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City of BRADFORD METROPOLITAN DISTRICT COUNCIL

Agenda for a meeting of the Health and Social Care Overview and Scrutiny Committee to be held on Thursday, 24 October 2019 at 4.30 pm in Committee Room 1 - City Hall, Bradford

Members of the Committee – Councillors

LABOUR	CONSERVATIVE	LIBERAL DEMOCRAT	BRADFORD INDEPENDENT GROUP
Greenwood Mir Godwin Kamran Hussain Lintern	Goodall Hargreaves	J Sunderland	Khadim Hussain

Alternates:

LABOUR	CONSERVATIVE	LIBERAL DEMOCRAT	BRADFORD INDEPENDENT GROUP
Akhtar Berry Iqbal Jenkins H Khan	Barker Riaz	Griffiths	Sajawal

NON VOTING CO-OPTED MEMBERS

G Sam Samociuk	Former Mental Health Nursing Lecturer
Susan Crowe	Bradford District Assembly Health and Wellbeing Forum
Trevor Ramsay	Healthwatch Bradford and District

Notes:

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- If any further information is required about any item on this agenda, please contact the officer named at the foot of that agenda item.

From: **To:**

Parveen Akhtar, City Solicitor
Agenda Contact: Jane Lythgow
Phone: 01274 432270
E-Mail: jane.lythgow@bradford.gov.uk

A. PROCEDURAL ITEMS

1. ALTERNATE MEMBERS (Standing Order 34)

The City Solicitor will report the names of alternate Members who are attending the meeting in place of appointed Members.

2. DISCLOSURES OF INTEREST

(Members Code of Conduct - Part 4A of the Constitution)

To receive disclosures of interests from members and co-opted members on matters to be considered at the meeting. The disclosure must include the nature of the interest.

An interest must also be disclosed in the meeting when it becomes apparent to the member during the meeting.

Notes:

(1) Members may remain in the meeting and take part fully in discussion and voting unless the interest is a disclosable pecuniary interest or an interest which the Member feels would call into question their compliance with the wider principles set out in the Code of Conduct. Disclosable pecuniary interests relate to the Member concerned or their spouse/partner.

(2) Members in arrears of Council Tax by more than two months must not vote in decisions on, or which might affect, budget calculations, and must disclose at the meeting that this restriction applies to them. A failure to comply with these requirements is a criminal offence under section 106 of the Local Government Finance Act 1992.

(3) Members are also welcome to disclose interests which are not disclosable pecuniary interests but which they consider should be made in the interest of clarity.

(4) Officers must disclose interests in accordance with Council Standing Order 44.

3. INSPECTION OF REPORTS AND BACKGROUND PAPERS

(Access to Information Procedure Rules – Part 3B of the Constitution)

Reports and background papers for agenda items may be inspected by contacting the person shown after each agenda item. Certain reports and background papers may be restricted.

Any request to remove the restriction on a report or background paper should be made to the relevant Strategic Director or Assistant Director whose name is shown on the front page of the report.

If that request is refused, there is a right of appeal to this meeting.

Please contact the officer shown below in advance of the meeting if you wish to appeal.

(Palbinder Sandhu - 01274 432269)

4. REFERRALS TO THE OVERVIEW AND SCRUTINY COMMITTEE

Any referrals that have been made to this Committee up to and including the date of publication of this agenda will be reported at the meeting.

B. OVERVIEW AND SCRUTINY ACTIVITIES

5. MEMBERSHIP OF THE MANDATORY NORTH YORKSHIRE AND WEST YORKSHIRE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE (VASCULAR SERVICES)

Recommended –

That Councillor Godwin be appointed to the mandatory North Yorkshire and West Yorkshire joint Health Overview and Scrutiny Committee (Vascular Services) in place of Councillor Greenwood.

(Caroline Coombes -01274 432313

6. ASSESSMENT AND DIAGNOSIS OF AUTISM IN ADULTS 1 - 4

The Director of Strategic Partnerships will present a report, (**Document "L")** which summarises the background and current position in relation to service delivery for the assessment and diagnosis of autism in adults.

Recommended –

That the report be noted.

(Clare Smart – 01274 237711)

7. REDUCING INEQUALITIES IN CITY (RIC) PROGRAMME - UPDATE 5 - 12

The Director of Strategy, NHS Bradford City Clinical Commissioning Group (CCT), will present a report, (**Document "M")** which:-

- Outlines the approach undertaken to utilise the increased allocation to Bradford City CCG and the creation of the Reducing Inequalities in City (RIC) Programme.

- Describes the three priority areas within the RIC Programme and the prioritised interventions within these areas.
- Describes the ways in which the funding allocation will be maintained to improve the health and wellbeing of people living within the city area following the creation of a new CCG for Bradford District and Craven.

Recommended –

(1) That the activity undertaken in the development of the RIC programme and its associated projects, contained in Document M, be noted.

(2) That the NHS Bradford City Clinical Commissioning Groups commitment and actions taken to ensure that the increased allocation be retained and used to address health inequalities for the City population, as reported in Document M, be noted.

(Polly Masson – 01274 237786)

8. PUBLIC HEALTH OUTCOMES FRAMEWORK (PHOF) PERFORMANCE REPORT 13 - 46

The report of the Director of Public Health, (**Document "N"**) provides an overview of the health and wellbeing of the population of Bradford District based on the indicators and sub indicators within the Public Health Outcomes Framework (PHOF). The report summarises how indicators and sub indicators compare against the England average and provides a summary of some of the key areas of Public Health relevant to the District.

Recommended –

That the content of Document N be acknowledged and the Director of Public Health be requested to provide a further performance report on Public Health Outcomes Framework indicators in 2020.

(Jonathan Stansbie – 01274 436031)

9. WORK PROGRAMME 2019/20 47 - 50

The report of the Overview and Scrutiny Lead (**Document "O**") presents the Committee's work programme 2019/20.

Recommended –

That Members note the information contained in Appendix A to Document O.

(Caroline Coombes – 01274 432313)

City of BRADFORD METROPOLITAN DISTRICT COUNCIL

Report of Director of Strategic Partnerships to the meeting of the Health and Social Care Overview and Scrutiny Committee to be held on 24 October 2019

L

Subject:

Assessment and Diagnosis of Autism in Adults

Summary statement:

This report summarises the background and current position in relation to service delivery for the assessment and diagnosis of autism in adults.

Ali Jan Haider
Director of Strategic Partnerships
Bradford Districts CCG

Report Contact: Clare Smart
Deputy Director
Phone: 01274 237711
E-mail: clare.smart@bradford.nhs.uk

Portfolio:

Healthy People and Place

Overview & Scrutiny Area:

Health and Social Care

1. SUMMARY

The report summaries the background and current position in relation to the assessment and diagnosis of neurodevelopmental disorders in adults.

2. DEFINING AUTISTIC SPECTRUM CONDITIONS

2.1 Autism occurs early in a person's development. Someone with autism can show marked difficulties with social communication, social interaction and social imagination. They may be preoccupied with a particular subject or interest. Autism is developmental in nature and is not a mental illness in itself. However, people with autism may have additional or related problems, which frequently include anxiety. These may be related to social factors associated with frustration or communication problems or to patterns of thought and behaviour that are focussed or literal in nature. Autism is known as a spectrum condition, both because of the range of difficulties that affect adults with autism, and the way that these present in different people. Autism spectrum disorder has no single known cause. Given the complexity of the disorder, and the fact that symptoms and severity vary, there are probably many causes. Both genetics and environment may play a role

3. BACKGROUND

3.1 The Assessment and diagnosis of adult autism is provided by Bradford and Airedale Neurodevelopment Service (BANDS), which also provides adult ADHD assessment. Apart from the referral route being the same the two functions run independently. The service specification for BANDS refers to 50 assessments for each "condition", support to mainstream services who are seeing patients with autism and/or ADHD and awareness raising/training for primary care, community and inpatient services. The service opened in April 2015 and after the first year of service both components of the pathway closed to new referrals due to higher than expected referral numbers. Following 18 months of closure, the ADHD pathway reopened to new referrals. The autism pathway had been unable to tackle the waiting list due to professionals leaving the service and difficulties in recruiting replacements. No assessments for autism were undertaken for over a year. Staffing levels are very low for this service and therefore there is little resilience in this provision.

4. CURRENT SITUATION

4.1 Peer review and support was requested by the service. Leeds and York Partnership Foundation Trust (LYPFT) autism service has been through a service improvement initiative to streamline their pathway, ensure robust triage and aim to

increase the numbers being assessed. The Leeds service has given peer support to share their learning and particularly to share their new triage process ensuring staff are able to identify quickly whether further information is required prior to assessment and to identify individuals where a more streamlined pathway to the current one offered in Bradford can be indicated. All referrals on the current waiting list within BANDS (autism service) were subject to this new triage process. Following more in-depth triage some referrals have not been accepted due the lack of information or due to the fact that there is no indication that Autism assessment is required.

4.2 The Autism assessment service is still closed to new referrals whilst the waiting list was reduced. Whilst the service has been closed to new patients the IFR process has been the only route for assessment/diagnosis. Over 100 requests were received through IFR whilst the service has been closed. A small number of patients were deemed appropriate for IFR approval (ie were funded to be seen by an alternative service primarily due to the severity/risk being presented). As of August 2019, the waiting list at Bradford District Care Trust has now been cleared. This required additional clinical capacity to be purchased from LYPFT using non-recurrent funds. Those patients who had been referred for IFR have also now been assessed using clinical services purchased directly from LYPFT and South West Yorkshire Partnership Foundation Trust (SWYPFT). Referrals continue to come in to the IFR process as the only route available to referrers.

5. CURRENT INVESTMENT

5.1 Recurrent investment for adult assessment and diagnosis service delivery is £115k. Non-recurrent funding to address the backlog waiting list was agreed by the CCGs at £100k.

6. NEXT STEPS

6.1 The CCGs are working with BDCFT to determine the future of an assessment and diagnosis service for Bradford district and Craven. Currently, the local service has clear limitations in terms of resilience, clinical leadership, and capacity. This situation offers us an opportunity to work with partners with assessment and diagnosis service serving much larger populations. This also allows us to consider collaborative working for pre and post-diagnostic support with partners across health and care that could maximise economies of scale.

7. RECOMMENDATION

10.1 That the update be noted.

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City of BRADFORD METROPOLITAN DISTRICT COUNCIL

Report of the NHS Bradford City CCG to the meeting of the Health and Social Care Overview & Scrutiny Committee to be held on 24 October 2019

M

Subject: Reducing Inequalities in City (RIC) Programme - Update

Summary statement:

This paper will:

- outline the approach undertaken to utilise the increased allocation to Bradford City CCG, and the creation of the Reducing Inequalities in City (RIC) Programme;
- describe the three priority areas within the RIC programme, and the prioritised interventions within these areas;
- describe the ways in which the funding allocation will be maintained to improve the health and wellbeing of people living within the city area, following the creation of a new CCG for Bradford district and Craven

Report Contact: Polly Masson
Phone: (01274) 237786
E-mail: polly.masson@bradford.nhs.uk

Portfolio: Healthy People and Places

1. Summary

On the 13 June 2019, the Health and Social Care Overview and Scrutiny Committee recommended that –

- *a report be submitted to the Committee in September 2019 on the additional allocated monies*.

This recommendation was based on a discussion about how the additional funding provided to NHS Bradford City CCG would be safeguarded following the creation of one CCG for Bradford district and Craven.

This paper will outline the work undertaken by NHS Bradford City CCG in developing an approach for utilising its increased allocation.

2. Background

Addressing areas of health inequalities is one of the core purposes of a clinical commissioning group and is enshrined in law. Recognising the need to improve progress in this area, NHS England has made reducing health inequalities a key element of the *NHS Long Term Plan.*

To support the delivery of the *NHS Long Term Plan,* NHS England has reviewed its funding allocation formula for 2019/20 – 2023/24. The new formula has a number of factors, including an element which focuses on supporting equal opportunity of access and reducing health inequalities amenable to healthcare.

As a result of this new funding formula, NHS Bradford City CCG has received an increased financial allocation of 15.3%, whilst other CCGs had on average a 5.65% increased allocation. This means that the uplift NHS Bradford City CCG has received above and beyond neighbouring CCGs is around £14 million.

From this increased allocation, NHS Bradford CCG had to effect the directions laid out in the NHS planning guidance, such as uplifts in mental health and community based services.

Where practicable increased funding which has directions attached to it is being used to target health inequalities in the city population. For example, proposals such as: at risk mental health states; culturally adapted behavioural action for IAPT; and an enhanced memory assessment clinic are being introduced as a result of the mental health contract uplift. Increases in staffing levels in school nursing and community nursing have been introduced as a result of the community services contract uplift.

After taking into consideration system requirements, the amount of uncommitted recurrent funding that can be attributed to reducing the high level of health inequalities and unmet need in the city population is £8 million. There is an additional £1.2 million for contingency in case of increased health care activity arising from addressing previously unmet need.

The clinical board of NHS Bradford City CCG is responsible for taking decisions about the allocation of this increased funding, having due regard to the collective decisions made by system partners (commissioners and providers) who are parties to the Strategic Partnering Agreement (SPA). There is a specific programme of work, called the Reducing Inequalities in City (RIC) Programme, to co-ordinate this activity and monitor effectiveness and impact.

3. Development of the Reducing Inequalities in City (RIC) Programme

Establishing priority areas

Significant work has been undertaken by the three community partnerships within the Bradford City area (central locality) to identify the specific needs of their registered populations. This has included feedback from the members of the community partnership teams, analysis of their specific health need assessment packs, and intelligence gathered from patient participation groups and engagement networks.

Building on this important work the clinical board determined that the RIC programme should focus on the priority areas identified by the community partnerships. These are:

- Pre-conception, maternity and children
- Primary and secondary prevention at scale to reduce premature mortality associated primarily with cardiovascular and respiratory conditions and cancer
- Ageing and dying well.

Proposals to reduce health inequalities have been developed within these three areas. (Please see below for further detail).

Developing an evidence-based approach to reducing health inequalities

To ensure that the increased allocation is used effectively, a small, dedicated research team has been commissioned by the CCG to support the design and delivery of the RIC programme through its five year duration. The Bradford Health Inequalities Research Unit (BHIRU) has been created in collaboration with Born in Bradford and the University of York to:

- Support the development of programme outcomes and logic model
- Help inform the selection of proposals for initial investment, and future investment
- Develop and co-ordinate the process for determining which proposals to implement (using a Delphi consensus model)
- Support the evaluation of commissioned projects

Proposal development

A RIC steering group has been created to co-ordinate the development of RIC proposals, and oversee the implementation and monitoring of associated projects. It is a multi-agency group consisting of representation from across the system, including public health, voluntary sector, health care provider and local authority colleagues.

Task and finish sub groups have been established to develop proposals within each of the priority areas. These proposals have been developed using:

- feedback from earlier City specific schemes (e.g. women's health network)
- needs identified in local strategies and health needs assessments
- learning from programmes, services and interventions that already exist
- learning from previous community engagement work and service user feedback

The proposals developed via the RIC programme have undergone a robust prioritisation process created by the BHIRU and public health colleagues to ensure only those proposals most likely to reduce or mitigate health inequalities are funded. See appendix 1 for the evaluation criteria used in this process.

The proposals prioritised for implementation planning are shown in the table below:

Ref	Scheme Name	Priority area	Prioritisation score

12	Tier 3 - Weight Management Service for Children and Adolescents	Children	9
1	Central Locality Integrated Care Services (CLICS)	All	9
19	BEEP exercise referral service (specific focus on type 2 diabetes and muscular skeletal conditions)	Premature mortality	9
23	Improving Health for Homeless People in Bradford City	Premature mortality	9
28	Welfare Benefits Advice	Premature mortality	9
36	Psychologically informed environments for people who are homeless	Premature mortality	9
15	Young people's social prescribing pilot	Children	8
5	Reducing the harm from smoking in pregnancy: a community approach	Children	8
4	Practice and community response to increased genetic risk associated with close relative marriage	Children	8
11	Living Well schools	Children	8
3	Making Every Contact Count (MECC) training (Pre Conception)	Children	8
2	Health messaging	All	8
18	Conversations for Change (motivational interviewing) training for staff	Premature mortality	8
20	Culturally Appropriate Bowel Screening (CABS) messaging	Premature mortality	8
21	Living Well Pharmacies	Premature mortality	8
24	Reducing premature mortality by developing skills and increasing capacity in general practice teams	Premature mortality	8
25	Proactive care team	Ageing well	8
26	Holistic approach to dying well	Ageing well	8
27	Dementia specialist nurses	Ageing well	8
35	CAMHS - mental health support teams for city schools and communities	Children	8

Developing implementation plans

The prioritisation process has just been completed and work is now starting on developing the implementation plans for prioritised proposals.

This initial range of proposals covers a broad scope, which aims to both reduce future health inequalities and mitigate against existing inequalities. This approach has been taken to ensure we are able to:

- implement some of the smaller scale projects in 2019/20, either as a proof of concept or the expansion of existing, successful projects
- work with system partners, via community partnerships, to co-design projects such as the central locality integrated care service (CLICS) and related projects such as the pro-active care team
- work with the BHIRU to develop a future pipeline of evidence based activities which focus on our priority areas

As the RIC programme infrastructure is developed, consideration will be given on how to improve the levels of community engagement and co-design in future proposal development.

Managing the increased allocation in the new CCG

The increased allocation to Bradford City CCG is a recurrent commitment for the period 2019/20 through to 2023/24, and has been made to specifically support the reduction in health inequalities in the City population.

For this reason a specific RIC programme has been set up to oversee the implementation and monitoring of the five year programme of work.

The commitment to ensure that the increased funding is retained for its specified purpose in the proposed new Bradford district and Craven CCG has been made in the heads of terms agreement. This outlines the requirement to use City CCG's increased allocation for the registered population of the three central community partnerships.

The challenging financial position within our local place has led to questions about the prudency of this approach. Despite this, the commitment remains in place. The Bradford Health and Care Partnership Board confirmed in the September 2019 meeting that the RIC funding would be used to address health inequalities in the City population, and not to manage financial risks in the system.

4. Options

Not applicable

5. Contribution to corporate priorities

The work of the RIC programme directly aligns to the Joint Health and Wellbeing Strategy, and contributes to the overarching outcomes of:

- Increase in life expectancy at birth for males and females
- Increase in healthy life expectancy in males and females

6. Recommendations

The Health and Social Care Overview and Scrutiny Committee is asked to:

- Receive and note the activity undertaken in the development of the RIC programme and its associated projects
- Receive and note the CCGs' commitment and actions taken to ensure that the increased allocation is retained and used to address health inequalities for the City population

7. Background documents

None

8. Not for publication documents

None

9. Appendices

Appendix 1 – Criteria used for prioritising proposals via the Delphi consensus model

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Appendix 1 – Criteria used in the prioritisation of RIC proposals

Note all questions are answered with a score between 1 – 10, where 1 = Definitely not; 10 = Definitely yes

1. In your opinion, is this intervention informed by an identified need in the City CCG area and meets one of the three key target areas of the RIC (preconception, children & maternity; primary & secondary prevention at scale to reduce premature mortality; improvements in elderly and end of life care)?

2. In your opinion does this intervention have research evidence of effectiveness from high quality studies?

3. In your opinion is this intervention well developed (e.g. with a strong theory of change, logic model and standardised manual for delivery) thereby indicating that the intervention will deliver the intended outcomes?

4. In your opinion is there evidence that the intervention will provide good value for money (i.e. there is evidence of cost-effectiveness; there are no other similar interventions with better value for money; resources have been allocated in a way that maximises value).

5. Does this interventions' proposed outcomes clearly link to one or more of the health inequalities targeted by the City CCG programme?

6. In your opinion is this intervention likely to reduce health inequalities in City CCG?

7. In your opinion is this intervention appropriately tailored to the local population (this includes being culturally appropriate and accessible (think convenient locations in communities, language, clear channels for access, unscheduled access, delivered at scale)).

8. Is there evidence of good implementation / successful delivery (e.g. acceptability, recruitment etc.) of the intervention in a similar population?

9. In your opinion, can this intervention be delivered at scale to achieve change at a population level (or alongside other interventions add up to change at a population level)?

10. Is this intervention systematic in its' delivery i.e. embedded in pathways and systems and not dependent on exceptional circumstances or specific people?

11. In your opinion, can this intervention be sustainable over time (e.g. is not vulnerable to other changes in the system such as changes in funding)?

12. Is this intervention complementary and coordinated: is the intervention complementary and aligned to existing activity? (e.g.they do not duplicate or undermine other programmes of work and interventions/services maximise our workforce assets (e.g. VCS, community pharmacies), and do not exacerbate existing workforce challenges)

13. In your opinion does this intervention recognise the context in which people live their lives (e.g. multi-morbidity, social determinants that drive health behaviours)

14. Would you recommend that this intervention was commissioned by the RIC?

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City of BRADFORD METROPOLITAN DISTRICT COUNCIL

Report of the Strategic Director of Health and Wellbeing to the meeting of Health and Social Care Overview and Scrutiny Committee to be held on Thursday 24 October 2019

N

Subject:

Public Health Outcomes Framework (PHOF) Performance Report

Summary statement:

This report provides an overview of the health and wellbeing of the population of Bradford District, based on the indicators and sub indicators within the Public Health Outcomes Framework (PHOF). The report summarises how indicators and sub indicators compare against the England average and provides a summary of some of the key areas of Public Health relevant to the District.

Sarah Muckle
Director of Public Health

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Portfolio:
Healthy People and Places

Overview & Scrutiny Area:
Health and Social Care

1. SUMMARY

1.1 This report provides an overview of the health and wellbeing of the population of Bradford District, based on the indicators and sub indicators within the Public Health Outcomes Framework (PHOF).

1.2 The report summarises how indicators and sub indicators within the Framework compare against the average for England.

1.3 The report provides additional focus on a number of indicators. These are indicators which are high profile; or where the Scrutiny Committee has asked for more detail on available indicators; or where there have been noteworthy changes in performance; or where long term trends are shown as 'getting worse'.

2. BACKGROUND

2.1 The PHOF was introduced by the Department of Health (DH) in April 2013 as part of health and social care reforms which gave local authorities statutory responsibilities for the health of their population. The PHOF examines indicators that help to understand trends in public health and how well public health is being improved and protected.

2.2 The framework is broken down into a set of overarching indicators which relate to life expectancy and reducing inequalities in life expectancy and healthy life expectancy between communities. The remaining indicators are grouped into four different domains:

- Wider determinants of health
- Health improvement
- Health protections
- Healthcare and premature mortality

2.3 Within the PHOF, data for all local authorities are presented for each indicator. Information presented is generally based on annual data information or an aggregate of years where numbers are small. Figures for each local authority are compared against the England average and show if an indicator is 'significantly worse', 'not significantly different' or 'significantly better' than the England average.

3. REPORT ISSUES

3.1 A full list of all indicators and sub indicators along with their current figures are available in **Appendix A**. This shows current values, provides an indication of recent or previous years trends where available and benchmarks our performance against the England average.

3.2 Of the 130 indicators and sub indicators where significance against the England average has been tested, 53 are significantly worse, 57 are not significantly different and 20 are significantly better. **Table 1** shows a breakdown of this information by domain.

Table 1 – Bradford District in comparison to England across all indicators where significance has been tested

Domain	Number of indicators	Significantly worse	Not significantly different	Significantly better
Overarching Indicators	8	8	0	0
Wider determinants of health	25	9	7	9
Health Improvement	46	20	22	4
Health protection	23	6	13	4
Healthcare and premature mortality	28	10	15	3

3.3 Of the 130 indicators and sub indicators, 21 are 'getting worse' – the gap between the district and England is widening; 27 are 'getting better' – the gap between the district and England is narrowing; and 73 show no significant change over recent years (**Table 2**).

Table 2 – Changes in trend in recent years for indicators within each domain

Domain	Number of indicators	Getting worse / gap is widening	No significant change	Getting Better / gap is narrowing	No trend data available
Overarching Indicators	8	0	8	0	0
Wider determinants of health	25	1	12	12	0
Health Improvement	46	8	21	10	7
Health protection	23	11	7	4	1
Healthcare and premature mortality	28	1	25	1	1

3.4 Because there are more than 100 indicators in PHOF it is not possible in this report to provide a detailed overview of all indicators. Therefore this report focuses on specific indicators within the PHOF that are of particular interest to the District or where long term trends are shown as 'getting worse'. Charts showing trends over time for these specific indicators can be found in **Appendix B**. Accordingly, a number of indicators across the four specific domains, in addition to the main overarching indicators, have been selected, and a more detailed analysis has been provided.

3.5 **Overarching indicators**:

3.5.1 **Life expectancy at birth**

Life expectancy at birth is the average number of years a person would expect to live based on death rates. It is one of the most important summary measures of the health and wellbeing of a population, and provides a measure of health inequalities.

Life expectancy at birth is measured separately for males and females. Historically life expectancy at birth for ***males*** in Bradford District has followed an upward trend although in recent years life expectancy has shown signs of levelling out. In 2015-17 life expectancy increased to the highest recorded (77.7 years compared to the England average of 79.6 years), and the gap between the national average and Bradford District has narrowed for the first time since 2012-14.

After a period of levelling off between 2012-14 and 2013-15, life expectancy at birth for ***females*** in Bradford District has risen slightly in recent years. In 2015-17 life expectancy at birth for females rose to 81.6 years compared to 83.1 years for England. Although life expectancy has increased for females in the District, the gap between Bradford District and the average for England remains the same.

District figures mask variation in life expectancy across Bradford, particularly relating to deprivation. A male in Bradford District living in the most deprived quintile of deprivation can expect to live 7.4 years less than a male from the least deprived area. This gap in life expectancy is lower than many of our comparator local authorities. A female in Bradford District living in the most deprived quintile of deprivation can expect to live 6.8 years less than a female living in the least deprived area; this is slightly above the average for our comparator local authorities.

3.5.2 **Healthy life expectancy at birth**:

Healthy life expectancy is the average number of years a person would expect to live in good health. It is an important summary measure of the health and wellbeing of a population on its own, and also when combined with other information, for example on life expectancy. The measure of good health is derived from responses to a survey question on general health from the Annual Population Survey.

Latest available data on healthy life expectancy shows that healthy life expectancy has fallen for both males and females. In 2015-17 healthy life expectancy at birth in males fell to 60.4 years in Bradford District. This is the lowest value recorded in recent years and remains below the average for England (63.4 years). For females, healthy life expectancy at birth fell to 59.0 years in 2015-17. As with males, this is the lowest value recorded in recent years, and remains below the average for England (63.8 years).

Long term trends show that there has been no statistically significant change in healthy life expectancy in the District since 2009-11. For women this follows the national trend, however, for males in England healthy life expectancy has shown a very small increase. Because healthy life expectancy has not improved and life expectancy has increased, this means that although people can expect to live longer, they are likely to spend more years in poor health.

Improving healthy life expectancy is not only important from a social justice and population health perspective, but it is crucial for the sustainability of our health and care system. If we continue to support people to live longer, without keeping people well, demand for health care will only increase for all parts of the system (primary care, community care, including the VCS, and emergency and planned hospital care). Furthermore, as our population ages with an increasing number of health issues and frailty, demand for care services will also rise.

Improving healthy life expectancy is also an economic issue. Spend on health and wellbeing is an investment in our communities.

There is an estimated 21 year difference in healthy life expectancy across the District. In the most deprived parts of the District people will spend just over 50 years in self reported good health; this compares to over 71 years in the least deprived parts of the District. This inequality in health life expectancy is significantly wider than is observed for differences in life expectancy. This means that although across the District people are living longer, primarily due to advances in modern medicine, people living in deprived areas are living 21 more of those years in poorer health that those in less deprived areas.

3.5.3 *Connecting People for Health and Place for Better Health and Wellbeing'* sets out how partners in the District will work together to improve the health and wellbeing of people in the District. The Health and Wellbeing Strategy, owned by the Health and Wellbeing Board, sets out the challenge and our ambition.

The strategy identifies four overarching outcomes: our children have a great start in life; people in Bradford District have good mental wellbeing; people in all parts of the district are living and ageing well; Bradford District is a healthy place to live, learn and work. To achieve these outcomes we will create a health promoting place to live, promote wellbeing and prevent ill health, and support people to get help earlier and manage their conditions.

3.6 Wider determinants of health: The wider determinants or social determinants of health are a range of social, economic and environmental factors which influence health and wellbeing. As defined by Public Health England, they determine the extent to which people have the physical, social and personal resources to identify and achieve goals, meet their needs and deal with changes to their circumstances. There are 25 indicators in the PHOF which relate to the wider determinants of health.

3.6.1 **Child poverty**

Poverty damages health and poor health increases the risk of poverty. It is an underlying factor for almost all of the health and wellbeing issues in the District. Tackling poverty is a long-term, cost system strategy across local government, the NHS, and wider partners, and should be seen as preventative action. This includes action to improve education standards and raise skills, and promoting long term economic growth that benefits everyone.

A multi-agency Bradford District Anti-poverty Co-ordination Group was formed in early 2017. Throughout 2018 the group developed an anti-poverty strategy: Bradford District Anti-poverty Co-ordination Group's Approach for Tackling Poverty.

Childhood poverty leads to premature mortality and poor health outcomes for adults. Reducing the numbers of children who experience poverty should improve adult health outcomes and increase healthy life expectancy.

The proportion of children aged 20 and under in low income families has

generally been falling over recent years but has remained above the average for England. Latest data shows an increase for the District from 21.8% in 2015 to 23.8%. Nationally an increase was also seen from 16.6% in 2015 to 17.0% in 2016. HMR Revenue and Customs believe this increase can be largely explained by the increase in the low-income threshold which increased from £233 in 2015 to £248 in 2016. The way child poverty is measured is to be changed and this is to be reflected in a refreshed indicator later in the year.

3.6.2 **Fuel poverty**

Fuel poverty exists when a household cannot afford to heat their home to an adequate level. The drivers of fuel poverty (low income, poor energy efficiency, and energy prices) are strongly linked to cold homes, with evidence showing that living in cold homes is associated with poor health outcomes and an increased risk of morbidity and mortality for all age groups. Fuel poverty in the district has consistently remained above the average for England, with values between 2011 and 2015 ranging between 12.6% and 15.0%. In 2016 14.3% of households in the District experienced fuel poverty, still higher than the 11.1% in England, however, a fall from the previous years value of 15.0% and this varies across the District.

Fuel poverty remains an issue for the District primarily as a result of the housing stock and tenure patterns. For instance, living in private sector accommodation either rented or owned has overtaken the use of social housing where decent homes standards apply and there is on the whole less fuel poor households. Private sector accommodation is often made up of large numbers of older Victorian and pre-Victorian housing; back to back housing and property built between the 1920's and 1930's which is hard to insulate effectively and has been renovated to include loft conversions and dorma windows which restrict home insulation options.

The District has an established winter warmth programme – the Warm Homes Healthy People programme which offers a range of help tailored to the needs of individual households who are vulnerable to the impact of cold weather to reduce fuel poverty and food poverty in the winter months. These include practical interventions such as food parcels, warm clothing, help to conserve energy and to reduce energy bills, including help to switch suppliers. Vulnerable households are also connected to other forms of support including the Council's Local Welfare Assistance scheme.

3.6.3 **Homelessness**

Homelessness is associated with severe poverty and is a social determinant of health. It is also associated with adverse health, education and social outcomes, particularly for children. Bradford District performs better than the England average for the rate of households in temporary accommodation, but is showing signs of increasing. The rate of homeless households in temporary accommodation awaiting a settled home has increased from 0.2 (n=48) per 1,000 households in 2013/14 to 0.6 (n=116) per 1,000 households in 2017/18.

Whilst factors such as Universal Credit and Welfare Reform likely contributed

to this increase, the Homelessness Reduction Act also played a major role in increasing the use of Temporary Accommodation. This has been the experience of LA's nationally. In 2018/19 the average stay in B&B accommodation also went up from 11 nights in 17/18 to just over 12 nights. Operational changes during the year mean it is now on a downward trend with the month of March 2019 showing just under 6 nights. New Housing and Homelessness Strategies are being prepared for the District, with input from a wide range of partner organisations. The strategies include a focus on health inequalities that relate to poor housing conditions and homelessness and the actions that can address these.

3.7 **Health improvement**: There are 46 indicators in PHOF which relate to health improvement. These indicators generally describe a range of behaviours which contribute to healthy lives, such as smoking, physical activity, fruit and vegetable intake, and substance misuse,

3.7.1 **Child excess weight**

All children are weighed and measured in reception and year 6 as part of the National Childhood Measurement Programme. The proportion of reception aged children who are either overweight or obese has fluctuated over time but has generally remained below or in line with the England average. The most recent measurement however has gone above the average for England for the first time since 2011/12. In 2017/18 the value for Bradford District rose to 23.0% from 22.5% in 2016/17, higher than the England average of 22.4%.

Between reception and year 6 there is a significant increase in the percentage of children who are overweight or obese. 38.6% of children in year 6 are overweight or obese – this compares to 34.3% in England. The proportion of overweight or obese children continues to increase each year, and has continued to increase over the last decade, leading to one of the highest proportions of overweight or obese children in the country.

This highlights the complexity of the issue to address, and why it remains a priority for the District. There is no single cause; there are many complex behavioural and societal factors that combine to contribute to the causes of obesity. Recognising this, partners including the local authority, CCGs, VCS, schools, local communities, Better Start Bradford, and Born in Bradford, are all working together to tackle the causes from a range of perspectives..

The Living Well Programme is undertaking a number of projects and initiatives to help reduce childhood obesity in the District, with a specific schools project team working on developing a charter to support schools across Bradford District to adopt a 'whole setting approach' towards implementing policies and practices to support healthy weight, healthy food and the promotion of physical activity.

3.7.2 **Smoking prevalence in adults**

Although smoking prevalence in adults remains high in the District, there are continued signs of improvement. In 2018, the proportion of the population

smoking fell to 18.5%, which is the lowest level recorded in Bradford District, and compares to 22.8% in 2013. Prevalence remains above the average for England, which was 14.4% in 2018 and the District has the second highest prevalence when compared to other areas with similar populations.

Tackling smoking requires a multifaceted approach, which includes offering people to support to quit, and warning people about the dangers of tobacco use.

The West Yorkshire and Harrogate Cancer Alliance Tackling Lung Cancer project has put a renewed focus on smoking for our whole system, rather than it being viewed as a Public Health responsibility. Funding has been made available to optimise smoking cessation interventions for patients, staff and visitors at BTHFT, with all care trust and hospital premises now being completely smoke free. The funding will enable the introduction of carbon monoxide screening at preoperative appointments and the recruitment of two stop smoking practitioners. The introduction of carbon monoxide screening provides an important early opportunity for clinicians to engage with people about smoking. Stop smoking practitioners based on the hospital site will create capacity to embed processes to identify smokers, and improve access to treatment and referral pathways.

Marketing plays an important role in driving motivation to quit, and there are a number of campaigns being rolled out across Yorkshire and Humber with a particular focus on routine and manual workers, that Bradford and Airedale are collaborating on.

Public Health continues to commission and provide stop smoking advice, currently through the integrated Living Well Service.

3.7.3 **Cancer Screening uptake**

Screening is important because it helps identify people with some types of cancer in its earliest stages. There are three indicators relating to screening uptake in the PHOF (breast cancer, cervical cancer and bowel cancer). Screening uptake has been a challenge in the District for many years. The District performs worse than England on all three of these indicators.

Trends over the last eight years show a reduction in the proportion of the eligible population being screened for breast and cervical cancer (breast cancer: 2010 – 73.8%, 2018- 68.1%), cervical cancer: 2010 – 74.7%, 2018 – 69.9%). This trend is mirrored nationally. Uptake of bowel cancer screening is, however showing some signs of improvement, (2015 – 54.6%, 2018 – 55.7%), although as the programme has been running for less time, limited trend data is available.

There is a national decline being seen in all screening programmes. NHS England are responsible for commissioning screening programmes; at a local level the West Yorkshire NHS England Team are working with the local authority, CCGs, and VCS to try to increase uptake.

There is strong local commitment through the Bradford Airedale Wharfedale

and Craven (BAWC) Screening Operational Group and BME screening sub group to work on increasing uptake. In the last 12 months there have been a number of pieces of work that staff have delivered and been involved in, including to raise awareness including the Cancer Research Roadshow, Practice Nurse forums and practice visits and events at Girlington Community Centre.

3.8 **Health protection**: There are 23 indicators included in the health protection domain, which includes the control of infectious diseases through a number of different vaccinations. There are a number of indicators relating to immunisations where, although the District performs either better or similar to the average for England, over recent years uptake has been falling. These include:

3.8.1 **Measles, mumps and rubella (MMR) vaccination**

The MMR is offered as part of the childhood immunisation programme. Children receive the first dose at 12/13 months and a second dose as part of the pre-school booster. There are three indicators relating to MMR – MMR for one dose (two year olds), MMR for one dose (five year olds) and MMR for two doses (five year olds). It is recommended that all children receive two doses for maximum protection.

In 2017/18, 92.0% (91.2% for England) of two year olds had received one dose of the MMR; this compares to 94.6% in 2013/14. Of all five year olds, 94.1% received one dose of the MMR in 2017/18 compared to 97.2% in 2013/14. However in 2017/18 a higher proportion of children had received two doses of the MMR at age five – 93.1% compared with 91.2% in 2016/17, although this is below the Department of Health target of 95%.

3.8.2 **Dtap / IPV / Hib vaccination**

The combined DTaP/IPV/Hib is the first in a course of vaccines offered to babies to protect against diphtheria, pertussis (whooping cough), tetanus, Haemophilus influenzae type b (an important cause of childhood meningitis and pneumonia) and polio (IPV is inactivated polio vaccine).

Although when compared to England, uptake of vaccination for both the 1 year old and two year old Dtap / IPV / Hib vaccination is either better or similar, uptake locally is following a slight downward trend. In 2017/18 uptake was 93.1% for one year olds and 96.6% for two year olds. Five years ago however uptake was 95.2% and 96.8% respectfully.

3.8.3 **HPV (human papillomavirus) vaccination**

The HPV immunisation programme was introduced in 2008 for secondary school year 8 females (12 to 13 years of age) to protect them against the main cause of cervical cancer. While it was initially a three dose vaccination programme, it was run as a two-dose schedule from September 2014 following expert advice. The first HPV vaccine dose is usually offered to females in year 8 (aged 12−13 years) and the second dose 12 months later in year 9. Uptake is above the average for England; however, over the last five years uptake has generally been falling year on year, from 93.0% in 2013/14 to 90.2% in 2017/18. Uptake in females aged 13-14 years is also above the average for England, but as the two-dose schedule has only been

running for three years there are not enough historical data to comment on general trends yet.

3.8.4 **Flu vaccination**

The seasonal flu vaccination programme covers a number of population groups, however, there are just two indicators relating to uptake of flu vaccine– people aged 65+ and those defined as at risk individuals (children and adults with any of the indicators included in the PHOF relating to vaccination). The flu vaccine is one of the most effective ways at preventing the spread of flu .Increasing the uptake of flu vaccine among high risk groups should also contribute to easing winter pressure on primary care services, hospital admissions and winter mortality of these two groups is falling and is below the average for England.

3.8.5 **PCV (pneumococcal infections that can cause pneumonia, septicaemia or meningitis) vaccination**

The PCV vaccine is given to all children under two years old as part of the childhood vaccination programme. The two indicators in relation to PCV are similar to the average for England; however, uptake in recent years is falling. In 2017/18 uptake for the PCV vaccine was 93.0%, with uptake for the PCV booster being 92.7%. In 2013/14 uptake was 94.9% and 94.6% respectfully

With respect to all the above immunisations, the NHS England Health Improvement Plan is working on an on-going basis to increase immunisation uptake, with a Yorkshire & Humber Group that is working on progressing on targeted immunisation work. There is a strong local commitment in Bradford Airedale Wharfedale and Craven (BAWC) Immunisation Operational Group and the BAW Flu Operational Group.

3.9 **Healthcare and premature mortality**: A number of indicators in the PHOF relate to the number of people dying before the age of 75, and those living with preventable health issues. Most indicators relating to early death are worse than the England average, and are not improving. This is a similar picture to many urban areas in the north of England. Prevention of ill health is key to improving these indicators; this requires action across health improvement and the wider determinants of health, in order to have an impact in the long term. In the shorter term, improvements will come from the better management of long term conditions. Long term condition management, has been prioritised by all three CCGs locally, for example, through diabetes new models of care, Bradford Breathing Better, and Bradford Healthy Hearts.

3.9.1 **Premature mortality due to cancer, respiratory and cardiovascular conditions**

The main causes of early death in under 75 year olds are circulatory disease (including heart disease and stroke), cancer and respiratory disease. These conditions can be linked to a variety of different factors including people's lifestyle and wider determinants of health including economic, social and environmental factors which can impact a person's health. The District has followed national trends in seeing a general decline in premature morality rates in general; however rates have remained above the average for England for all three of these indicators.

3.9.2 **Infant mortality**

The high levels of infant mortality have long been recognised in the District. Whilst substantial progress has been made over the last decade, the infant mortality rate remains higher than in England (5.8 per 1,000 live births compared to 3.9 per 1,000 live births in England). After year on year decreases since 2001-2003, the infant mortality rate has remained relatively static for the last five years. There is, however, variation across the District, with rates remaining highest in the most deprived areas of the District.

Work led by the Every Baby Matters Steering Group to reduce the risk of babies dying during the first year of life continues, focusing on the three main causes of infant mortality; genetics, nutrition and maternal smoking. Reducing infant mortality continues to be a priority work programme for the District and working towards this target is recognised within the Bradford District Partnership, Children's Trust and Children and Young People's Plan, and within the three CCGs strategies and plans.

4. FINANCIAL & RESOURCE APPRAISAL

4.1 Tackling public health issues requires long term commitment and investment. Much of this already exists and is directed towards activity which will positively influence the indicators in the PHOF. The Public Health service is grant funded by Department of Health, the total funding for 2019-20 is £40.7m and it is anticipated that the service will balance the budget. There are no financial issues arising from this PHOF performance report.

5. RISK MANAGEMENT AND GOVERNANCE ISSUES

5.1 The PHOF has been recognised as the most widely-understood and readily-available means of assessing the Health and Wellbeing of the population of Bradford and District. It is acknowledged that Health and Wellbeing depends upon joint work between the Council and its key partners in a variety of different multi-agency settings. The responsibility for delivering change and the actions designed to improve health and wellbeing, whilst reducing inequalities, has been interwoven into the Bradford District Partnership and its main strategic partnership groups. This ensures accountability across all agencies.

6. LEGAL APPRAISAL

6.1 Part 1 of the Health and Social Care Act 2012 (the Act) places legal responsibility for Public Health within Bradford Council. Specifically, Section 12 of the Act created a new duty requiring Local Authorities to take such steps as they consider appropriate to improve the health of the people in its area. Section 31 of the Act requires the Director of Public Health to prepare an annual report on the health of the people in the area of the Council, which it must then publish. The contents of the report are a matter for local determination.

6.2 The Director of Public Health is obliged to pay regard to guidance issued by the Secretary of State for Health when exercising public health functions and in

particular to have regard to the Department of Health's Public Health Outcomes Framework (PHOF). The PHOF identifies differences in life expectancy and healthy life expectancy between communities by measuring a series of health metrics, and is regularly reviewed.

7. OTHER IMPLICATIONS

7.1 EQUALITY & DIVERSITY

7.1.1 The Public Health Outcomes Framework is designed to focus Public Health activity on improving health outcomes AND reducing health inequalities. It is, therefore, reasonable to infer that better performance in each of the areas covered by this report will also lead to a reduction in inequality, and therefore greater equality.

7.2 SUSTAINABILITY IMPLICATIONS

7.2.1 The PHOF has been recognised as the most widely understood and readily available means of assessing the Health and Wellbeing of the population of the District. As such, it is used to guide all Public Health programmes and services

7.3 GREENHOUSE GAS EMISSIONS IMPACTS

7.3.1 Some of the indicators in the PHOF have a direct impact on reducing the impact of climate change. For example, actions taken to reduce fuel poverty aim to improve housing and heat/light and power systems for vulnerable households. These make a direct difference for the occupants, creating warm and safer environments and in the process reduce carbon emissions from poor housing.

7.3.2 Actions to improve indicators in the PHOF may reduce greenhouse gas emissions. If people exercise outside more, it may reduce car ownership/use, and heating / lighting of premises that would be used for indoor activity. In turn, reduced car ownership/use may lead to reduced air pollution.

7.3.3 It is, however, important to recognise that energy and emissions can be linked with better standards of living - such as car ownership, domestic energy, good diet and flights abroad. Work needs to take place to ensure that improvements in wellbeing do not therefore automatically lead to increased carbon emissions.

7.4 COMMUNITY SAFETY IMPLICATIONS

7.4.1 In broad terms, the health and wellbeing of communities includes perception of safety and security within the household and wider society. Specifically, the PHOF includes indicators which may give some indication of community safety, including complaints about noise and domestic violence indicators. Many of the indicators mentioned in the report could potentially have some impact upon individuals' perceptions of their own community.

7.5 HUMAN RIGHTS ACT

None

7.6 TRADE UNION
None

7.7 WARD IMPLICATIONS

7.7.1 PHOF indicators are complex and are influenced by differences in economic, cultural and social factors across populations and communities. Across the 30 wards of the District, achievement against each of the indicators will vary substantially. Upon request, the Public Health Intelligence team is able to advise on whether more detailed information is available at ward level, and whether any further analysis of this is valuable.

7.8 AREA COMMITTEE ACTION PLAN IMPLICATIONS (for reports to Area Committees only)
N/A

7.9 IMPLICATIONS FOR CORPORATE PARENTING
N/A

7.10 ISSUES ARISING FROM PRIVACY IMPACT ASSESMENT
None

8. NOT FOR PUBLICATION DOCUMENTS
None

9. OPTIONS
9.1 That members examine and comment on the report content

10. RECOMMENDATIONS
10.1 That the Committee acknowledges the content of the report and seeks a further performance report on PHOF indicators in 2020

11. APPENDICES

Appendix A: Public Health Outcomes Framework at a Glance. A list of all PHOF Indicators, there current value for Bradford, how each indicator compares to the average for England and any recent trends available.

Appendix B: Charts of specific indicators. A selection of charts showing recent trends in the selected indicators mentioned in paragraphs 3.5 to 3.9

12. BACKGROUND DOCUMENTS

Connecting People and Place for Better Health and Wellbeing 2018-2023. Available at: https://bdp.bradford.gov.uk/media/1331/connecting-people-and-place-for-better-health-and-wellbeing-a-joint-health-and-wellbeing-strategy-for-bradford-and-airedale-2018-23.pdf

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Public Health England

Public Health Outcomes Framework - at a glance summary

Bradford

Key

Significance compared to goal / England average:

Significantly worse	Significantly lower	↑ Increasing / Getting worse	↑ Increasing / Getting better
Not significantly different	Significantly higher	↓ Decreasing / Getting worse	↓ Decreasing / Getting better
Significantly better	Significance not tested	↑ Increasing	↓ Decreasing
		→ No significant change	– Could not be calculated

Notes

- Indicators that are shaded blue rather than red/amber/green are presented in this way because it is not straightforward to determine for these indicators whether a high value is good or bad.
- In the change columns, prev refers to the change in value compared to the previous data point. Statistically significant changes highlighted in this column have been calculated by comparing the confidence intervals for the respective time points. If the confidence intervals do not overlap, the change has been flagged as significant.
- Recent trend refers to the analysis done in the Fingertips tool which tests for a statistical trend. Changes in this column are calculated using a chi-squared statistical test for trend. This is currently only available for certain indicator types; full details are available in the tool.
- Increases or decreases are only shown if they are statistically significant. Where no arrow is shown, no comparison has been made. This may be due to the fact that the required data to make the comparison is not available for the time point, or that no confidence interval values are available for the indicator.

Overarching indicators

Indicator	Age	Sex	Period	Value	Value (Region)	Value (England)	Unit	Recent trend	Change from previous
0.1i - Healthy life expectancy at birth	All ages	Male	2015 - 17	60.4	61.7	63.4	Years	-	→
0.1i - Healthy life expectancy at birth	All ages	Female	2015 - 17	59.0	61.5	63.8	Years	-	→
0.1ii - Life expectancy at birth	All ages	Male	2015 - 17	77.7	78.7	79.6	Years	-	→
0.1ii - Life expectancy at birth	All ages	Female	2015 - 17	81.6	82.4	83.1	Years	-	→
0.1ii - Life expectancy at 65	65	Male	2015 - 17	17.6	18.2	18.8	Years	-	→
0.1ii - Life expectancy at 65	65	Female	2015 - 17	20.2	20.6	21.1	Years	-	→
0.2iii - Inequality in life expectancy at birth	All ages	Male	2015 - 17	9.10	10.3	9.40	Years	-	→
0.2iii - Inequality in life expectancy at birth	All ages	Female	2015 - 17	7.80	8.40	7.40	Years	-	→
0.2iii - Inequality in life expectancy at 65	65	Male	2015 - 17	5.20	5.10	4.90	Years	-	→
0.2iii - Inequality in life expectancy at 65	65	Female	2015 - 17	4.80	5.20	4.50	Years	-	→
0.2iv - Gap in life expectancy at birth between each local authority and England as a whole	All ages	Male	2015 - 17	-1.81	-0.90	0.00	Years	-	→
0.2iv - Gap in life expectancy at birth between each local authority and England as a whole	All ages	Female	2015 - 17	-1.54	-0.75	0.00	Years	-	→
0.2vi - Inequality in healthy life expectancy at birth LA	All ages	Male	2009 - 13	19.1	-	-	Years	-	-
0.2vi - Inequality in healthy life expectancy at birth LA	All ages	Female	2009 - 13	22.1	-	-	Years	-	-

Wider determinants of health

Indicator	Age	Sex	Period	Value	Value (Region)	Value (England)	Unit	Recent trend	Change from previous
1.01i - Children in low income families (all dependent children under 20)	0-19 yrs	Persons	2016	23.8	19.5	17.0	%	↓	↑
1.01ii - Children in low income families (under 16s)	<16 yrs	Persons	2016	23.2	19.7	17.0	%	↓	↑
1.02i - School Readiness: the percentage of children achieving a good level of development at the end of reception	5 yrs	Persons	2017/18	66.8	69.5	71.5	%	↑	→
1.02i - School Readiness: the percentage of children with free school meal status achieving a good level of development at the end of reception	5 yrs	Persons	2017/18	57.0	54.1	56.6	%	↑	→
1.02ii - School Readiness: the percentage of Year 1 pupils achieving the expected level in the phonics screening check	6 yrs	Persons	2017/18	80.8	80.3	82.5	%	↑	→
1.02ii - School Readiness: the percentage of Year 1 pupils with free school meal status achieving the expected level in the phonics screening check	6 yrs	Persons	2017/18	70.1	66.9	70.1	%	↑	→
1.03 - Pupil absence	5-15 yrs	Persons	2016/17	5.03	4.86	4.65	%	↓	→
1.04 - First time entrants to the youth justice system	10-17 yrs	Persons	2017	455.0	319.0	292.5	per 100,000	↓	→
1.05 - 16-17 year olds not in education, employment or training (NEET) or whose activity is not known	16-17 yrs	Persons	2017	6.48	5.75	6.00	%	–	→
1.06i - Adults with a learning disability who live in stable and appropriate accommodation	18-64 yrs	Persons	2017/18	88.1	80.9	77.2	%	↑	→
1.06ii - Adults in contact with secondary mental health services who live in stable and appropriate accommodation	18-69 yrs	Persons	2017/18	72.0	69.0	57.0	%	–	→
1.08i - Gap in the employment rate between those with a long-term health condition and the overall employment rate	16-64 yrs	Persons	2017/18	11.7	12.0	11.5	Percentage points	–	→
1.08ii - Gap in the employment rate between those with a learning disability and the overall employment rate	18-64 yrs	Persons	2017/18	64.5	66.1	69.2	Percentage points	–	→
1.08iii - Gap in the employment rate for those in contact with secondary mental health services and the overall employment rate	18-69 yrs	Persons	2017/18	61.1	64.5	68.2	Percentage points	–	→
1.08iv - Percentage of people aged 16-64 in employment	16-64 yrs	Persons	2017/18	68.1	73.5	75.2	%	↑	→
1.09i - Sickness absence - the percentage of employees who had at least one day off in the previous week	16+ yrs	Persons	2015 - 17	1.86	2.31	2.10	%	–	→
1.09ii - Sickness absence - the percentage of working days lost due to sickness absence	16+ yrs	Persons	2015 - 17	1.28	1.32	1.12	%	–	→
1.10 - Killed and seriously injured (KSI) casualties on England's roads	All ages	Persons	2015 - 17	34.9	45.7	40.8	per 100,000	–	→
1.11 - Domestic abuse-related incidents and crimes - current method	16+ yrs	Persons	2017/18	29.5 &	28.4	25.1	per 1000	–	–
1.12i - Violent crime (including sexual violence) - hospital admissions for violence	All ages	Persons	2015/16 - 17/18	60.5	53.3	43.4	per 100,000	–	→
1.12ii - Violent crime (including sexual violence) - violence offences per 1,000 population	All ages	Persons	2017/18	40.2	28.8	23.7	per 1000	↑	↑
1.12iii - Violent crime (including sexual violence) - rate of sexual offences per 1,000 population	All ages	Persons	2017/18	3.87	2.86	2.37	per 1000	↑	↑
1.13i - Re-offending levels - percentage of offenders who re-offend - current method	All ages	Persons	2016/17	32.1	31.4	29.2	%	–	–
1.13i - Re-offending levels - percentage of offenders who re-offend - historic method	All ages	Persons	2014	26.4	26.8	25.4	%	→	→
1.13ii - Re-offending levels - average number of re-offences per offender - current method	All ages	Persons	2016/17	1.38	1.32	1.17	per offender	–	–

Indicator	Age	Sex	Period	Value	Value (Region)	Value (England)	Unit	Recent trend	Change from previous
1.13ii - Re-offending levels - average number of re-offences per offender - historic method	All ages	Persons	2014	0.90	0.89	0.82	per offender	↑	↑
1.13iii - First time offenders	All ages	Persons	2017	183.3	161.2	166.4	per 100,000	↓	↓
1.14i - The rate of complaints about noise	All ages	Persons	2015/16	4.19	5.91 x	6.34 x	per 1000	↓	→
1.14ii - The percentage of the population exposed to road, rail and air transport noise of 65dB(A) or more, during the daytime	All ages	Persons	2016	4.60	4.11	5.50	%	-	-
1.14iii - The percentage of the population exposed to road, rail and air transport noise of 55 dB(A) or more during the night-time	All ages	Persons	2016	5.83	6.48	8.48	%	-	-
1.15i - Statutory homelessness - Eligible homeless people not in priority need	Not applicable	Persons	2017/18	0.45	1.04	0.79	per 1000	↓	→
1.15ii - Statutory homelessness - households in temporary accommodation	Not applicable	Persons	2017/18	0.56	0.38	3.40	per 1000	↑	↑
1.16 - Utilisation of outdoor space for exercise/health reasons	16+ yrs	Persons	Mar 2015 - Feb 2016	12.4 ~	17.5	17.9	%	-	→
1.17 - Fuel poverty	All ages	Persons	2016	14.3	12.1	11.1	%	↑	-
1.18i - Social Isolation: percentage of adult social care users who have as much social contact as they would like	18+ yrs	Persons	2017/18	47.4	47.5	46.0	%	-	→
1.18ii - Social Isolation: percentage of adult carers who have as much social contact as they would like	18+ yrs	Persons	2016/17	41.6	38.7	35.5	%	-	→

Health improvement

Indicator	Age	Sex	Period	Value	Value (Region)	Value (England)	Unit	Recent trend	Change from previous
2.01 - Low birth weight of term babies	=37 weeks gestational age at birth	Persons	2017	4.01	3.02	2.82	%	↓	→
2.02i - Breastfeeding initiation	All ages	Female	2016/17	71.5	69.3	74.5	%	↑	↑
2.02ii - Breastfeeding prevalence at 6-8 weeks after birth - current method	6-8 weeks	Persons	2017/18	- ^	- [a]	42.7 [b]	%	–	–
2.03 - Smoking status at time of delivery	All ages	Female	2017/18	14.4	14.2	10.8	%	↓	→
2.04 - Under 18s conception rate / 1,000	<18 yrs	Female	2017	19.1	20.6	17.8	per 1000	↓	→
2.04 - Under 16s conception rate / 1,000	<16 yrs	Female	2017	1.87	3.33	2.70	per 1000	↓	→
2.05ii - Proportion of children aged 2-2½yrs receiving ASQ-3 as part of the Healthy Child Programme or integrated review	2-2.5 yrs	Persons	2017/18	74.3	87.6	90.2	%	–	–
2.06i - Reception: Prevalence of overweight (including obesity)	4-5 yrs	Persons	2017/18	23.0	22.9	22.4	%	↑	→
2.06ii - Year 6: Prevalence of overweight (including obesity)	10-11 yrs	Persons	2017/18	38.6	34.7	34.3	%	↑	→
2.07i - Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-14 years)	<15 yrs	Persons	2017/18	126.9	105.0	96.4	per 10,000	→	→
2.07i - Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-4 years)	0-4 yrs	Persons	2017/18	147.6	123.1	121.2	per 10,000	↓	→
2.07ii - Hospital admissions caused by unintentional and deliberate injuries in young people (aged 15-24 years)	15-24 yrs	Persons	2017/18	166.7	145.2	132.7	per 10,000	↓	↑
2.08i - Average difficulties score for all looked after children aged 5-16 who have been in care for at least 12 months on 31st March	5-16 yrs	Persons	2017/18	13.8	14.9	14.2	Score	–	–
2.08ii - Percentage of children where there is a cause for concern	5-16 yrs	Persons	2017/18	36.7	42.7	38.6	%	–	→
2.09i - Smoking prevalence at age 15 - current smokers (WAY survey)	15 yrs	Persons	2014/15	9.46	8.68	8.20	%	–	–
2.09ii - Smoking prevalence at age 15 - regular smokers (WAY survey)	15 yrs	Persons	2014/15	6.49	6.21	5.45	%	–	–
2.09iii - Smoking prevalence at age 15 - occasional smokers (WAY survey)	15 yrs	Persons	2014/15	2.97	2.47	2.74	%	–	–
2.10ii - Emergency Hospital Admissions for Intentional Self-Harm	All ages	Persons	2017/18	215.7	194.6	185.5	per 100,000	–	→
2.11i - Proportion of the population meeting the recommended '5-a-day' on a 'usual day' (adults)	16+ yrs	Persons	2017/18	47.4	53.3	54.8	%	–	↓
2.11ii - Average number of portions of fruit consumed daily (adults)	16+ yrs	Persons	2017/18	2.38	2.46	2.51	Average daily quantity	–	↓
2.11iii - Average number of portions of vegetables consumed daily (adults)	16+ yrs	Persons	2017/18	2.46	2.59	2.65	Average daily quantity	–	↓
2.11iv - Percentage who eat 5 portions or more of fruit and veg per day at age 15	15 yrs	Persons	2014/15	49.6	49.6	52.4	%	–	–
2.11v - Average number of portions of fruit consumed daily at age 15 (WAY survey)	15 yrs	Persons	2014/15	2.45	2.30	2.39	Average daily quantity	–	–
2.11vi - Average number of portions of vegetables consumed daily at age 15 (WAY survey)	15 yrs	Persons	2014/15	2.25	2.27	2.40	Average daily quantity	–	–
2.12 - Percentage of adults (aged 18+) classified as overweight or obese	18+ yrs	Persons	2017/18	61.5	64.1	62.0	%	–	→
2.13i - Percentage of physically active adults	19+ yrs	Persons	2017/18	61.9	64.0	66.3	%	–	→

Indicator	Age	Sex	Period	Value	Value (Region)	Value (England)	Unit	Recent trend	Change from previous
2.13ii - Percentage of physically inactive adults	19+ yrs	Persons	2017/18	23.0	24.1	22.2	%	-	→
2.14 - Smoking Prevalence in adults (18+) - current smokers (APS)	18+ yrs	Persons	2018	18.5	16.7	14.4	%	-	→
2.15i - Successful completion of drug treatment - opiate users	18+ yrs	Persons	2017	6.33	5.52	6.50	%	→	→
2.15ii - Successful completion of drug treatment - non-opiate users	18+ yrs	Persons	2017	49.8	37.7	36.9	%	↑	→
2.15iii - Successful completion of alcohol treatment	18+ yrs	Persons	2017	36.9	38.9	38.9	%	↑	→
2.15iv - Deaths from drug misuse	All ages	Persons	2015 - 17	5.35	5.49	4.33	per 100,000	-	→
2.16 - Adults with substance misuse treatment need who successfully engage in community-based structured treatment following release from prison	18+ yrs	Persons	2017/18	37.0	37.5	32.1	%	-	→
2.17 - Estimated diabetes diagnosis rate	17+ yrs	Persons	2018	85.1	81.9	78.0	%	-	→
2.18 - Admission episodes for alcohol-related conditions (Narrow)	All ages	Persons	2017/18	771.7	697.0	632.3	per 100,000	-	→
2.19 - Cancer diagnosed at early stage (experimental statistics)	All ages	Persons	2017	51.8	50.6	52.2	%	→	→
2.20i - Cancer screening coverage - breast cancer	53-70 yrs	Female	2018	68.1	75.0 @	74.9 @	%	↓	↓
2.20ii - Cancer screening coverage - cervical cancer	25-64 yrs	Female	2018	69.9	74.2 @	71.4 @	%	↓	↓
2.20iii - Cancer screening coverage - bowel cancer	60-74 yrs	Persons	2018	55.7	60.3 @	59.0 @	%	-	→
2.20iv - Abdominal Aortic Aneurysm Screening - Coverage	65	Male	2017/18	79.5	83.3 @	80.8 @	%	→	→
2.22iii - Cumulative percentage of the eligible population aged 40-74 offered an NHS Health Check	40-74 yrs	Persons	2014/15 - 18/19	104.2 $	82.2	90.0	%	-	-
2.22iv - Cumulative percentage of the eligible population aged 40-74 offered an NHS Health Check who received an NHS Health Check	40-74 yrs	Persons	2014/15 - 18/19	47.5	46.3	48.1	%	-	↓
2.22v - Cumulative percentage of the eligible population aged 40-74 who received an NHS Health check	40-74 yrs	Persons	2014/15 - 18/19	49.5	38.1	43.3	%	-	↑
2.23i - Self-reported wellbeing - people with a low satisfaction score	16+ yrs	Persons	2017/18	4.50	4.92	4.41	%	-	→
2.23ii - Self-reported wellbeing - people with a low worthwhile score	16+ yrs	Persons	2017/18	4.06	4.02	3.57	%	-	→
2.23iii - Self-reported wellbeing - people with a low happiness score	16+ yrs	Persons	2017/18	9.51	9.05	8.20	%	-	→
2.23iv - Self-reported wellbeing - people with a high anxiety score	16+ yrs	Persons	2017/18	18.7	21.2	20.0	%	-	→
2.24i - Emergency hospital admissions due to falls in people aged 65 and over	65+ yrs	Persons	2017/18	2224	2102	2170	per 100,000	-	→
2.24ii - Emergency hospital admissions due to falls in people aged 65 and over - aged 65-79	65-79 yrs	Persons	2017/18	1115	1004	1033	per 100,000	-	→
2.24iii - Emergency hospital admissions due to falls in people aged 65 and over - aged 80+	80+ yrs	Persons	2017/18	5440	5288	5469	per 100,000	-	→

Health protection

Indicator	Age	Sex	Period	Value	Value (Region)	Value (England)	Unit	Recent trend	Change from previous
3.01 - Fraction of mortality attributable to particulate air pollution	30+ yrs	Persons	2017	4.27	4.18	5.06	%	–	–
3.02 - Chlamydia detection rate / 100,000 aged 15-24	15-24 yrs	Persons	2018	1562 *	2096 *	1975 *	per 100,000	→	→
3.03i - Population vaccination coverage - Hepatitis B (2 years old)	2 yrs	Persons	2017/18	92.3	- ^	- ^	%	→	→
3.03iii - Population vaccination coverage - Dtap / IPV / Hib (1 year old)	1 yr	Persons	2017/18	93.1 *	94.5 *	93.1 *	%	↓	→
3.03iii - Population vaccination coverage - Dtap / IPV / Hib (2 years old)	2 yrs	Persons	2017/18	95.8 *	96.2 *	95.1 *	%	↓	→
3.03iv - Population vaccination coverage - MenC	1 yr	Persons	2015/16	96.6 *	97.0 *	- [a] *	%	–	→
3.03v - Population vaccination coverage - PCV	1 yr	Persons	2017/18	93.0 *	94.7 *	93.3 *	%	↓	→
3.03vi - Population vaccination coverage - Hib / MenC booster (2 years old)	2 yrs	Persons	2017/18	92.7 *	93.4 *	91.2 *	%	↓	→
3.03vi - Population vaccination coverage - Hib / Men C booster (5 years old)	5 yrs	Persons	2017/18	94.3 *	93.8 *	92.4 *	%	↓	↓
3.03vii - Population vaccination coverage - PCV booster	2 yrs	Persons	2017/18	92.7 *	93.5 *	91.0 *	%	↓	→
3.03viii - Population vaccination coverage - MMR for one dose (2 years old)	2 yrs	Persons	2017/18	92.0 *	93.3 *	91.2 *	%	↓	→
3.03ix - Population vaccination coverage - MMR for one dose (5 years old)	5 yrs	Persons	2017/18	94.1 *	95.9 *	94.9 *	%	↓	↓
3.03x - Population vaccination coverage - MMR for two doses (5 years old)	5 yrs	Persons	2017/18	93.1 *	90.5 *	87.2 *	%	↑	↑
3.03xii - Population vaccination coverage - HPV vaccination coverage for one dose (females 12-13 years old)	12-13 yrs	Female	2017/18	90.2 *	91.5 *	86.9 *	%	↓	→
3.03xiii - Population vaccination coverage - PPV	65+ yrs	Persons	2017/18	73.9 *	71.3 *	69.5 *	%	↑	↓
3.03xiv - Population vaccination coverage - Flu (aged 65+)	65+ yrs	Persons	2017/18	73.7 *	73.7 @ *	72.6 *	%	↓	↑
3.03xv - Population vaccination coverage - Flu (at risk individuals)	6 months-64 yrs	Persons	2017/18	49.1 *	50.3 @ *	48.9 *	%	↓	→
3.03xvi - Population vaccination coverage - HPV vaccination coverage for two doses (females 13-14 years old)	13-14 yrs	Female	2017/18	87.8 *	89.6 *	83.8 *	%	–	→
3.03xvii - Population vaccination coverage - Shingles vaccination coverage (70 years old)	70	Persons	2017/18	44.2 *	46.8 *	44.4 *	%	–	–
3.03xviii - Population vaccination coverage - Flu (2-3 years old) - current method	2-3 yrs	Persons	2017/18	30.9	42.8 @	43.5	%	–	→
3.04 - HIV late diagnosis (%)	15+ yrs	Persons	2015 - 17	42.1 *	47.8 *	41.1 *	%	–	→
3.05i - Proportion of drug sensitive TB cases who had completed a full course of treatment by 12 months	All ages	Persons	2016	87.7	86.1	84.4	%	↑	→
3.05ii - TB incidence (three year average)	All ages	Persons	2015 - 17	17.7	7.39	9.93	per 100,000	–	→
3.06 - NHS organisations with a board approved sustainable development management plan	Not applicable	Not applicable	2015/16	50.0	67.1	66.2	%	→	→
3.08 - Adjusted antibiotic prescribing in primary care by the NHS	All ages	Persons	2017	1.04 *	1.09 *	1.04 *	per STAR-PU	–	↓

Healthcare and premature mortality

Indicator	Age	Sex	Period	Value	Value (Region)	Value (England)	Unit	Recent trend	Change from previous
4.01 - Infant mortality	<1 yr	Persons	2015 - 17	5.83	4.12	3.92	per 1000	–	→
4.02 - Proportion of five year old children free from dental decay	5 yrs	Persons	2016/17	60.2	69.6	76.7	%	–	–
4.03 - Mortality rate from causes considered preventable	All ages	Persons	2015 - 17	212.2	197.2	181.5	per 100,000	–	→
4.04i - Under 75 mortality rate from all cardiovascular diseases	<75 yrs	Persons	2015 - 17	102.2	82.6	72.5	per 100,000	–	→
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable	<75 yrs	Persons	2015 - 17	63.5	53.3	45.9	per 100,000	–	→
4.05i - Under 75 mortality rate from cancer	<75 yrs	Persons	2015 - 17	152.1	143.5	134.6	per 100,000	–	→
4.05ii - Under 75 mortality rate from cancer considered preventable	<75 yrs	Persons	2015 - 17	88.6	84.7	78.0	per 100,000	–	→
4.06i - Under 75 mortality rate from liver disease	<75 yrs	Persons	2015 - 17	19.7	19.1	18.5	per 100,000	–	→
4.06ii - Under 75 mortality rate from liver disease considered preventable	<75 yrs	Persons	2015 - 17	17.5	16.9	16.3	per 100,000	–	→
4.07i - Under 75 mortality rate from respiratory disease	<75 yrs	Persons	2015 - 17	53.9	39.7	34.3	per 100,000	–	→
4.07ii - Under 75 mortality rate from respiratory disease considered preventable	<75 yrs	Persons	2015 - 17	29.7	22.0	18.9	per 100,000	–	→
4.08 - Mortality rate from a range of specified communicable diseases, including influenza	All ages	Persons	2015 - 17	9.20	10.6	10.9	per 100,000	–	→
4.09i - Excess under 75 mortality rate in adults with serious mental illness	18-74 yrs	Persons	2014/15	426.3	376.9	370.0	%	–	→
4.09ii - Proportion of adults in the population in contact with secondary mental health services	18-74 yrs	Persons	2014/15	4.82	5.46	5.36	%	–	↑
4.10 - Suicide rate	10+ yrs	Persons	2015 - 17	9.03	10.4	9.57	per 100,000	–	→
4.11 - Emergency readmissions within 30 days of discharge from hospital	All ages	Persons	2011/12	12.0	12.0	11.8	%	–	→
4.12i - Preventable sight loss - age related macular degeneration (AMD)	65+ yrs	Persons	2017/18	91.9	127.0 @	106.7	per 100,000	↓	→
4.12ii - Preventable sight loss - glaucoma	40+ yrs	Persons	2017/18	10.1	15.0 @	12.6	per 100,000	→	→
4.12iii - Preventable sight loss - diabetic eye disease	12+ yrs	Persons	2017/18	1.83	3.35 @	2.81	per 100,000	↓	→
4.12iv - Preventable sight loss - sight loss certifications	All ages	Persons	2017/18	31.8	48.2 @	41.1	per 100,000	↓	↓
4.13 - Health related quality of life for older people	65+ yrs	Persons	2016/17	0.72	0.73	0.74	Score	–	→
4.14i - Hip fractures in people aged 65 and over	65+ yrs	Persons	2017/18	566.1	569.2	577.8	per 100,000	–	→
4.14ii - Hip fractures in people aged 65 and over - aged 65-79	65-79 yrs	Persons	2017/18	258.1	237.0	246.3	per 100,000	–	→
4.14iii - Hip fractures in people aged 65 and over - aged 80+	80+ yrs	Persons	2017/18	1459	1533	1539	per 100,000	–	→
4.15i - Excess winter deaths index (single year, all ages)	All ages	Persons	Aug 2016 - Jul 2017	14.7	24.9	21.6	%	–	→
4.15ii - Excess winter deaths index (single year, age 85+)	85+ yrs	Persons	Aug 2016 - Jul 2017	26.3	36.7	30.8	%	–	→
4.15iii - Excess winter deaths index (3 years, all ages)	All ages	Persons	Aug 2014 - Jul 2017	17.7	21.8	21.1	%	–	→
4.15iv - Excess winter deaths index (3 years, age 85+)	85+ yrs	Persons	Aug 2014 - Jul 2017	22.9	31.0	29.3	%	–	→
4.16 - Estimated dementia diagnosis rate (aged 65 and over)	65+ yrs	Persons	2018	80.6 *	71.2 *	67.5 *	%	–	→

Accompanying indicator value notes

symbols	Data note
*	Value compared to a goal (see below)
~	Value based on effective sample size <100
$	There is a data quality issue with this value
^	Value suppressed due to incompleteness of source data
&	LAs are allocated the rate of the police force area within which they sit
x	Value is modelled or synthetic estimate
@	Aggregated from all known lower geography values
[a]	Value not published for data quality reasons
[b]	Annual figure includes constituent area(s) with annual figure scaled up data from three quarters' data

Thresholds for indicators that are compared against a goal

Indicator Name	Green	Amber	Red
3.02 - Chlamydia detection rate / 100,000 aged 15-24	>= 2,300	1,900-2,300	< 1,900
3.03iii - Population vaccination coverage - Dtap / IPV / Hib (1 year old)	>= 95%	90-95%	< 90%
3.03iii - Population vaccination coverage - Dtap / IPV / Hib (2 years old)	>= 95%	90-95%	< 90%
3.03iv - Population vaccination coverage - MenC	>= 95%	90-95%	< 90%
3.03v - Population vaccination coverage - PCV	>= 95%	90-95%	< 90%
3.03vi - Population vaccination coverage - Hib / MenC booster (2 years old)	>= 95%	90-95%	< 90%
3.03vi - Population vaccination coverage - Hib / Men C booster (5 years old)	>= 95%	90-95%	< 90%
3.03vii - Population vaccination coverage - PCV booster	>= 95%	90-95%	< 90%
3.03viii - Population vaccination coverage - MMR for one dose (2 years old)	>= 95%	90-95%	< 90%
3.03ix - Population vaccination coverage - MMR for one dose (5 years old)	>= 95%	90-95%	< 90%
3.03x - Population vaccination coverage - MMR for two doses (5 years old)	>= 95%	90-95%	< 90%
3.03xii - Population vaccination coverage - HPV vaccination coverage for one dose (females 12-13 years old)	>= 90%	80-90%	< 80%
3.03xiii - Population vaccination coverage - PPV	>= 75%	65-75%	< 65%
3.03xiv - Population vaccination coverage - Flu (aged 65+)	>= 75%		< 75%
3.03xv - Population vaccination coverage - Flu (at risk individuals)	>= 55%		< 55%
3.03xvi - Population vaccination coverage - HPV vaccination coverage for two doses (females 13-14 years old)	>= 90%	80-90%	< 80%
3.03xvii - Population vaccination coverage - Shingles vaccination coverage (70 years old)	>= 60%	50-60%	< 50%
3.04 - HIV late diagnosis (%)	< 25%	25-50%	>= 50%
3.08 - Adjusted antibiotic prescribing in primary care by the NHS	<= mean England prescribing (2013/14)		> mean England prescribing (2013/14)
4.16 - Estimated dementia diagnosis rate (aged 65 and over)	>= 66.7% (significantly)	Similar to 66.7%	< 66.7% (significantly)

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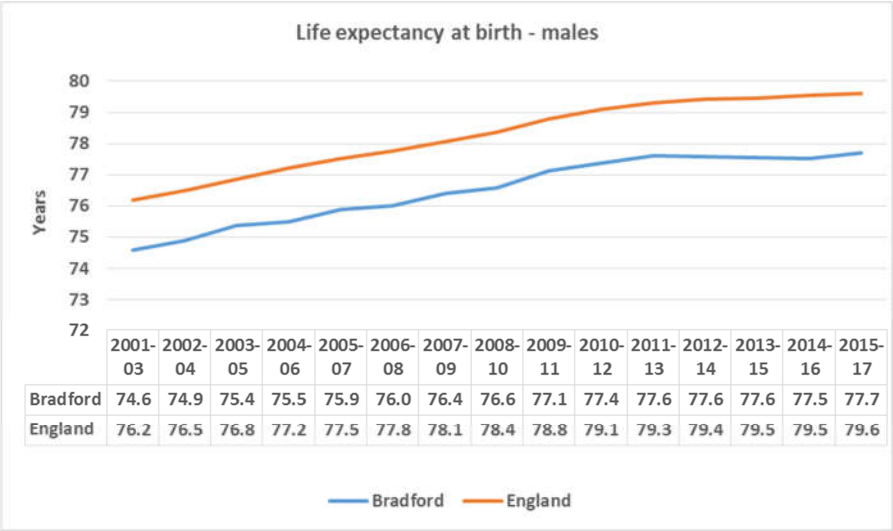
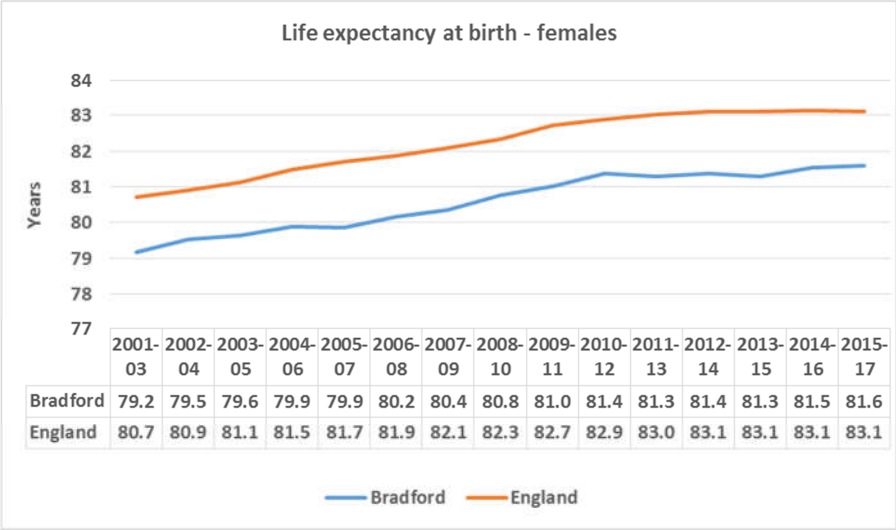
Appendix B – Charts relating to specific indicators

3.5.1 Life expectancy at birth

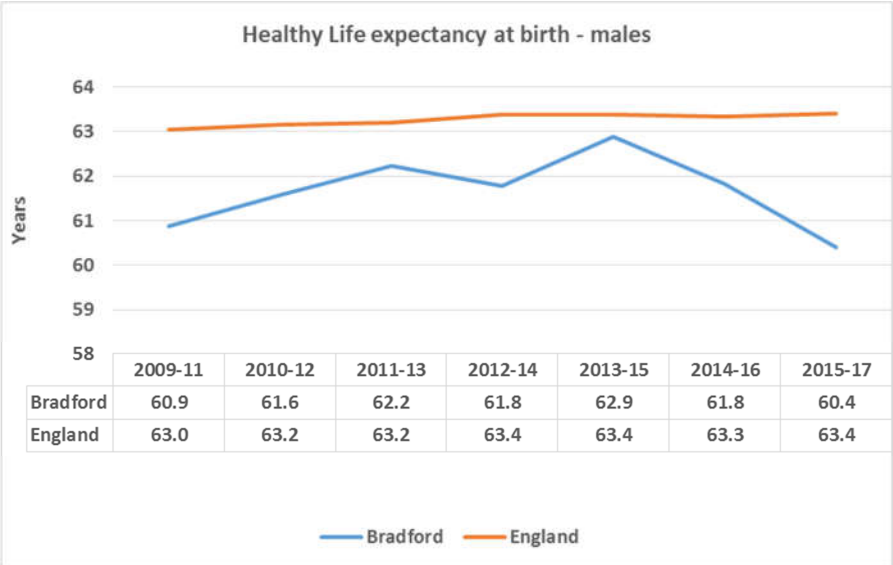


	2001-03	2002-04	2003-05	2004-06	2005-07	2006-08	2007-09	2008-10	2009-11	2010-12	2011-13	2012-14	2013-15	2014-16	2015-17
Bradford	74.6	74.9	75.4	75.5	75.9	76.0	76.4	76.6	77.1	77.4	77.6	77.6	77.6	77.5	77.7
England	76.2	76.5	76.8	77.2	77.5	77.8	78.1	78.4	78.8	79.1	79.3	79.4	79.5	79.5	79.6

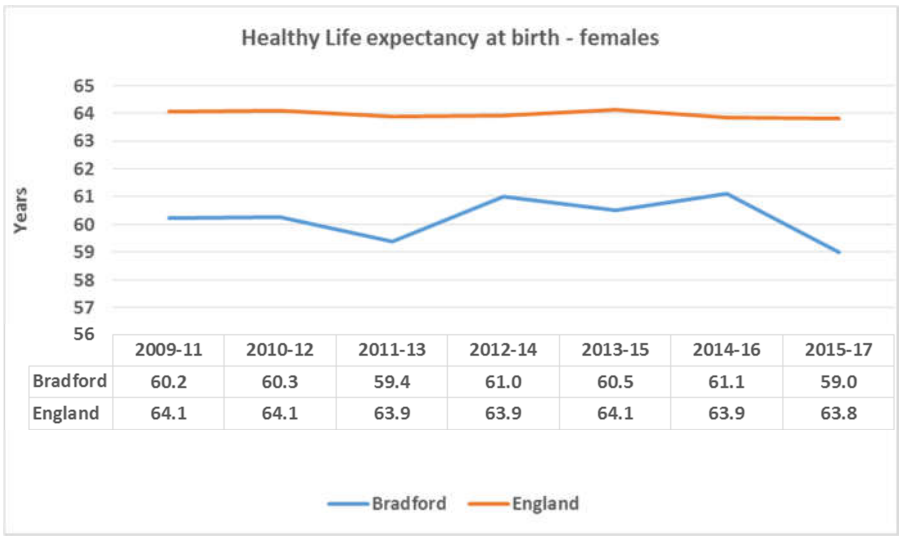


	2001-03	2002-04	2003-05	2004-06	2005-07	2006-08	2007-09	2008-10	2009-11	2010-12	2011-13	2012-14	2013-15	2014-16	2015-17
Bradford	79.2	79.5	79.6	79.9	79.9	80.2	80.4	80.8	81.0	81.4	81.3	81.4	81.3	81.5	81.6
England	80.7	80.9	81.1	81.5	81.7	81.9	82.1	82.3	82.7	82.9	83.0	83.1	83.1	83.1	83.1

3.5.2 Healthy Life expectancy at birth

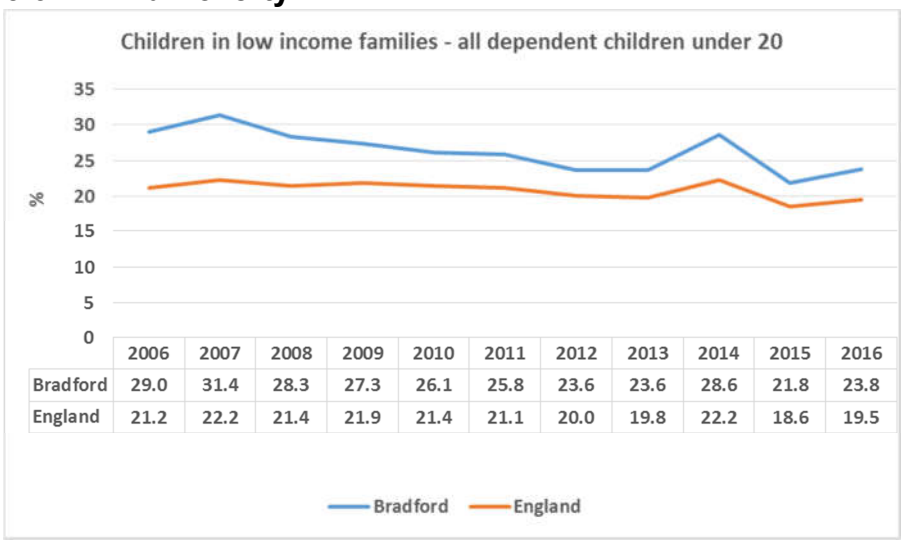


	2009-11	2010-12	2011-13	2012-14	2013-15	2014-16	2015-17
Bradford	60.9	61.6	62.2	61.8	62.9	61.8	60.4
England	63.0	63.2	63.2	63.4	63.4	63.3	63.4



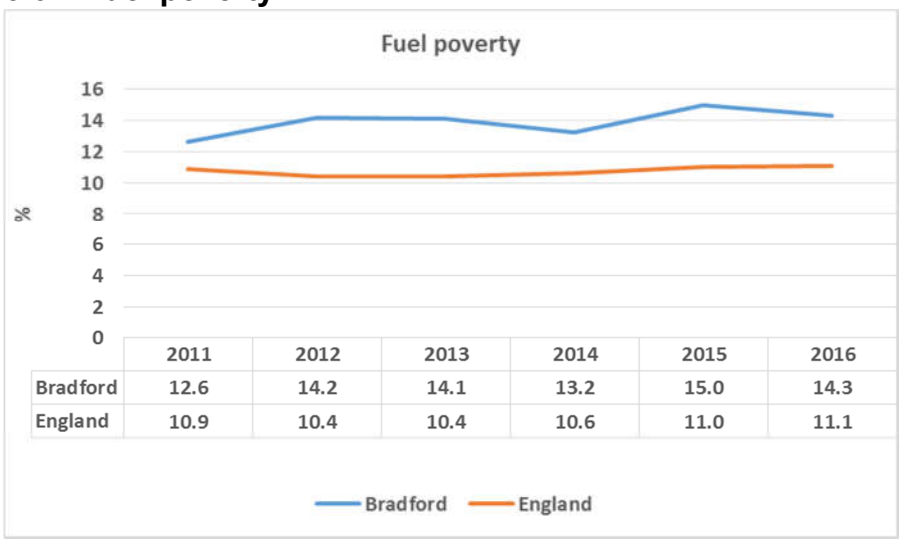
	2009-11	2010-12	2011-13	2012-14	2013-15	2014-16	2015-17
Bradford	60.2	60.3	59.4	61.0	60.5	61.1	59.0
England	64.1	64.1	63.9	63.9	64.1	63.9	63.8

3.6.1 Child Poverty



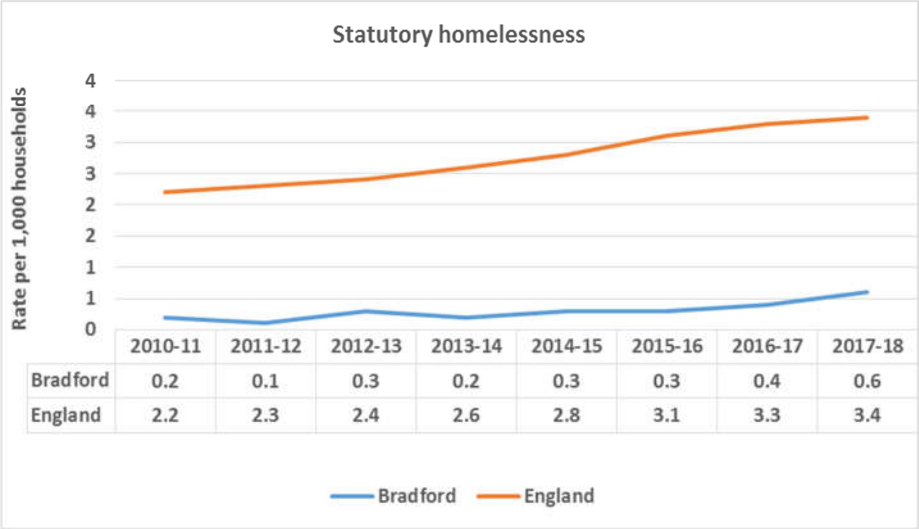
	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Bradford	29.0	31.4	28.3	27.3	26.1	25.8	23.6	23.6	28.6	21.8	23.8
England	21.2	22.2	21.4	21.9	21.4	21.1	20.0	19.8	22.2	18.6	19.5

3.6.2 Fuel poverty



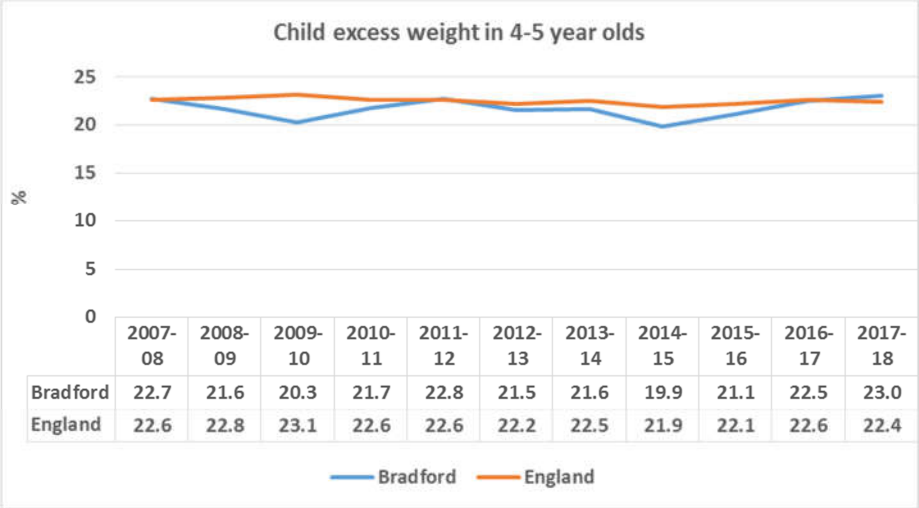
	2011	2012	2013	2014	2015	2016
Bradford	12.6	14.2	14.1	13.2	15.0	14.3
England	10.9	10.4	10.4	10.6	11.0	11.1

3.6.3 Homelessness

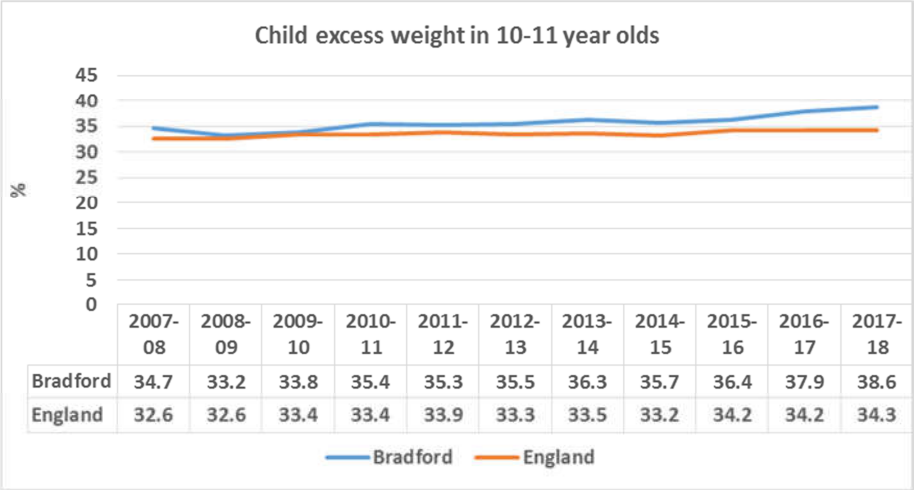


	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18
Bradford	0.2	0.1	0.3	0.2	0.3	0.3	0.4	0.6
England	2.2	2.3	2.4	2.6	2.8	3.1	3.3	3.4

3.7.1 Child excess weight

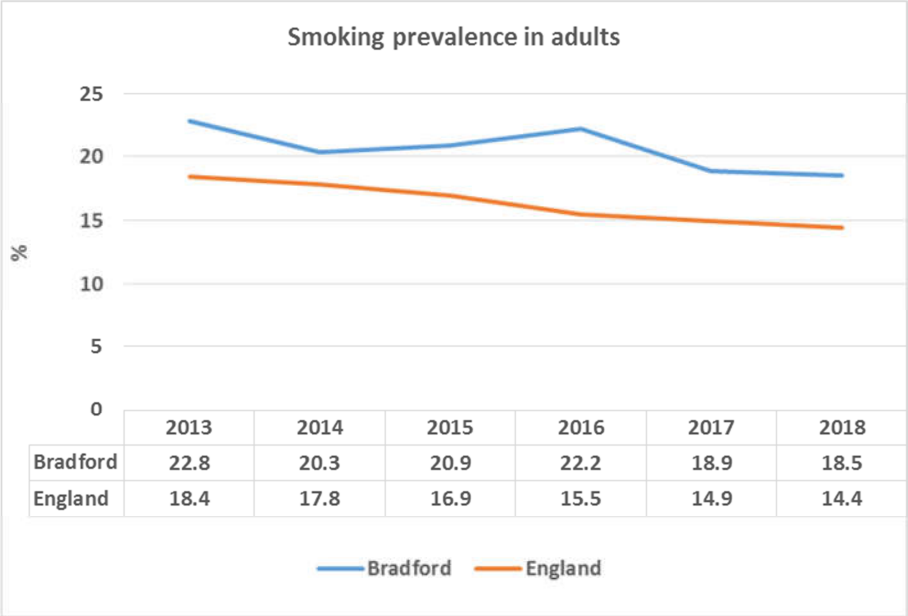


	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18
Bradford	22.7	21.6	20.3	21.7	22.8	21.5	21.6	19.9	21.1	22.5	23.0
England	22.6	22.8	23.1	22.6	22.6	22.2	22.5	21.9	22.1	22.6	22.4



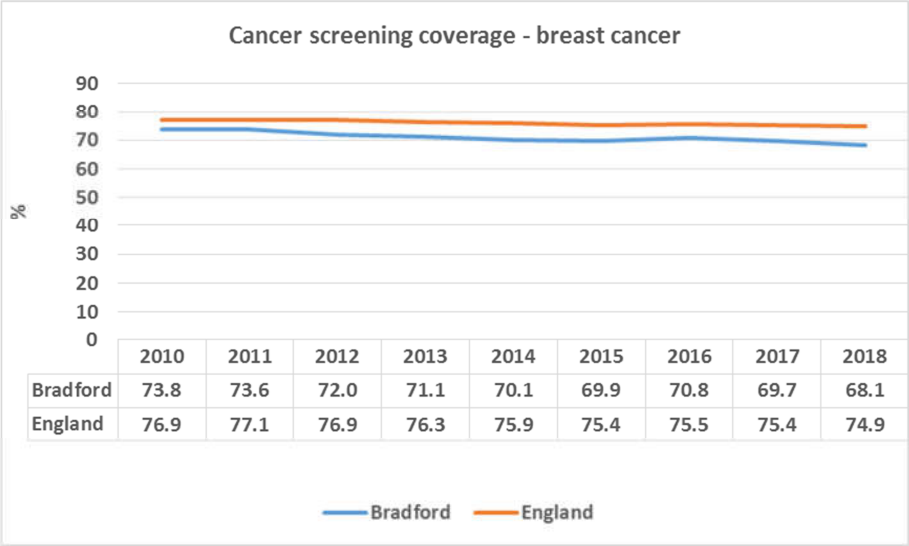
	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18
Bradford	34.7	33.2	33.8	35.4	35.3	35.5	36.3	35.7	36.4	37.9	38.6
England	32.6	32.6	33.4	33.4	33.9	33.3	33.5	33.2	34.2	34.2	34.3

3.7.2 **Smoking prevalence in adults**

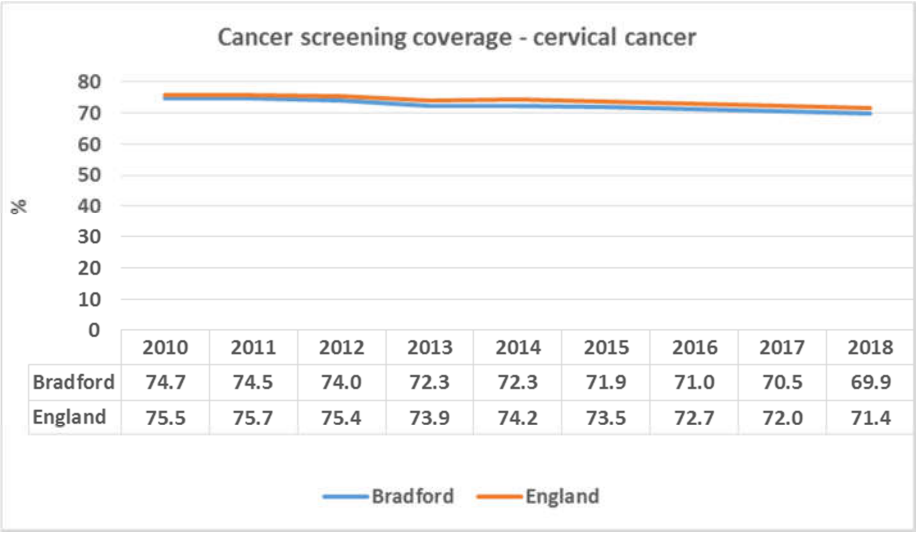


	2013	2014	2015	2016	2017	2018
Bradford	22.8	20.3	20.9	22.2	18.9	18.5
England	18.4	17.8	16.9	15.5	14.9	14.4

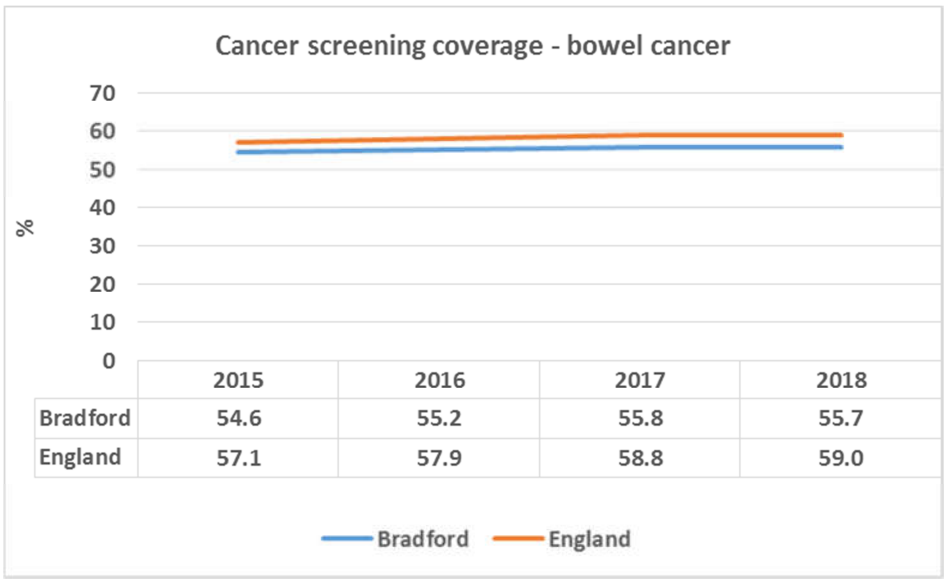
3.7.3 **Cancer Screening coverage**



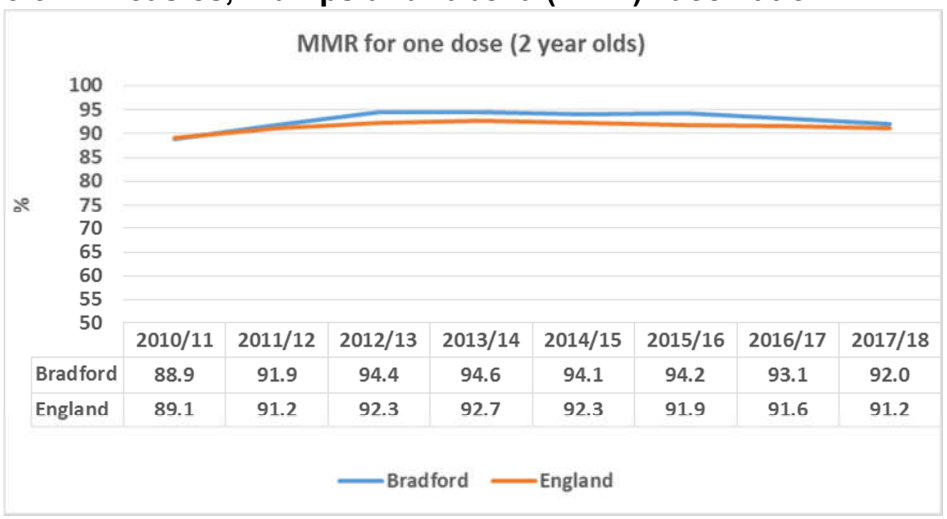
	2010	2011	2012	2013	2014	2015	2016	2017	2018
Bradford	73.8	73.6	72.0	71.1	70.1	69.9	70.8	69.7	68.1
England	76.9	77.1	76.9	76.3	75.9	75.4	75.5	75.4	74.9

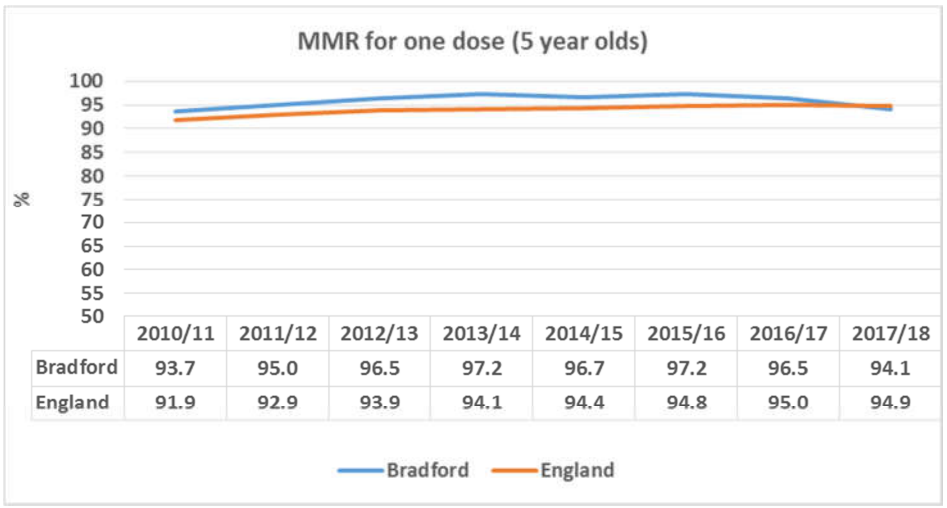


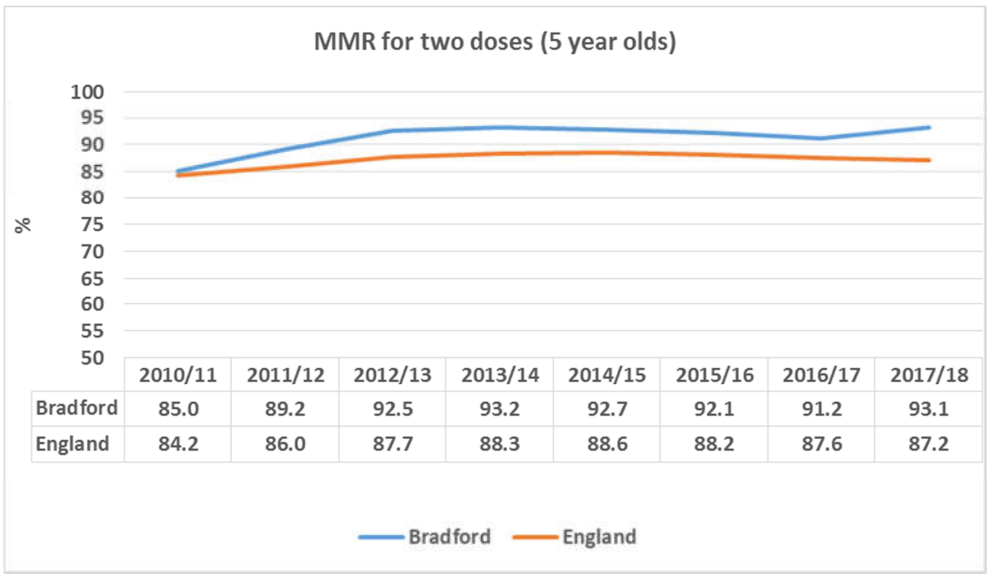
	2010	2011	2012	2013	2014	2015	2016	2017	2018
Bradford	74.7	74.5	74.0	72.3	72.3	71.9	71.0	70.5	69.9
England	75.5	75.7	75.4	73.9	74.2	73.5	72.7	72.0	71.4



3.8.1 **Measles, mumps and rubella (MMR) vaccination**

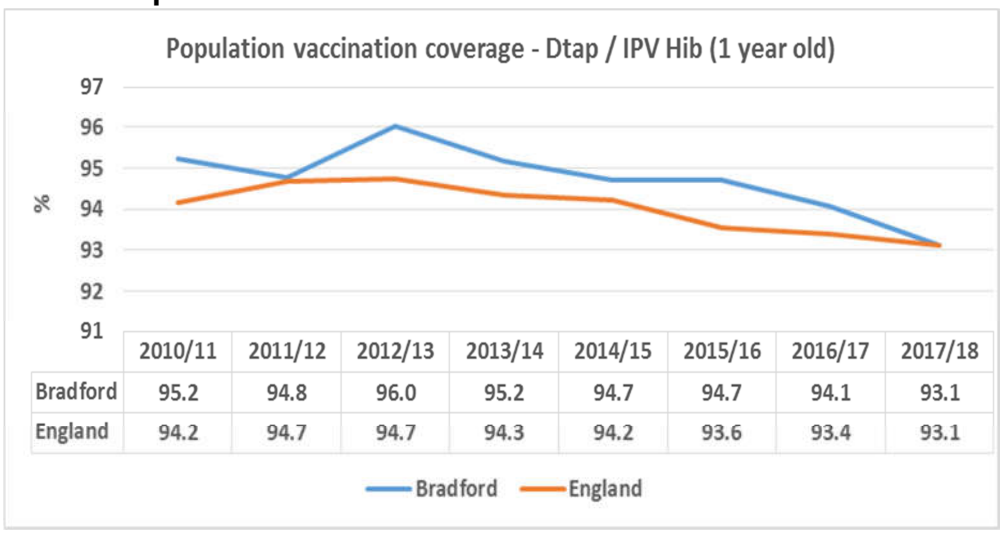




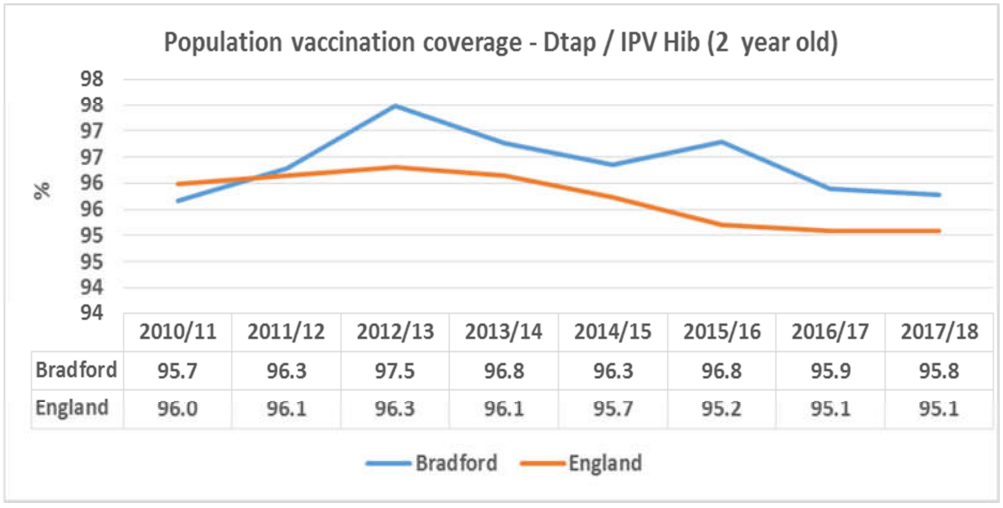


	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Bradford	85.0	89.2	92.5	93.2	92.7	92.1	91.2	93.1
England	84.2	86.0	87.7	88.3	88.6	88.2	87.6	87.2

3.8.2 **Dtap / IPV / Hib vaccination**

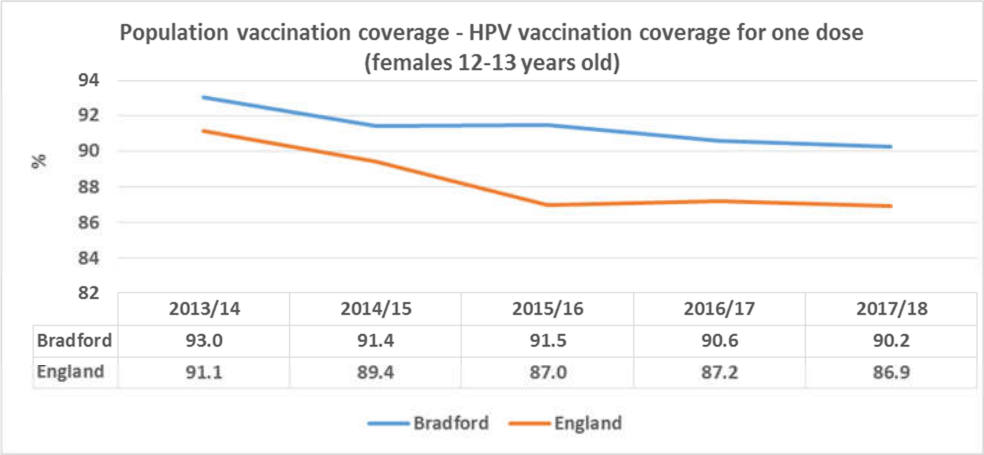


	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Bradford	95.2	94.8	96.0	95.2	94.7	94.7	94.1	93.1
England	94.2	94.7	94.7	94.3	94.2	93.6	93.4	93.1



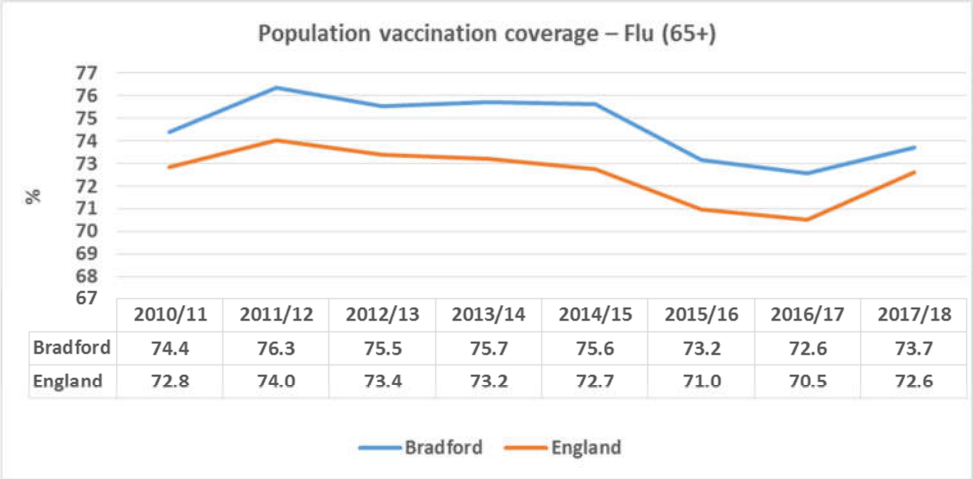
	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Bradford	95.7	96.3	97.5	96.8	96.3	96.8	95.9	95.8
England	96.0	96.1	96.3	96.1	95.7	95.2	95.1	95.1

3.8.3 **HPV vaccination**

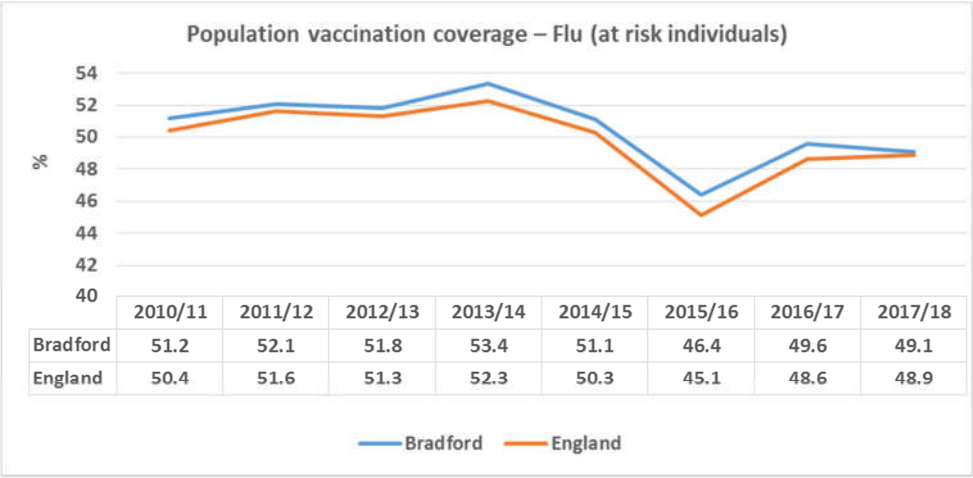


	2013/14	2014/15	2015/16	2016/17	2017/18
Bradford	93.0	91.4	91.5	90.6	90.2
England	91.1	89.4	87.0	87.2	86.9

3.8.4 **Flu vaccination**

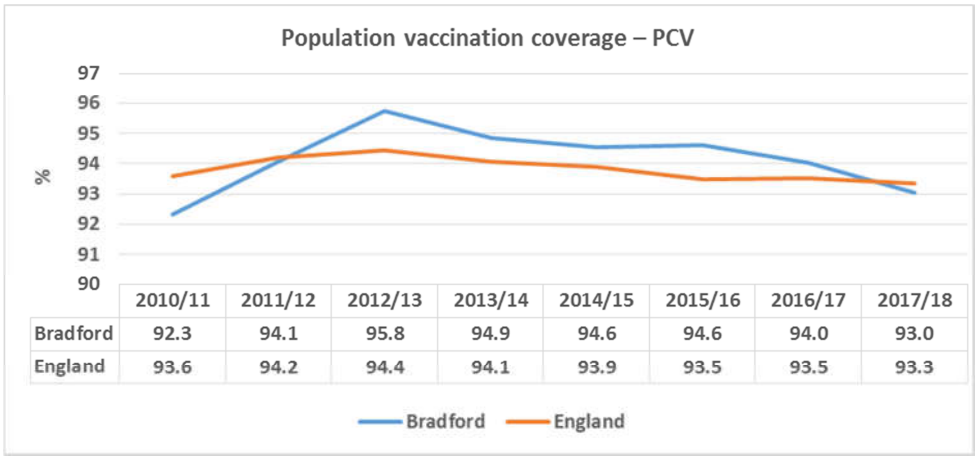


	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Bradford	74.4	76.3	75.5	75.7	75.6	73.2	72.6	73.7
England	72.8	74.0	73.4	73.2	72.7	71.0	70.5	72.6

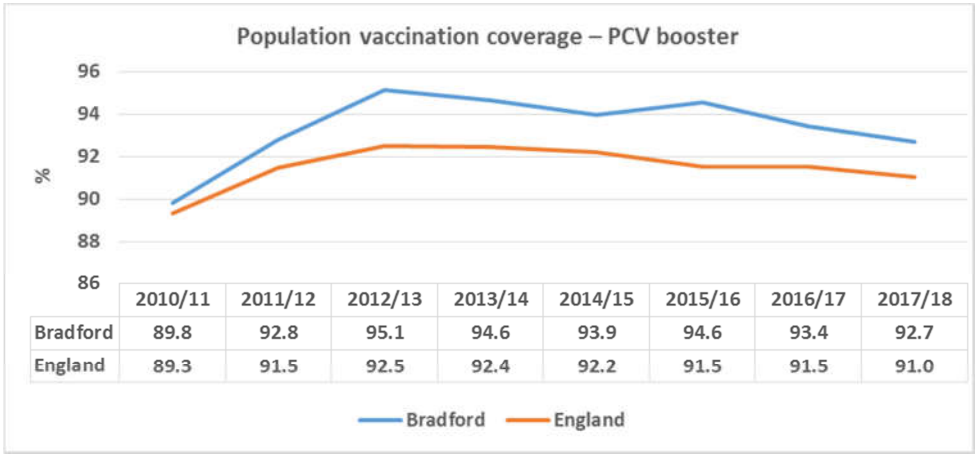


	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Bradford	51.2	52.1	51.8	53.4	51.1	46.4	49.6	49.1
England	50.4	51.6	51.3	52.3	50.3	45.1	48.6	48.9

3.8.5 **PCV vaccination**

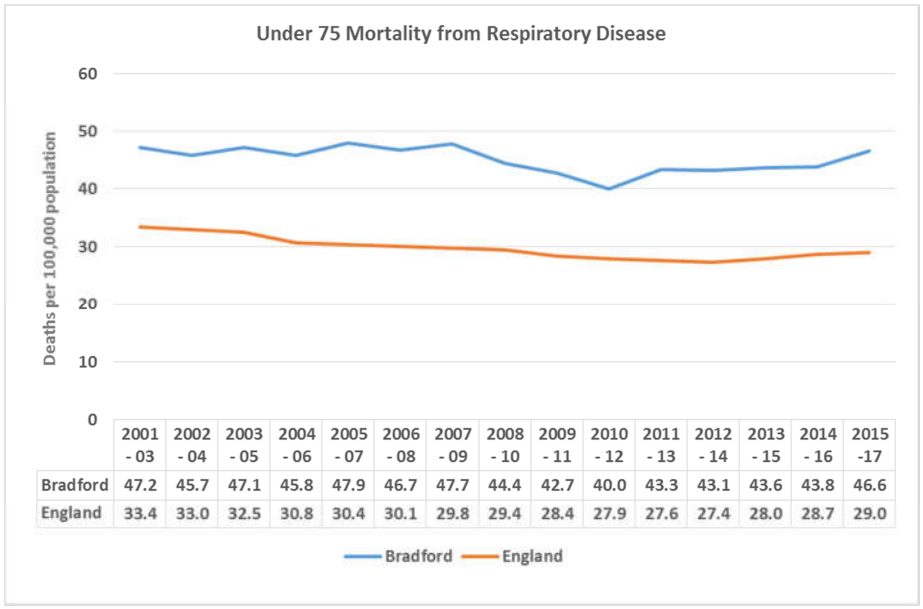


	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Bradford	92.3	94.1	95.8	94.9	94.6	94.6	94.0	93.0
England	93.6	94.2	94.4	94.1	93.9	93.5	93.5	93.3

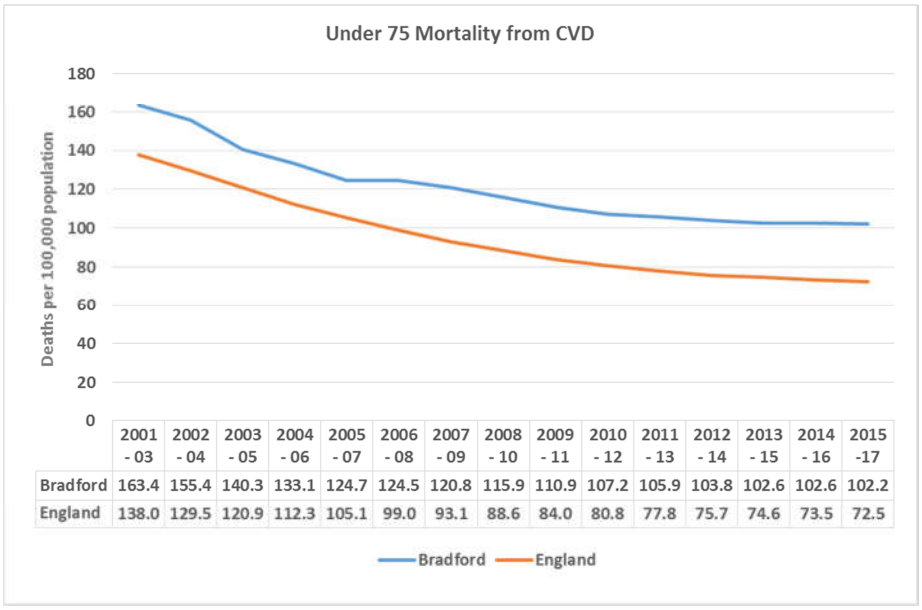


	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Bradford	89.8	92.8	95.1	94.6	93.9	94.6	93.4	92.7
England	89.3	91.5	92.5	92.4	92.2	91.5	91.5	91.0

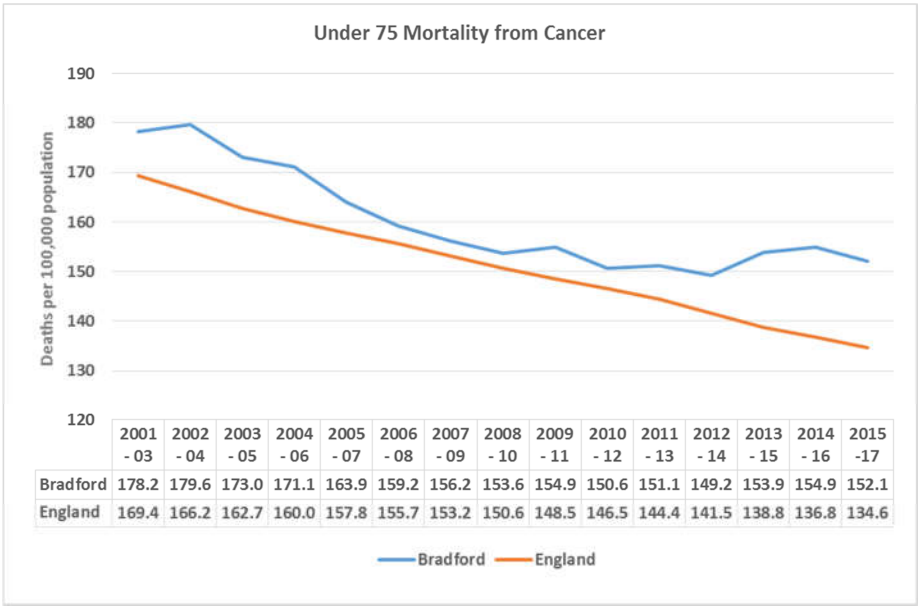
3.9.1 **Premature Mortality**



	2001 - 03	2002 - 04	2003 - 05	2004 - 06	2005 - 07	2006 - 08	2007 - 09	2008 - 10	2009 - 11	2010 - 12	2011 - 13	2012 - 14	2013 - 15	2014 - 16	2015 -17
Bradford	47.2	45.7	47.1	45.8	47.9	46.7	47.7	44.4	42.7	40.0	43.3	43.1	43.6	43.8	46.6
England	33.4	33.0	32.5	30.8	30.4	30.1	29.8	29.4	28.4	27.9	27.6	27.4	28.0	28.7	29.0

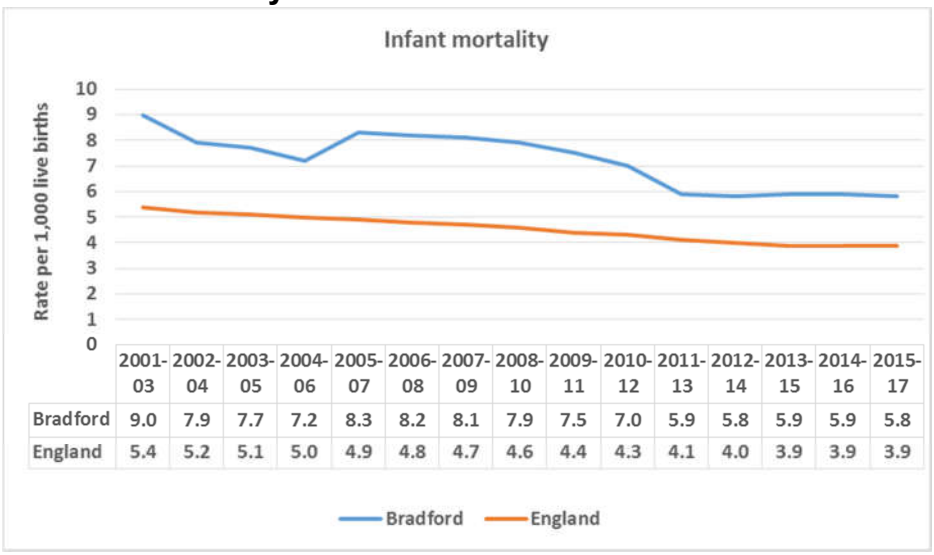


	2001 - 03	2002 - 04	2003 - 05	2004 - 06	2005 - 07	2006 - 08	2007 - 09	2008 - 10	2009 - 11	2010 - 12	2011 - 13	2012 - 14	2013 - 15	2014 - 16	2015 -17
Bradford	163.4	155.4	140.3	133.1	124.7	124.5	120.8	115.9	110.9	107.2	105.9	103.8	102.6	102.6	102.2
England	138.0	129.5	120.9	112.3	105.1	99.0	93.1	88.6	84.0	80.8	77.8	75.7	74.6	73.5	72.5



	2001 - 03	2002 - 04	2003 - 05	2004 - 06	2005 - 07	2006 - 08	2007 - 09	2008 - 10	2009 - 11	2010 - 12	2011 - 13	2012 - 14	2013 - 15	2014 - 16	2015 -17
Bradford	178.2	179.6	173.0	171.1	163.9	159.2	156.2	153.6	154.9	150.6	151.1	149.2	153.9	154.9	152.1
England	169.4	166.2	162.7	160.0	157.8	155.7	153.2	150.6	148.5	146.5	144.4	141.5	138.8	136.8	134.6

3.9.2 **Infant mortality**



	2001-03	2002-04	2003-05	2004-06	2005-07	2006-08	2007-09	2008-10	2009-11	2010-12	2011-13	2012-14	2013-15	2014-16	2015-17
Bradford	9.0	7.9	7.7	7.2	8.3	8.2	8.1	7.9	7.5	7.0	5.9	5.8	5.9	5.9	5.8
England	5.4	5.2	5.1	5.0	4.9	4.8	4.7	4.6	4.4	4.3	4.1	4.0	3.9	3.9	3.9

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City of BRADFORD METROPOLITAN DISTRICT COUNCIL

Report of the City Solicitor to the meeting of the Health and Social Care Overview & Scrutiny Committee to be held on 24 October 2019

O

Subject: Health and Social Care Overview and Scrutiny Committee Work Programme 2019/20

Summary statement:
This report presents the work programme 2019/20

Parveen Akhtar
City Solicitor

Portfolio:

Healthy People and Places

Report Contact: Caroline Coombes
Phone: (01274) 432313
E-mail: caroline.coombes@bradford.gov.uk

1. **Summary**

1.1 This report presents the work programme 2019/20.

2. **Background**

2.1 The Committee adopted its 2019/20 work programme at its meeting of 1 August 2019.

3. **Report issues**

3.1 **Appendix A** of this report presents the work programme 2019/20. It lists issues and topics that have been identified for inclusion in the work programme and have been scheduled for consideration over the coming year**.**

4. **Options**

4.1 Members may wish to amend and / or comment on the work programme at **Appendix A**.

5. **Contribution to corporate priorities**

5.1 The Health and Social Care Overview and Scrutiny Committee Work Programme 2019/20 reflects the ambition of the District Plan for 'all of our population to be healthy, well and able to live independently for a long as possible' (District Plan: Better health, better lives).

6. **Recommendations**

6.1 That the Committee notes the information in **Appendix A**

7. **Background documents**

7.1 Constitution of the Council

8. **Not for publication documents**

None

9. **Appendices**

9.1 **Appendix A** – Health and Social Care Overview and Scrutiny Committee work programme 2019/20

Democratic Services - Overview and Scrutiny

Appendix A

Health and Social Care O&S Committee

Scrutiny Lead: Caroline Coombes tel - 43 2313

Work Programme

Agenda	Description	Report	Comments
Thursday, 28th November 2019 at City Hall, Bradford			
Chair's briefing 12/11/2019 Report deadline 14/11/2019			
1) Health and Wellbeing Board Annual Report	Annual update	Sadia Hussain	resolution of 4 October 2018
2) Carers' Services	Update on the Carers' Service and Carers' Strategy	Julie Robinson-Joyce / Tony Sheeky	resolution of 25 October 2018
3) Adult and Community Services Annual Performance Report 2018-19	Annual Report	Paul Swallow	Resolution 4 October 2018
4) Clinical Commissioning Groups' annual performance report	Annual report	Michelle Turner	Resolution of 4 October 2018
Thursday, 12th December 2019 at City Hall, Bradford			
Chair's briefing 27/11/2019 Report deadline 28/11/2019			
1) Home support services	Update	Paul Hunt	Resolution of 12 July 2018
2) Adult Services Service Improvement Boards	To be scoped	TBC	Resolution of 22 November 2018
3) An update from the Care Quality Commission	Annual report	TBC	
4) Older People's Accommodation Across the district	Progress update	Lyn Sowray	Resolution of 24 January 2019
Thursday, 30th January 2020 at City Hall, Bradford.			
Report deadline 16/01/2020			
1) Budget and Financial Outlook - Dept of Health and Wellbeing	Annual report	Wendy Wilkinson	
3) Safeguarding Adults Strategic Plan and Multi-Agency Safeguarding Hub	Update	TBC	Resolution of 6 September 2018
3) Living Well service	Report to cover business/work charter, schools charter and social movement work	Liz Barry	

Health and Social Care O&S Committee

Scrutiny Lead: Caroline Coombes tel - 43 2313

Work Programme

Agenda	Description	Report	Comments
Thursday, 13th February 2020 at City Hall, Bradford			
Report deadline 30/01/2020			
1) Primary medical care update - Bradford District and Craven	To include information on the patient voice portal and community navigators. Patient engagement leads working in Bradford City CCG area to be invited to attend	Victoria Wallace	
2) Healthwatch Bradford and District	Item to be scoped but to include an update on work on patient voice related to stroke services	Healthwatch Bradford and District	Resolution of 20 February 2019
Thursday, 5th March 2020 at City Hall, Bradford			
Report deadline 20/02/2020			
1) Advocacy Services	Report to include presentation of performance information and outcomes, and consideration of demand for services, cultural competency and diversity	Kerry James/Sasha Bhatt	Resolution of 21 March 2019
2) Shipley Hospital	Report on the consultation process and findings on the proposed closure of Shipley Hospital to include details of travel planning to alternative provision	Helen Farmer	Resolution of 1 August 2019
3) Sexual Health Services	To be scoped	TBC	
Thursday, 2nd April 2020 at City Hall, Bradford.			
Report deadline 19/03/2020.			
1) Cancer	Report on the outcomes of the lung cancer pilot programme and an update on the cancer waiting times target performance	Janet Hargreaves	Resolution of 4 July 2019