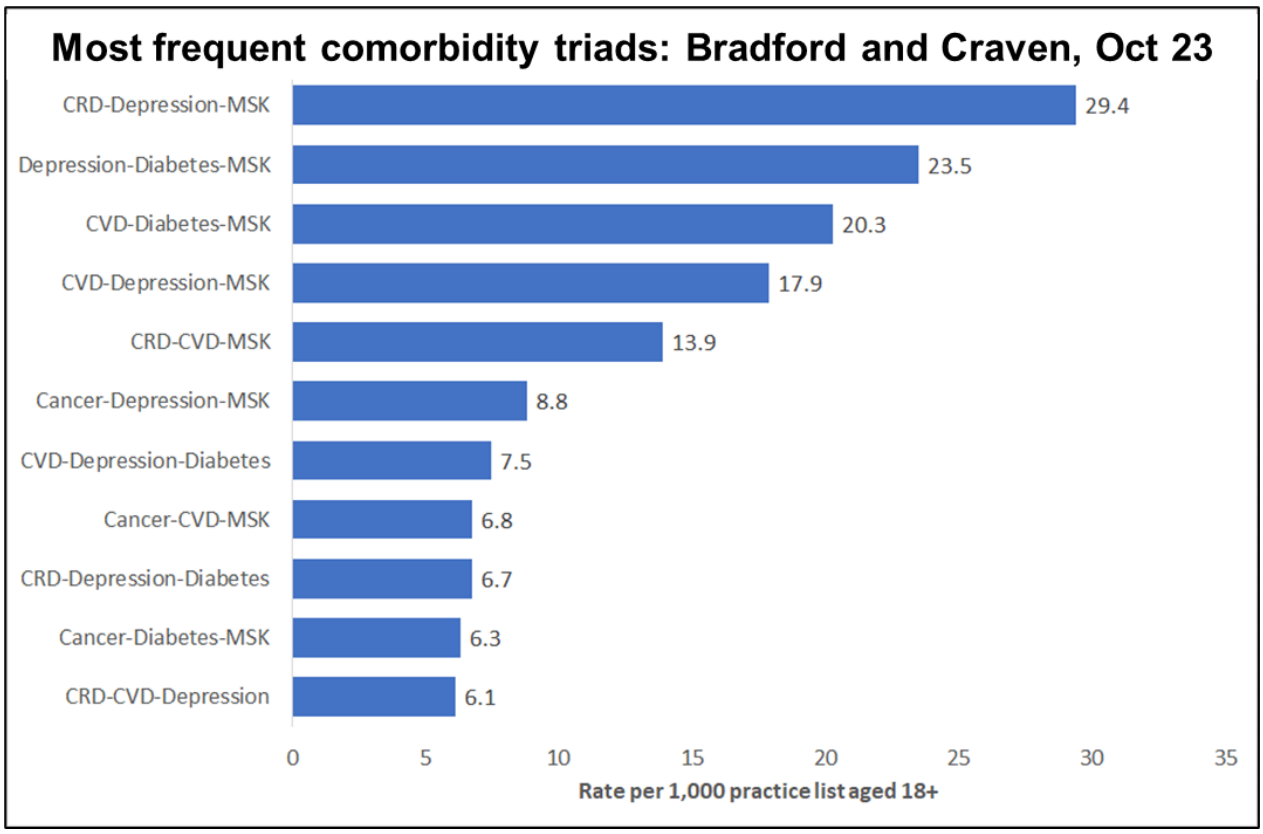

Figure 36: Chart showing common triads of long term conditions

6.4 Key insights

The following insights are a summary from a review of national literature:

By age 50 years, half of the population had at least one morbidity, and by age 65 years most are multimorbid. Young and middle-aged adults living in the most deprived areas have rates of multimorbidity equivalent to those aged 10–15 years older in the most affluent area. In deprived areas people and are twice as likely to be multimorbid

We see this in our local data - the deprivation impact on multi-morbidity is highest for 40-60 years. This leads to a greater number of years living in poor health and in some cases premature mortality. To try to avoid this we could focus on this key age to maximise the impact of prevention, early intervention and screening programmes (leading to early diagnosis).

People with multimorbidity have tend to have poorer functional status, quality of life, and health outcomes, and are higher users of ambulatory and inpatient care than are those without multimorbidity. They have more difficulties with fragmentation of care and a higher risk of medical error because most specialist care is focused on the treatment of one disease.

Existing approaches focusing on single disease approaches dominate most hospital care. These care pathways need to be complemented by support of primary care, providing continuity, coordination, and above all a personal approach for people with multimorbidity.

A lot of research is single morbidity, single condition guidelines and multimorbidity research is focused on the elderly. We need to be aware that multimorbidity occurs at a much younger age group in our population and pathways need to reflect this.

People living in deprived areas are more likely to have chronic obstructive pulmonary disease, depression, and painful disorders as comorbidities than other disorders.

One study found that 79% of white individuals have been recorded as having two or more conditions compared with 60% of Black and 60% of south Asian individuals. Further analysis of this finding is needed to determine the reasons for this – it could be due more frequent consultation, preferential access, recording bias or truly higher multimorbidity levels in this cohort. This is an area for further consideration in our place.

Whilst the evidence base of 'what works' in supporting people with multimorbidity it sparse, the following interventions are recommended as having potential:

- Moving to multimorbidity appointments, rather than "asthma checks" reduces the number of contact appointments for the individual but increases the utility
- In primary care using stratification of complex and multimorbidity cohorts (often frequent attenders) to target tailored interventions such as multidisciplinary team support
- Rebalancing out-patient support to focus on these complex cases, with clear management support for routine care

Qualitative research exploring the barriers and facilitators to self-manage multiple long-term conditions (amongst people who experience socioeconomic deprivation) concluded four areas of response are required to deal with:

1. Challenges in accessing healthcare services, financial assistance, and cultural awareness
2. Empowerment and disempowerment through technology, including digital exclusion, and use of technology
3. Impact and causes of exclusion on self-management, including social isolation, area-based and economic exclusion, and health-related stigma, and
4. Adapting self-management strategies, including cost-effective, and culturally/lifestyle appropriate strategies

References for this section

- Epidemiology of multimorbidity and implications for health care, research, and medical education: a cross-sectional study. [Barnet et al, Lancet 2012; 380: 30-37. 2007]
- Impact of multimorbidity on healthcare costs and utilisation: a systematic review of the UK literature [Soley-Bori et al. Br J Gen PRact 2020]
- Impact of deprivation on occurrence, outcomes and health care costs of people with multiple morbidity [Charlton et al. J of H Serv Res & Pol. 2013]
- Identifying and visualising multimorbidity and comorbidity patterns in patients in the English National Health Service: a population-based study [Kuan et al. Lancet Digit Health. 2023]

- Woodward A, Nimmons D, Davies N,et al. A qualitative exploration of the barriers and facilitatorsto self-managing multiple long-term conditions amongstpeople experiencing socioeconomic deprivation.HealthExpect. 2024;27:e14046.doi:10.1111/hex.1404612 of 12|WOODWARDET AL. A qualitative exploration of the barriers and facilitators to self-managing multiple long-term conditions amongst people experiencing socioeconomic deprivation (wiley.com)

6.5 Local examples of best practice

Shifting pathways into communities	• The WISHH and Affinity primary care networks have recruited Community Centre Health Development Workers to help people navigate support available for a range of conditions
Holistic care	• The Proactive Care Team (RIC project) supports the proactive management of people with multi-morbidity. The team combines eleven professionals, including mental health support and pharmacists. The team works on a case finding basis and have done significant engagement work with local communities. Academic research shows the team has had a positive impact on reactive hospital care usage and has improved patient outcomes. • The Rethinking Pain service (see MSK section above) has successfully integrated physical and mental health support into a single disease pathway, showing the importance of holistic care.

6.6 High impact areas for action

Primary and secondary prevention	• Healthcare planning should prioritise preventive strategies that target common risk factors for chronic conditions, especially in deprived areas. This includes initiatives to reduce smoking, improve nutrition, and increasing physical activity. These should be adaptable so that they can support all ages. • Primary prevention should be offered to people at risk of developing a major health condition as well as to those living with major condition. For example, using smoking cessation services to provide support after a heart attack
Health literacy	• We need to recognise that levels of health literacy vary across population, and help people adopt healthy lifestyles, understand and manage their conditions and reduce inappropriate prescriptions. Professionals need the resources and time to deliver personalised care. • Small but powerful adjustments, like simple, clear explanations of what had been diagnosed and what they need to do about their condition, professionals checking their understanding of

	what they had been told and asking their opinions on what they wanted to happen, would make a huge difference
Target specific patients / reduce variation	• Systematically stratify population groups and then create specific appointments to undertake checks among people who are at risk of having multiple long-term conditions, addressing health behaviours and physiological risks
Holistic care	• The healthcare workforce should be trained to provide patient-centred care for individuals with multimorbidity. This includes generalist skills, care coordination, cultural competence and communication skills. • Healthcare systems need to shift from a single-disease focus to a more holistic approach that considers the complex needs of individuals with multimorbidity. This includes addressing physical and mental health, as well as social determinants of health. This may include developing specific pathways for people with multimorbidity. • Coordinated, integrated care models that involve primary care, specialists, and mental health services are essential for effectively managing multimorbidity. These models help prevent fragmented care and improve outcomes
Support self-management	• Patients with multimorbidity should be actively involved in their care plans. Tailored care plans should consider patients' preferences, goals, and social circumstances. Offering self-care support to individuals as well for family and carers is as important as the specific clinical care.

References for this section

- https://evidence.nihr.ac.uk/collection/multiple-long-term-conditions-multimorbidity-and-inequality-addressing-the-challenge-insights-from-research/
- You only had to ask: What people with multiple conditions say about health equity - Richmond Group (richmondgroupofcharities.org.uk)

7. Risk factors

City of Bradford Metropolitan District Council has updated its Health Improvement dashboard: [Public Health - Joint Strategic Needs Assessment (bradford.gov.uk)] and its public health resource pack on Smoking in Bradford District 2024 [smoking-in-bradford-District-2024.pptx (live.com)]

The North Yorkshire Joint Strategic Needs Assessment 2021: Craven District Summary Profile contains references to key risk factors. [craven-2021.pdf (datanorthyorkshire.org)]

Wider determinants of health

The wider determinants of health are a range of factors which influence an individual's wellbeing and outcomes throughout their life, from pre-conception to the end of life. The following diagram illustrates this range of factors:

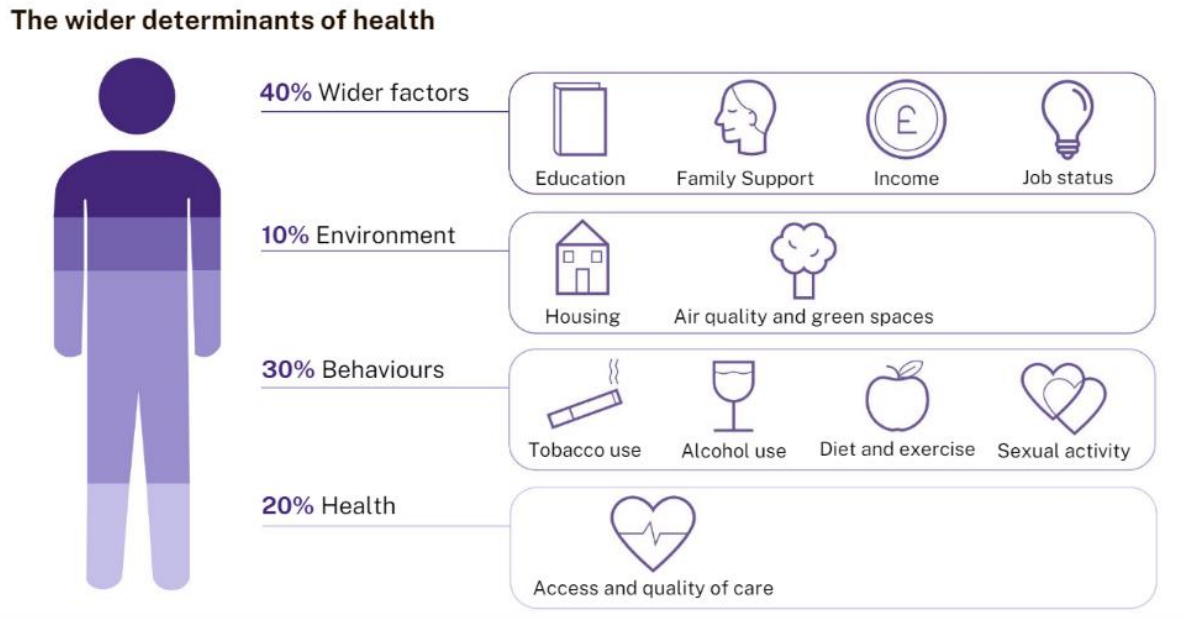

Figure 37: Factors which determine an individual's state of health

Up to 80 per cent of what affects health – both physical and mental – occurs outside of the healthcare system. This means that health and health inequalities are largely determined by lifestyle risks, living conditions and wider social, economic, cultural and political factors.

Behavioural and environmental factors have a significant impact on if and when a person will develop a long term condition (or conditions), and also their ability to manage and live well with their condition(s).

7.1 Shared risk factors

The long term conditions have common risk factors. These include:

- Cancer, cardiovascular disease, stroke, and diabetes often share common risk factors, including obesity, smoking, high blood pressure, and poor dietary choices.
- Environmental factors, such as exposure to air pollution and carcinogens, can contribute to both cancer and chronic respiratory diseases.
- Dementia and serious mental illness have common risk factors, including social isolation and limited early access to mental healthcare.

The following table shows how these risk factors contribute to the burden of disease across our population. It uses estimates from the Global Burden of Disease Study 2021. Please note that data is not available for Craven within this study, so the data for North Yorkshire has been used instead. Factors such as social isolation are not included in this study as a risk factor.

	Bradford				North Yorkshire			
Condition	Tobacco	Dietary Risks	Air pollution	Total	Tobacco	Dietary Risks	Air pollution	Total
Cancer	22%	7%	2%	31%	19%	8%	1%	28%
CVD	16%	29%	7%	52%	12%	24%	5%	41%
Diabetes & CKD	8%	32%	7%	48%	7%	33%	6%	46%
MSK	9%	0%	0%	9%	8%	0%	0%	8%
Respiratory	30%	0%	6%	35%	28%	0%	5%	33%

Table 11: Table showing the portion of DALYs attributed to main risk factors.

7.2 Prevalence of the two main risk factors in our population

Smoking

Smoking remains the biggest single cause of preventable illness and death, driving health disparities and directly contributing to developing all major groups of conditions. The majority of smokers start smoking before turning eighteen, and people who start smoking at a young age lose on average 10 years of life expectancy[1].

OHID data for smoking prevalence in adults (aged 18 and over) - current smokers (APS)[19] shows that the prevalence rate for Bradford District in 2022 was 15.6%, which is higher than both the regional average (13.1%) and the national average (12.7%). The rate for North Yorkshire was 9.6% (data not available for Craven District).

The following maps show how the people with a primary care record of current smoker status **added in last 5 years** are distributed across our place. This data was extracted from SystmOne in February 2024 and includes 168,609 people. The blue line shows the ICB boundary.

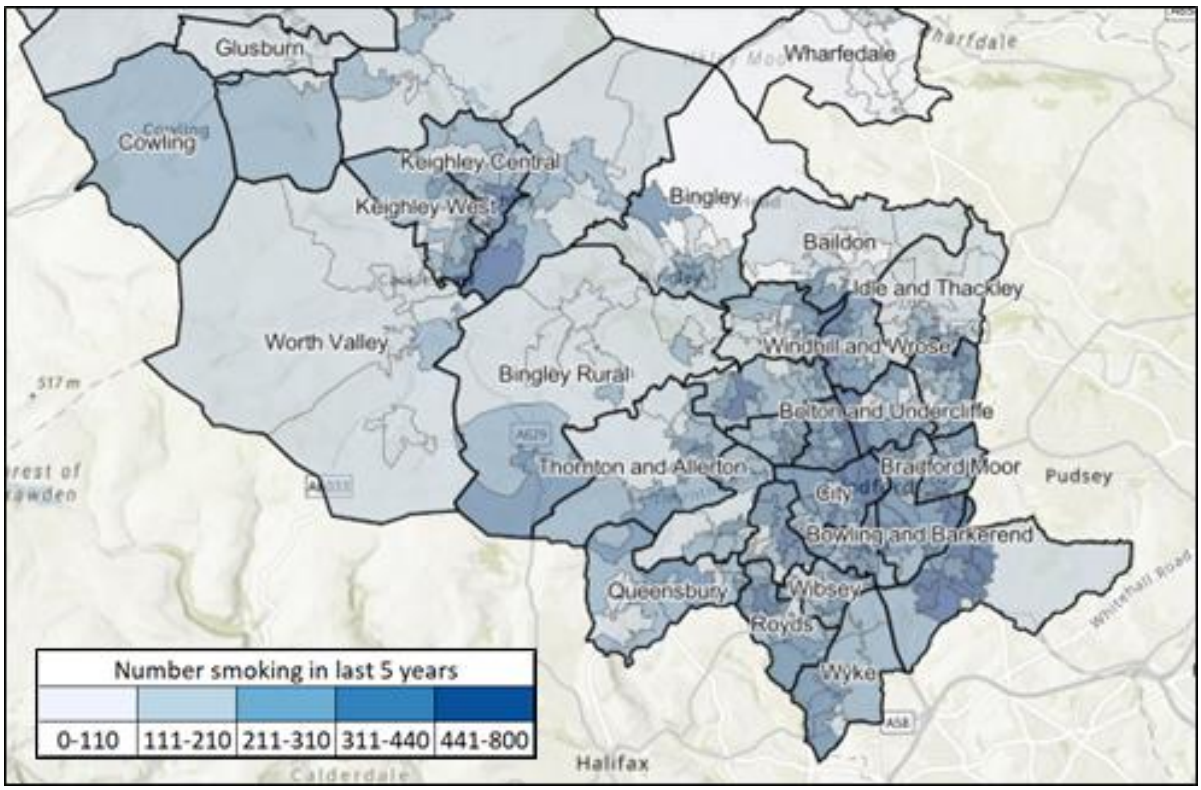

Figure 38: Geographical spread of the number of people with a smoking status in Bradford

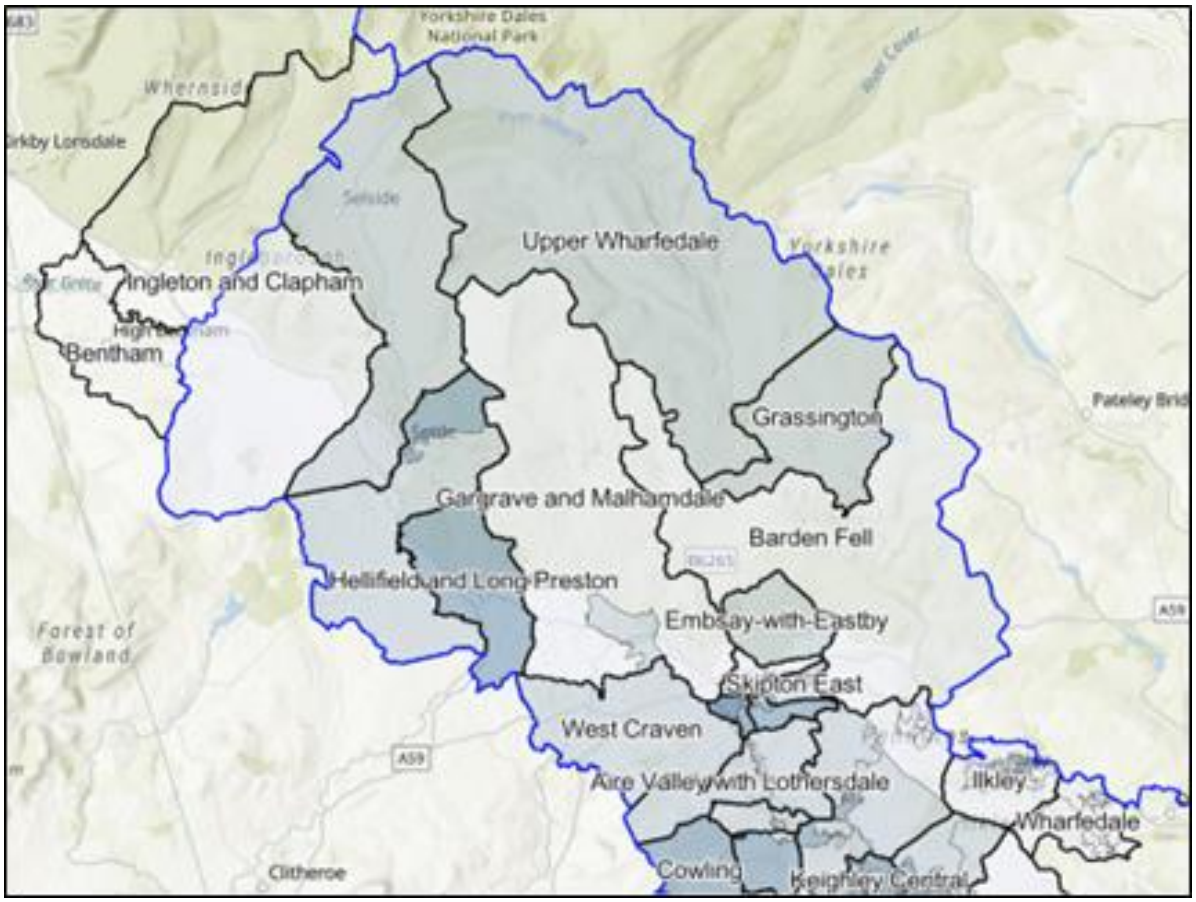

Figure 39: Geographical spread of the number of people with a smoking status in Craven

Both of these maps show that there are high numbers of smoking in specific areas in our place. Areas with high numbers of smokers include Tong, the inner-city ward in Bradford, Keighley and Skipton East. This is important to note as it helps to target existing services and support offers to areas with higher need.

Obesity

Poor diet and physical inactivity, which contribute to overweight and obesity, are significant risk factors in long term conditions. For instance, a woman living with obesity is more than three times more likely to have a heart attack than a woman of healthy weight[1]. Obesity is also linked with Type 2 diabetes, cardiovascular diseases and some cancers.

Access to affordable, healthy food and safe, unpolluted open spaces are vital for people to be able to make positive dietary choices and increase their physical activity levels, which in turn impact on obesity levels and other conditions.

OHID data for the prevalence of being overweight (including obesity) in adults (aged 18 and over) shows that the prevalence rate for Bradford District in 2022/23 was 65.7%, which is slightly lower than the regional average (66.6%) but higher than the national average (64%). The rate for North Yorkshire was 64.6% (data not available for Craven District).

The following maps show how the people with a primary care record of obesity are distributed across our place. This data was extracted from SystmOne in February 2024 and includes 77,145 people. The blue line shows the ICB boundary.

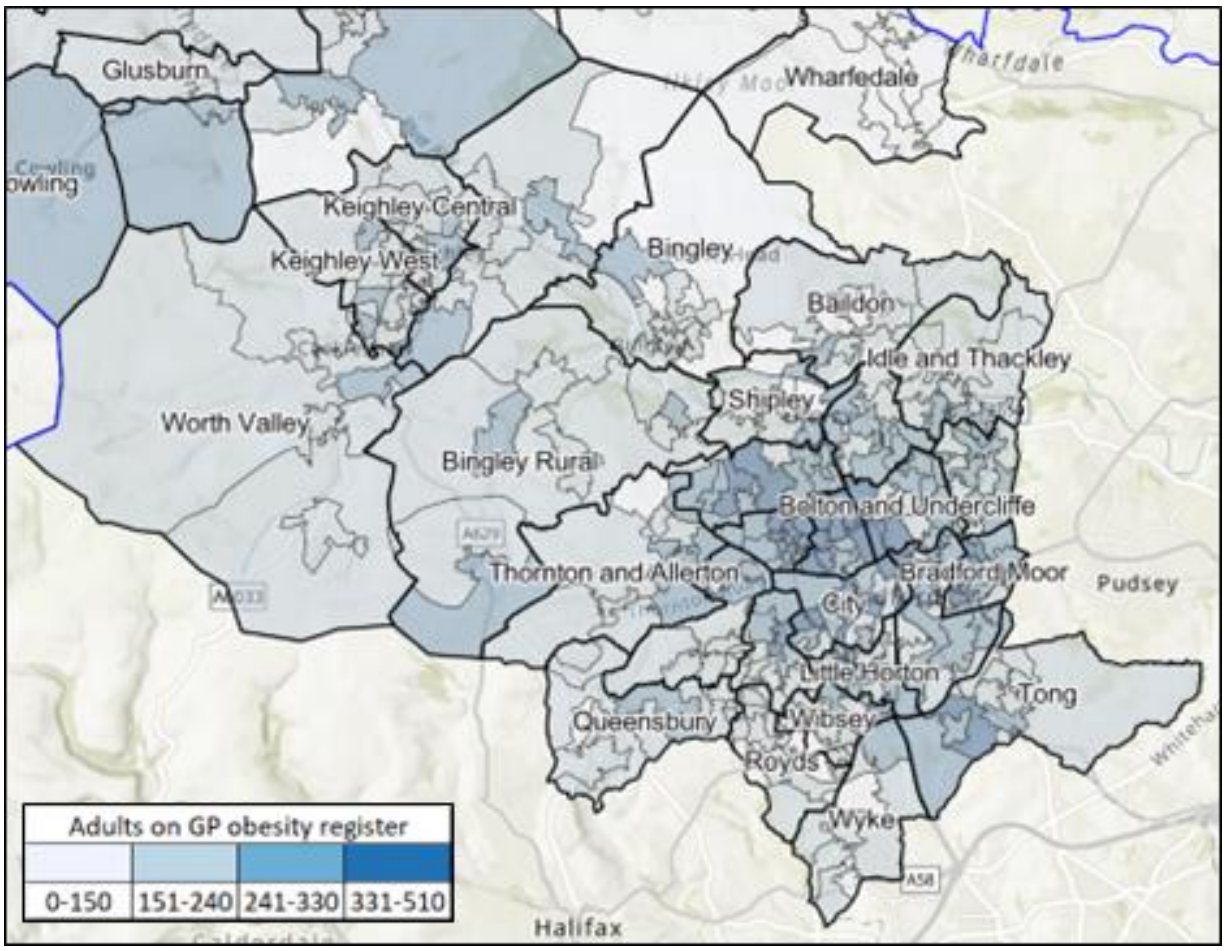

Figure 40: Geographical spread of the number of people living with obesity in Bradford

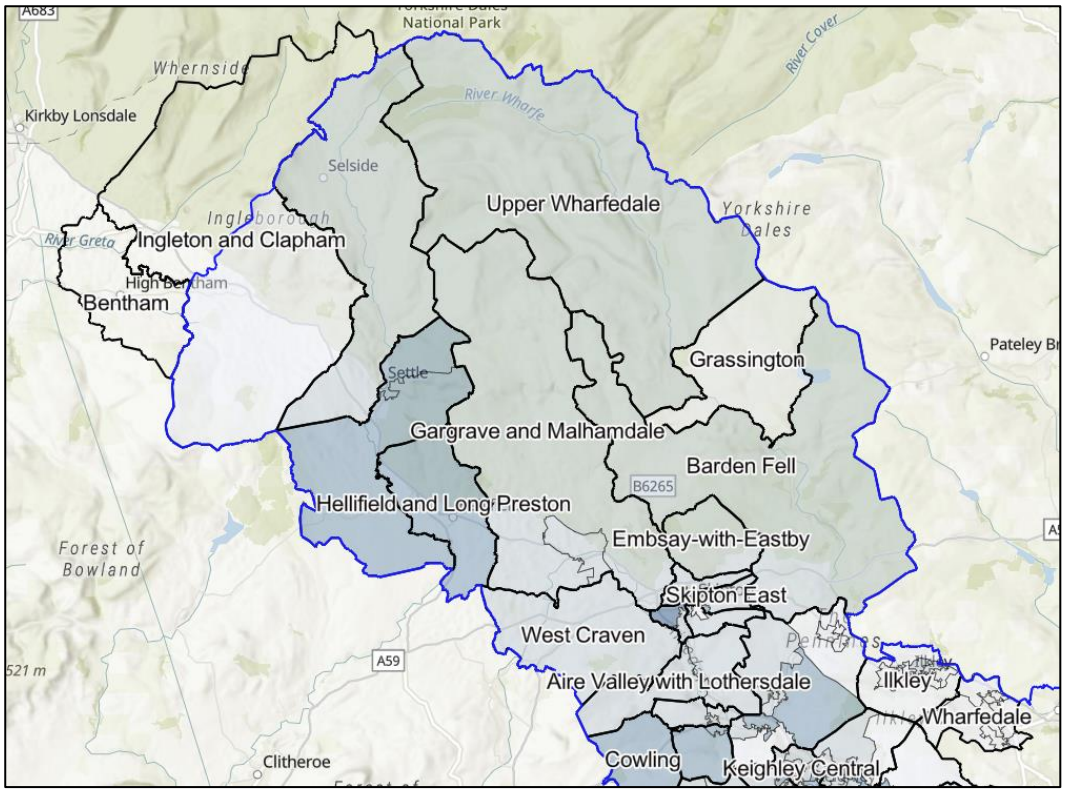

Figure 41: Geographical spread of the number of people living with obesity in Craven

Manningham, Bowling and Barkerend, City, Toller, Little Horton and Bradford Moor have high numbers of adult residents with a record of high BMI. Awareness of the geographical distribution of people living with obesity is important to note as it helps to target existing services and support offers to areas with higher need.

7.3 Trends

Trends in data from the Office of Health Inequalities and Disparities indicate that improvements need to be made in this area. Although trends in smoking prevalence are falling, the rate for Bradford District is still higher than the national average. See figure 42 below.

High rates of smoking are persistent in groups known to experience inequalities. For example, in Bradford district:

- the smoking prevalence for adults with a long term mental health condition (aged 18 and over) is 28.6%. The value for England is 25.1%
- the smoking prevalence for adults in routine and manual occupations (Aged 18 to 64) is 29.7%. the value for England is 19.5%

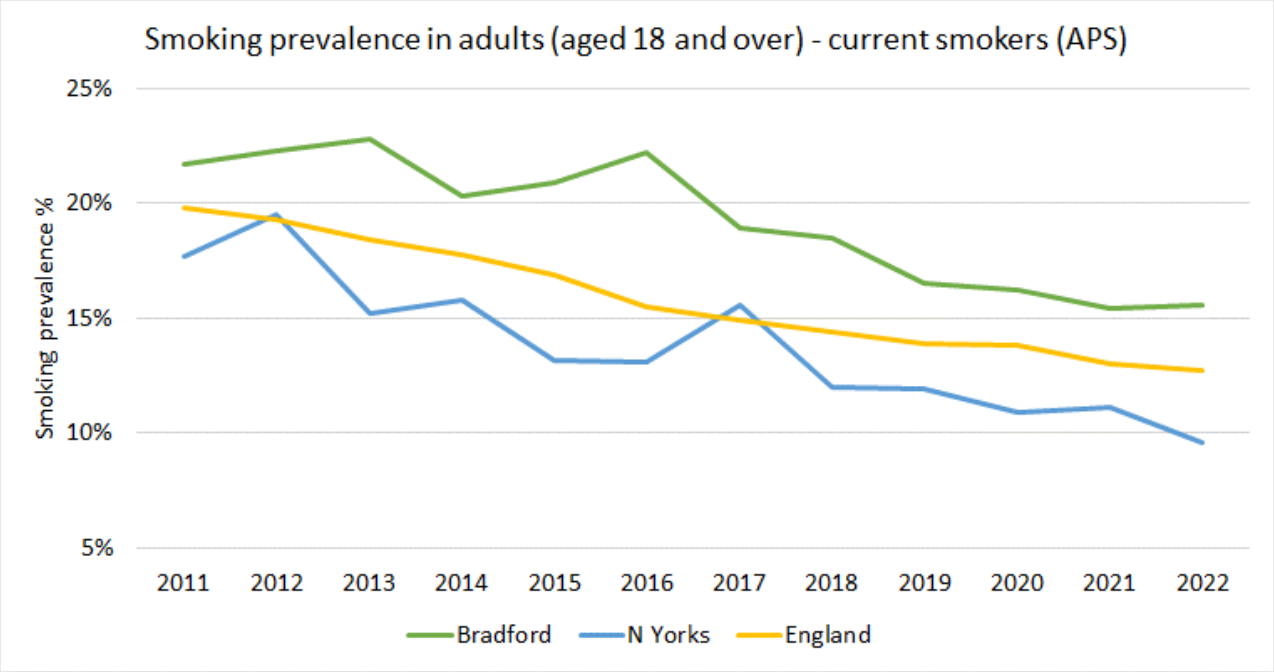

Figure 42: Chart showing smoking prevalence

The prevalence rate for overweight (including obesity) is higher that the nation average for both Bradford District and North Yorkshire. See figure 43 below.

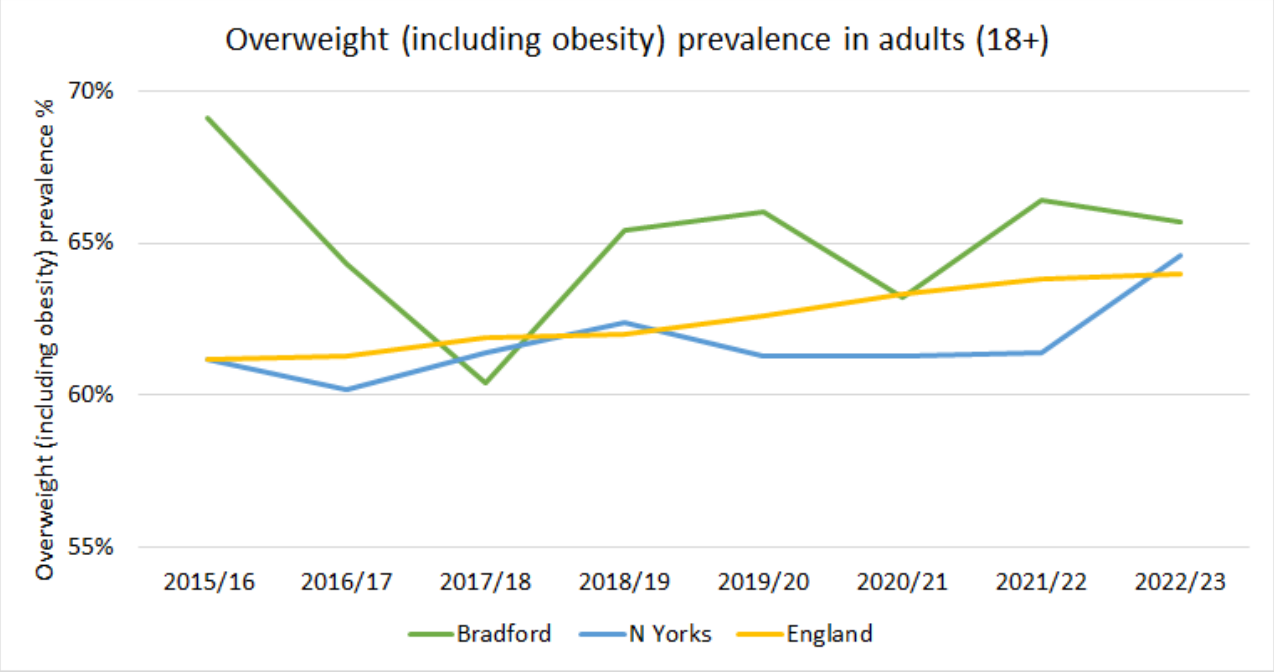

Figure 43: Chart showing prevalence of overweight including obesity

These trends are also shown in the Global Burden of Disease Study 2021 where they compare the risk factors which are attributed to the main causes of DALYs. For both Bradford and North Yorkshire the top three risks contributing to the burden of disease in 2021 are:

- Tobacco
- Dietary risks
- High body-mass index

For both areas high body-mass index has replaced high blood pressure as a top three cause when comparing the 2021 rank to the 1990 rank.

Please see our data annex for more detail. Slides in annex: Comparison charts showing trends in key risk factors and their contribution to DALYs

7.4 What action can be taken?

Whilst there are a range of risk factors which determine if and when a person will develop a long term condition (or conditions), and also their ability to manage and live well with their condition(s), smoking and obesity are areas which can have an impact on outcomes.

We can:

A. Utilise existing services, by increasing awareness and signposting in pathways

Within Bradford District and Craven we have a range of prevention and early intervention offers and services which are already commissioned via the Living Well (Bradford District), Healthy Living (Craven) and Healthy Minds (Bradford District and Craven) programmes.

B. Embed best practice into our work

We can review our commissioned services and determine if we are using evidence based, best practice in our pathways. For example NHS England has produced a summary of high-impact interventions which have evidence of impact[20]. (13) These are:

- Tobacco dependence identification and treatment in secondary care. Identification of smokers in inpatient hospital settings and maternity services, providing advice and treatment (behavioural and/or pharmacological).
- Weight Management services for people with diabetes and/or hypertension e.g. the NHS Digital Weight Management Programme Identification by GP practices and community pharmacists and referral to structured service to support people to lose weight and reduce their associated clinical risk. (This should also be considered for other CVD risk factors).
- Alcohol Care Teams Identification of people with alcohol dependency in acute hospitals, provision of specialist interventions and referral into community services for ongoing support and treatment

C. Review service and population data

We can review service and population data to determine if services and support offers are targeted to the appropriate cohorts and uptake reflects population demographics.

8. Inequalities in long term conditions and multimorbidity

Health inequalities are unfair and avoidable differences in health across the population and between different groups within society. Inequalities arise in access to; experience of; and outcomes from healthcare services.

8.1 Taking a data driven approach to tackle inequalities

When tacking action to address health inequalities, it is important to be clear on what the inequality is, and which group of people are experiencing the inequality. The table below shows some of the common areas of focus:

Differences experienced include	Groups who may experience the difference
• Health status, for example life expectancy • Access to care, for example the availability of services • Quality and experience of care, for example levels of patient satisfaction • Behavioural risks to health, for example smoking and obesity rates, and the • Wider determinants of health, for example the quality of housing and income	• Socio-economic deprived population groups • Geography • Inclusion health and vulnerable groups • Protected characteristics

Table 12: Summary of differences commonly addressed when tackling inequalities.

Within this section we will focus on ethnicity and deprivation.

8.2 Ethnic disparities

Ethnic inequalities in UK healthcare and outcomes occur across the entire life course. Nationally reports indicate that there are wide variations in patterns of illness between broad ethnic groups (White, Asian, Black, and mixed); for example, contacts with mental health services are lowest for Asian groups, but these groups have higher rates of cardiovascular disease.[21]

It should be noted that ethnic inequalities are intrinsically linked to deprivation.

Within Bradford and Craven there is a good level of awareness of potential inequalities experienced by our diverse population and examples to action taken to address these are referred to in section ‘Overview of long term conditions.’ However, there is still more we can do. Improving data collection around ethnicity coding, and disaggregating data to reflect ethnic groups will help us to better understand where variations in access, experience and outcomes are occurring.

8.3 Deprivation

Deprivation is a compounding factor in inequalities and is a key concern for our place. 45% of all Bradford District and Craven residents live in areas defined as the 20% nationally most deprived areas (the ‘Core20’ of the Core20Plus5 framework). Our core population is affected by this multiple disadvantage – not just a minority.

Within our local data we can see that long term conditions occur at a younger age for people living in the most deprived quintiles of Bradford District and Craven than for people living in the least deprived quintile.

Using histograms to compare ages of people with a long term condition in the most deprived area with the ages of those in the least deprived area, we can see that the most frequently recorded age value is younger in the most deprived deciles. An example of this is shown in figures 42 and 43 below.

It should be noted that the numbers of patients are higher in the most deprived national quintile because more people live in these areas. (45% of Bradford and Craven residents lived in areas in the nationally most deprived 20%, and 10% lived in areas in the nationally least deprived 20%).

Figure 44 shows the age distribution of people with a record of a musculoskeletal condition within the most deprived quintile. In this chart we can see that the highest proportions of people with the condition is at age 35 with relatively high values at age bands at either side. Figure 45 shows the age profile for the same condition for the least deprived area. In this chart we can see that the onset of MSK follows a different pattern, with the highest proportions of people with the condition occurring at age 50.

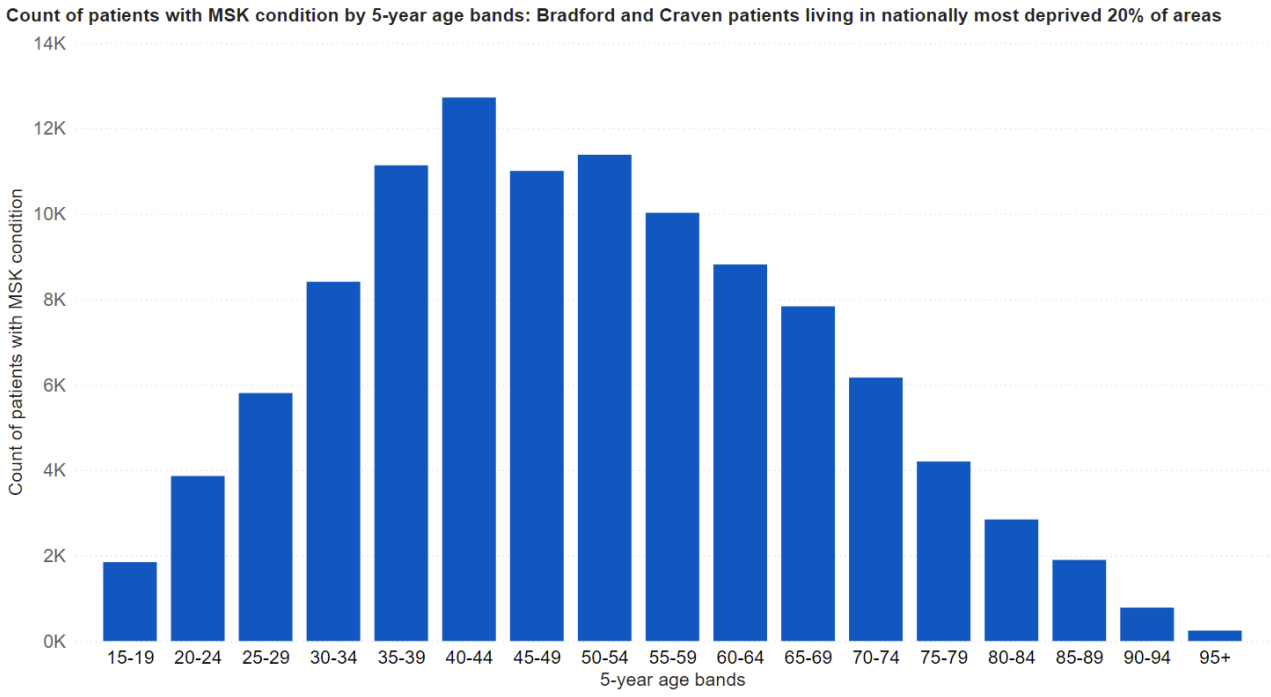

Figure 44: Histogram showing age distribution of people with MSK in the most deprived quintile

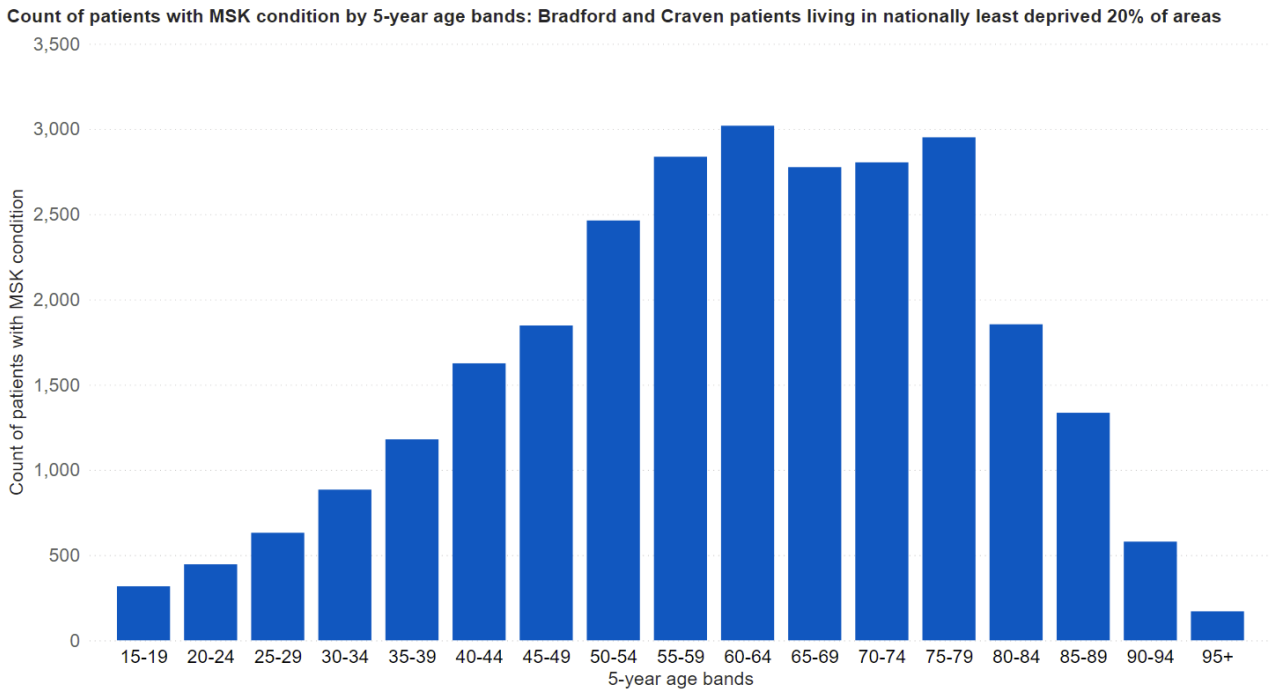

Figure 45: Histogram showing age distribution of people with MSK in the least deprived quintile

This pattern is similar for all of the long term conditions included within this needs assessment. Not only is it a feature for single conditions, but it is also replicated in multi-morbidity. Section 6.2 shows that in more deprived areas people with long term conditions are more likely than those in less deprived areas to experience multimorbidity at a younger age.

Please see our data annex for more detail. Slides in annex: Histograms comparing age distribution by deprivation for the long term conditions

Emergency care and mortality

Deprivation has a significant impact on how people access care. The following charts illustrate the variation in healthcare usage and mortality for long term conditions. These charts are based on OHID data, and as such are limited to two of the long term conditions considered in this needs assessment.

Figures 46 and 47 show the rate of emergency hospital conditions for each of the electoral wards in Bradford District and Craven, for coronary heart disease and for chronic obstructive pulmonary disease. The data is based on a standardised admission ratio and the chart includes the figure for England (in red) and figures for both Bradford District and Craven District (in green) for comparison.

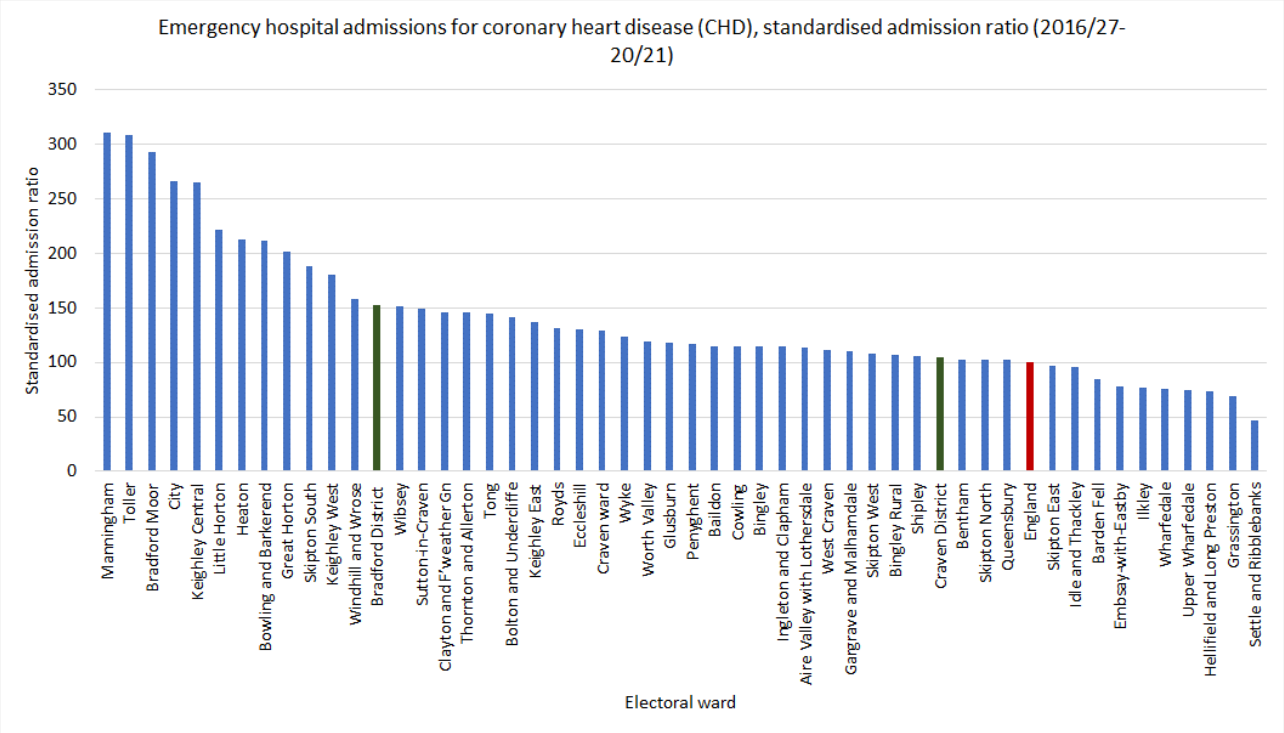

Figure 46: Chart showing rates of emergency admissions for CHD, by ward

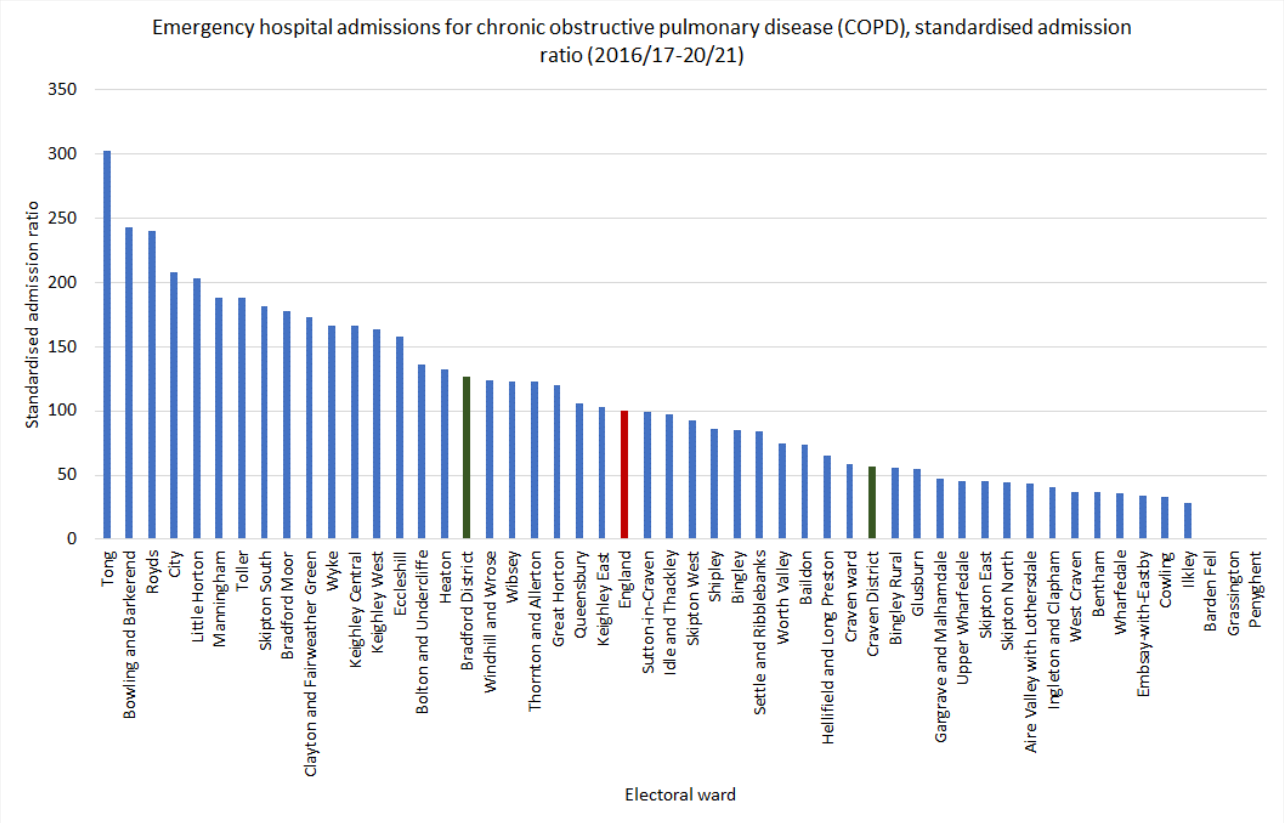

Figure 47: Chart showing rates of emergency admission for COPD, by ward

For both conditions admissions are highest from wards with high levels of deprivation and many of the wards also have high proportions of residents of minoritised ethnicities. Tong and Royds are exceptions to this as they are areas with a high proportion of White British residents. Whilst many of the wards with high admission rates are in the Bradford District area, there are also some from Craven District, specifically Skipton South and Sutton in Craven.

The pattern of people living in the most deprived areas having highest rates of emergency healthcare usage is also seen in people with multiple long term conditions. The following graph shows the proportion of emergency hospital admissions for people with three or more long term conditions, by age and deprivation. The graph shows that people with three or more conditions will experience more emergency admissions at a younger age in the most deprived areas.

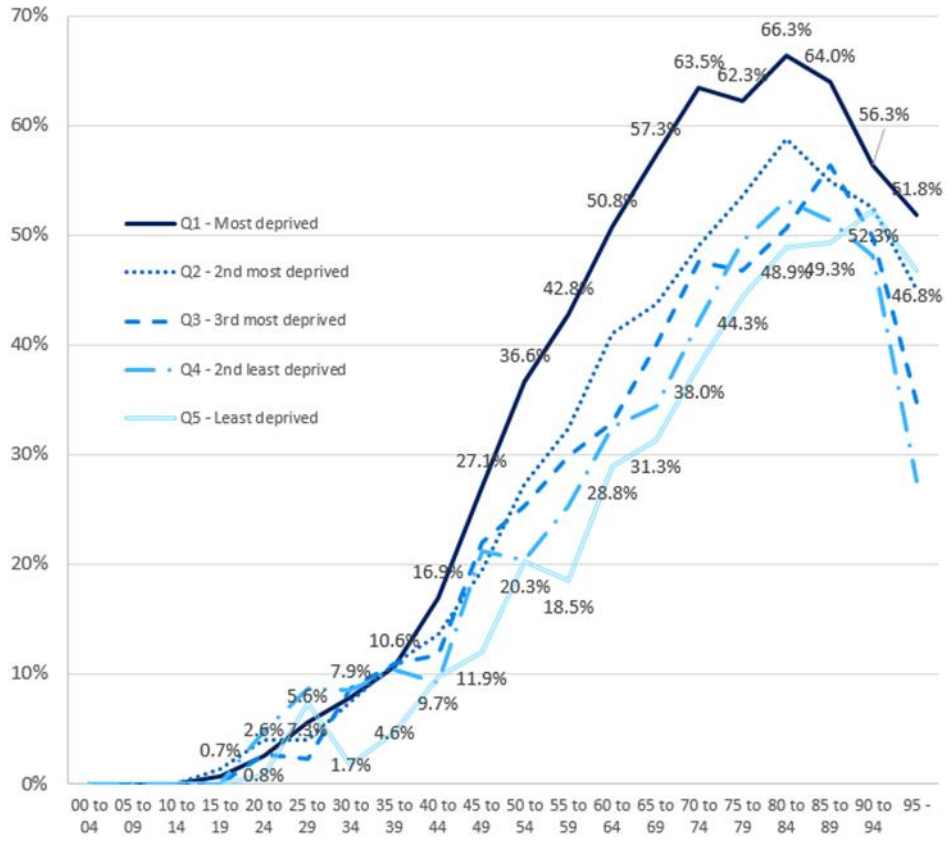

Figure 48: Chart showing % of emergency admissions for people with 3+ long term conditions by age and deprivation

Impact on mortality

The impact of deprivation can be seen in excess mortality and in the number of deaths considered preventable.

In a review of excess deaths in 2022, where excess deaths were compared against a baseline (2016-2019 plus 2021), excess deaths were seen in the following conditions:

- Cardiovascular **and** diabetes had a 27.8% increase over baseline,
- Diabetes 25%,
- Kidney disease 17%,
- Cardiovascular disease 10%,
- Respiratory 5%

There was a particular pattern of excess mortality for men in areas of deprivation.

The following chart illustrates how the number of deaths from cause causes considered preventable, under 75 years are higher in the most deprived areas. For this data ‘considered preventable’ indicates that the causes could be prevented through primary

prevention such as vaccination and lifestyle modification. In the period 2015-19, 17 wards had higher values than the England. Tong and Bradford Moor had values that were double the national rate.

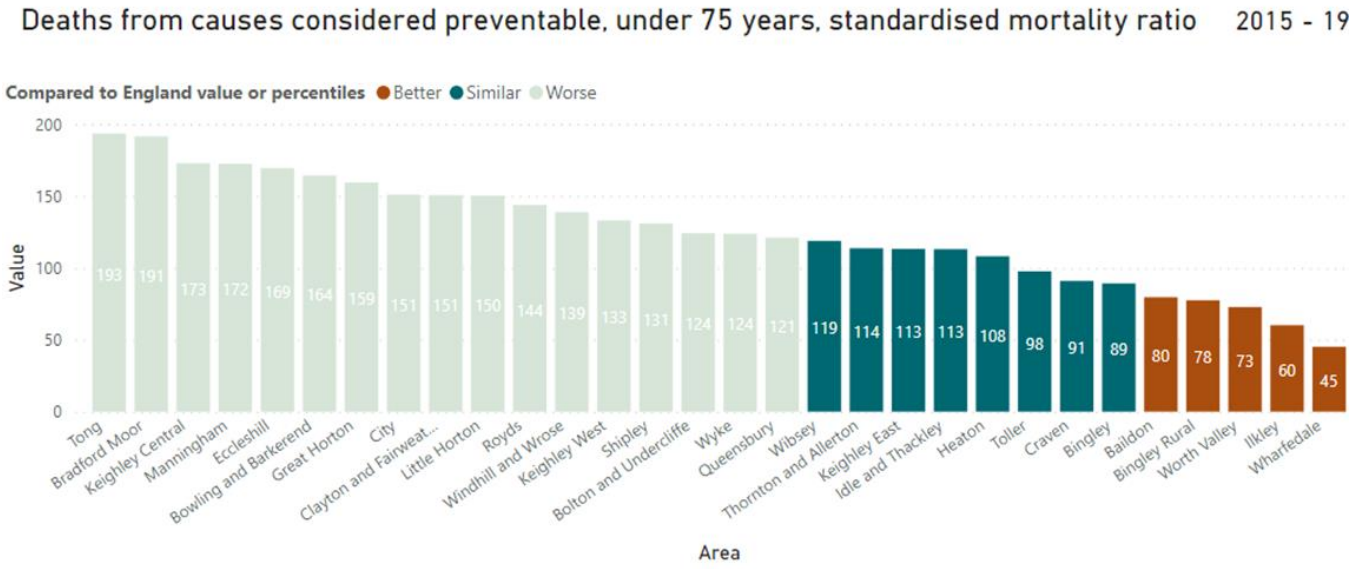

Figure 49: Chart showing number of deaths considered preventable for areas in Bradford District

We also see this in data for specific long term conditions. Figures 50 and 51 show the premature mortality rates for cancer and circulatory disease for electoral wards. Whilst the cancer data includes both Bradford District and Craven, the circulatory data only includes Bradford District. The data is based on a standardised mortality ratio and the chart includes the figure for England (in red) and figures for both Bradford District and Craven District (in green) for comparison.

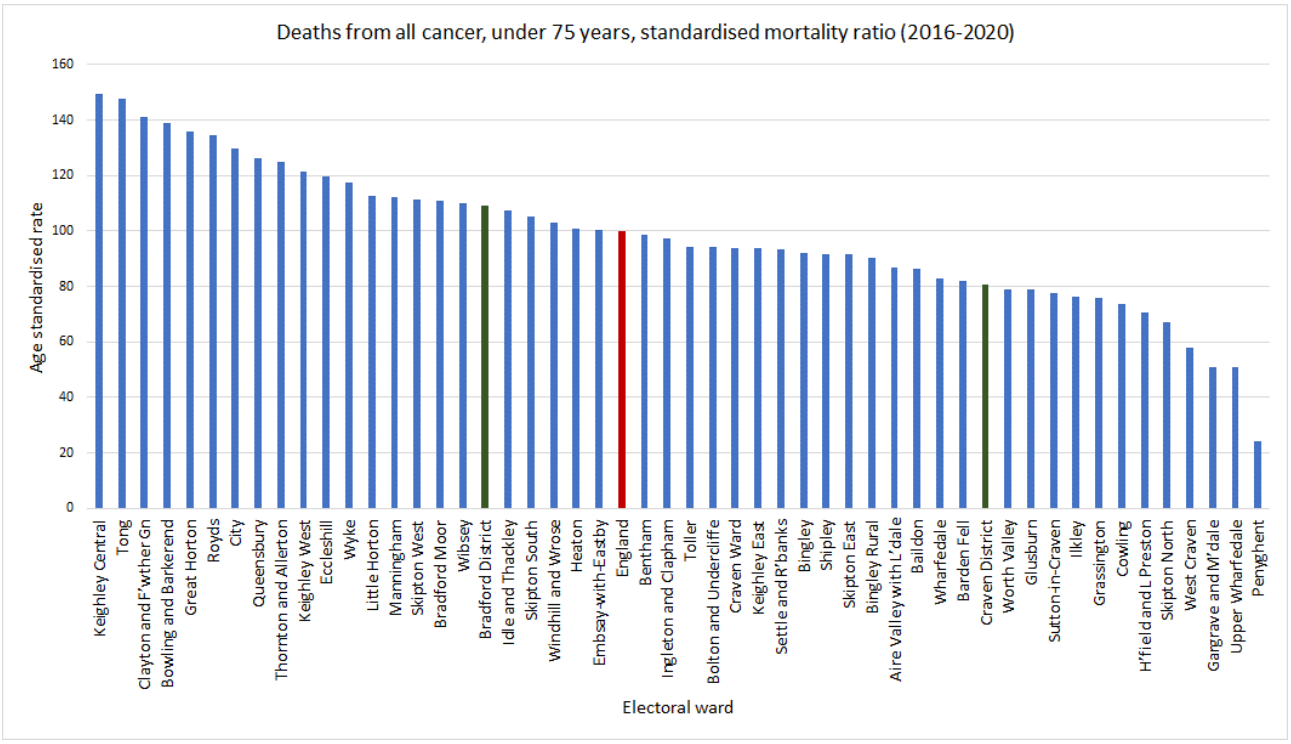

Figure 50 – Chart showing rates of premature mortality for cancer, by ward

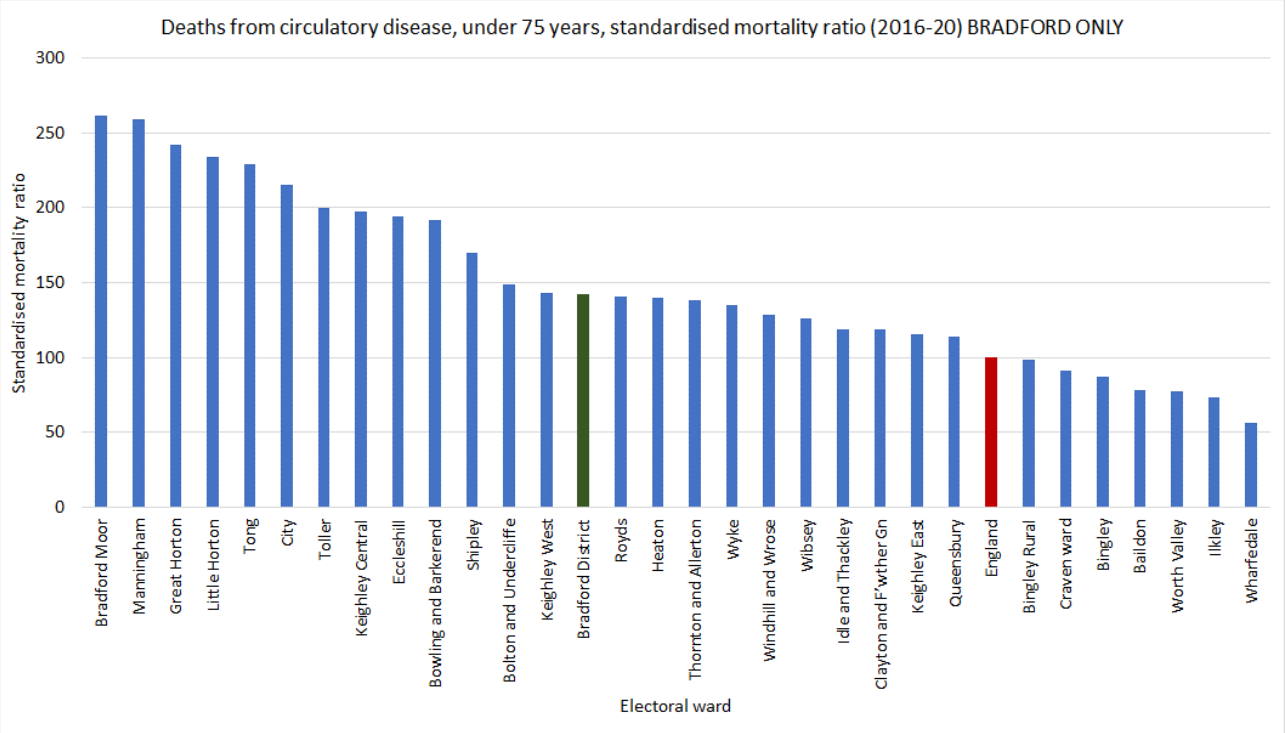

Figure 51: Chart showing rates of premature mortality for circulatory disease, by ward

For both conditions, the wards with highest rates of premature mortality are mainly but not exclusively characterised by high levels of deprivation.

9. The financial cost of inequalities

9.1 Effectiveness and efficiency

Inequalities in long term conditions has an impact on the effectiveness and efficiency of our services and the system we work in. The is illustrated in a number of ways:

The cost of inequalities

In 2016, researchers at the University of York calculated that socio-economic inequalities cost the NHS acute sector £4.8 billion each year. Data showed that people living in the most deprived fifth of neighbourhoods had 72% more emergency admissions and 20% more planned admissions, than those living in the most affluent fifth of neighbourhoods.

Unnecessary costs linked to health inequalities can arise in the NHS for a variety of reasons, such as:

- missed appointments due to working patterns or transport availability
- emergency admissions through a lack of preventative care
- inappropriate service usage, for example A&E attendance for minor ailments
- exacerbation of conditions due to poor living standards

This means that whilst people from the most deprived areas have a lower life expectancy compared to those in more affluent areas, the per capita cost of healthcare due to emergency admissions, multimorbidity, prolonged length of stay means that the spend of healthcare is higher for those from more deprived areas.

Analysis of our local data shows that the estimated annual cost of inequalities for people of working age is £27.5 million. This is similar to annual cost of emergency admissions for all people with long term conditions aged 19-64. This is shown in the following table:

Type of care	Actual cost 2022/23 (Bradford and Craven residents)	Cost if per head cost in all quintiles were the same as quintile 5 (least deprived 20%)	Estimated cost of health inequalities
Inpatient	£83,090,531	£67,754,038	£15,336,493
A&E	£16,721,956	£10,400,124	£6,321,832
Outpatient	£21,695,484	£15,872,308	£5,823,176
Total			**£27,481,501**

Table 13: Estimated costs on inequalities in Bradford District and Craven

The financial impact to inequalities is not just limited to the NHS. The estimated annual costs of health inequalities in Bradford and Craven include

- Working age secondary care: £27.5M (cost to NHS)
- Loss of tax revenue: £62M (cost to government)
- Health-related Universal Credit: £137M (cost to government)
- Loss of gross earnings: £311M (cost to economy)

9.2 Future demand

National data shows that that the likelihood of having a long term condition rises significantly for older age groups: most people in the 55-64 age group and older have at least one long term condition, including 80% of people over 85, and a rapidly increasing proportion of the population is over 65.

In our local data we see similar patterns, but these are occurring in the 40+ age group for some of our local population.

In the previous sections we have high lights the burden of disease on individuals, and the increasing levels of health and care needs for our existing population with long term conditions and multimorbidity. However, the size of this group (as a proportion of the whole population) is likely to grow as trend data for most of related OHID and GP data metrics are showing increases.

Whilst it is inevitable that some people will develop long term conditions and complex health problems, we need to consider how we can stop this increasing faster than it is decreasing, to achieve a healthier population.

The following chart uses locally produced data to illustrate healthcare utilisation for the population of Bradford District and Craven.

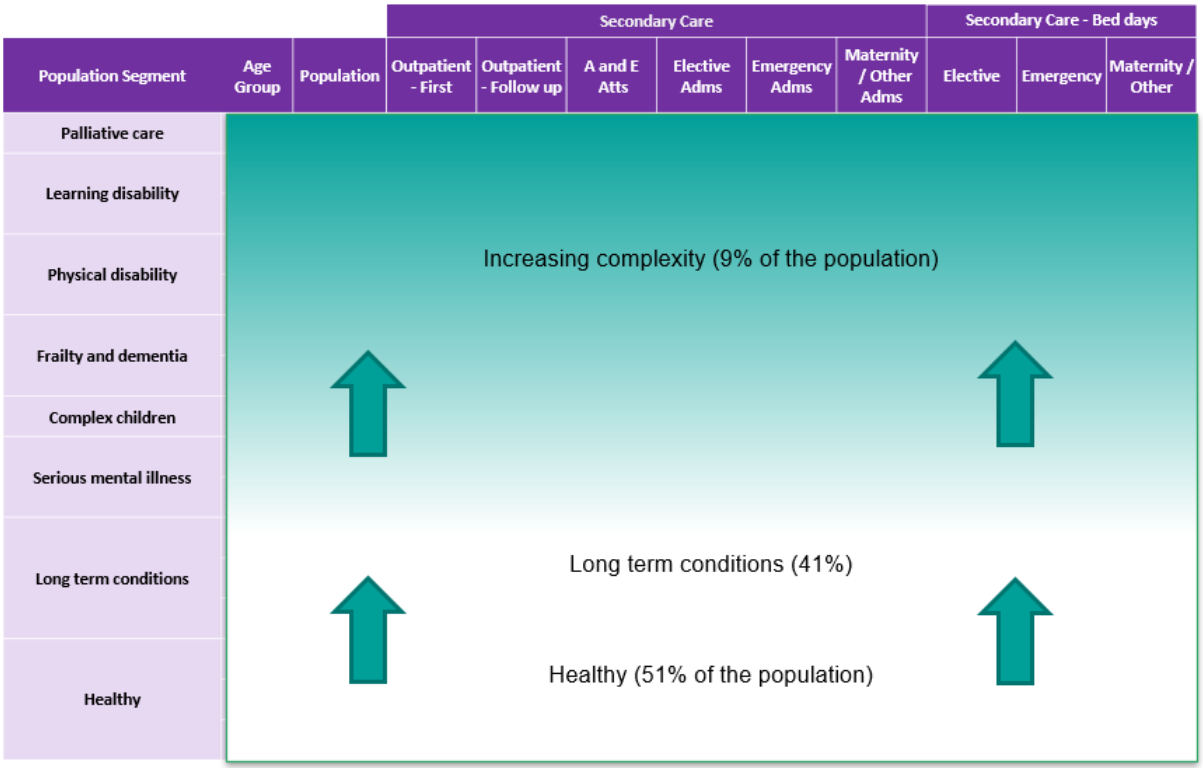

Figure 52: Chart showing % of people in our population in key groupings

As a system, we need to take action to delay, or reduce, the 51% of the population from developing a long term condition. We also need to delay the onset of multimorbidity in the population that already have one long term condition.

10. Areas for action

In the previous sections the Intervention Decay Model has been used as a framework to describe and categorise the actions that can be taken to reduce health inequalities in long term conditions and multimorbidity. A reminder of the model is shown in figure 26.

The areas for action described throughout the document are grouped together in this section, for ease of reference. At the end of the section there is a high level summary of key themes.

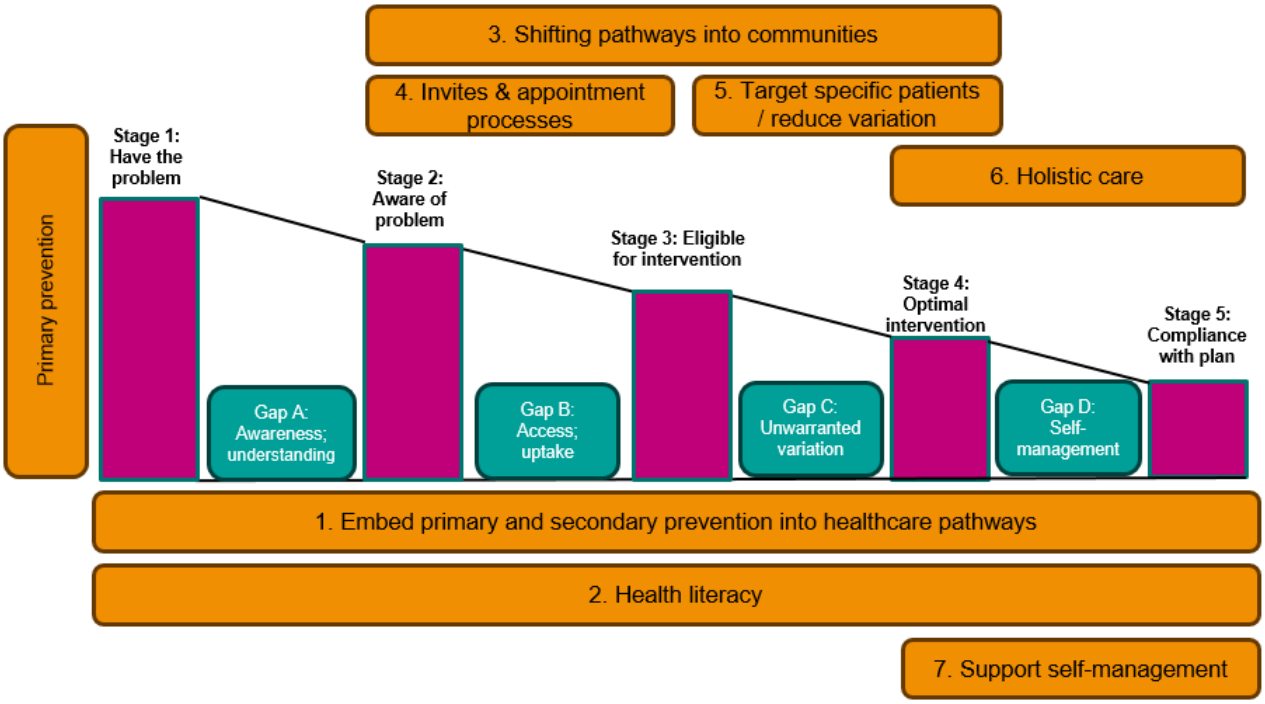

Figure 53: Intervention Decay Model

10.1 Primary and secondary prevention

- Increase uptake of existing offers such as:
    - the NHS Health Check,
    - the NHS Diabetes Prevention Programme,
    - quit smoking support
    - Living Well service offers
    - community pharmacy hypertension case finding
- Target interventions to cohorts most likely to benefit e.g.:
    - provision of health checks for those younger than 40 years (in recognition of earlier disease progression in areas of most deprivation).
    - developing training to raise awareness of the cardiovascular health needs of people with mental health, learning disabilities or neurodiversity needs
- Target interventions on the modifiable risk factors which are known to contribute to the development and progression of a range of long term conditions. (See figure 9 for the

14 modifiable risk factors specified for dementia, but also influence the other specified conditions).

- Primary prevention should be offered to people at risk of developing a major health condition as well as to those living with major condition. For example, using smoking cessation services to provide support after a heart attack.
- Prioritise preventive strategies that target common risk factors for chronic conditions, especially in deprived areas. This includes initiatives to reduce smoking, improve nutrition, and increasing physical activity. These should be adaptable so that they can support all ages.
- Develop interventions which increase early diagnosis of long term conditions such as COPD, to improve quality of life and keep people healthy for longer

10.2 Health literacy

- Increase awareness of conditions within communities and provide information and / or resources which:
    - Support the early recognition of signs and symptoms
    - Encourage uptake of prevention interventions such as screening and vaccination
    - Increase understanding of the value of interventions such as vaccination and early diagnosis
- Empower local community leaders to be more aware of conditions, starting early in mother and toddler groups to the knit and natter groups. Consider the use of peer supporters and community champions
- Broaden target audiences of communications to include the wider community (not just immediate population) to increase understanding and uptake e.g. Involvement of men in the discussions around women's health (cervical screening engagement with wider South Asian community).
- Work with trusted partners such as VCSE organisations to reduce stigma and provide trusted spaces to raise awareness and discuss concerns about conditions and treatment pathways.
- Proactively ask groups who do not engage with services to share their concerns and work to counter any myths or misconceptions. Build on existing work such as myth busting in learning disability/autism communities.
- Develop culturally competent information about conditions and interventions (such as screening). Use a combination of tools i.e. written and visual, and use materials that consider language barriers.
- Assessment tools should also be culturally appropriate and should not be dependent on inappropriate literacy and education levels to complete them.
- We need to recognise that levels of health literacy vary across population and time needs to be made in pathways to help people understand their conditions. Small but powerful adjustments, like simple, clear explanations of what had been diagnosed and

what they need to do about their condition, professionals checking understanding would make a huge difference.

- Develop bespoke support and guidance for long term conditions which are tailored to the specific needs for individual cohorts. For example, the 'Keeping My Chest Healthy' website with was coproduced with people with learning disabilities, their families and carers. The website supports people to manage their respiratory health at home by providing of suite of accessible videos and text guidance available in multiple languages.

10.3 Shifting pathways into communities

Actions

- Build on successful programmes which have delivered interventions in community settings i.e. target lung checks and the mobile chemo van. This will reduce inequalities and assist with access issues people may face
- Use community venues for testing, prevention promotion and patient education. Community health checks are an example of success in this approach.
- Work with VCSE organisations to extend and embed pathways into communities. Mental health services have seen a positive shift in the uptake of early intervention as a result of this approach and the new Crisis House in Bradford has provided an alternative support option which meant that admissions were avoided.
- Consider the used of roles such as Community Centre Health Development Workers to help people navigate the support available for a range of conditions

10.4 Invites and appointment processes

- Spread successful interventions across invitation and booking processes e.g.:
    a. nudge theory from cancer screening invites,
    b. targeted reminders to cohorts less like to attend,
    c. building in options for people to choose their appointment date/ time and location
    d. endorsed invitations (i.e. from a named GP) to people who have not attended
- Utilise support workers to offer education, appointment scheduling assistance and reminder/follow-up calls to increase compliance with screening
- Ensure booking processes can capture support needs and reasonable adjustments and share with services ahead of appointments.
- Support to ensure people who are disadvantaged to attend appointments (this may include help with transport, postal prompts and offering home visits).
- Ensure key staff can speak community languages

10.5 Target 'under-treated' patients/ reduce variation

- Focus on reducing variation in uptake of screening – continue to target groups who do not attend e.g. inclusion health groups

- Undertake robust collection and assessment of equity data by services, and use insights to evaluate equity of access, experience and outcomes. Develop targeted services such as alternative therapy for depression for Muslim clients to reduce inequalities in access and outcomes.
- Use case finding and risk stratification to identify people with conditions that would benefit from interventions such as:
    a. cholesterol
    b. direct-acting oral anticoagulation to prevent atrial fibrillation related strokes
    c. prediction and management of exacerbations for people with COPD
    d. lipid management
- Participate in supported audits such as antipsychotic audit to reduce variation in prescribing rates and support deprescribing
- Optimisation of:
    a. hypertension treatment
    b. heart failure treatment through annual reviews
    c. management post ACS, including lipid management
    d. delivery of 9 diabetes care processes
    e. inhaler usage
    f. medicines
- Embed spirometry in the diagnosis of asthma & COPD
- Ensure those with SMI or those on antipsychotic medication are identified and supported to access their physical health checks
- Systematically stratify population groups and then create specific appointments to undertake checks among people who are at risk of having multiple long-term conditions, addressing health behaviours and physiological risks

10.6 Holistic care

- Make screening a standard issue for relevant healthcare professionals to routinely raise when they come into contact with someone eligible, with an offer to provide information or assist with booking if needed.
- Develop pathways which shift from a single-disease focus to a more holistic approach that considers the complex needs of individuals with multimorbidity. This includes addressing physical and mental health, as well as social determinants of health. The Rethinking Pain service has successfully integrated physical and mental health support into a single disease pathway, showing the importance of holistic care.
- Provide continuity of care to support people with complex diseases (such as dementia), and their carers, through their care pathway.
- Coordinated, integrated care models that involve primary care, specialists, and mental health services are essential for effectively managing multimorbidity. These models help prevent fragmented care and improve outcomes. The Proactive Care Team (RIC project) is a successful example of this approach. The team works on a case-finding

basis and have done significant engagement work with local communities. Academic research shows the team has had a positive impact on reactive hospital care usage and has improved patient outcomes.

- The healthcare workforce should be trained to provide patient-centred care for individuals with multimorbidity. This includes generalist skills, care coordination, cultural competence and communication skills. This may include developing specific pathways for people with multimorbidity.

10.7 Support self-management

- Increase access to exercise and rehabilitation programmes to all relevant groups i.e.:
    - pulmonary rehabilitation to all appropriate people with COPD
    - cardiac rehabilitation for patients post ACS and diagnosis of heart failure
    - exercise classes designed for those recovering from a heart attack
- Increase access to structured education programmes (DAFNE and X-PERT are cited, others are available). However, recognise that the NHSE education offer does not work for all cohorts. Levels of health literacy vary across population and we need service offers and invites that reflect this
- Increase availability of, and access to, the range of tools to support people to self-manage their conditions i.e.:
    - Self-care videos in community languages
    - Digital technologies and home BP machines
    - Telehealth
    - Patient self-management apps which have evidence of impact such as Asthmahub and COPDhub
    - The use of VR headsets to support remote monitoring of COPD
- Support patients to be actively involved in their care plans. Tailored care plans should consider patients' preferences, goals, and social circumstances. Examples include personalised asthma action plan for all children and young people with asthma, and personal health budgets for people in mental health inpatient units.
- Offering self-care support to individuals as well for family and carers is as important as the specific clinical care. This should include signposting to practical support such as access to benefits advice, counselling, complementary therapies
- Use already commissioned services such as the Living Well services to support people to ‘wait well.’ This includes the opportunity to change their lifestyle (eating, smoking, exercise) and engage in safe activities that would benefit them whilst awaiting a diagnosis and treatment plan
- Use community venues to promote self-care advice

10.8 Summary of key themes

I. **Target inequalities.** The impact of inequalities is seen in long term conditions and multimorbidity – both in terms of distribution and how care is utilised to support these conditions. Focused work on health & healthcare inequalities is a “must do” to achieve system financial stability and sustainability, in the short, medium and long term.

II. **Prioritise and embed prevention into care pathways.** The development and progression of long term conditions can be avoided and/or delayed through effective prevention. Maximising uptake of existing prevention offers, and targeting those who would benefit most, will improve outcomes and help manage future health and care demands.

III. **Design pathways with a greater consideration of health literacy.** Increasing community awareness of long term conditions can improve healthcare inequalities. Simplify and tailor language and messaging to overcome health literacy, cultural barriers and stigma and customise communications to specific groups where needed.

IV. **Shift pathways of care into communities.** Delivering interventions in community settings improves access. Working with partners such as VCSE organisations can help understand community readiness for interventions and tailor delivery accordingly.

V. **Improve invites and appointment processes.** Having a combination of approaches, and the functionality to tailor messages to specific cohorts of people, improves uptake of services. Recognising that some groups will need reasonable adjustments to attend appointments is important, as well as taking action to avoid digital exclusion.

VI. **Target specific groups and reduce variation.** Tackling variation in care delivery, from screening uptake through to treatment optimisation, and across population groups (i.e. inclusion health groups, people with learning disabilities) will improve experience and outcomes. A data driven approach should be used to identify the parts of population (and conditions) that account for large numbers of unplanned and avoidable admissions. This is where are greatest gains can be made.

VII. **Develop holistic and integrated care to address multi-morbidity.** Coordinated care approaches are needed for people with complex long term conditions and multimorbidity. Generalist pathways and approaches (with support for single specialty care) using multidisciplinary teams where possible should be used for these cohorts to avoid fragmented care and to integrate mental and physical care needs.

VIII. **Support self-management.** Increasing the availability of, and access to, support tools will help people to be more actively involved in their care plans and to be more confident in managing symptoms and exacerbations. This includes the use of digital technologies where appropriate. Offers may need to be tailored to meet the needs of individuals, with a range of access options available.

IX. **Take a population health approach.** Be clear on the groups and communities we are targeting our interventions on, so we can understand if we are making the expected impact.

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