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Report of the Director of Public Health CBMDC, the Strategic Director of Adult and Community Services CBMDC, the Strategic Director of Children's Services and the Director of Collaboration NHS Airedale, Wharfedale and Craven, Bradford City and Bradford Districts CCGs to the meeting of the Health and Wellbeing Board to be held on 29th July 2014.

Subject: **D**

The Health Inequalities Action Plan (HIAP)

Summary statement:

The purpose of the HIAP is to identify and implement priority actions that have the potential to reduce inequalities in health outcomes experienced between different populations within Bradford district, and between Bradford district and other parts of the UK. Addressing health inequality requires action over the short, medium and long term. This report focuses on areas within the sphere of influence of the Health and Wellbeing Board.

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Portfolio:

Adult Services and Health

Overview & Scrutiny Area:

Health and Social Care

1. SUMMARY

1.1 The HIAP aims to identify and implement priority actions that have the potential to reduce inequalities in health outcomes experienced between different populations within Bradford district, and between Bradford district and other parts of the UK.

1.2 Addressing health inequality requires action over the short, medium and long term. This report focuses on areas within the sphere of influence of the Health and Wellbeing Board.

2. BACKGROUND

2.1 In December 2011 a meeting of the full Council noted the high level of health inequalities in Bradford Metropolitan District. The Council recognised that improving health outcomes for residents was one of the most important challenges the district faces and asked the Shadow Joint Health and Wellbeing Board (SHWBB) and its successor body to develop a HIAP for Bradford District.

2.2 In January 2012, the SHWBB agreed a framework for the Bradford and Airedale Joint Health and Wellbeing Strategy (JHWS) that would include a HIAP. The JHWS was approved at the 19th March 2013 meeting of the SHWB and the HIAP agreed at the 19th September 2013 meeting of, what was now, the Health and Wellbeing Board (HWBB)

2.3 The priorities in the JHWS are grouped under the six policy objectives described by Sir Michael Marmot in 'Fair Society, Healthy Lives'. The HIAP follows this approach and is made up of commitments (actions) to reduce health inequalities against the 18 priorities identified in the JHWS.

2.4 The HWBB and the Bradford District Partnership (BDP) agreed an overseeing partnership for each of the 18 priorities in the HIAP. The partnership took responsibility for identifying and agreeing the commitments for each of the 18 priorities and performance indicators that would help to understand the progress in these areas. The performance indicators were mainly taken from the National Outcome Frameworks for public health, adult social care and the NHS with additional local standards where appropriate.

2.5 Each of the partnerships has reviewed progress against the performance indicators for the priority or priorities they oversee and has provided a summary for the year to end March 2014.

2.6 'Health Inequalities' are the differences in the health of different parts of the population. For example people in more deprived areas may have a shorter life expectancy than in more affluent areas. Differences may also occur between groups of people related to other factors such as gender, disability, ethnicity or those with caring responsibilities.

2.7 The issue of how to reduce 'health inequalities' is complex. Some describe it as a 'wicked' issue because of a number of complicating factors:

- there are no clear solutions
- a number of organisations are required to co-ordinate their approach, in order for the situation to be addressed
- evidence of the extent and nature of the problem can be incomplete, or contestable, or both
- there may be disagreement about the cause of the issue, and therefore how it might be addressed
- it can be hard to ascertain that improvements are being made

- although short-term interventions can be introduced, their impact may not be felt for a long time
- the issue may never be solved completely; the greatest aspiration may therefore be to *reduce* the extent of the problem
- because of the long-term nature of the issue, external influences (such as technological change or new evidence) can mean changes to long-term policies and programmes
- it can be difficult to reach agreement around the geographical area over which inequalities are measured. With some indicators of health and wellbeing, the whole of Bradford and district may appear very similar – and yet the inequalities *within* Bradford may be so stark that they merit local attention and action
- the greatest inequalities can occur in aspects of health which are, in and of themselves, very complex issues. Obesity and infant mortality, for instance, are areas in which inequalities occur, but also which can be considered 'wicked' issues in isolation, when assessed by the criteria above
- most of the causes of health inequalities are multi-dimensional and complex to tackle; examples include the 'wider determinants' of public health such as poverty, housing, education and the environment.

2.8 In spite of the complicated nature of the issues, Bradford has witnessed some sustained long-term success in reducing inequalities in important aspects of health and wellbeing, for example infant mortality and teenage conception.

2.9 The Public Health Outcomes Framework (PHOF), published by the Department of Health in 2013, emphasises that "the whole system is now focused on achieving positive health outcomes for the population and *reducing inequalities in health*". The structure of the PHOF is such that there are just two 'outcomes' in Public Health:

- Increased healthy life expectancy.
- Reduced differences in life expectancy and healthy life expectancy between communities.

2.10 Beneath the two 'outcomes' are 66 indicators of Public Health, divided into 4 topic areas known as 'domains'. A strong feature all of the 4 domains is that each has an 'objective' assigned to it, and each of those 4 objectives either refers to "health inequalities" or "reducing the gap between communities".

2.11 The 66 indicators are important for a number of reasons. Firstly, they highlight – and thereby compel Local Authorities to address - the "causes of the causes" of health inequalities. Secondly, they are constructed in such a way that "the majority of indicators … have potential to impact on inequalities". Thirdly, the indicators communicate to interested parties what one can expect a Local Authority to prioritise following the transition of Public Health departments into Local Authorities. This is because, the PHOF clearly sets out that the responsibility for reducing health inequalities belongs to the Local Authority:
"outside the clinical arena the key responsibility for improving the health of local populations, including reducing health inequalities, rests with democratically accountable upper tier and unitary local authorities".

2.12 The indicators in the PHOF are suggestions of what actions we can take to influence high level outcomes

3. OTHER CONSIDERATIONS

3.1 As mentioned above, Bradford has a track record of identifying and addressing inequalities in health. The HIAP sets out responsibilities for ensuring that the 18

priorities in the Joint Health and Wellbeing Strategy (JHWS) are addressed in such a way that attention is given to inequalities. However, it does not examine what challenges are unique to Bradford, or what inequalities are like in other places. To understand these issues better, it is useful to look at the PHOF Data Tool (http://www.phoutcomes.info/).

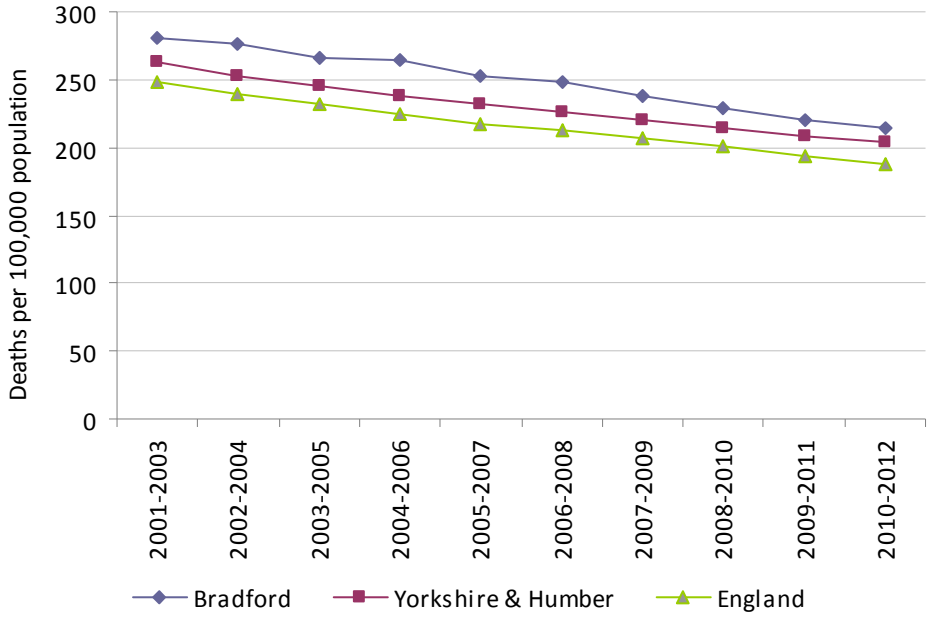
3.2 The Data Tool confirms that measurement of the first PHOF outcome, *healthy* life expectancy, is not yet well-established. This means it is not possible to compare Local Authorities, or to assess trends over time. Nevertheless, some useful data is available on the measure. In May 2014, Public Health England published analysis of Office for National Statistics (ONS) data which showed that women in the most deprived areas of England can expect to live in good health for 19 years fewer than mean in the least deprived areas. For men, the difference is 18.4 years.

3.3 Between 1991-1993 and 2010-2012, life expectancy at birth in Bradford has increased by over 5 years from 72.2 years to 77.5 years for males and by over 3 years from 78.0 years to 81.5 years for females. Life expectancy in Bradford remains below the England average for both males and females (79.2 years and 83.0 years in 2010-2012 respectively).

3.4 'Preventable mortality' is the term applied to deaths that are considered preventable if, "in the light of the understanding of the determinants of health at the time of death, all or most deaths from the underlying cause could potentially be avoided by public health interventions in the broadest sense." Examples of preventable deaths include excess winter deaths or deaths from cardiovascular disease caused by lifestyle factors such as smoking, overconsumption of alcohol and obesity.

3.5 Mortality rates for deaths which are considered presentable have fallen year on year since 2001-2003. Mortality rates have fallen more in Bradford when compared to the regional average and – particularly recently – when compared with the England average. Thus the 'gap' in mortality rate for deaths considered preventable between Bradford and England has narrowed.

Chart: Mortality from causes considered preventable



3.6 The areas below are ones of particular concern with regard to health inequalities in Bradford. The list is not exhaustive, but the issues have been highlighted as ones where the HWBB is considered to have the influence and ability to authorise and support the actions needed to make progress.

a. Infant mortality (HIAP Priority 2)
Headline indicator: Rate of infant deaths, in persons aged less than one year, per 1,000 live births
New figures show the infant mortality rate is now 7.0 per 1,000 live births in 2010-12. This is down from 7.5 in 2009-11 and 8.3 in 2005-07. (See Appendix 1a for more detail). The continued decline in infant mortality is noted over the last 7 years; however, rates remain higher than regionally and nationally. The gap between the most deprived quintiles and the rest of Bradford District still remains; however, the percentage change in more deprived areas in the last few years has been significantly higher than in the district, meaning that the inequalities gap is being narrowed and deaths in the more deprived wards are reducing at a faster rate than in least deprived.

The Every Baby Matters (EBM) Action Plan is being implemented through a partnership approach with a detailed plan in place across 10 Recommendation areas including early access to high quality maternity services, identification of at risk of vulnerable families with evidence based support and interventions for families in the first year of life, reducing smoking, substance and alcohol misuse in pregnancy, breastfeeding, improved nutrition, genetic inheritance training and awareness and communication of key messages for families. The Better Start Bradford Programme; £49 million 10 year Programme funded by Big Lottery, is a unique opportunity to improve outcomes for pregnant women and young children in a deprived area of Bradford district and learn lessons for the district wide work.
HWBB Focus: The HWBB is asked to endorse the approach to infant mortality and ensure all partners are fully engaged in improving maternal and child health and reducing deaths in infants.

b. Oral health in children (HIAP Priority 6)
Headline indicator: - Tooth decay in under 5s;
The 2011/2012 survey shows over the past five years the number of 5 year olds free from tooth decay has increased from 48% in 2007/08 to 54% in 2011/2012. The average number of teeth affected by tooth decay has reduced from 2.42 in 2007/08 to 1.98 in 2011/2012. Children in the least deprived areas have a mean dmft (decayed, missing, filled teeth) of 0.74, which is significantly lower than those from the most deprived areas, who have a mean dmft of 2.67. (See Appendix 1b for more detail). There has been progress in the proportion of children accessing dental care. In the quarter ending September 2013, 66% of children in Bradford district had attended the dentist in the previous 24 month period. Although this is below the average for England (70%) and below the average for Yorkshire and The Humber (73%) numbers have increased from March 2006.

Public Health in the Council are responsible for the commissioning of oral health improvement programmes and includes embedding oral health targets in children centres as well as the commissioning the following evidence based programmes and interventions. The commissioning of general dental care lies with NHS England and inequalities in relation to accessing dental care still remain. The oral health strategy and action plan is currently being reviewed and refreshed.
HWBB Focus: The HWBB is asked to endorse the approach and ensure all partners are fully engaged in improving oral health and reducing tooth decay.

c. Road traffic collisions in children and young people (HIAP Priority14)
Although the absolute numbers are small, deaths and serious injury caused by road traffic collisions remain preventable. Bradford's Road Safety Plan outlines key areas of interventions for reducing casualty levels and features a heavy emphasis on the need for partnership working and a holistic approach to casualty reduction. Devolved responsibility to the Area Committees provides greater local input into providing appropriate local safety interventions that are tailored to suit the areas needs. Aspects such as education and training for schools and parents feature along side build solutions such as 20mph zones, traffic calming and other traffic management measures.

National studies indicate a strong link between casualty levels and deprivation. This is clearly visible in Bradford with higher incidence of child casualties in more deprived parts of the city.
HWBB focus: The HWBB is asked to endorse the need for improved data collection and to request a review of the national evidence on successful interventions and of the effectiveness of local road safety interventions with a view to promoting effective interventions.

d. Mental wellbeing and workplace health (HIAP Priorities 7 and 12)
The case for focusing on public mental wellbeing (PMWB) as a means of making individuals and communities more resilient is being made across Bradford. The approach has been supported by the Clinical Commissioning Groups, Council Management Team and the Bradford Health Improvement Partnership. A paper has been requested by the HWBB in the autumn.

One strand of this work will be around the health of the workforce and supporting mental wellbeing, and will include the sharing of best practice on absence management across all sectors. Latest available data for 2009/11 show that across Bradford District, 2.6% of all working days were lost to sickness. This was significantly higher than the England average of 1.5% and placed Bradford in the bottom decile (tenth) nationally. In seeking to improve workforce health, it is anticipated that productivity will be increased.
HWBB focus – A paper will be presented to the HWBB later this year.

e. Cancer screening uptake (HIAP Priority 18)
There is notable variation between the three CCGs in cancer screening uptake. When compared with demographically similar CCGs across the country, Bradford City CCG has the lowest uptake rates in all three cancer screening

programmes – breast, cervical and bowel. (See Appendix 1c for more detail) The public health department is working with the CCGs to raise awareness and address the low uptake. NHS England is responsible for commissioning screening programmes, and efforts are underway to engage NHS England in this local work.
HWBB focus: The HWBB is asked to instruct NHS England, the CCGs and Local Authority Public Health Department to develop and implement an evidence-based action plan to increase cancer screening uptake, with a particular focus on the population of Bradford City CCG.

f. Diabetes and cardiovascular disease (HIAP Priority 18)
The recorded prevalence rate of diabetes (number of patients diagnosed with diabetes) has increased over the previous 12 months. This is in part due to the increase in screening programmes and publicity generated by the Bradford Beating Diabetes Initiative within Bradford City CCG. The work in Bradford City CCG has also impacted indirectly on patients across the district. The proportion of diabetics who receive the nine care processes has increased to approximately 60% in March 2014. This is in excess of the 55% target for 2013/14. A service review of diabetes care was completed in spring 2014. This made a number of wide ranging recommendations about both specific processes of care and the broader model. These recommendations are being considered by the CCGs with a view to informing future commissioning.

A new Cardiovascular Health initiative will be launched by Bradford Districts CCG in September 2014. This programme will identify patients at high risk of cardiovascular disease (CVD), and will ensure that appropriate tests are offered and that medications are prescribed. This collaborative will be modelled on the highly successful Atrial Fibrillation (AF) Stroke prevention programme where there was an increase from 49% of patients receiving anticoagulation to reduce stroke risk to 70%, or 714 additional patients. This has reduced the number of AF strokes by approximately 25, a 10-15% reduction. It will also focus on a self-management approach to reduce premature death from CVD. A strong focus will be placed on prevention including the uptake of stop smoking and weight management services and on broader policies that influence lifestyle choices. These will need to be carefully targeted to ensure maximum uptake.
HWBB Focus: The HWBB is asked to:

- note the update on some of the specific actions being undertaken to improve outcomes in diabetes and cardiovascular disease
- request a further report from the Director of Public Health outlining the broad opportunities for prevention of CVD and diabetes, as discussed at the HWBB in May
- consider its role in influencing public policy changes that support healthier lifestyles, for example the current BMDC consultation on Supplementary Planning Guidance for Hot Food Takeaways, and the Government consultation on exposure to passive smoking in cars.

g. Tuberculosis (HIAP Priority 18)
Tuberculosis (TB) remains a significant public health issue for Bradford and Airedale. The district has the highest rate and the greatest growth in new cases

in Yorkshire and Humber. (See Appendix 1d for more detail). Although the rate currently seems to be stabilising, this is in the context of declining rates in other major cities with similar demographics across the Region such as Leeds and Sheffield. In Bradford, the majority of people with TB are born outside the UK, particularly among South Asian and Black-African communities. We have also observed a rising incidence of TB in some of our newer Eastern European communities. A number of factors contribute to high TB rates such as high level of deprivation, social exclusion, poor housing, overcrowded living conditions and poor nutrition. Homelessness and lifestyle factors such drug and alcohol misuse are also important risk factors for TB. TB rates in children in Bradford are also higher than regional and national rates for TB incidence in children. TB in children can suggest a future reservoir of disease in the population. To help tackle the high prevalence of active TB, the Local Authority has recently part funded a latent TB screening pilot for entrants and re-entrants from high risk groups.

HWBB Focus: The Board is asked to note and support three key priorities for TB prevention and control in Bradford:

i. Improving treatment outcomes
ii. Early identification and treatment of latent TB infections following contact tracing or new entrant screening
iii. Reducing diagnostic delays.

4. FINANCIAL & RESOURCE APPRAISAL

The HIAP provides an element of guidance and direction in the setting of commissioning priorities for health and wellbeing in the district. It is important that this is agreed by everyone and that performance is monitored and reviewed.

5. RISK MANAGEMENT AND GOVERNANCE ISSUES

N/A

6. LEGAL APPRAISAL

By identifying and implementing priority actions that have the potential to reduce the inequalities in health outcomes, the Health Inequalities Action Plan contributes to the Council meeting its obligations under the Equalities Act 2010.

7. OTHER IMPLICATIONS

7.1 EQUALITY & DIVERSITY

An intention of the HIAP is to promote equality of opportunity between people who share a protected characteristic and those who do not, and to reduce the health inequalities experienced by local people. The HIAP also considers health inequalities linked to social factors and living and working conditions and will seek to reduce health inequalities linked to poverty and deprivation. The HIAP has been developed in partnership with the Strategic Partnerships and has involved extensive engagement and consultation. All groups and Partnerships were asked to identify actions that address health inequalities and this formed part of the final Equality Impact Assessment.

7.2 SUSTAINABILITY IMPLICATIONS

Environmental awareness and education acts as a springboard for increasing health and wellbeing. Acting on climate change is a catalyst for behaviour change

that acknowledges individual impacts on aspects such as waste, pollution and biodiversity. There are also economic advantages to reducing emissions that can benefit all parts of society. Ensuring that the dwelling stock in the district is more sustainable in terms of reducing domestic carbon emissions will have a positive effect on reducing fuel poverty and improving health and wellbeing in the district by reducing excess winter deaths; improving health and educational opportunities for children; increasing work and training opportunities; and helping households to reduce domestic energy bills thereby alleviating poverty. There are 10 aims within the Bradford District Food Strategy which address a range of issues such as land availability, to sourcing food locally, to improving schools meals etc. Many of the 18 priorities are linked with those aims and objectives of the Bradford District Food strategy. The projects created to achieve the strategy are aligned with the HIAP and aim to reduce health inequalities within the District.

7.3 GREENHOUSE GAS EMISSIONS IMPACTS

Actions to improve health outcomes will largely reduce greenhouse gas emissions. Active travel is a good example, achieving multiple outcomes for heath and the environment. However it's important to recognise that energy and emissions are intrinsically linked with better standards of living e.g. car ownership, domestic energy, good diet and flights abroad. Changing patterns of lifestyle behaviour and adapting to new technology can act to de-couple carbon emissions from a continuous improvement in wellbeing.

7.4 COMMUNITY SAFETY IMPLICATIONS

N/A

7.5 HUMAN RIGHTS ACT

N/A

7.6 TRADE UNION

N/A

7.7 WARD IMPLICATIONS

The HIAP links with the Ward Area Assessments and can address geographical issues and issues for specific communities in the district.

8. NOT FOR PUBLICATION DOCUMENTS

None.

9. OPTIONS

The focus for potential Health and Wellbeing Board action or support has been highlighted within the overview of each area in Section 3.6. These are listed again below:

1. The HWBB is asked to endorse the approach to infant mortality and ensure all partners are fully engaged in improving maternal and child health and reducing deaths in infants.
2. The HWBB is asked to endorse the approach and ensure all partners are fully engaged in improving oral health and reducing tooth decay.

3. The HWBB is asked to endorse the need for improved data collection and to request a review of the national evidence on successful interventions and of the effectiveness of local road safety interventions with a view to promoting effective interventions.

4. The HWBB is asked to instruct NHS England, the CCGs and Local Authority Public Health Department to develop and implement an evidence-based action plan to increase cancer screening uptake, with a particular focus on the population of Bradford City CCG.
5. The HWBB is asked to:
   - note the update on some of the specific actions being undertaken to improve outcomes in diabetes and cardiovascular disease
   - request a further report from the Director of Public Health outlining the broad opportunities for prevention of CVD and diabetes, as discussed at the HWBB in May
   - consider its role in influencing public policy changes that support healthy lifestyles, for example the current BMDC consultation on Supplementary Planning Guidance for Hot Food Takeaways, and the Government consultation on exposure to passive smoking in cars.
6. The HWBB is asked to note and support three key priorities for TB prevention and control in Bradford:
   - Improving treatment outcomes
   - Early identification and treatment of latent TB infections following contact tracing or new entrant screening
   - Reducing diagnostic delays.

10. RECOMMENDATIONS

1. While the responsibility for addressing health inequalities rests primarily with the Health and Wellbeing Board, it acknowledges that in order to reduce health inequalities in the long term, socioeconomic determinants of health must be addressed. Addressing the wider determinants of health is a responsibility of a wider range of partners than the Local Authority and the NHS. Work on the 18 priorities in the HIAP being undertaken through the Bradford District Partnership structure should continue and be supervised by the BDP.
2. The HWBB recognises and promotes the opportunity to bring the work of the HWBB and the BDP together in their common aim to reduce health inequalities by working on the areas where each has the most influence and ability to make a difference.
3. The Health and Wellbeing Board requires officers across the local authority and the NHS to initiate, consolidate or accelerate action where reductions in health inequalities may be achieved in the shorter term for the areas highlighted in Section 3.6 and summarised in Section 9 of this report.

11. APPENDICES

Appendix One: Data Supplement for Section 3.6

12. BACKGROUND DOCUMENTS

Bradford and Airedale Health and Wellbeing Strategy 2013 – 2017
Bradford Health Inequalities Action Plan 2013 – 2107
http://www.observatory.bradford.nhs.uk/Documents/Bradford%20and%20Airedale%20Health%20Ineq

ualities%20Action%20Plan%202013.pdf

APPENDIX ONE: DATA SUPPLEMENT FOR SECTION 3.6

Appendix 1a: Infant Mortality

Table 1: Infant mortality rates in the most deprived quintiles for Bradford District, Region and England 2007-09 to 2010-2012				
Year	**Bradford Most Deprived Quintile**	**Bradford rate**	**Yorkshire & Humber**	**England**
2007-2009	10.6	8.1	5.3	4.6
2008-2010	10.2	8.0	5.4	4.6
2009-2011	9.0	7.5	5.2	4.4
2010-2012	7.8	7.0	4.8	4.3
% Change	**-26.7%**	**-13.1%**	**-9.4%**	**-6.5%**

Appendix 1b: Oral health in children

Mean dmft by Deprivation Quintile 2007 and 2012				
Most to least deprived quintile (1 to 5)	**Confidence interval (Lower-Upper)**		**Mean dmft**	
	2007	**2012**	**2007**	**2012**
Quintile 1	3.03 - 4.35	2.5 - 2.8	3.69	2.67
Quintile 2	2.54 - 3.70	1.2 - 1.5	3.12	1.36
Quintile 3	1.25 - 2.27	1.0 - 1.3	1.76	1.12
Quintile 4	1.17 - 2.05	0.6 - 0.8	1.61	0.68
Quintile 5	0.56 -1.14	0.6 - 0.9	0.85	0.74

Appendix 1c: Cancer screening uptake in the three Bradford and Airedale CCGs

Breast, cervical and bowel cancer screeing
2013
Source: NCIN GP Profiles

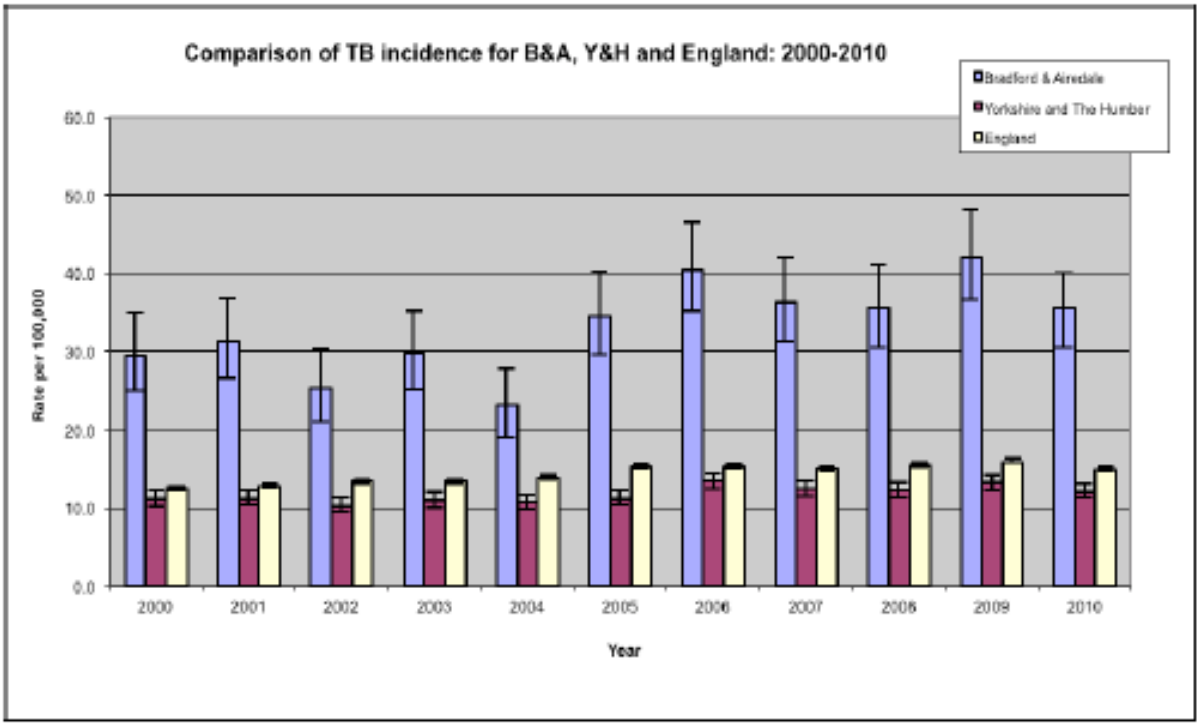
Screening Indicator	England mean (% screened)	Airedale, Wharfdale and Craven				Compared against top 10 most similar CCG's		
		% screened	Lowest practice	Highest practice	No. of practices below England average	Lowest CCG	Highest CCG	Rank (1 = highest % screened, 11 = lowest)
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage)	72.1%	71.8%	48.2%	79.0%	10 out of 17 (58.8%)	67.4%	78.6%	9th
Females, 25-64, attending cervical screening within target period (3.5 or 5.5 year coverage)	74.0%	76.9%	63.6%	88.4%	5 out of 17 (29.4%)	75.1%	78.4%	6th
Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage)	58.8%	64.6%	30.7%	69.9%	3 out of 17 (17.6%)	58.8%	64.6%	1st

Screening Indicator	England mean (% screened)	Bradford City				Compared against top 10 most similar CCG's		
		% screened	Lowest practice	Highest practice	No. of practices below England average	Lowest CCG	Highest CCG	Rank (1 = highest % screened, 11 = lowest)
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage)	72.1%	48.6%	33.2%	64.7%	27 out of 27 (100%)	48.6%	71.8%	11th
Females, 25-64, attending cervical screening within target period (3.5 or 5.5 year coverage)	74.0%	62.5%	41.7%	81.2%	26 out of 27 (96.3%)	62.5%	74.7%	11th
Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage)	58.8%	34.6%	18.4%	69.2%	26 out of 27 (96.3%)	34.6%	55.4%	11th

Screening Indicator	England mean (% screened)	Bradford Districts				Compared against top 10 most similar CCG's		
		% screened	Lowest practice	Highest practice	No. of practices below England average	Lowest CCG	Highest CCG	Rank (1 = highest % screened, 11 = lowest)
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage)	72.1%	66.1%	43.5%	76.1%	36 out of 41 (87.8%)	63.6%	74.7%	10th
Females, 25-64, attending cervical screening within target period (3.5 or 5.5 year coverage)	74.0%	74.5%	50.7%	88.3%	16 ot of 41 (39.0%)	69.2%	75.9%	4th
Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage)	58.8%	55.7%	28.3%	67.0%	30 out of 41 (73.2%)	52.1%	57.6%	3rd

Appendix 1d: Tuberculosis

Bradford has the highest rate of TB disease in the region and one of the highest rates nationally.



Change in TB Incidence Rates 2004-2011