Reducing Inequalities Alliance

CORE20PLUS5

Bradford District and Craven Health and Care Partnership

ACTasONE

Reach and Impact Report

March 2026

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Core20PLUS5 Reach and Impact Report

Bradford District and Craven

The Reducing inequalities Alliance (RIA) and Healthy Communities Team within the Bradford Health and Care Partnership have been responsible for the delivery of the Core20Plus5 programme since 2023. RIA led this programme on behalf of the Act as One Partnership working with Bradford District and Craven's priority boards, strategic partners and the Voluntary and Community Sector Enterprises (VCSE sector).

It is vital that we understand the impact of the Core20Plus5 programme in order to support future work to reduce health inequalities across Bradford District and Craven. By evaluating the reach and impact of the main interventions commissioned as part of the (and its wider system impact) we aim to guide future resource allocation and strategic planning to reduce health inequalities locally.

A mid-term Core20Plus5 progress report was published in March 2025 and was presented at our Core20Plus5 Learning Week in October 2025. This second report covers our 3-year reach and impact evaluation for the Core20Plus5 programme in Bradford District and Craven.

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Executive summary

- The Core20Plus5 national approach to reducing healthcare inequalities seeks to narrow the health gap between the most and least advantaged populations. It focuses on five national clinical priorities—maternity, severe mental illness, chronic respiratory disease, cancer and cardiovascular disease with reducing smoking as a cross-cutting priority. In Bradford District and Craven there is also an additional local sixth priority, addressing 'adversity, trauma, and resilience (ATR) in Children and Young People'.

- Since 2023 the Core20Plus5 programme in Bradford District and Craven has been a key element of the system-wide effort to reduce health inequalities locally. It has been led by the Reducing Inequalities Alliance (RIA) team in the Bradford District and Carven Health and Care Partnership.

- A deprivation weighted allocation formula was used to allocate funding to thirteen Community Partnerships (CPs) in 2023. CPs led discussions of local needs, working up solutions with local partners. This approach was supported by the RIA team and wider ICB to align work to district wide programmes. The funding was used to develop initiatives with mainly local VCSE organisations (and the NHS locally). Additional match funding was provided by Bradford Local Authority and an external charity.

This evaluation report addresses the population, reach, impact and effectiveness of the programme over the past three years.

Key findings

- Between 2023-2025 the Core20Plus5 programme reached over 14,000 people across the district, employed 48 paid and 39 volunteer staff, and implemented 73 different initiatives focused on prevention and reducing inequalities.
- Core20Plus5 has demonstrated the value of devolved decision-making to Community Partnerships (CPs) to identify priorities and design interventions based on local populations needs.
- The programme has built capacity, strengthened local leadership, and fostered innovation in tackling health inequalities.
- It has demonstrated that targeted efforts to reduce health inequalities through hyperlocal and community-led interventions can identify priority cohorts (by deprivation, ethnicity and inclusion health groups).
- Data from our Core20plus5 providers shows that the programme has been broadly successful in reaching target groups most at risk of poor health outcomes (when measured against deprivation and ethnicity).

- Evaluation of the programme's impact reveals promising outcomes in both primary and secondary prevention, with many interventions showing effectiveness in improving access, experience, and health literacy among disadvantaged groups.
- The emphasis on relationship-based models, cultural competency, and holistic support (taking a bio-psychosocial approach) has proven essential in engaging inclusion health populations (such as refugees, Roma communities, and those experiencing homelessness).
- The flexibility afforded to Community Partnerships enabled tailored approaches that reflected local needs, resulting in a diverse portfolio of pilot projects to build on and scale up where the local evidence base was supportive.
- The scale of individual interventions was modest relative to the whole population. However, the collective learning demonstrates potential to integrate these approaches into wider system efforts to support equitable health improvements.

Effectiveness and value

- Of the 73 projects delivered, 51 were deemed effective (in terms of addressing their initial aims) and focused on reducing inequalities in target populations (particularly in deprived and diverse communities).
- High-performing interventions included health literacy and awareness campaigns, health coaching for target communities, smoking cessation for COPD patients, targeted wellbeing in primary schools, a universal sleep service for CYP and health checks in community settings.
- Other interventions that show promise were maternity circles, physical activity for target groups, befriending and advocacy models, respiratory physiotherapy for those with COPD and broader models of crisis intervention for target groups.
- The average return on investment (ROI) for interventions developed by CPs was £7.62 per £1 invested (99% CI: £5.96–£9.28) [estimated by matching international evidence to individual interventions rather than undertaking health economic analysis for each intervention].

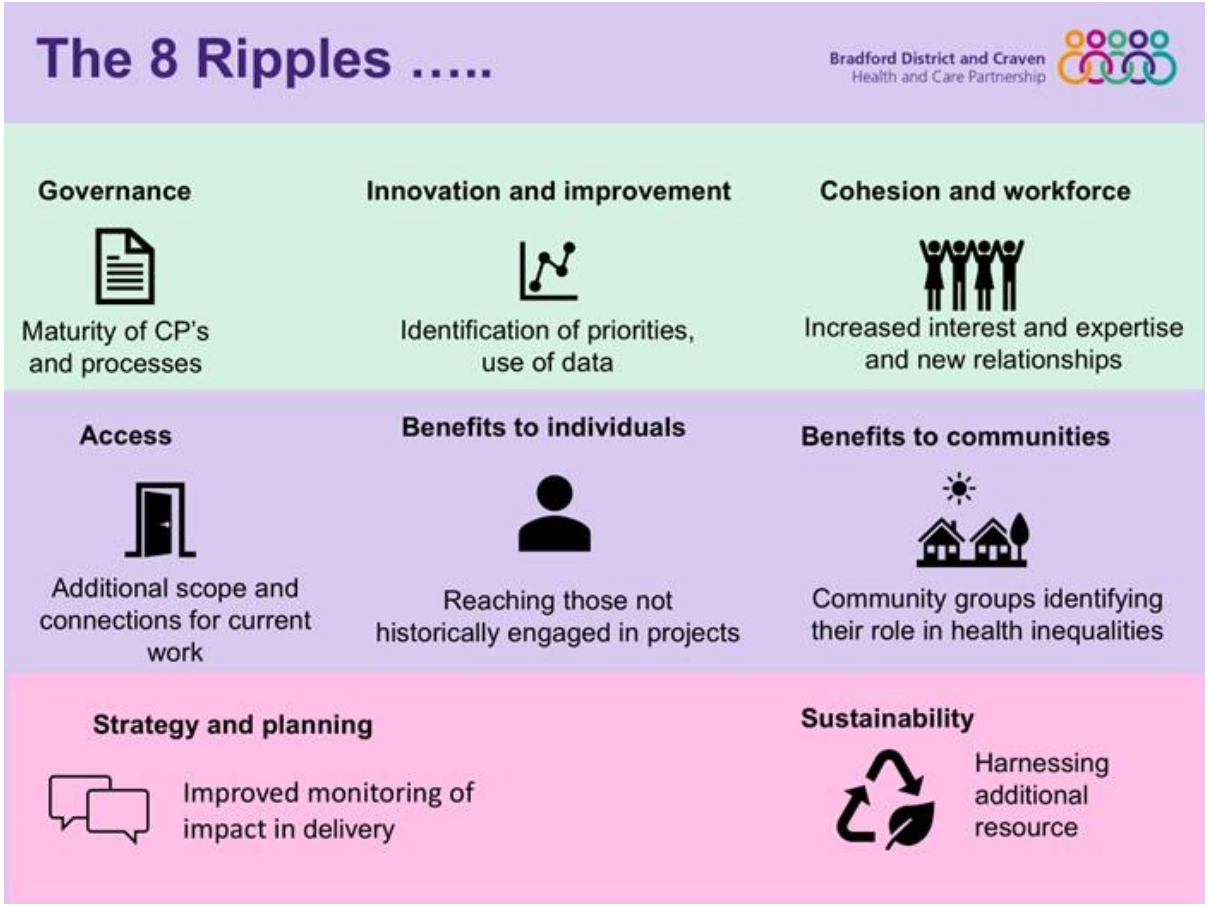
Clinical priority areas

- **Maternity**: Maternity circles were well received in diverse communities, especially among South Asian women. Further integration with NHS maternity systems is needed for them to meet their potential.
- **Adversity, trauma, and resilience**: Interventions for children and families in IMD1&2 areas supported resilience through sleep, school, crisis, and parenting support. Embedding these into universal services is key.
- **Respiratory**: Respiratory physiotherapy and smoking cessation services for targeted groups have the potential to contribute to improved clinical outcomes and reduced hospital admissions.

- **Mental wellbeing & SMI**: Public mental health interventions expanded access to digital support, counselling, and targeted services for specific groups including older adults, dementia patients, and men.
- **Cancer**: Community-led awareness and culturally tailored messaging increased screening uptake.
- **CVD**: Health coaching and community-based NHS health checks improved awareness and access, though stronger links to primary care systems are needed for follow-up.

System impact

Ripple Effects Mapping (REM) with partners revealed broader system consequences of the Core20plus5 programme, as follows:



Challenges

- Time is needed to align true co-production with a commitment to evidence-based investment.
- Community partnership infrastructures progressed at a differential rate in terms of developing into mature, adaptive and effective decision-making bodies.
- Restrictions of the Core20Plus5 framework (to specific clinical outcomes) led to frustrations in meetings to develop true bio-psychosocial models.
- Building skills and capacity in Community Partnerships to evolve and maintain Core20Plus5 beyond 2025 is challenging during NHS organisational change (and with budget constraints)

- Innovative models of delivery can be difficult to monitor with traditional quantitative performance indicators (and need to combined with qualitative evidence).

Recommendations

As the district moves forward with the NHS 10-year plan and broader system transformation, the Core20Plus5 programme provides a robust foundation for embedding inequality-focused approaches into mainstream prevention and health and care delivery.

In making these recommendations we have drawn on a recent West Yorkshire wide 'Review of Core20PLUS5 funding' and the developing Bradford District and Craven Integrated Neighbourhood Health programme, as a natural home for implementing some of these findings. We are also mindful of the forthcoming WY ICB restructure and reduced size of the BDC place team.

Recommendations for Bradford District and Craven new NHS structure and leadership (ICB Integrator team and provider partnership):

1. Promote the distribution and use of digestible population health data (showing clear variation in outcomes) at community level, to support local needs led decision making.

2. Maintain an equity-led approach to health inequalities resource allocation within Core20plus5 or equivalent grant funding (due to the 22-year difference in healthy life expectation across the District).

3. Due to the expected reduction in local commissioning capacity in the Bradford and Craven ICB, contract a lead VCSE provider to deliver Core20plus5 grant funding and evaluation (with ICB support and oversight to transfer Core20Plus5 momentum into the Integrated Neighbourhood Health programme).

4. Support Community Partnership's pivotal role in developing Core20plus5 interventions with VCSE partners, by maintaining sufficient ICB infrastructure support to retain these neighbourhood structures as 'engine' rooms for local innovation.

5. Embed areas of prevention activity, where we have seen multiple successful interventions, into longer term and more strategic programme areas, for example:
   - maternity circles within Bradford District's Family Hubs and Start for Life programme
   - school based interventions within a wider District Adversity, Trauma and Resilience programme (ICB and LA Public Health)
   - sleep service within longer term neurodiversity pathway planning
   - supporting health coaching, health literacy and community health checks within strategic commissioning of primary care.

6. Retain capacity to explore additional funding streams to sustain health inequalities work, for example:
    - Using Core20Plus5 seed funding to leverage match funding from other statutory partners (e.g between the ICB and LA for ATR projects)
    - From the charity sector (as was successful for additional Core20plus5 maternity funding).
    - Aligning the Core20plus5 grant with complimentary LA Public Health preventive grant programmes.
    - Exploring links with local academic institutions and Bradford Council HDCR for support with future evaluation.

7. Move to a more sustainable model of supporting community designed and led initiatives to reduce inequalities, ideally with a minimum 3 year settlement within core funding.

Recommendations for the Bradford District and Craven Integrated Neighbourhood Health (INH) programme.

8. Maintain Core20plus5 as a known ‘brand’ for funding and delivery (with a broad overall framework to address deprivation, inclusion health and moving to locally defined population health priorities).

9. Facilitate cross-place collaboration, facilitating opportunities for shared learning, innovation and peer support, within INH models.

10. Scale up good practice, continuing to invest Core20plus5 funding in high-impact areas. Key areas of promise for scaling up (within a learning network approach) are community health checks, maternity circles, interventions that improve health literacy and health coaching.

11. Recognise the time and trust required to embed community-led projects (especially those involving volunteers), to encourage trusted community roles that build self-efficacy and navigation of statutory and community services.

Purpose and aims

Background

Core20Plus5 is a national approach first launched in 2021 to reduce health inequalities. It is focused on:

- Core20: The most deprived 20% of the national population.
- PLUS: Inclusion health groups experiencing poorer than average health outcomes
- Five clinical areas of focus: maternity, severe mental illness, chronic respiratory disease, cancer diagnosis, hypertension case finding.

Figure 1 below is a graphic illustrating the national Core20Plus5 framework.

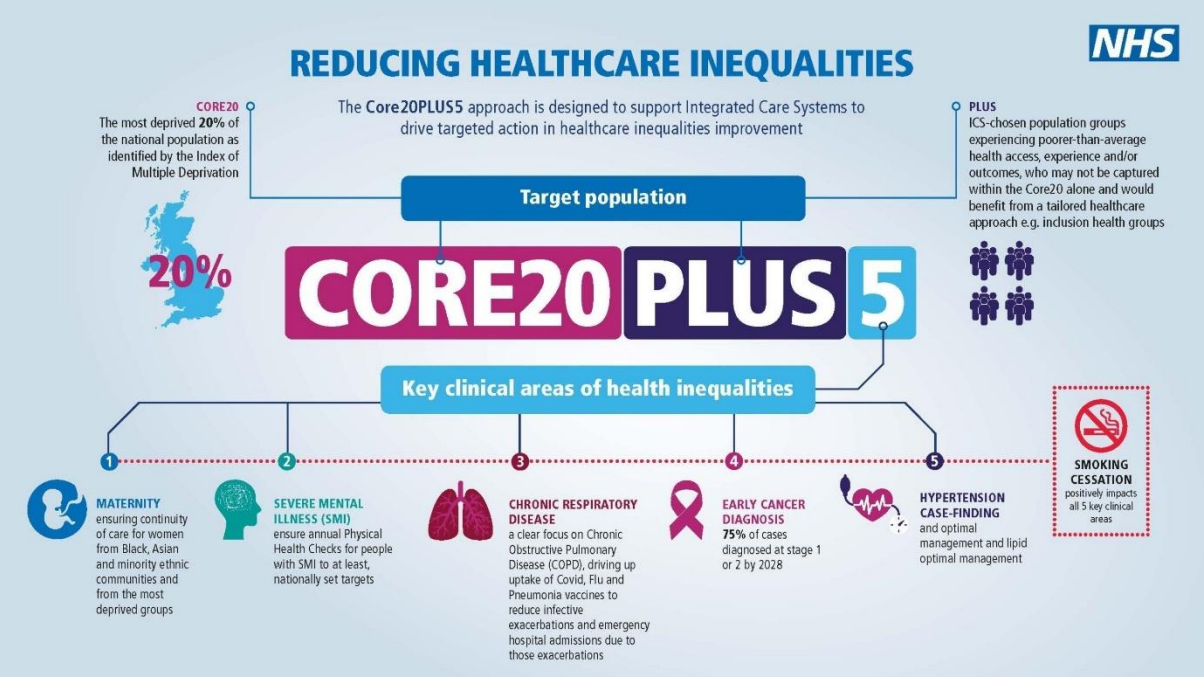


Figure 1: Core20Plus5 National Framework for Reducing Healthcare Inequalities

In Bradford District & Craven an additional sixth area was proposed by the local CorePLUS5 group to align with partnership priorities, and to address wider determinants of health. This was prevention and early help for Adverse Childhood Experiences (ACEs).

In 2022, a children and young people (CYP) Core20Plus5 framework was also released covering five clinical areas (asthma, epilepsy, oral health, diabetes, mental health). The CYP framework has not been as widely adopted as the adult one, largely because it was released after most of the planning and funding decisions had already been made (both nationally and locally). This report describes the impact and reach of the adult focused programme (see figure 1) with the additional local clinical priority of prevention and early help.

The Core20Plus5 programme in Bradford District and Craven is based on a theory of change with a supporting programme level logic model. The logic model (appendix F) describes the needs to be addressed, the activities planned and the short- and long-term outcomes anticipated from the programme.

Aims

The Core20Plus5 programme in Bradford District and Craven is part of a wider system approach to reducing health inequalities. This report is the second of two papers describing our evaluation of the Core20Plus5 programme (which has taken place over the last two and a half years). The programme evaluation seeks to address:

1. The influence and impact of the programme on a wider system of health and care partners in Bradford District and Craven (NHS, Local Authority, VCSE partners)
2. The reach and impact of the funded Core20Plus5 interventions (for residents and patients)

The first of these aims was largely addressed by our first progress report published in March 2025 which used the Ripple Effect Mapping (REM) methodology to tease out (with stakeholders) the wider strategic system impact of the Core20Plus5 programme. The main findings of the first report are presented in figure 2 below.

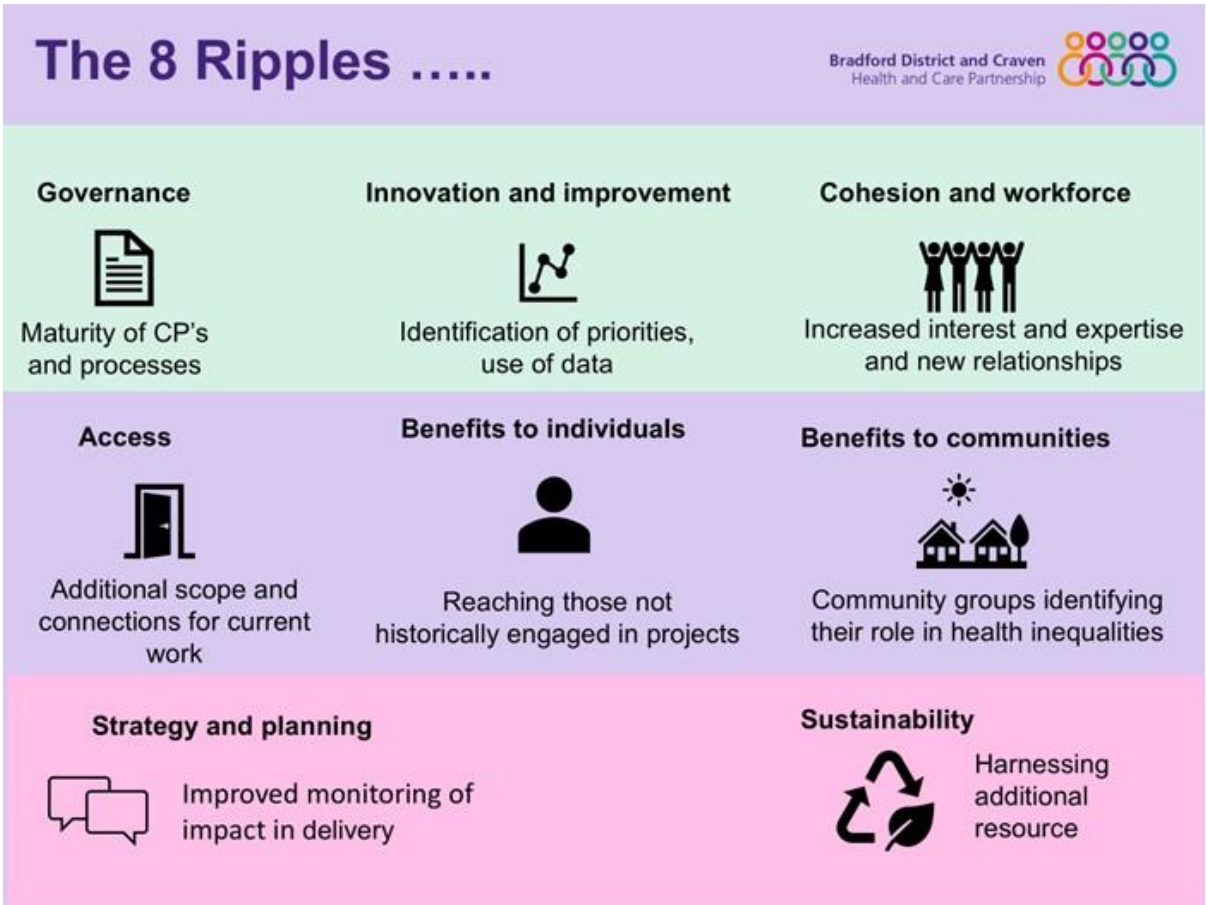


Figure 2 illustrates the '8 Ripples' identified in the first Core20Plus5 progress report.

This report will focus on our evaluation of the reach and impact of the Core20Plus5 programme in Bradford District and Craven.

Methodology

Since 2023 the Core20Plus5 preventative intervention funding, in total £1.2m per annum, has been distributed to the 13 Community Partnerships (population circa 50,000) using a weighted allocation (per capita deprived population). This resulted in funding allocations ranging from £53,000 to £122,000 across the partnerships.

Six selected community partnerships were identified as having the greatest concentration of population living in the 20% most deprived nationally (as measured by the Index of Multiple Deprivation 2019). These were given the greatest proportion of funding as well as additional capacity to set up, implement and monitor projects in the form of Reducing Inequalities Managers.

All community partnerships (Appendix A) were given the freedom to use data, evidence and community insight to determine the clinical area(s) on which they would focus their partnership's attention and prioritise interventions via ICB and Community Partnership collaboration.

This second evaluation report has used monitoring data from 66 of 73 Core20Plus5 interventions collected between April 2023 and 30 June 2025. Seven projects were not included in the evaluation due to having insufficient data because they were new or had not been implemented.

For some projects included in the evaluation demographic data collection was incomplete due to challenges relating to the nature of the project (eight projects) or because it had not been reported (13 projects).

The evaluation report is structured in two main sections.

Firstly, we address the reach of the Core20Plus5 interventions in terms of:

- Geographical Reach
- Characteristics of service users
- Deprivation and ethnicity profile
- Inclusion health groups
- Clinical priorities

We then evaluate the overall programme impact looking at the:

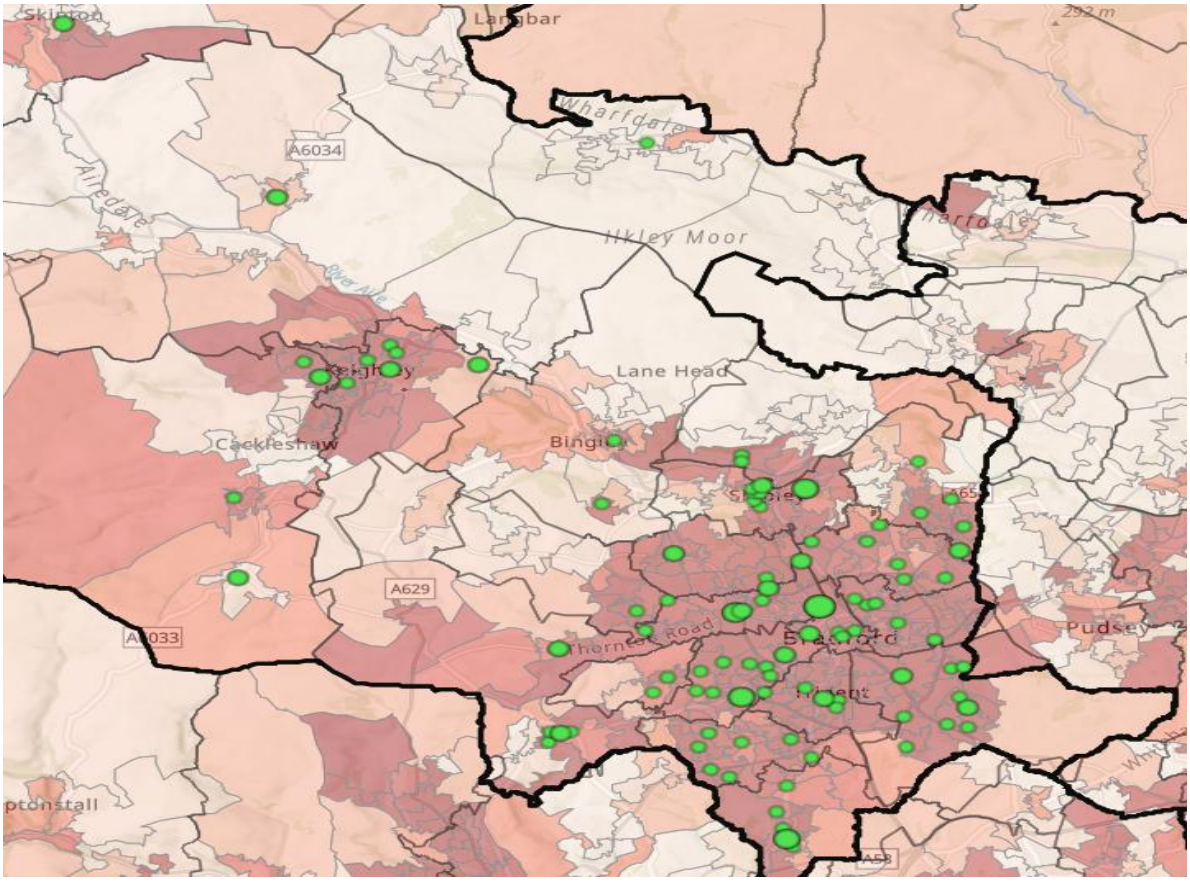
- Effectiveness of the projects delivered.
- Relative focus on reducing inequalities of the individual interventions
- Types of intervention delivered.
- Focus on connectedness and community strength
- Clinical outcomes
- Learning from the hyperlocal delivery model
- Estimated economic return

Programme Reach

Geographical reach

The map below shows Bradford District and Craven with the deprivation illustrated across the lower super output areas (LSOA). This shows the location of the organisations leading the Core20Plus5 interventions – and where there is more than one activity taking place or a suite of activities the spots become larger. The areas of higher deprivation are shown in darker red.

The map clearly shows much more activity taking place in areas of greater deprivation. This is down to two main factors, firstly, areas of greater deprivation were awarded greater resource as previously described, and secondly, that in areas of greater affluence activity was focused on more specific and smaller cohort populations in pockets of deprivation. This required greater targeting of fewer resources either by using community assets in those more deprived areas or referral/signposting methodologies to identify participants from certain postcode areas.



Map 1: Geographical location of Core20Plus5 activity by delivery site postcode.

The characteristics of those reached

Community Partnerships (CPs) implemented a wide range of projects. Figure 3 below shows that there was a wide range in how many participants have been supported by the hyperlocal projects implemented. The number of participants was not set as a target for partnerships in acknowledgement of the variable nature of both need and intensity of interventions.

The participant numbers below are indicative and represent those participant contacts for which we have data (86% of our interventions). Due to the nature of some of the hyper-local delivery it is not always possible to either count individuals or collect the demographic data on which the numbers below are based. It is also possible that individuals will be represented more than once in the data below. Therefore, this is an estimation, and we expect that the actual number of people reached across the whole Core20Plus5 programme will be greater than those presented below. In total we estimate that approximately 15, 337 people have engaged with the Core20Plus5 programme between April 2023 and June 2025.

Figure 3: Number of participants reached in each community partnership.

The Core 20 population: Deprivation

The focus for CPs has been to concentrate their interventions on improving access and service for those living in the most deprived 20% of the national population as identified by the top two deciles (20%) of the Index of multiple deprivation (IMD 1 and 2).

Bradford District is one of the most deprived local authorities in England and ranks 13th out of 317 Local Authority Districts. 34% of the District's LSOAs fall within the 10% most deprived neighbourhoods (IMD 1) with just under 50% of the population living within the 20% most deprived areas in the country (Bradford JSNA). Five community partnerships; T4H, CP5, K&WV, BD4+, HCHC, WOW have the highest proportion of their community living in these conditions. (See Appendix A for list of CP names).

Reaching into more deprived pockets of the community becomes harder where community partnerships are in areas of relative affluence (e.g. Bingley, Craven).

Figure 4 below illustrates the proportion of participants living in the most deprived 20% of England (IMD areas 1 or 2) for each community partnership.

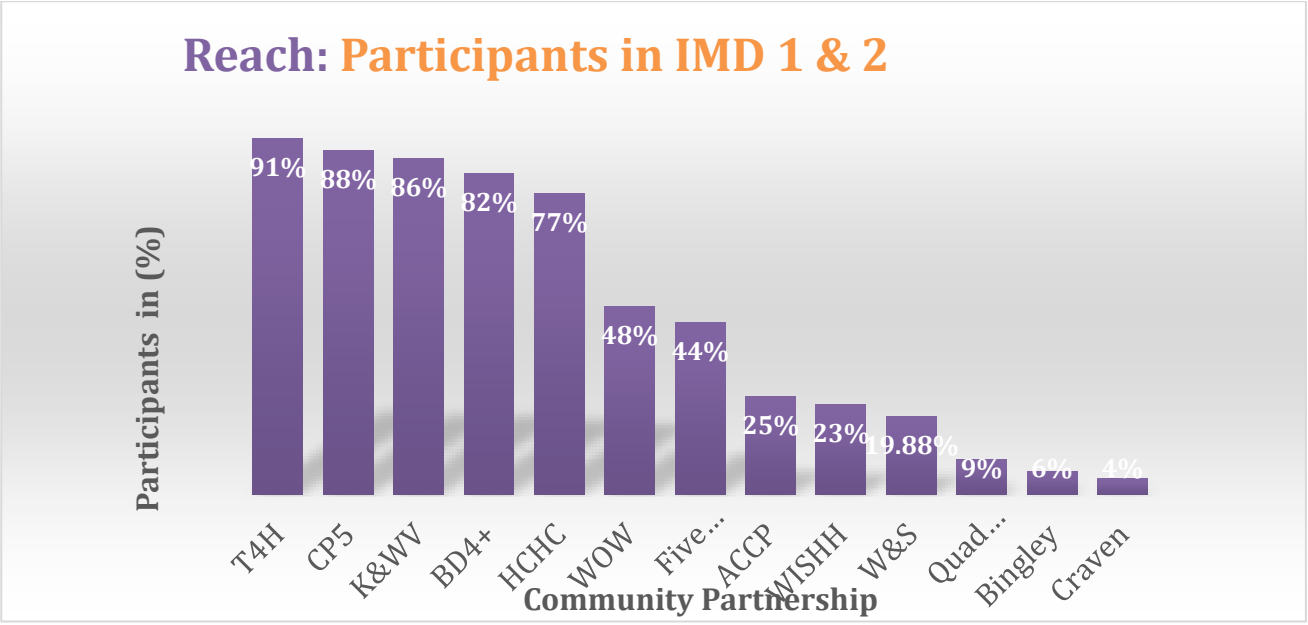


Figure 4: Participants and percentage of those reached in IMD 1 and 2

For those community partnerships with lower levels of deprivation, work has been more targeted on the pockets of deprivation that are often hidden by the data. Despite these challenges it is possible to demonstrate that the characteristics of people reached by community partnerships are representative of their general populations.

We have analysed participant numbers against the general population characteristics for each community partnership to derive a ratio of the proportion of Core20Plus5 participants in the most deprived 20% against background population in the most deprived 20%. Figure 5 below illustrates the extent to which CPs have reached a representative population. We would hope to see a ratio of 1 and above to demonstrate representativeness (ratio of 1) or above 1 where overrepresented (ratio > 1).

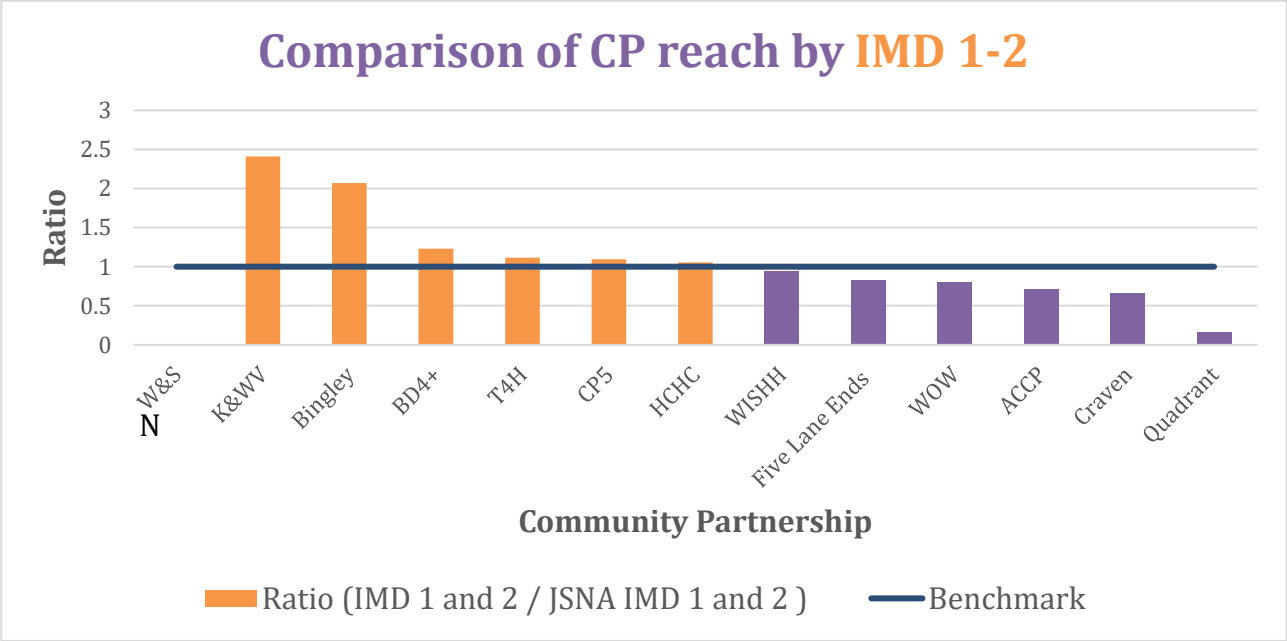


Figure 5: Comparison of CP Reach V Representative population by deprivation

In summary, Core20Plus5 projects in CPs have generally been effective at targeting those living in the most deprived areas (by LSOA). Ratios are between 0.7 and 1.3 for all except

Wharfedale & Silsden (insufficient data), Quadrant (under-represented but with a relatively low % of LSOAs in deprived areas) Keighley & Worth Valley and Bingley (where Core20Plus5 targeted above the background rate of deprivation).

The Core20 population: Ethnicity

The Core20Plus5 programme acknowledges high levels of health inequalities in people from Black, Asian and Minority groups with these populations having worse health outcomes than their White British counterparts. It is also important that we understand how intersectionality factors i.e. ethnicity, race, age, religion, gender etc, can further exacerbate inequity amongst the most marginalised in society, resulting in multiple discrimination.

As described in the Bradford JSNA the largest proportion of the population of Bradford District describe themselves as White with 61.1%, followed by those who describe their ethnicity as Asian, with 32.1%. 2.7% of the population of Bradford District described their ethnicity as mixed or multiple ethnic; 2% described themselves as Black and a further 2% were classified as other ethnic group in the 2021 census.

Figure 6 below illustrates the percentage of those people reached by each community partnership who are from Black, Asian and Minority Ethnic groups. For example, 99% of the participants reached by Together for Heath were from those target groups, followed by HCHC who had 90% of participants. Reaching into these communities becomes increasingly difficult where community partnerships are in areas with lower numbers of people from Black, Asian and Minority Ethnic groups.

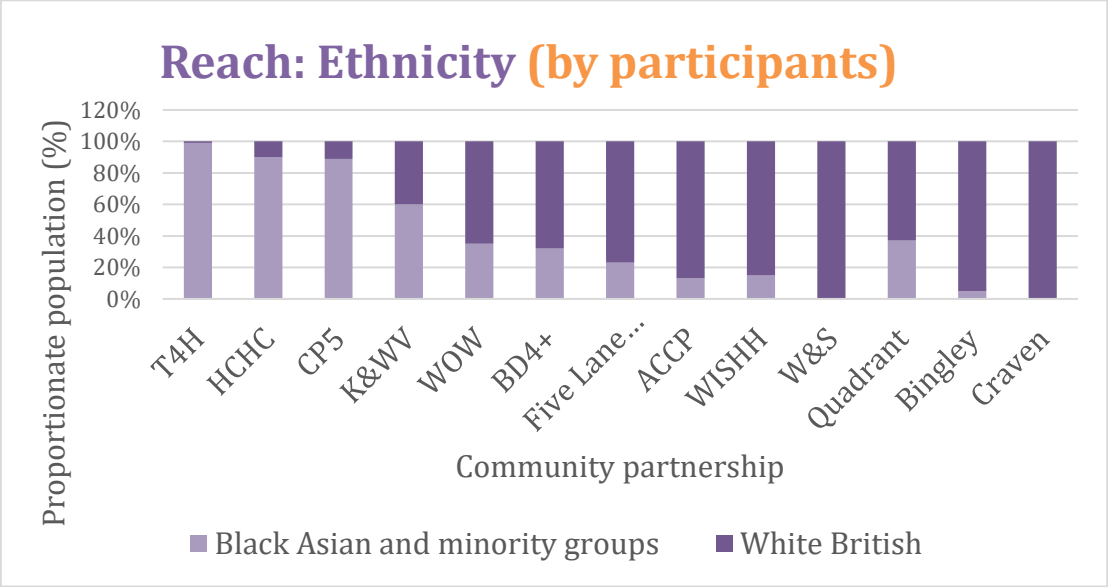


Figure 6: Participants/percentage of those reached from Black, Asian and Minority Ethnic groups.

Figure 7 below shows Core20Plus5 participant ratios comparing actual participation rates to representative populations. A ratio of 1 demonstrates representation of background minority ethnic groups in the participant numbers and ratio greater than 1 over representativeness. Most CPs have overrepresented Black, Asian and Minority Ethnic groups.

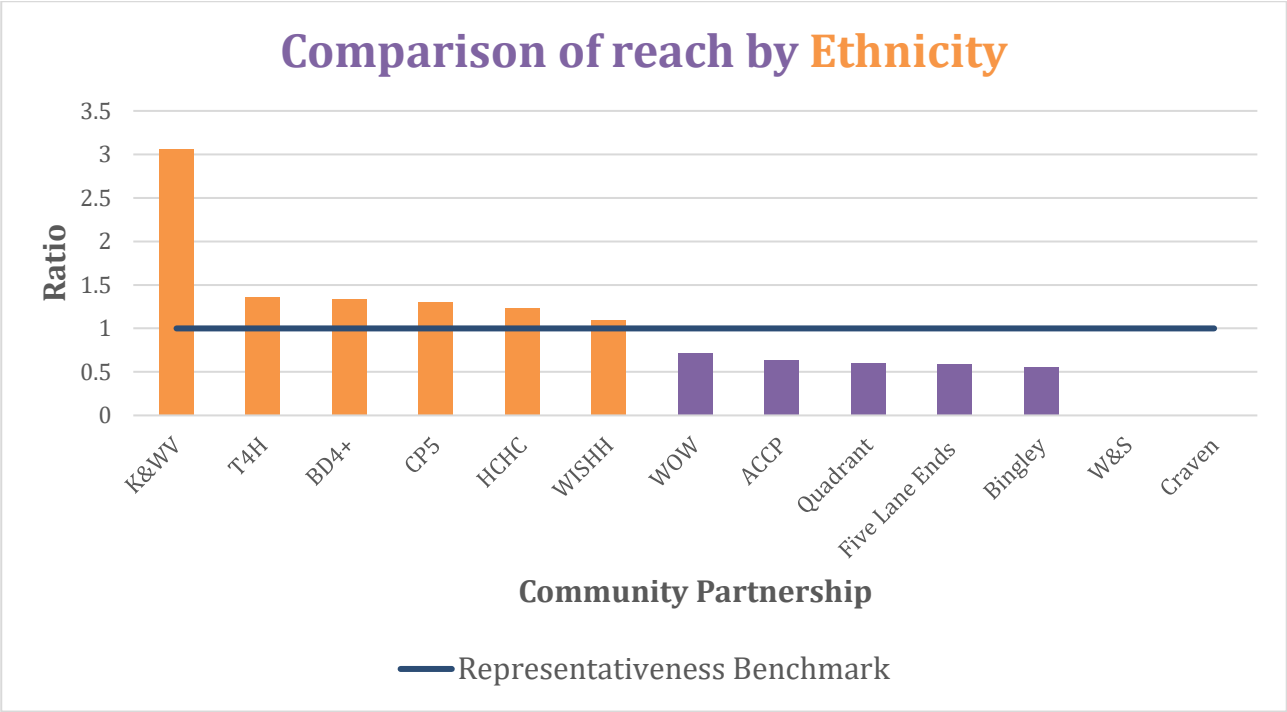


Figure 7: Participant ratios CP participant numbers compared to representative populations

The Plus groups

Within the Core20Plus5 programme, in addition to the Core20 and minority ethnic populations described above, there is also a focus on inclusion health – those population groups who are most marginalised and least likely to engage in healthcare.

The Reducing Inequalities Alliance has led an assessment of the needs of inclusion health groups in Bradford District and Craven. The inclusion health needs assessment summarises and provides an estimate for the inclusion health groups in Bradford District and Craven (estimating a total population of approx. 20,000) and makes recommendations on how best to support he needs of those groups.

The Bradford District and Craven Health Needs Assessment highlighted findings in relation to these groups:

- Homeless people – tri-morbidity of physical, mental and substance use needs is common, particularly for rough sleepers.
- Eastern European Roma – less engagement with preventative interventions and poor ethnicity recording.
- Asylum seekers and refugees - mental health needs appear to be under-reported in primary care.
- Gypsies and Travellers – self report the highest levels of “bad or very bad health” compared to people of other ethnic backgrounds.

Two community partnerships prioritised work with inclusion health groups targeting homeless, refugee and vulnerable migrant communities with additional projects targeting Roma and gypsy and traveller communities. These were funded via a participatory grant making process. The projects (shown below in figure 8) support the delivery of the key

recommendations made in the inclusion health needs assessment, notably, to 'Improve patients' healthcare literacy and trust and services' cultural competency'.

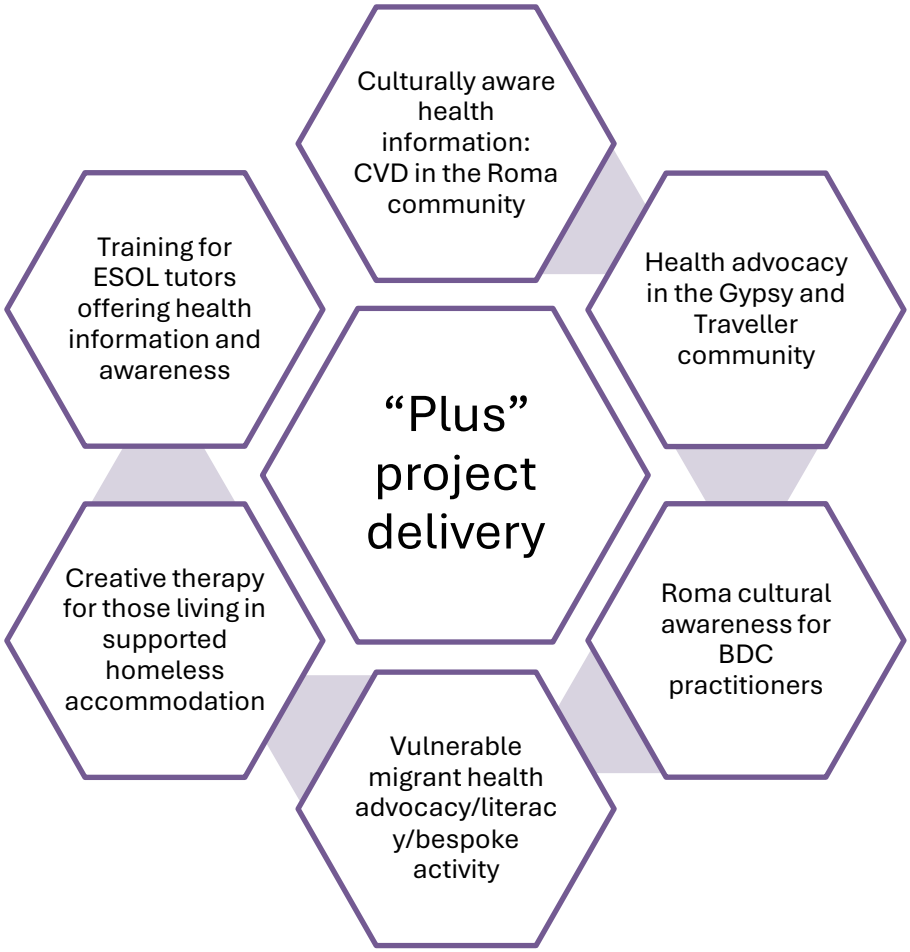


Figure 8: The projects carried out to support inclusion health groups

The projects shown above are small and targeted in nature. Learning from delivery has highlighted the need for:

- Time and flexibility to deal with the often, complex nature of individual's needs and the need to support people with issues wider than health before health interventions may be broached. This work is often focused on targeting the wider determinants of health but at the same time can have a direct impact on individuals mental and physical health.
- Relationship based models with lived experience are critical where trust can be developed over longer periods of time and more effective connections can be made. Longer term funding options are therefore important in being able to support this type of work.
- Holistic approaches that encompass motivational coaching, relaxation, sleep management, exercise and nutrition are effective in helping people to manage their stress and anxiety as a first step to being able to develop the resilience and tools to help themselves to deal with problems.

Clinical reach

The Core20Plus5 programme provided population health data to each of 13 community partnerships relating to the health outcomes in their area allowing them authority over the projects they wanted to deliver in their communities. The spread of clinical focus can be seen in figure 9 below with many of the partnerships choosing a focus on children under the adversity, trauma and resilience clinical area that Bradford District and Craven added to the framework. Partnerships also identified maternity as a focus across the district having been provided with infant mortality data demonstrating that our more deprived communities remain high nationally and in some areas is rising rather than decreasing over recent years.

The respiratory and cancer clinical areas were those with the least projects with this as a specific focus. Feedback from partnerships described an overarching desire to work predominantly in primary prevention and with projects that had a much wider focus such as wellbeing and physical activity projects rather than those targeting specific clinical outcomes.

The graphs below show the number of projects across the district focusing on each clinical area (figure 9) as well as the second table showing how each community partnership chose to spread its investment across differing clinical areas (figure 10).

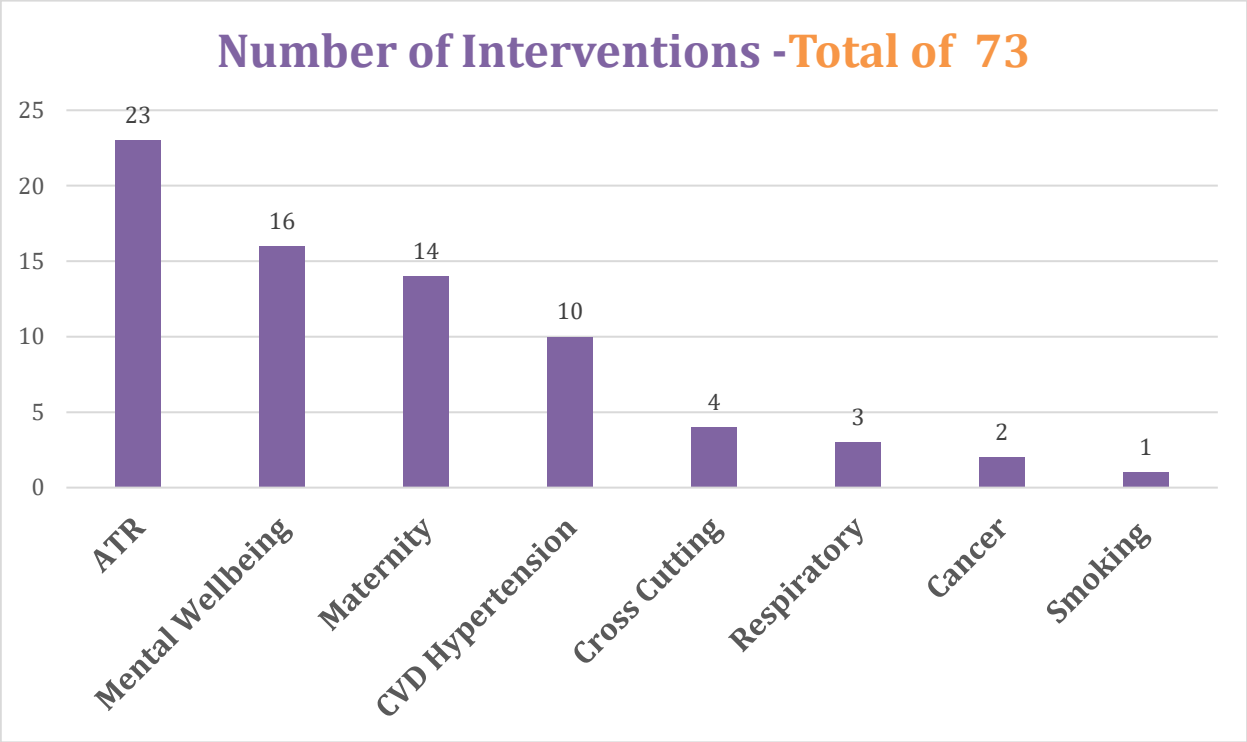


Figure 9: Number of projects delivered in each clinical area.

Figure 10 shows all community partnerships invested in interventions under the mental health priority that supporting the prevention of mental health and serious mental illnesses whereas both cancer and respiratory having fewer interventions across the district. With the proportionate distribution of funding previously described some community partnerships (as depicted on the left side of the graph) had the flexibility to implement multiple projects addressing several priorities. In contrast, others with lesser funding

(shown towards the right) opted to concentrate their investment on one or two of their top priorities (figure 10).

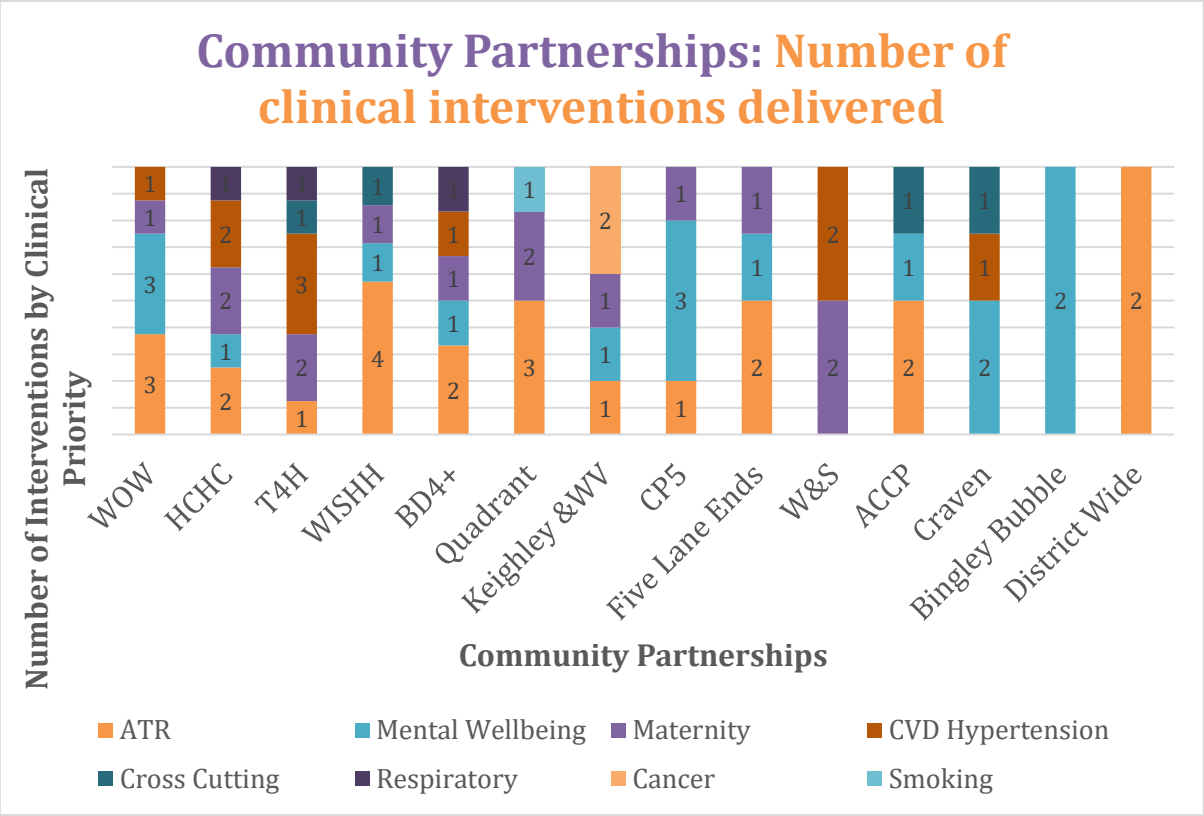


Figure 10: Split of clinical interventions across each community partnership.

Programme impact

The Core20Plus5 programme is underpinned by both a logic model which identified the short and long term outcomes from the interventions and a Theory of Change which provides an evidence based narrative as to how intervention level outcomes are expected to contribute towards programme level short and long term outcomes.

Methodology

Each intervention within the programme has been assessed in terms of impact against a set of defined criteria using a consistent scoring methodology (See Appendix B).

The aim of this exercise was to determine:

- How well activities have delivered against programme level outcomes.
- How well they have reached the target cohorts of 20% most deprived and PLUS groups.
- How well they have reached individuals from ethnic minority backgrounds, and
- If they were implemented as intended
- How acceptable they were to participants.
- How well providers were connected into wider networks and partnership.

It is important that we can use the findings from this analysis to consider what the implications may be for health care as we move forward with implementing the 10-year health plan for England 'Fit for the Future', and we have sought to:

- Categorise interventions as having a primary prevention focus, secondary prevention focuses or both.
- Identify intervention or types of intervention that have an evidence base for economic impact
- Identify those interventions that have evaluated well for addressing Inequalities and for Effectiveness coupled with evidence for economic impact.
- Identify the lessons and consideration needed to use the model in the future.

Types of Intervention delivered

The NHS 10-year plan ('Fit for the Future') defines the NHS' role in delivering secondary prevention and recognises the importance of these types of approaches over the short term to achieve financial sustainability. Vaccination, screening, and early diagnosis will be priorities and new delivery approaches – 'Prevention Accelerators' - will be tested through the Neighbourhood Health Service.

We have therefore assessed interventions according to their type – primary or secondary – using the following definitions:

- Primary prevention – proactive approaches to preventing disease before it occurs by addressing the root causes of ill health, identifying risk factors and promoting healthy lifestyles. For example, interventions that support people to take up physical activity that are not specifically targeted to people with known diagnosed conditions.

- Secondary prevention – interventions aimed at early detection of health conditions to prevent their progression and reduce complications. For example, cancer champions supporting individuals to take up cancer screening offers, community NHS health checks.
- Both primary and secondary prevention – interventions that have an element of both, an example would be health checks in the community where there is the opportunity to both identify cases of hypertension but also provide health literacy /awareness and signposting to Living Well services.

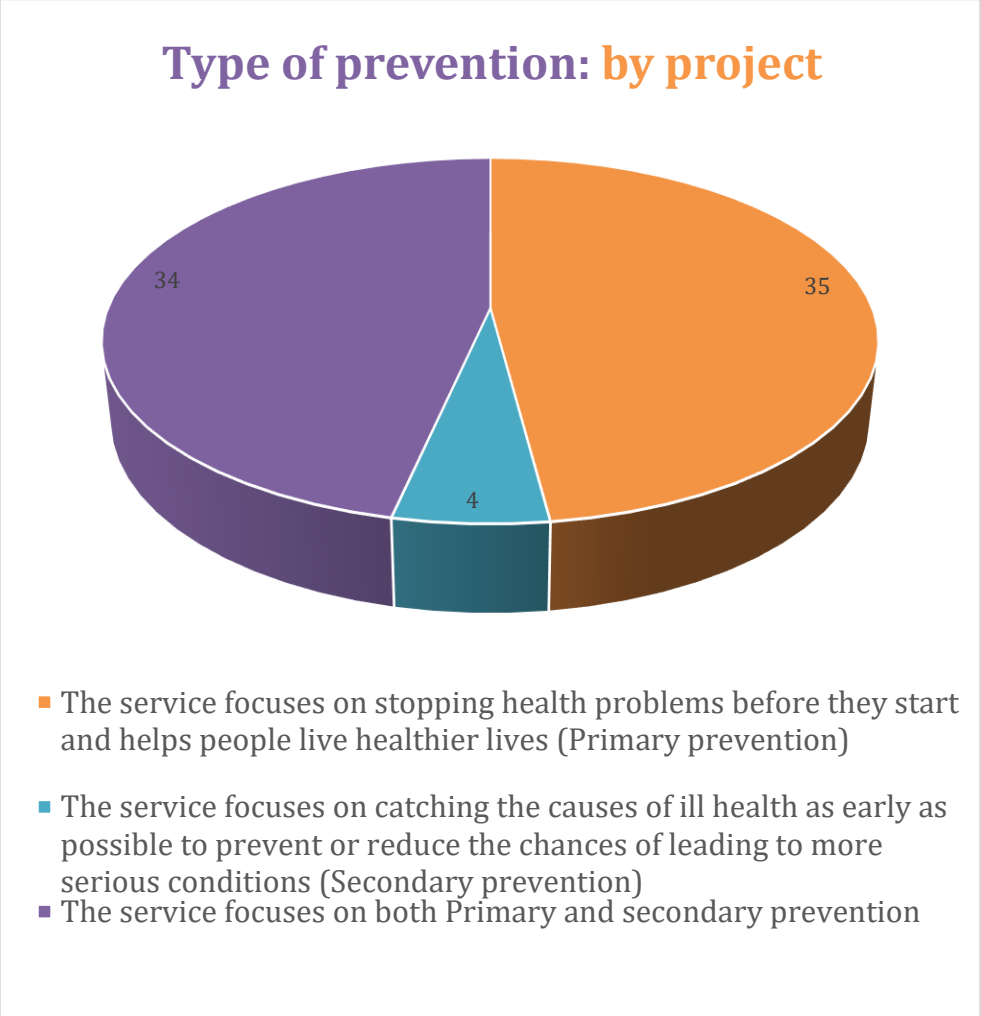


Figure 11: No of projects by type of intervention activity

Approximately half of the interventions chosen by community partnerships were focused on primary prevention choosing to keep their populations healthy, reducing risk factors for poor health and preventing the onset of ill health, helping to provide NHS financial security over the longer term (figure 11).

These projects included services that supported people to lead healthier lifestyles by addressing barriers to taking up physical education, addressing low/moderate levels of anxiety and mental health and connecting people to wider support to address wider determinants of health. Interventions that addressed health literacy and social isolation also fell into this group.

A further thirty-four interventions had a secondary prevention focus, in addition to primary prevention activities, targeting specific cohorts of people to help them manage health conditions or identify conditions early. Four projects were secondary prevention only.

Projects with a secondary prevention focus that scored the highest for effectiveness and inequalities are KCAN Cancer champions, Community Health Checks, Maternity Circles, Breathe, Health Coaching, Counselling and Recreate, Family Crisis and Respiratory Physio.

The NHS 10-year, plan recognises the challenge of variable uptake of secondary prevention interventions across the country. All these projects have been effective in targeting our most deprived populations and/or Black, Asian, minority ethnic populations demonstrating a strong potential, if delivered at scale, to address inequalities through a reduction in the unequal take up of services.

Within the 10-year plan for England there is a focus on community-led methods to tackle take up of high impact cardiovascular disease and diabetes interventions. The Core20Plus5 programme in Bradford District and Craven has developed a consistent approach to delivering community health checks and demonstrated how the offer can be replicated at scale to deliver NHS health checks within accessible community settings targeting those communities with the lowest take up. This model coupled with health literacy and health coaching approaches has significant potential to diagnose more people with underlying hypertension and diabetes and connect them to health care to enable them to manage their condition.

Effectiveness of the projects delivered

For the purposes of this report the effectiveness of interventions within the Core20Plus5 programme was defined as ‘How well the intervention has delivered against the intended outcomes as described in the Core20Plus5 Theory of change and logic model’. Every project within the programme has a corresponding logic model that identifies clearly the need to be addressed, activities, outputs and outcomes. Our understanding of impact is based upon a judgement of how well services have delivered against their individual logic models. When considering effectiveness, the project team analysed all available data both quantitative and qualitative to determine how well the project could demonstrate both intervention and programme level outcomes.

For each of the Core20Plus5 clinical priorities within the theory of change there is a set of outcomes that, if achieved at an intervention level, are likely to deliver short term change at a programme level. Most of the Core20Plus5 programmes can be linked to a clinical priority area and therefore deliver against at least one of the intervention level outcomes within a priority area, therefore not every intervention is expected to deliver against all outcomes.

All projects were scored on a scale of 1-4 with four being the highest. Those projects that delivered directly against the short term programme level outcomes as defined in the programme logic model scored the most for effectiveness (a score of 4).

As an example, the short-term outcome for cardiovascular disease is ‘More of those with hypertension will be aware of the need to attend primary care and will be taking anti-

hypertensives. More of those identified as a high risk for CVD will access lifestyle support.' Community health checks deliver directly against this outcome by identifying people with hypertension and linking them into their GP as well as providing advice and access to lifestyle support.

Projects that could not demonstrate impact against programme outcomes but could demonstrate that they had delivered against all the intervention level outcomes expected for their project (and in some cases, additional outcomes) scored a 3.

Projects that scored a 2 were those that could demonstrate that they had delivered against at least one of their intended outcomes and those that scored a 1 did not meet any of the intervention level outcomes within the theory of change that were expected for their service.

It is important to note that as activities were benchmarked against the programme theory of change, a low effectiveness score in this context does **not** indicate that a service was ineffective in delivering secondary outcomes for the population it serves.

Seven projects were relatively new to the programme they were not included in this assessment. Of the 66 projects assessed, 51 scored either a 4 or a 3 and could demonstrate that they had delivered against either the programme outcomes or all or more of the intervention level outcomes. See Figure 12 below.

A high proportion of projects were deemed effective (scoring 3 or 4) as a considerable amount of work over the last 2 years (to set up, monitor and evolve projects) has meant that less effective projects have evolved, closed early or did not mobilise.

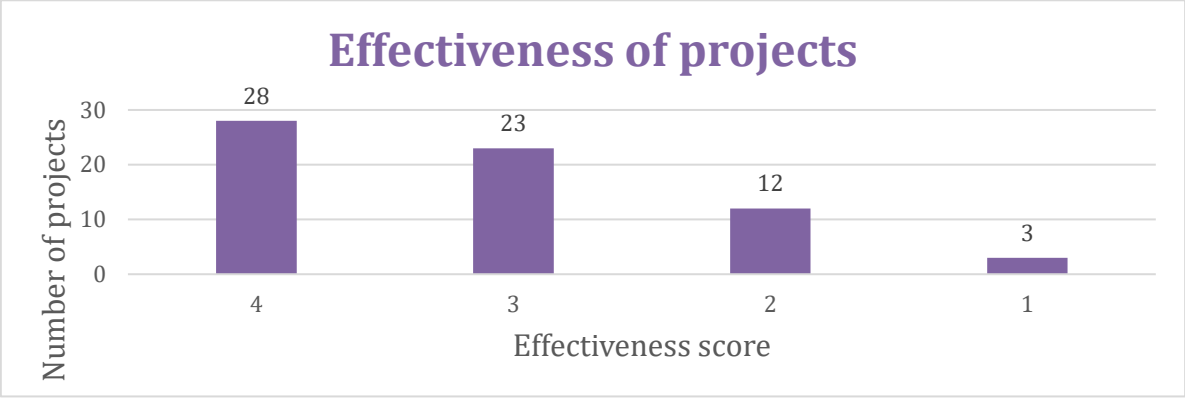


Figure 12: Effectiveness scoring by project.

Please note that scores are based on available data, incomplete data may have resulted in a lower score but does not necessarily mean that the outcome was not achieved.

The inequalities addressed by interventions delivered

The Core20Plus5 programme is a nationally defined framework for addressing healthcare inequalities where we know that people experiencing the most severe deprivation (Core20) and those from ethnic minority backgrounds or other disadvantaged groups (PLUS) will experience the greatest inequality.

It is therefore essential that we consider 'how well interventions have helped to reduce unfair differences in health between diverse groups of people.

To do this we created a Bradford Core20Plus5 inequalities index incorporating the following factors:

1. How well the intervention targeted people within the IMD 1 and 2 population groups
2. How well the intervention targeted people from other disadvantaged groups/plus population groups
3. How well the intervention addressed inequalities in access, experience, or outcome for the clinical priorities.

This approach allowed us to account for the variation in levels of deprivation and/or disadvantaged groups across the 13 CP areas ranging from areas with very small pockets of deprivation and very small ethnic minority populations to others that are largely located within deprivation areas IMD 1 and 2 with very high levels of disadvantaged groups. In addition, our approach also allowed us to accommodate those CPs with more targeted and fewer projects due to the proportionate allocation of funding.

Interventions were scored from 1-4 with the highest being four. All the above factors were considered when assessing these criteria however those projects that were located within areas of greatest deprivation and able to work with the greater numbers have the greatest capacity to address inequalities, when these interventions also impacted directly on clinical outcomes, they were awarded the highest score of 4. Thirteen projects fell into this group.

The largest number of projects (27) were scored as 3 – these projects were those that strongly targeted people in IMD areas 1 /2 or PLUS groups but were more preventative in nature (Figure 13).

Figure 13: Inequalities scoring by project.

Thirty-three of the seventy-three projects in the programme have shown to be both effective in delivering outcomes and have a strong focus on inequalities using the Core20Plus5 Inequalities index described above. Examples of the types of intervention that could demonstrate a strength (either a score of 4 or 3) for both criteria are shown in table 1 below.

Level of effectiveness	Interventions achieving this level of effectiveness
Strongest local evidence of effectiveness and reducing inequalities (Effectiveness score 4 & Inequalities score 4)	Health awareness and messaging for targeted communities Health coaching/champions and health awareness for targeted communities Health literacy for asylum seekers and refugees Smoking cessation for those with COPD using primary care data. Community health checks delivered in areas of deprivation and diversity
Some local evidence of effectiveness and reducing inequalities (Effectiveness 4 & Inequalities 3 OR Effectiveness 3 & Inequalities 4)	Physical activity in communities for targeted communities Befriending support for health advocacy Creative health intervention for those in sheltered housing Family crisis intervention Mobile Adventure Play for children and young people. Integrated young people and parents' interventions. Resilience in primary schools' projects Maternity circles Sleep interventions for primary school children. Respiratory physiotherapy

Table 1: Type of intervention against local evidence base

Connectedness and acceptability

Given the hyper local nature of the Core20Plus5 programme, with devolved funding and governance arrangements, it is important to consider how well interventions worked with wider health and care or community services. In assessing these criteria, we considered the impact at an individual, service and system level using the data and reporting available to us to assess how well interventions were able to attract participants, the development of support pathways, and how well participants were supported beyond the life of the project by signposting and referral onto other services.

As part of the assessment of impact at an individual level we also considered participant feedback data as well as actual and expected participation rates (including retention) to determine how acceptable an intervention was to the people it was aimed at.

Most of interventions in the programme could demonstrate good connectivity to wider services with corresponding good participation and retention. Projects that could demonstrate good working relationships with general practitioners (GPs) (where appropriate) were able to develop the most robust patient identification and referral pathways. Participant feedback data also indicated an elevated level of satisfaction with services and support received.

Connectivity and acceptability are important considerations when considering how health inequalities at a hyper local level may be addressed in the future. The interventions that scored highly on their ability to target health inequalities aligned to deprivation and/or ethnicity were also able to demonstrate good relationships with partners and a well-regarded intervention from an individual perspective. Strong working relationships with GPs including referral mechanisms and data sharing will enhance future hyper-local approaches to addressing healthcare inequalities.

Economic return

Core20Plus5 interventions were classified by the national Core20Plus5 priority areas, and a rapid literature search was conducted to find evidence of cost effectiveness preventative public health interventions. This was matched where possible to the Core20Plus5 interventions in Bradford District and Craven. Return on Investment (ROI) values were extracted from systematic reviews or other evidence summaries (see references in Appendix C). Where ROI values were not available other measures of cost effectiveness were used (e.g. Incremental Cost Effectiveness Ratios (ICERs).

Findings

Health economic evidence was found for two thirds of the Core20Plus5 interventions, with just over half (53%) having a matched ROI of above 1 (i.e. estimated to be cost saving to the NHS or society (increased social value)). The literature review also found evidence of cost effectiveness (defined as below the NICE threshold of £20,000 per ICER) for a further 5 interventions. See table 2 below

Rating of Core20plu5 intervention	Number of interventions	Percentage of the total
Evidence of return on investment (ROI) > 1 (i.e. cost saving)	30	53%
Evidence of cost effectiveness (ICER < 20,000)	5	9%
ICER >20,000 or ROI <1	3	5%
No evidence found or difficult to define the specific intervention (discussed elsewhere)	19	33%

Table 2 – Number of interventions demonstrating ROI

Within the evidence base, researchers use different definitions of where the potential benefit from ROI is seen (i.e. ROI could benefit the NHS, other government funded services or wider society as a whole).

Lack of evidence of does not necessarily mean lack of affect, as some areas of community and public health have not been researched extensively from a health economic perspective. There was a lack of health economic evidence covering community-based wellbeing activities involving the arts, creativity, and activity sessions; and for inclusion health groups such as homeless people and asylum seekers. Maternity and mental wellbeing (including CYP) were areas with particularly rich health economic evidence.

The average ROI across Core20Plus5 interventions for which we found applicable evidence was estimated to be 7.62 (99%CI 5.96-9.28). This is an estimated £7.62 of NHS or social value returned for £1 invested. It represents good value for money for the £1.03m per annum invested in these 30 interventions (within an estimated total financial return of £5.26m - £8.20m). The time horizon for this return was less than 5 years.

It is important not to draw too strong a conclusion from this review of cost effectiveness as local interventions are unlikely to be delivered within the exact delivery model of those referenced in research (or be based on identical populations).

Implications

The implications of these findings are that:

- The range of community-based interventions analysed here represent an opportunity to pursue the two national shifts outlined in the 10-year plan (to shift from treatment to prevention and to shift care from hospital to community settings).
- They build on the local evidence base to begin a left shift in NHS and other funding to a longer term and more preventive ethos. One where sufficient investment in areas of high inequalities could reduce demand on primary and secondary care treatment within the short to medium term.
- This work supports the developing BDC Integrated Neighbourhood Health programme focus on a locality footprint as (with some support and oversight) Community Partnerships have invested in cost effective Core20Plus5 interventions to reduce health inequalities.
- Areas of particular focus (with a supporting evidence base) are mental wellbeing (including children and young people), community-based maternity support, and community health check models (for early identification of risk factors of long-term health conditions).
- There is still work to do with some of our investment (and evaluation) to clarify the outcome and ROI we expect when collaborating with local communities.

See references for this analysis in **Appendix C**

Clinical outcomes

The clinical areas of greatest health inequality as defined in the national framework have provided focus for the Bradford District and Craven Core20Plus5 programme delivery. From the provision of population health data relating directly to these clinical areas to the delivery of preventative interventions in communities the focus has provided clarity for the hyperlocal commissioning.

To realise the ambition and derive valuable insights that can guide future actions, resource allocation and strategic planning to reduce health inequalities in Bradford District and Craven, analysis has been undertaken to be able to share specific insight into what has been learnt relating to each of the six clinical areas.

63 projects were included in this analysis, and the following snapshots collate data and intelligence to reflect the following considerations:

- Type of activity and interventions delivered.
- Projects deemed most effective following analysis of outcomes.
- Projects deemed most effective for tackling health inequalities.
- Exemplar interventions from the programme impact on the clinical area
- Cost effectiveness and evidence relating to the return on investment for the interventions.
- The impact that has been seen on the clinical indicators
- Risks and challenges identified through the delivery of the interventions.

Tables 3 to 8 below summarise the analysis for each of the clinical priority areas.

Note that ten projects were not included in this analysis because they were deemed either to have not had enough time to demonstrate an impact or were more cross-cutting in nature and not attributable to a specific clinical priority.

Maternity

Theory of change: programme outcome:

Of those women attending preventative interventions in the community more women will access their antenatal support:

Intervention level outcomes:

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

Number of projects	14
Types of projects delivered	Maternity circles Preconception training Perinatal support programmes
Type of prevention	Twelve offering both primary and secondary prevention Two offering primary prevention only
Most effective projects in meeting the short-term programme outcomes	Maternity circles delivered in locations with a diverse communities reached 94% from Black and Asian communities. Monitoring suggests these are South Asian women with very few from Black communities accessing support.
Most focused-on inequalities projects	Maternity circles delivered in locations of greatest deprivation reached as many as 94% from IMD 1 and 2 such as in Keighley and Worth Valley. In areas with a more diverse population acceptability of antenatal interventions is challenging affecting the number of participants in interventions.

Exemplar project	Maternity circles delivered in community partnerships in areas of greatest deprivation reaching 1,382 participants show how the intervention can reach women that may not access statutory services.
Are these interventions deemed cost effective?	Yes
Have they had an impact on a clinical outcome?	The rate of infant mortality is sadly rising in Bradford. We are closing the gap on women smoking at the time of delivery. We are reducing the inequality gap for the number of women booking their pregnancy by 10 weeks
Risks and challenges	1. Interventions need embedding in systems that identify pregnant women, or they can become isolated become postnatal support groups. 2. Interventions need to be delivered from and within the communities they aim to serve to meet those living in IMD 1 and 2 3. Antenatal support needs the clinical oversight of maternity services to ensure women are supported into the clinical pathways
Overall impact on this clinical priority	Maternity circles provide a social model of support during pregnancy and the post-natal period and can demonstrate participation of Black and South Asian women where they are delivered in areas with these populations. The maternity circles in this programme can demonstrate that they improve understanding of the importance of antenatal care, wider support available and provide an element of continuity to support women to take up services. Improved data collection would support an enhanced understanding of the value of this model for Black and Asian women and increased uptake of antenatal provision.

Table 3 – Summary of analysis for maternity related interventions

Adversity, trauma and resilience

Theory of change: programme outcome:

Children, young people, and their families living in IMD1 & two will be equipped with skills to support their wellbeing.

Intervention level outcomes:

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

• More children and young people in Bradford will be equipped with skills to support their wellbeing.	
Number of projects	21 (19 hyper-local interventions + 2 District wide commissions)
Types of projects delivered	Integrated CYP social prescribing models Extra curricula wellbeing and social activity and mobile adventure play Primary school resilience support models (District wide commissioned model + locally commissioned interventions) Sleep support for 2–11-year-olds (District wide commissioned model) Family crisis and welfare models Parenting support models
Type of prevention	Eighteen offering both primary and secondary prevention One offering only secondary prevention. Two offering primary prevention only
Most effective projects in meeting the short-term programme outcomes	Mobile adventure play offered in areas of greatest deprivation such as that delivered with 93% from IMD1/2 and supporting skills to support their wellbeing. Family crisis support offered in a Community Partnership (CP) area HCHC is working with 100% of participants in IMD1/2 and showing evidence of equipping families with long term skills in managing household income.
Most focused-on inequalities projects	Sleep tight BDC has adopted an approach that ensures they see children living in IMD1/2 as a priority leading to 73% of their recipients being from these homes. This focus on inequalities narrows the gap significantly.
Exemplar project	The resilience in primary school's model support children understand their feelings, delivered in only schools reaching children in IMD1/2 this model is an example of how to target inequalities through universal provision
Are these interventions deemed cost effective?	There is mixed evidence on cost effectiveness for these projects.
Have they had an impact on a clinical outcome?	The number of children being referred to CAMHS continues to rise rapidly post Covid and this is a continuing picture with this rising from 4,332 in 2022 to 8,166 in 2025.
Risks and challenges	1. Interventions need to focus on a whole family approach to ensure improved home conditions.

	2. Strategies need to be embedded in universal services to be acceptable to families
Overall impact on this clinical priority	All interventions have demonstrated that they can support children and families to equip them with skills to build resilience and support their own wellbeing with effective targeting of those children and families within areas of greatest deprivation.

Table 4 – Summary of analysis for adversity, trauma and resilience related interventions

Chronic respiratory disease

Theory of change: programme outcome:

More of those from deprived areas will be able to get a Flu/COVID19 vaccine in a community venue.

Intervention level outcomes:

- More people to be aware of the risk factors associated with COPD and be equipped to manage their condition protecting against acute exacerbations and emergency hospital admissions.
- More people with COPD to be connected to smoking cessation services.
- More young people will be aware of the risks associated with COPD and be more active. More people will be aware of the benefits of taking up vaccinations.
- More people will be connected to support to address the wider socio-economic determinants of health as a protective factor against stress, anxiety, and depression.

Number of projects	3
Types of projects delivered	Respiratory Physio Support for smoking cessation targeted at people with asthma and COPD
Type of prevention	Both primary and secondary prevention activities
Most effective projects in meeting the short-term programme outcomes	Multiple projects in CP areas have supported smokers with COPD aiding them to connect to and engage in smoking cessation services
Most focused-on inequalities projects	Both projects are effective at addressing inequalities. 84% of Respiratory Physio participants live in IMD1/2 areas.
Exemplar project	CP projects are examples of how support can be targeted to people with long term conditions (COPD) who smoke. A good example of achieving high engagement from people living in IMD1/2 to support them to access smoking cessation services.

Are these interventions deemed cost effective?	Respiratory physio and smoking cessation interventions have evidence for cost effectiveness and economic return on investment.
Have they had an impact on the clinical outcomes?	Both projects have the potential to support the respiratory clinical outcome by reducing exacerbations and emergency admissions to hospital by helping people to manage their COPD although a direct causal relationship cannot be established.
Risks and challenges	Strong working relationships with PCNs with access to data and patient lists are necessary for both interventions to target cohorts effectively.
Overall impact on this clinical priority	Both projects target people with COPD and support them to be aware of the risk factors associated with their condition and manage/improve their condition. Breathe supports people to access and engage in smoking cessation services and encourages take up of vaccinations.

Table 5 – Summary of analysis for chronic respiratory disease related interventions

Mental wellbeing and severe mental illness (SMI).

Theory of change: programme outcome:

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

Intervention level outcomes:

- More people to lead healthier lifestyles protecting against developing/worsening physical health conditions.
- More people will be supported to manage their low/moderate levels of mental health issues protecting against developing SMI (for those at risk) and equipping them to access the support that is available to them when needed.

Number of projects	13
Types of projects delivered	Creation of videos featuring mental health showcases Counselling/talking therapy sessions/soul art to improve wellbeing and mental health. Working with refugee/asylum seekers to promote understanding and increase access to services. Supporting older people with mental health awareness Volunteer befriending Holistic health approach to prevent severe mental illness.

	Non-medical triage and direct access into wider support services Promotion of brain health/dementia support Health and wellbeing support for men.
Type of prevention	7 interventions offer primary prevention only. 5 offer both primary and secondary prevention. 1 intervention offers secondary prevention only.
Most effective projects in meeting the short-term programme outcomes	Although none of the projects specifically target people with SMI - Counselling and recreate and Refugee Health worker projects have told us that they have worked with people with SMI to support them with accessing support to manage their physical and mental health and wellbeing.
Most focused-on inequalities projects	3 projects have demonstrated that they can work with a high proportion of people from IMD 1/ 2 areas with participant rates ranging from 85-100% from these groups. Two projects that target refugees and vulnerable migrants have high participation from people from Black, Asian minority ethnic backgrounds
Exemplar project	Refugee Health Worker Project
Are these interventions deemed cost effective?	There is some evidence for ROI for 6 of the 13 projects relating to counselling/talking therapies, befriending and dementia support activities.
Have they had an impact on the clinical outcome?	Projects that work with targeted cohorts more likely to be living with trauma and subsequently SMI have the greatest potential to support people into services to ensure they receive sufficient health checks and support to manage their physical health. 2 projects have been able to demonstrate this.
Risks and challenges	There are already local initiatives working with people with SMI and mental health problems – therefore to best use resources future funding should consider how these existing projects (if they remain) may be further supported and enhanced by hyper- local approaches to address inequalities and aligned more closely with the local 'family' of mental health services (Healthy Mind).
Overall impact on this clinical priority	Although the uptake of health checks for people with SMI are increasing, we cannot state a direct causal relationship with the interventions within the Core20Plus5 interventions have supported mental wellbeing in community settings for a variety of inclusion health groups (and both adults and children).

Table 6 – Summary of analysis for mental wellbeing and severe mental illness related interventions

Early cancer diagnosis

Theory of change: programme outcome:

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

Intervention level outcomes:

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

Number of projects	2
Types of projects delivered	Video creation in various languages to support community awareness. Community champions /cancer awareness raising and messaging.
Type of prevention	Both projects offer primary prevention 1 project offers primary and secondary prevention.
Most effective projects in meeting the short-term programme outcomes	Both projects support increased uptake of routine cancer screening through culturally appropriate health messaging. Cancer champions can provide a more targeted offer that has demonstrated an increased uptake in cancer screening.
Most focused-on inequalities projects	90% of the Cancer champion/health messaging participants live within IMD 1 / 2 areas of deprivation with 65% being of Black, Asian, Minority ethnic background.
Exemplar project	Cancer champions demonstrate the importance of peer led, relationship-based approaches to delivering targeted culturally appropriate health messaging and support. A good example of how this approach can lead to tangible results.
Are these interventions deemed cost effective?	There is a lack of robust published research on the ROI of this type of intervention work. There is, however, some indication that Cancer champion type activities may be cost effective, particularly for colorectal cancers
Have they had an impact on the clinical outcome?	Local data for Modality PCN indicates that there has been a 2.51% increase in Cervical screenings for women aged 25-49 since 23/24 and 8.7% in cervical screenings for women aged 50-64 since 23/24.

Risks and challenges	Volunteering models of support offer strong, peer to peer engagement based on trusted relationships. Critical to the success of these models are: • Ongoing recruitment, training and support for volunteers • Dedicated capacity to engage, recruit, train and co-ordinate champions • Strong relationships with PCNs/GPs where the aim is to support people to take up health services.
Overall impact on this clinical priority	Cancer champions have been effective in supporting more people to access routine health screenings and increase health awareness and health literacy with a particular focus on women's health within minority ethnic communities.

Table 7 – Summary of analysis for early cancer diagnosis related interventions

Cardiovascular disease

Theory of change: programme outcome:

More of those with hypertension will be aware of the need to attend primary care and will be taking hypertensives. More of those identified as high risk for CVD will access lifestyle support.

Intervention level outcomes:

- More people access activities for their physical health.
- More people understand the importance of lifestyle choices.
- More people will have access to health checks in the community.
- More people will be aware of the importance of monitoring hypertension and diabetes.
- More people will be connected to support

Number of projects	10
Types of projects delivered	Community health checks (CHC) Health coaching/messaging Physical activity
Type of prevention	4 offering both primary and secondary 6 providing primary prevention only
Most effective projects in meeting the short-term programme outcomes	CHC and health coaching models have demonstrated they can improve access to activities to improve health awareness as well as providing access to the NHS health check. Monitoring from health checks show evidence of participants being

	identified with CVD risk and accessing lifestyle support as a result.
Most focused-on inequalities projects	CHC delivered in areas of greater deprivation have shown to reach in HCHC 79% of those in IMD 1 and 2 and 99% from Black, Asian and Minority ethnic groups.
Exemplar project	Successful projects had community organisations leading health coaching and messaging alongside a CHC model. The intervention includes diverse activities including on site physical activity, nutrition, health education alongside use of a BP machine and local leader advice
Are these interventions deemed cost effective?	Yes with strongest evidence being for the community health checks and health coaching models.
Have they had an impact on the clinical outcome?	Local clinical indicators show a 3-year trend that we are closing the gap in identifying hypertension and treating those identified to target. Hypertension prevalence remains the same across the district.
Risks and challenges	1. CHC models need to be connected to primary care clinical systems to allow follow up activity. 2. Funding for CHC needs to be area and setting specific, based on local data.
Overall impact on this clinical priority	Health checks delivered in the community have proved effective in engaging the most deprived populations. Hypertension case finding can be evidenced with effective follow up by GPs contributing to more people being managed to target.

Table 8 – Summary of analysis for cardiovascular disease related interventions

In addition to the interventions commissioned at a hyper-local level the programme has also invested in district wide or common approaches to address healthcare inequalities.

Addressing inequalities in Covid19 and Flu vaccine take up

Through the Core20Plus5 programme we have provided a focus on targeting the low uptake of vaccinations within some of our populations, with a specific focus on Covid19 and Flu during the winter vaccination programmes for 23/24 and 24/25. Action to target this has included the provision of vaccination ‘pop-up’ clinics in community and faith centres, a mobile vaccination offer in public spaces, and community outreach and engagement via a community champion model.

The community champion model is a scalable model with emerging indication of effectiveness in addressing vaccine hesitancy amongst minority ethnic groups in areas of greatest deprivation within Bradford. The model includes one-to–one conversations and community outreach to address concerns regarding Covid19 and Flu vaccinations. Data collected from follow up conversations suggests that approximately 50% of one-to-one conversations lead to a vaccination.

Adversity, trauma and resilience:

In the autumn of 2022 as the programme was being designed there was no Core20Plus5 framework for children and an additional sixth clinical area was added to the Bradford District and Craven approach incorporating 'Adversity, Trauma and Resilience' acknowledging the impact intervening early in children's lives can have on their long-term health outcomes, covered below.

Following a process of prioritisation with children and young people's system leadership in the district two priorities were identified - **wellbeing and resilience in primary schools** and **sleep support** for children aged 2-11 years old. The impact of these two district wide commissions on the clinical area of Adversity and Trauma has been easier to capture due to their larger level of investment and therefore scale and is in addition to the impact delivered through hyper-local interventions.

The sleep service has reached 657 children. The universal sleep service is seeing 77% of children from the targeted areas of IMD 1 and 2 with an average of 97% of those families receiving support from reporting progress in their children's sleep. The service has used an equity-based model with families with postcodes in areas of greatest deprivation being expedited for one-to-one support whilst those from more affluent areas are provided with resources and group-based support whilst waiting much longer for their one-to-one intervention.

The wellbeing in primary schools' service has reached over 35,000 children and has also described considerable impact on the children it has reached, all of whom attend a school predominantly serving children living in households in IMD 1 and 2. More detail on this service's reported impact can be found on the myHappymind website.

Population health trends

Appendix D summarises the last three years' worth of data (mainly from primary care) for the whole of Bradford District and Craven. We have included a judgement of the 3-year trend and whether the inequality gap is widening or closing. It is important to note that our Core20Plus5 interventions are quite small in scale and are in specific parts of Bradford District and Craven. So, it is important to not draw causation between these interventions and population trends covering our total population (670,000 people). Core20Plus5 has been part of a combined effort with other NHS, VCSE, LA and community efforts to improve health and reduce inequalities. Nevertheless, we need to inspect and monitor these trends to identify areas to prioritise and increase whole system buy in to improving.

Summary of trends

Trend	Impact seen within clinical priority areas
Inequalities reducing	**Maternity:** The % of mums booking into maternity before 10 weeks is improving (negligible inequality gap by deprivation and reducing gap by ethnicity). **SMI:** Annual physical health check completeness for people with SMI is increasing and there is no inequality gap

	Respiratory: Flu vaccination uptake is improving **Smoking:** Adult smoking rate & smoking during pregnancy is falling gradually (the inequality gap has narrowed slightly)
No significant change	**Cancer:** Cancer screening uptake is lower in deprived areas, but with slow improvement in overall breast /bowel cancer screening rate
Inequalities widening	**Maternity:** The infant mortality rate in Bradford District is rising **COPD:** Pneumococcal vaccination uptake rate is falling (and the inequality gap is widening) **High blood pressure:** The inequality gap in the % of patients with well managed blood pressure is not closing

Table 9 – Summary of trends in impact seen within clinical priority areas

Learning from the hyperlocal delivery model

Ripple effect mapping, an evaluation method designed to ascertain both intended and unintended consequences, was used as part of the programme evaluation and development. The process allowed 8 key themes to emerge that have contributed to the learning from the Core20Plus5 programme. The key benefits of the Core20Plus5 programme (for community stakeholders) are illustrated in figure 14 below:

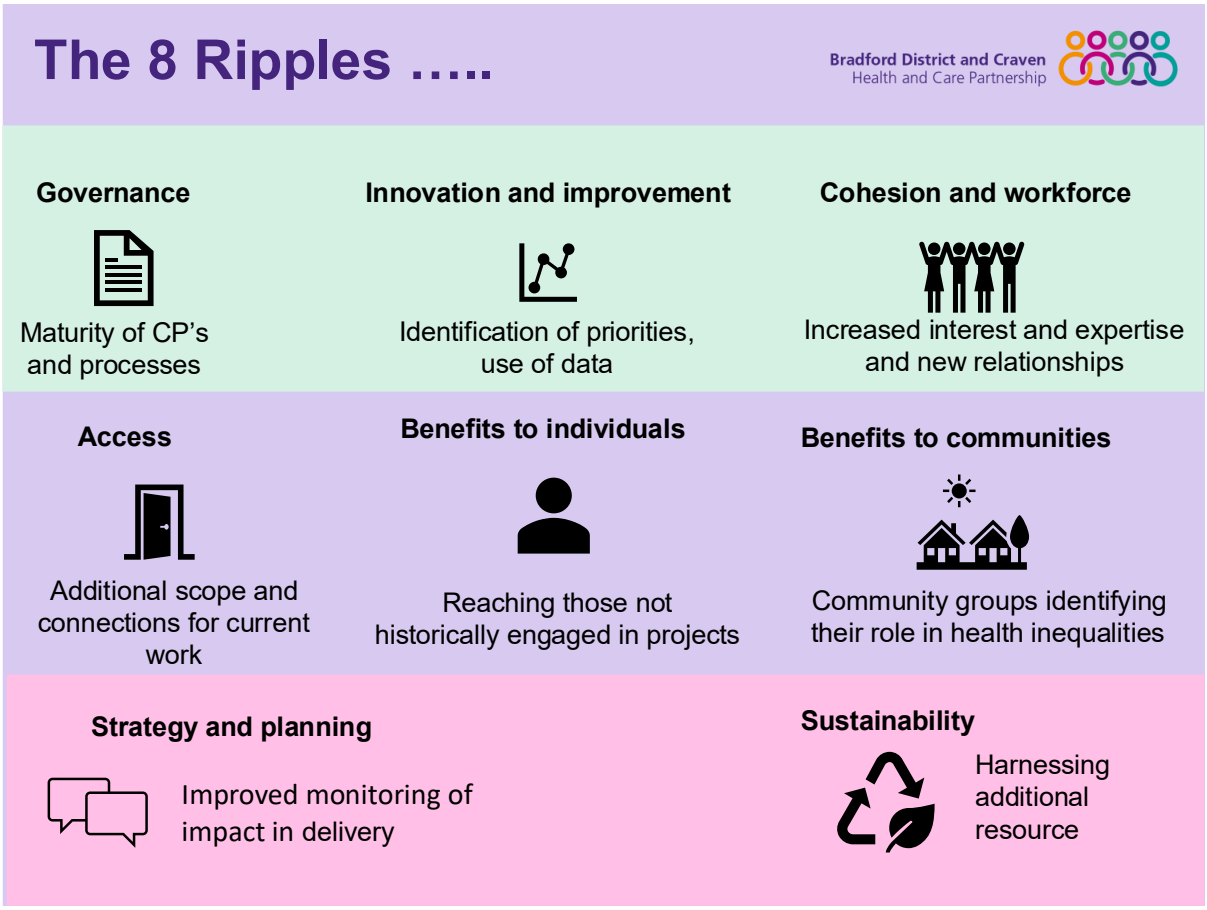


Figure 14: Key benefits for community stakeholders

The programme aimed from the very beginning to be able to share the learning from the model the programme used for delivery. Alongside the impact described already there have been several challenges worthy of consideration in a future of using hyperlocal commissioning to tackle health inequalities. The following summary of challenges have been drawn from both project level feedback and the ripple effect mapping with stakeholders.

- Considerable time needs to be taken to undertake true co-production and merge this with a commitment to an evidence-based approach.
- Community infrastructures need to be given time to mature and be effective decision makers, without this it is difficult to both prioritise and commission local provision.

- Restrictions of the Core20Plus5 framework (that has specific clinical outcomes) can lead to frustrations in meeting identified community needs. Some communities identify challenges outside the framework and would have appreciated freedom to make choices entirely independent of the framework.
- Providing monitoring data to support learning can be difficult especially if this is a new demand on a service. Small grass roots organisations often receive small funding allocations and have small teams making data collection an additional burden to delivery.
- There can be an administrative burden of such a broad diverse portfolio of projects especially where there are small resource allocations to a broad range of providers offering NHS services for the first time.
- Developing models with lived experience and volunteers can be challenging to deliver and can take time requiring empathy and understanding in short term outcomes.
- Building skills and capacity in community organisations and partnerships takes resource and capacity from the system and support networks.
- Innovative models of delivery can be difficult to monitor for participation and impact despite often being based on qualitative evidence that needs to be set against more formal quantitative monitoring processes.

Main findings and recommendations

Main findings

- Between 2023-2025 the Core20Plus5 programme reached over 14,000 people across the district, employed 48 paid and 39 volunteer staff, and implemented 73 different initiatives focused on prevention and reducing inequalities.
- Core20Plus5 has demonstrated the value of devolved decision-making to Community Partnerships (CPs) to identify priorities and design interventions based on local populations needs.
- The programme has built capacity, strengthened local leadership, and fostered innovation in tackling health inequalities.
- It has demonstrated that targeted efforts to reduce health inequalities through hyperlocal and community-led interventions can identify priority cohorts (by deprivation, ethnicity and inclusion health groups). Data from our Core20plus5 providers shows that the programme has been broadly successful in reaching target groups most at risk of poor health outcomes.
- Evaluation of the programme's impact reveals promising outcomes in both primary and secondary prevention, with many interventions showing effectiveness in improving access, experience, and health literacy among disadvantaged groups.
- The emphasis on relationship-based models, cultural competency, and holistic support (taking a bio-psychosocial approach) has proven essential in engaging inclusion health populations (such as refugees, Roma communities, and those experiencing homelessness).
- The flexibility afforded to Community Partnerships enabled tailored approaches that reflected local needs, resulting in a diverse portfolio of pilot projects to build on and scale up where the local evidence base was supportive.
- The scale of individual interventions was modest relative to the whole population. However, the collective learning demonstrates potential to integrate these approaches into wider system efforts to support equitable health improvements.

Characteristics of those reached

- The programme successfully targeted areas of high deprivation: over 80% of participants in the five most deprived CPs lived in IMD quintiles 1 and 2, demonstrating effective reach (Figure 4).
- In the six CPs identified for greatest investment, between 50–90% of participants were from IMD1&2, supporting our proportionate universalism approach to funding across our 13 CPs.
- There was high representativeness from Black, Asian and minority groups in areas with a high proportion of these groups, e.g. 99% of participants in Together for Health, 90% in Horton City Health Collaboration and 60% in Keighley & Worth Valley (Figure 6).

- Inclusion Health groups (such as vulnerable migrants, gypsy and traveller communities, Roma, and homeless populations) were supported through culturally competent, relationship-based interventions. These projects showed promising engagement, though further evaluation is needed to assess long-term impact.

Effectiveness and value

- Of the 73 projects delivered, 33 were deemed effective (in terms of addressing their initial aims) and focused on reducing inequalities in target populations (particularly in deprived and diverse communities).
- High-performing interventions included health literacy and awareness campaigns, health coaching for target communities, smoking cessation for COPD patients, targeted wellbeing in primary schools, a universal sleep service for CYP and health checks in community settings (Table 1).
- Other interventions that show promise were maternity circles, physical activity for target groups, befriending and advocacy models, respiratory physiotherapy for those with COPD and broader models of crisis intervention for target groups.
- The average return on investment (ROI) for interventions developed by CPs was £7.62 per £1 invested (99% CI: £5.96–£9.28) [estimated by matching international evidence to individual interventions rather than undertaking health economic analysis for each intervention]. This suggests strong social and economic value from the Core20Plus5 community focused funding.

Connectedness and acceptability

- Successful interventions demonstrated strong relationships with local partners and high levels of acceptability among participants, particularly in areas of high deprivation.

Clinical priority areas

- **Maternity**: Maternity circles were well received in diverse communities, especially among South Asian women. Further integration with NHS maternity systems is needed for them to meet their potential.
- **Adversity, trauma, and resilience**: Interventions for children and families in IMD1&2 areas supported resilience through sleep, school, crisis, and parenting support. Embedding these into universal services is key.
- **Respiratory**: Respiratory physiotherapy and smoking cessation services for targeted groups have the potential to contribute to improved clinical outcomes and reduced hospital admissions.
- **Mental wellbeing & SMI**: Public mental health interventions expanded access to digital support, counselling, and targeted services for specific groups including older adults, dementia patients, and men.
- **Cancer**: Community-led awareness and culturally tailored messaging increased screening uptake.

- **CVD**: Health coaching and community-based NHS health checks improved awareness and access, though stronger links to primary care systems are needed for follow-up.

System impact

Ripple Effects Mapping (REM) with partners revealed broader system consequences of the Core20plus5 programme, including:

- **Governance**: Improved decision-making and assurance processes within CPs.
- **Innovation**: Locally driven priorities based on evidence and insight.
- **Workforce**: Expanded membership and new partnerships.
- **Access**: New service entry points and deeper reach into marginalised groups.
- **Strategy**: Enhanced monitoring, evaluation and awareness of value-for-money.
- **Sustainability**: Opportunities to attract additional resources beyond Core20Plus5.

Challenges

- Time is needed to align true co-production with a commitment to evidence-based investment.
- Community partnership infrastructures progressed at a differential rate in terms of developing into mature, adaptive and effective decision-making bodies.
- Restrictions of the Core20Plus5 framework (to specific clinical outcomes) led to frustrations in meetings to identify community needs, as challenges and innovative project ideas were identified outside the Core20Plus5 framework.
- Providing monitoring data to support learning and evaluation imposed an administrative burden on some small grass root organisations.
- There is a considerable administrative and management burden for such a broad diverse portfolio of projects (from the commissioner), to move resource allocation to evaluation and shoring up longer term funding.
- Developing locally led models using lived experience and volunteers can be challenging to deliver within short time constraints (trust and empathy are essential).
- Building skills and capacity in community organisations to evolve and maintain Core20Plus5 partnerships is worthwhile but is challenging in an NHS environment of constant organisational change (with some staff reduction).
- Innovative models of delivery can be difficult to monitor for participation and impact despite, often being based on qualitative evidence that needs to be set against more formal quantitative monitoring processes.

Recommendations

As the district moves forward with the NHS 10-year plan and broader system transformation, the Core20Plus5 programme provides a robust foundation for embedding inequality-focused approaches into mainstream prevention and health and care delivery.

In making these recommendations (February 2026) we have drawn on a West Yorkshire wide 'Review of Core20PLUS5 funding' (WY ICB, November 2025) and the developing Bradford District and Craven Integrated Neighbourhood Health programme (as a natural home for implementing some of these findings). We are also mindful of the forthcoming WY ICB restructure and reduced BDC place teams that currently provide support and oversight of the Core20plus5 programme.

Recommendations for Bradford District and Craven new NHS structure and leadership (ICB Integrator team and provider partnership):

12. Promote the distribution and use of digestible population health data (showing clear variation in outcomes) at community level, to support local needs led decision making.

13. Maintain an equity-led approach to health inequalities resource allocation within Core20plus5 or equivalent grant funding (due to the 22 year difference in healthy life expectation across the District).

14. Given the reduction in local commissioning capacity in the ICB, contract a lead VCSE provider to deliver Core20plus5 grant funding and evaluation (with ICB support and oversight to transfer Core20Plus5 momentum into the Integrated Neighbourhood Health programme).

15. Given Community Partnerships pivotal role in developing Core20plus5 interventions with VCSE partners, maintain sufficient ICB infrastructure support to retain these neighbourhood structures and 'engine' rooms for ABCD.

16. Embed areas of interventions where we have seen multiple successful interventions into longer term and more strategic programme areas, for example:
    - maternity circles within Bradford District's Family Hubs and Start for Life programme
    - school based interventions within a wider District Adversity, Trauma and Resilience programme (ICB and LA Public Health)
    - sleep service within longer term neurodiversity pathway planning
    - supporting health coaching, health literacy and community health checks within strategic commissioning of primary care.

17. Retain capacity to explore alternative finding streams (external to the ICB) to sustain health inequalities work, for example:

- Using Core20plus5 seed funding to leverage match funding from other statutory partners (e.g between the ICB and LA for ATR projects)
- From the charity sector (as was successful for additional Core20plus5 maternity funding).
- Aligning the Core20plus5 grant with complimentary LA Public Health preventive grant programmes.
- Exploring links with local academic institutions and Bradford Council HDCR for support with future evaluation.

18. Move to a more sustainable model of supporting community designed and led initiatives to reduce inequalities, ideally with a minimum 3 year settlement within core funding

Recommendations for the Bradford District and Craven Integrated Neighbourhood Health (INH) programme.

19. Maintain Core20plus5 as a known 'brand' for funding and delivery (with a broad overall framework to address deprivation, inclusion health and moving to locally defined clinical priorities).

20. Facilitate cross-place collaboration, facilitating opportunities for shared learning, innovation and peer support, within INH models.

21. Scale up good practice, continuing to invest Core20plus5 funding in high-impact areas. Key areas of promise for scaling up (within a learning network approach) are community health checks, maternity circles, interventions that improve health literacy and health coaching.

22. Recognise the time and trust required to embed community-led projects (especially those involving volunteers), to encourage trusted community roles that build self-efficacy and navigation of statutory and community services.

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Appendices

Appendix A: List of Community Partnerships and Abbreviations

Abbreviation	Community Partnership	Locality
ACCP	Affinity Care Community Partnership	All
BBCP	Bingley Bubble Community Partnership	Shipley
WISHH	Windhill, Idle & Saltaire Happy and Healthy Community Partnership	Shipley
W&S	Wharfedale & Silsden Community Partnership	Keighley
CCT	Craven Communities Together	Craven
KWV	Keighley & Worth Valley	Keighley
FLE	Five Lane Ends Community Partnership	Bradford East
CP5	Central 5 Community Partnership	Bradford East
T4H	Together4Health Community Partnership	Bradford West
HCHC	Horton & City Health Collaboration Community Partnership	Bradford West
Quadrant	Quadrant Community Partnership	Bradford West
WOW	Working on Wellbeing Community Partnership	Bradford South
BD4+	BD4+ Community Partnership	Bradford South

Appendix B: Project prioritisation criteria

Criteria	Effectiveness
Definition	How well the intervention has delivered against the intended outcomes as described in the Core20Plus5 Theory of change and short-term programme outcomes as described in the Logic model
Key questions	How well has the intervention delivered against the theory of change?
Consideration	Is there an indication that the intervention has delivered against the Programme level outcome defined in the logic model? Is there an indication that the intervention has delivered against any of the intervention level outcomes defined in the Theory of Change? What evidence is there to support this? Is evidence quantitative or qualitative?
Example	
Assessment	Scoring 1-4 (see individual effectiveness matrices for each clinical priority)

Criteria	Implementation
Definition	How well the intervention was delivered in the way it was intended.
Key questions	Was the intervention delivered as expected?
Consideration	Did the intervention deliver all the activities that it intended and were these delivered in the original timescale? Were there any aspects of the intervention that had to change because they were not working and did these impact on the expected outcomes? Did the intervention reach the number of participants anticipated?
Example	An intervention intended to deliver 3x12 week programmes of activity to thirty-six people over 12 months, although the programme needed to make some changes to delivery content the changes did not impact on the intended outcomes. The intervention still delivered the expected number of sessions for the expected number of people and so was implemented effectively
Assessment	Yes - the intervention has delivered what it intended to do in the timeframe that was indicated No - the intervention either did not deliver what it intended to do or did not deliver within the timescale envisaged

Criteria	Impact on Health Inequalities
Definition	How much the service helps reduce unfair differences in health between different groups of people.
Key questions	To what extent doe the intervention address health inequalities as defined by the Core20Plus5 framework?
Consideration	Does the intervention target people from disadvantaged IMD areas 1 or 2? Does the intervention target people from disadvantaged/plus population groups? Does the intervention address inequalities in access, experience or outcome for Core20Plus5 clinical areas? How firmly does the intervention address the clinical priorities? Does it impact directly on the specific indicator or is it more preventative in nature? Does the intervention address the inequalities specific to a CP geography as highlighted through the data?
Example	A Health check intervention is delivered in a CP area where the data shows there are inequalities in outcome for people with CVD. The CP sits within IMD area 1 where people may have less access to healthcare or find it more difficult to get to appointments (e.g. they are unable to afford to travel). By offering free check-ups, it reduces the gap in health outcomes between this community and wealthier areas. The intervention is identifying high BP cases and therefore impacts directly on the clinical priority outcome. This project would be scored a 4
Assessment	1 - the intervention addresses inequalities aligned to CP specific health inequalities as highlighted in the data but does not target IMD1/2 or plus groups. 2 - the intervention targets inequalities in access/experience or outcome for the clinical priorities but does not target IMD1/2 or inclusion health groups. 3 - the intervention targets IMD1/2 or inclusion health groups but is a more preventative approach to addressing the clinical priority areas. 4 - the intervention targets IMD1/2 or inclusion health groups and is expected to impact directly on the clinical priorities.

Criteria	Prevention (Primary)
Definition	How much the service focuses on stopping health problems before they start and helps people live healthier lives

Key questions	Does the intervention have a primary prevention focus?
Consideration	Does the intervention support people to live healthier and make healthier lifestyle choices regarding exercise, nutrition, smoking cessation, risky behaviours?
Example	Prevention means stopping people developing any illnesses or health conditions by supporting them to take actions to stay and live well. A diabetes prevention programme teaches healthy eating and exercise to people at risk of diabetes. As a result, fewer people develop the condition, showing that it focuses on prevention.
Assessment	Individual judgement Yes / No

Criteria	Prevention (Secondary)
Definition	Catching the causes of ill health as early as possible to prevent or reduce the chances of leading to more serious conditions.
Key questions	Does the intervention have a secondary prevention focus?
Consideration	Does the intervention seek to identify health conditions such as High blood pressure, cancer, diabetes (including gestational) mild to moderate mental health issues, including maternal mental health, (that could escalate to serious mental health issues), respiratory conditions. Does the intervention target a cohort of people with existing long-term conditions to help manage the condition and prevent escalation?
Example	Identifying high blood pressure early and working to treat people to target reduces the chances of more serious cardio-vascular disease.
Assessment	Individual judgement Yes / No

Criteria	Acceptability
Definition	How much the people the service is aimed at like and accept it, making it more likely to succeed – the intervention can demonstrate a high % of participants indicating satisfaction with the service
Key questions	Is there an indication that the intervention is liked by participants?
Consideration	What % of participants are satisfied with the service? Is the service well attended? Does the service retain participants or is there a large degree of drop off?
Example	A mental health support group is well-attended, and participants feel comfortable sharing their experiences. This shows that the service is

	accepted by the people it's designed to help, making it more likely to succeed
Assessment	Yes - the service is well attended with good retention and a high % of participants tell us they are satisfied. No - the service is either not well taken up/people do not continue to be engaged (if appropriate) or are dissatisfied with the service.

Criteria	Connectedness
Definition	How well the intervention works with other health and care services/community organisations that may use the service or provide further support once the service intervention is complete.
Key questions	Is there an indication that the intervention is well linked into the organisations it needs to be to deliver the service to the expected number of people and to link them to ongoing support if required?
Consideration	How does the intervention attract participants, referral, signposting, publicity/word of mouth etc Have referral pathways been developed and agreed with referring agencies if appropriate? Does the service receive the expected level of participation If not – why not? Is this due to a poor relationship or understanding/awareness of the service? Does the service refer onwards to other support and how well do this work with partners?
Example	An intervention receives referrals from GPs, Community organisations and self-referrals and these are regularly received in sufficient quantities. There are also clear pathways identified to move people onto to further support.
Assessment	Yes - the intervention is connected to all necessary organisations. No - the intervention is not sufficiently connected, and this is impacting on the service in terms of participation and ongoing support for individuals

Criteria	Building Community Strengths
Definition	How much the service helps communities become stronger by giving people the tools to look after their own health or make use of local community services to get the help they need.
Key questions	Is there an indication that the intervention serves to strengthen the community in some way?
Consideration	Does the intervention build individual knowledge/learning/capacity to make healthy lifestyle choices or manage their own health?

	Does the intervention build capacity within communities/community organisations to support people with the own health or connect people to health or wider support services?
Example	An intervention trains and support volunteers to engage with their community to raise awareness of healthy lifestyle choices. A community centre is supported to work with the community to develop health and wellbeing projects increasing access to and use of the centre by the community.
Assessment	Yes - the intervention can demonstrate one of the above considerations No - the intervention does not meet any of the above.

Criteria	Cost-effectiveness
Definition	How much value the service provides and the likelihood that it saves money in the long run.
Key questions	Is there an indication of cost-effectiveness?
Consideration	What has been delivered for what cost? Is there any evidence for Return on Investment?
Example	Community health checks delivered in community settings have been effective in identifying people with high blood pressure and referring them on for follow up at their GP. Each health check event costs £x and will typically identify x number of cases to refer to a GP. Evidence suggests that by identifying BP early it will save money in future emergency hospital admissions and elective admissions.
Assessment	Yes - the intervention meets both the criteria above No - the intervention does not meet the criteria above

Appendix C: References for Return on Investment

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Appendix D: Population Health Trends

C20P5 Clinical Priority	Metric	BI Data Source	Reporting period	Previous year value 12months ago	Current value	Three Year Trend*	Comparison to Y&H	Inequalities trend	RAG rating
Deprivation	Deprivation Score	NHSE Data	Jul-25	36.2	35.46	▼		Closing the Gap	
Inclusion	Ethnicity Estimate	Fingertips	2021	29.7%	37.2%	▲			
Inclusion	% with a learning Disability	CP Dashboard	2025-26	0.8%	0.8%	↔		Same Gap	
Inclusion	% with 2 or more long term conditions	Fingertips	2023	12.70%	12.8%	↔	15.1%		
Maternity	Rate of infant mortality	National	2020-2022	6.4	6.8	▲			
Maternity	% booking before 10 and 18 weeks	WY ICB dashboard	Jun-25		68.60%	▲			
Maternity	Smoking at the time of delivery	WY ICB dashboard	Jun-25		10.70%	▼			
Maternity	Pertussis vaccine uptake	WY ICB dashboard	Jun-25		53.00%	▼			
SMI	Prevalence	SMI dashboard	Q1 2024-2025	11.72	11.88	↔			
SMI	Completeness of annual health check (SMI)	SMI dashboard	Q1 2024-2026	62.1%	63.5%	▲		Closing the Gap	
COPD	Prevalence	Fingertips	2023/24	2.0%	2.0%	↔	2.30%		
COPD	% on COPD register with Flu Vaccination in current year	CP Dashboard	Q1 2025-26	76.1%	76.2%	▲		Same Gap	
COPD	% on COPD register with 2nd COVID Vaccination in current year	CP Dashboard	Q1 2025-26	91.2%	90.5%	▼		Same Gap	
COPD	% on COPD register with record of Pneumococcal Vaccination ever	CP Dashboard	Q1 2025-26	78.5%	78.1%	▼		Widening Gap	
COVID	Covid Booster % eligible vaccinated	COVID Campaign data	Spring 25	51.9%	48.1%	▼	51.80%		
Flu	Flu vaccine uptake	Flu Dashboard	24 Mar-25 to 30 Mar-25	41.9%	40.9%	▼			
Cancer	People aged 60-74 screened for bowel cancer in last 30 months	CP Dashboard	Feb-25	69.5%	70.0%	▲	72.30%	Same Gap	
Cancer	People aged 50-70 screened for breast cancer in last 36 months	CP Dashboard	Feb-25	59.9%	58.7%	▲	66.90%	Same Gap	
Cancer	People aged 25-64 attending cervical screening within target period	CP Dashboard	Jun-24	67.1%	67.4%	↔		Same Gap	
Hypertension	Hypertension prevalence	CP Dashboard	Q1 2025-26	14.7%	15.2%			Same Gap	
Hypertension	% of patients aged 18 and over, with GP recorded hypertension, in whom the last blood pressure reading (measured in the preceding 12 months) is below the age-appropriate treatment threshold	CP Dashboard	Q1 2025-26	17.4%	17.2%	↔		Closing the Gap	
Hypertension	% of patients aged 18 and over with no GP recorded CVD and a GP recorded QRISK score of 20% or more, on lipid lowering therapy	CP Dashboard	Q1 2025-26	37.5%	35.8%	▼		Closing the Gap	
Smoking	QOF prevalence	Fingertips	2023/24	18.1	17.7	▼		Same Gap	
Smoking	Smokes setting a quit date as a rate of smokers aged 16+								
ACEs	Number of children in relative low-income families	Fingertips	2023/24	43.4%	44.2%	▲	30.4%		
NHS Health Checks	Percentage of NHS Health Checks received by the total eligible population in the quarter	Fingertips	Q1 2025/26	2.3%	2.0%	▲			

*Three-year trend is based on the direction of travel over three years

RAG rating Key

	Trend data is getting worse OR trend data is showing no change and widening the inequalities gap
	Trend data is not improving, but closing inequality gap OR trend data is getting better but widening the inequalities gap
	Trend data is getting better and closing the inequalities gap

Appendix E: Abbreviation table

ATR	Adversity, Trauma and Resilience
BDC	Bradford District and Craven
BME	Black and Minority Ethnic
BVCSE	Bradford Voluntary, Community and Social Enterprise (sector)
CAMHS	Child and Adolescent Mental Health Services
CHC	Community Health Checks
CP	Community Partnership
COPD	Chronic Obstructive Pulmonary Disease
CVD	Cardiovascular Disease
DNA	Did Not Attend (appointments)
ICB	Integrated Care Board
IMD	Index of Multiple Deprivation
INH	Integrated Neighbourhood Health
JSNA	Joint Strategic Needs Assessment
KCAN	Keighley Cancer Awareness Network
LA	Local Authority
LSOA	Lower Super Output Area
NHSE	NHS England
NHS	National Health Service
PHE	Public Health England
RIA	Reducing Inequalities Alliance
REM	Ripple Effects Mapping
ROI	Return on Investment
SMI	Severe Mental Illness
VCSE	Voluntary, Community and Social Enterprise

Appendix F: Logic Model for the Core20Plus5 porgramme

Key Needs to be Addressed	What we will do (activities)	How we will do it (actions)	How we will know we have done it (outputs)	How we will know we have made a difference (S-T outcomes)	How we will know that we have reduced health inequalities (L-T outcomes)
ICSs are all expected to see a measurable improvement in healthcare service access, experience, and outcomes in their 'Core20PLUS' population, thus reducing avoidable mortality					
Women from BAME communities have poorer pregnancy outcomes than others with a 4x higher risk of dying in pregnancy in England.	Support organisations and develop services working with pregnant women from BAME communities to take up antenatal services and access wider support	Work with the best 1001 days programme in providing preventative interventions in the community for pregnant women from BAME communities.	Targeted preventative interventions for BAME pregnant women are in place in communities otherwise not served.	Of those women attending preventative interventions in the community more women will access their antenatal support	Fewer BAME women will experience complications in labour and there will be fewer lower birth weight babies from this community.
In Bradford more than 30% of deaths of people aged 50-69 were attributed to smoking (2019). In Bradford people in routine and manual occupations are nearly 3x as likely to smoke as those in other occupations resulting in worse health and premature mortality.	Collaborate with public health on the tobacco strategy to ensure smoking cessation services meet the needs of the target population.	Ensure the tobacco strategy has a focus on the target populations and access for these groups to smoking cessation is considered throughout.	Core20 population receiving additional smoking cessation services proportionate to the need identified in data.	Services will be proportionate to need with more access to smoking cessation in communities identified as higher risk.	Smoking prevalence in deprived communities is decreasing
In Bradford district people with SMI are more than 3x as likely to die prematurely than people without SMI. Financial hardship can be both a cause and a result of mental illness.	Primary care and VCS organisations will consider suitable access for those with SMI to their annual health checks	Co-produce accessible and relevant communications and deployment of skilled staff in acceptable venues to improve uptake of the health check with the target population.	More of those with SMI will be receiving their annual health check in a way in which is accessible for them including smoking cessation.	There will be a reduction in undiagnosed conditions for those with SMI that access preventative support in their community	More of those with SMI will receive their annual health check and a reduction in un-diagnosed conditions including improved access and support for long term conditions
In the 20% Bradford and Craven practices with the most deprived populations only 23.2% of eligible people receive a flu vaccination compared with 61.6% in the 20% practices with least deprived populations. Only 54.4% (most deprived 20%) but 81.1% (least deprived 20%) have received a 1st COVID vaccination.	Influence strategy and work through communities increase access and understanding of vaccines.	Improve messaging about vaccines using trusted community voices and increase the amount of outreach into communities to access vaccines	Increased year on year offer of vaccine in community settings and reported decrease in vaccine uptake hesitancy using community intelligence.	More of those from deprived areas will be able to get a vaccine in a community venue.	Vaccine uptake in deprived communities increases and for those with increased risk from additional vulnerability e.g. COPD and chronic respiratory disease
People from the most deprived communities are more likely to get cancer, be diagnosed at a late stage for certain types of cancer and to die from the disease. In Bradford district 48% of premature mortality from cancer and 45% of lung cancer incidence is linked to deprivation.	Create opportunities for communities to understand cancer screening and lung health checks to improve uptake and early diagnosis	Provide communities with culturally sensitive information on cancer screening and improve access to screening using VCS partners	Targeted cancer champions are in place in CP's with a cancer priority and prevention interventions are including education on cancer screening.	Attendance at routine cancer screening and lung health checks in Primary care will improve for those target communities not currently attending.	Early diagnosis of cancer is increasing in deprived communities and lung cancer screening is more readily available in target areas.
27% of the gap in life expectancy for men and 23% of the gap for women between most and least deprived populations in Bradford is due to cardiovascular disease (2020/21).	Increase the amount of people knowing their BP and accessing the NHS health check through community-based health checks and preventative interventions eg. weight, physical activity projects	Maximise the opportunities in communities to improve access to community health checks and preventative projects.	There is a consistent offer of ways to receive your NHS health checks in target communities. Improved acceptable opportunities for physical activity, availability of healthy food, smoking cessation and alcohol support in areas of deprivation.	More of those with hypertension will be aware of the need to attend primary care and will be taking anti hypertensives. More of those identified as high risk for CVD will access lifestyle support.	More people with high blood pressure will be diagnosed in deprived communities decreasing the risks from CVD
24% of Bradford's population are under 15 (highest percentage in Yorkshire and Humber). Approximately 22% of children in Bradford experience income deprivation. In Bradford 6,890 households are affected by the national 2 child limit on benefits (3rd highest in UK). High deprivation increases risk of adversity and trauma, significantly contributing to disease burden.	Collaborate with the district Adversity Trauma and Resilience programme to acknowledge the influence of poverty and increase resilience in CYP in the most deprived areas.	Implement locally enhanced and district wide evidence-based programmes that support families at risk and increase resilience in children. Maximise investment in areas of greatest need in co-production with CYP and families.	Communities have access to culturally appropriate family support with proportionately more provision in areas of deprivation. Increased local support for pregnant women and young families in need of welfare and social support	Children and families living in IMD 1 and 2 will be receiving additional support to improve access and their experience of social and emotional support. Schools' data will show an improvement in attendance.	More CYP and families at risk of the impact of deprivation will be accessing local support when needed and living in improved home conditions and CYP in Bradford will be equipped with skills to support their wellbeing.
Bradford investment of core20plus5 funding is utilised according to need and to address health access, experience and outcomes and sustainability plans are discussed and prepared before the end of the program	Provide data and evidence to communities and CP to improve access to preventative interventions and screening for those in target communities. Seek opportunities for external/alternative funding.	Recruit and embed additional resource (5 RI managers) in the HCP and communities to focus on inequalities with provision of regular data to inform delivery. Present Core20 projects in appropriate priority boards.	Implementation of preventative interventions and strategies to tackle inequalities in communities. Clear opportunities for funding identified across other funders.	Improvements in health behaviour and outcomes through more people accessing screening and interventions to promote health improvement	Data and intelligence is consistently used to make well informed decisions on supporting access, experience and outcomes for residents in Bradford