City of
BRADFORD
METROPOLITAN DISTRICT COUNCIL

Report of the Director of Health and Wellbeing to the meeting of Bradford and Airedale Health and Wellbeing Board to be held on 24th July 2019

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Subject:

Living well for longer: what the Joint Strategic Needs Assessment is telling us about the health and wellbeing of people in Bradford District

Summary statement:

The Health and Wellbeing Board has a statutory duty to produce a Joint Strategic Needs Assessment (JSNA). This paper summarises the main findings of the JSNA, focusing on the headline indicator of health and wellbeing for a population - healthy life expectancy - and health inequalities. The paper goes on to consider what issues might require further consideration in response to the findings.

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1. SUMMARY

The Health and Wellbeing Board has a statutory duty to produce a Joint Strategic Needs Assessment (JSNA). This paper summarises the main findings of the JSNA, focusing on the headline indicator of health and wellbeing for a population - healthy life expectancy - and health inequalities. The paper goes on to consider what issues might require further consideration in response to the findings.

2. BACKGROUND

The NHS and upper tier local authorities have had a statutory duty to produce a JSNA since 2007. The purpose of the JSNA is to inform the Joint Health and Wellbeing Strategy (JHWBS) which, in turn, aims to improve the health and wellbeing of the local population and to reduce inequalities. Both the JSNA and JHWBS are intended to be part of a continuous process of assessment and planning, supporting the identification of priorities and gaps for commissioning, based on both evidence and need.

JSNAs are assessments of the current and future health and social care needs of the local community. These are needs that could be considered to be best addressed by the local authority, CCGs, NHS England, or by working in partnership with others across the public, private and third sectors. JSNAs are produced by health and wellbeing boards, and are unique to each local area. The policy intention is for health and wellbeing boards to also consider wider factors that impact on their communities' health and wellbeing, and local assets that can help to improve outcomes and reduce inequalities. Local areas are free to undertake JSNAs in a way best suited to their local circumstances.

3. OTHER CONSIDERATIONS

3.1 The Bradford JSNA

Our JSNA describes the health problems and ***needs*** of the population of Bradford District. Over the last 12 months we have tried to move away from a primarily deficit model of need, towards a more asset based approach; identifying factors or resources which enhance the ability of individuals, communities and populations to maintain and sustain health and wellbeing in the District. Such an approach provides a new way of challenging health inequalities, valuing resilience, strengthening community networks and recognising local expertise.

The JSNA is a living document with updates regularly published. There is a 12 month work plan which is overseen by the JSNA Steering Group.

The JSNA is not a single static document that can be summarised; it is a suite of resources that is intended to be dynamic and current:

- Overarching: There are five overarching chapters (aligned to the Joint Health and Wellbeing Strategy) which provide an overview of the health and wellbeing needs of people in Bradford District.
    - The population of Bradford District
    - Our children have the best start in life
    - The people of Bradford District have good mental wellbeing

    - People are living their lives well and ageing well
    - Bradford District is a healthy place to live, learn and work
- Health needs assessments: There are a number of more detailed service/population specific health needs assessments that have been undertaken to provide a more useful and accurate picture of need in response to specific commissioning intentions or identified gaps, for example, dementia, learning disability and autism, and families.
- Localities: There is also a locality element to the JSNA; this includes ward and area profiles, as well as profiles for the 13 community partnerships.
- Bespoke analyses: There are a number of bespoke analyses in response to requests from partners. Some analyses are also produced proactively in response to changes in outcome data which warrant further exploration, for example, infant mortality and suicide prevention.
- The annual Director of Public Health Report.
- Pharmaceutical Needs Assessment.

In January 2019 we published a refresh of all of the JSNA content. It is available at: https://jsna.bradford.gov.uk/

3.2 What is the JSNA is telling us about the health and wellbeing needs of our population?

People in Bradford District experience poorer health and wellbeing than people in many other parts of the country. We know this because life expectancy is lower, and a secondary measure, healthy life expectancy, tells us that people in Bradford District also spend more years of their life in poor health.

What is healthy life expectancy?
Healthy life expectancy is a summary measure of mortality and ill health; it shows the years a person can expect to live in good health (rather than with a disability or in poor health). A measure of the average number of years a person would expect to live in good health based on contemporary mortality rates and prevalence of self-reported good health. The prevalence of good health is derived from responses to a survey question on general health from the Annual Population Survey.

Life expectancy is improving in Bradford District, a trend that is not necessarily replicated in other parts of the country. However, the overarching challenge for us as a District is not just about how long people live, but how well ***all*** people in the District live, and living happy and fulfilling lives. The latter is measured by healthy life expectancy.

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).

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.

The overarching reasons why people die early are not necessarily the same as why people may be in poor health. The main causes of early death in the District are the same as many other areas: cardiovascular disease, respiratory disease and cancer; infant mortality is also an important cause to note in the District.

Long term conditions such as diabetes, asthma and COPD all influence levels of ill health and disability during a person's life. Evidence from research also suggests that pain, musculoskeletal conditions, skin conditions, and sensory organ diseases also contribute. Mental health is one of the most important factors, including anxiety, depression and serious mental illnesses such as schizophrenia.

We often consider the contribution of individual conditions and diseases separately, missing the fact that for many people it is the norm to have multiple long term conditions (multimorbidity), and mental and physical health problems also co-exist. There is a growing body of evidence, including our own data, to show that it is multimorbidity and not age per se that is driving demand in our health and care system.

Although the causes of ill health, disability and early death differ, the underlying causes are largely the same. Factors such as smoking, poor diet and obesity, low levels of physical activity, and drug and alcohol use are the dominant drivers. We often think of these as lifestyle factors, however, the term lifestyle factors is misleading as it encourages a disproportionate focus on individuals and their ability to make different lifestyle choices, rather than on the commercial, environmental and social determinants of health. It is these that are the biggest influence on our

opportunities to improve the number of years that we live in good health.

We know that people are ageing in poor health *now*, and that people are dying early *now*; accordingly we need to strike a balance between long and short term action. There is very good evidence about what we can do in the short term to improve both life expectancy and healthy life expectancy: focused and targeted health care to support people to give up smoking, blood pressure control, control of cholesterol, and interventions to reduce infant mortality. If we were also thinking about how we might support independence in later life, physical activity, or simply moving more, would be added to this list.

We often assume that action to tackle the social determinants of health is about long term health gains, and this would largely be right, but not entirely. The above interventions are medical ones; however, they can't be tackled effectively without considering the context in which people live their lives. A recently published study from the Born in Bradford cohort emphasises this; the study examining the impact of the 2008-2010 economic recession on smoking during pregnancy, found that women who continued to smoke during pregnancy were most likely to experience financial stress. This underlines the fact that we can't rely on a basic smoking cessation offer, without addressing the underlying factors such as debt and financial stress which affect the likelihood of a person smoking, and consequently any decision to quit.

There is no single most important intervention, idea or policy that will increase healthy life expectancy and reduce inequalities at a population level. A range of approaches are needed at scale, delivered systematically over a prolonged period of time to make a difference.

We must look to promote health and wellbeing and prevent ill health. This will require a whole systems response, recognising the complex factors that combine to influence our behaviours and health and wellbeing. We must delay the onset of ill health, long term conditions and multimorbidity as long as possible, and if and when people do develop poor health and long term conditions, they should be well managed, taking into account the context in which people live their lives.

Published almost a decade ago, the recommendations of the Marmot Review remain relevant: giving every child the best possible start in life; creating job opportunities and fair employment for all; ensuring a healthy standard of living for the whole population; developing health creating physical environments; empowering communities; and strengthening health prevention. These recommendations are reflected in our Joint Health and Wellbeing Strategy: Connecting People and Place for Better Health and Wellbeing.

The Joint Health and Wellbeing Strategy already sets out the actions that we will take to create the conditions for health and wellbeing to flourish in Bradford District. However, the JSNA highlights some important areas for further consideration:

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 described in the JSNA. The fact that people living in the most deprived parts of Bradford can only expect to get to age 50 in good health is also a challenge in terms of economic

productivity. 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 has been developing an anti-poverty strategy: Bradford District Anti-poverty Co-ordination Group's Approach for Tackling Poverty.

Mental wellbeing: Whilst we already have a Mental Wellbeing Strategy, the JSNA emphasises the need for action. There is an overwhelming body of evidence that most lifetime mental ill health arises before adulthood; the age of onset of mental ill health predates physical illness by several decades. Mental health issues are common, and will affect about 155,000 people in our District at some point during a person's life, with approximately 6,200 people being in need of, and in contact with specialist mental health services at any given time. As many as one in ten children and young people are affected by mental health problems.

The determinants of mental health and mental wellbeing are largely the same as many physical health problems, including deprivation, unemployment, financial stress, violence, stressful life events, and poor housing. Accordingly, much of the action needed to improve mental health and mental wellbeing, will occur outside of health care settings. Consideration should be given to how we consider wellbeing as a policy goal and embed in all decisions.

Adverse childhood experiences (ACEs): These are stressful or traumatic events that occur before the age of eighteen; for example, sexual or emotional abuse, domestic violence in the home, or a family member being incarcerated. The long term consequences are significant across crime, social circumstance, education and health and wellbeing. ACEs are not uncommon and the impact is, therefore significant. A huge body of research has repeatedly shown a link between experiencing early adversity and ill health. Adverse childhood experiences are estimated to account for around 30% of adult mental ill health.

Minimisation of exposure to early adversity is key, alongside building resilience in children and young people. The evidence base about what to do at scale is still developing; however, whole systems place based approaches are emerging across the country. These approaches aren't about new infrastructure, but about raising awareness ('becoming ACE aware'), trauma informed care, and prevention.

Loneliness and social isolation: Loneliness is harmful to our health. Research suggests that loneliness is as harmful to our health as smoking 15 cigarettes per day. Anyone can experience social isolation and loneliness. It is not an issue that just affects older people; all ages, including children are known to experience loneliness. Those living in more deprived areas are more likely to lack adequate social support than those living in more affluent areas. We need to create the right conditions to help people make social connections and use what we know about the population groups who may be more vulnerable to experiencing loneliness to intervene early.

Multimorbidity: 16% of the population has two of more long term conditions – this

is equivalent to more than 83,000 people, and this number is growing. There is also an inequalities gap, with people living in the most deprived areas developing multimorbidity 10-15 years earlier than those in the least deprived areas. Most people with multimorbidity are <65, highlighting the importance of the health and wellbeing of people of working age. Whilst prevention is clearly important and best value, for those people who continue to experience poor health, good quality care and support is needed. This means focusing on the individual and what is important to them; their goals and priorities; and moving away from a focus on single diseases and conditions.

***Childhood obesity*:** The number of children who are overweight or obese when measured in Year 6 continues to increase; there have been year on year rises over the last decade, and for the first time the number of children who are overweight of obese when measured in Reception is higher than the national average. This highlights the complexity of the issue to address, and why it remains a priority, with action coordinated through the Living Well Programme.

Healthy ageing: Healthy life expectancy is a good indicator of healthy ageing. Ageing is often viewed as an inevitable process, rather than one which is modifiable. As a consequence we frequently attribute the problems experienced by older people to the ageing process, rather than viewing those problems as treatable and preventable. Our response has historically been a medical and paternalistic one – to provide more care and treatment.

There is a growing body of research that is challenging the traditional view and response to ageing. It recognises that the experience of ageing isn't homogenous, and isn't restricted to a period of life defined by how old you are. Ageing is complex and is only loosely associated with how old a person is. Ageing is a normal and inevitable process, however, evidence suggests that it is the impact that ageing has on us that we need to influence. Long term conditions, are often associated with ageing, but they are a consequence of long term exposure to social and environmental factors, and lifestyle behaviours. These elements are all modifiable; many diseases can be prevented, as can disability, dementia and frailty. Accordingly, we need to focus our efforts on the modifiable elements where we can make the biggest difference and view the increasing number of older people as an opportunity not a burden. This starts in childhood. Social and environmental experiences appear to be more important than biological ones in terms of determining how a person ages, highlighting the need for a predominantly social response.

3.3 What do we need to do in response to the challenges identified in the JSNA?

Much work is already being undertaken to address the health and wellbeing needs identified in the JSNA. This is reflected in a number of key strategies and work programmes delivered by partners across the District including: Anti poverty strategy; Mental Wellbeing Strategy, Economic Strategy, and the Living Well Programme, amongst others.

What is clear from the JSNA is that the drivers of mental and physical ill health that contribute to poor health in the District are complex; there is no single intervention, policy or organisation that can address inequalities in healthy life expectancy. The

drivers of ill health are, however, largely preventable, with action and commitment from partners. The whole systems approach that forms the foundation of our efforts to address obesity (through Living Well) is needed to tackle the causes of ill health. This means linking together many of the influencing factors and coordinated action across all stakeholder organisations at scale. This goes beyond lifestyle decisions, but recognises both the places that people live, and also the context in which people live their lives.

Poverty appears to be one of the most notable factors influencing so many of the drivers of poor healthy life expectancy. Accordingly, a system wide commitment to tacking poverty should be at the heart of our efforts to improve healthy life expectancy for all people in the District, but importantly, to improve it most (and fastest) for those living in the most deprived areas who spend a greater number of years living in poor health.

4. FINANCIAL & RESOURCE APPRAISAL

Making a difference to the health and wellbeing of our population requires long term commitment and investment. Much of this already exists and is directed towards activities which will positively influence the four outcome areas of the Health and Wellbeing Strategy. There are no financial issues arising from this report.

5. RISK MANAGEMENT AND GOVERNANCE ISSUES

The Health and Wellbeing Board is responsible for producing a JSNA and owns, leads and provides governance of the Joint Health and Wellbeing Strategy. Risk will be managed by the Health and Wellbeing Board through a performance management framework (the logic model), with quarterly updates provided to the Health and Wellbeing Board.

6. LEGAL APPRAISAL

There are no direct legal issues arising from this summary report. As stated, the paper summarises the main findings of the JSNA, focusing on the headline indicator of health and wellbeing for a population.

As stated in the report, JSNAs analyse the health needs of populations to inform and guide commissioning of health, well-being and social care services within local authority areas.

The Health and Social Care Act 2012 (‘the Act’) amends the Local Government and Public Involvement in Health Act 2007 (’the 2007 Act’) to introduce duties and powers for health and wellbeing boards in relation to Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWSs).

In preparing JSNAs and JHWSs, health and wellbeing boards must have regard to guidance issued by the Secretary of State and any future revisions issued, and as such, boards have to be able to justify departing from it if wishing to do so.

Under the 2007 Act (as amended by the Act). Local authorities and clinical commissioning groups (CCGs) have equal and joint duties / responsibilities to prepare JSNAs and JHWSs, through the health and wellbeing board

The 2007 Act – section 116 (as amended by the Act – section 192 require a “responsible local authority” and each of its partner CCGs to prepare JSNAs and JHWSs; and section 116A (as inserted by the Act – section 193); and the Act – section 196 provides that these functions are to be exercised by the health and wellbeing board established by the local authority.

Section 103 of the 2007 Act provides that each of the following is a “responsible local authority”: a county council in England, a district council in England other than a council for a district in a county for which there is a county council; a London borough council, the Council of the Isles of Scilly and the Common Council of the City of London in its capacity as a local authority. CBMDC falls into the category of “responsible local authority”.

7. OTHER IMPLICATIONS

7.1 EQUALITY & DIVERSITY

The JSNA identified health inequalities which in some instances can disproportionately affect people with protected characteristics under the Equality Act 2010.

7.2 SUSTAINABILITY IMPLICATIONS

None

7.3 GREENHOUSE GAS EMISSIONS IMPACTS

No direct implications. There are, however, links between greenhouse gas emissions and health and wellbeing. Action to address air quality, and to increase physical activity levels and sustainable travel may have some impact on greenhouse gas emissions.

7.4 COMMUNITY SAFETY IMPLICATIONS

No direct implications, however community safety is an enabling factor, allowing people to engage in community activities, and to use streets and neighbourhood amenities for physical activity and other leisure activities. Reduced social isolation and increased physical activity will both act to enhance wellbeing. Furthermore, feeling unsafe can have a negative impact on a person’s mental wellbeing.

7.5 HUMAN RIGHTS ACT

No direct implications.

7.6 TRADE UNION

No direct implications

7.7 WARD IMPLICATIONS

The current and future health and wellbeing needs of people in Bradford District vary enormously across the 30 wards of the District. Significant inequalities exist, with need generally highest in the most deprived wards of the District.

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

Area profiles are published as part of the JSNA, describing the health and wellbeing needs of specific areas and communities in the District. These are used to inform the area committee action plans, and are available at: https://jsna.bradford.gov.uk/Community%20Partnership%20and%20area%20profiles.asp

7.9 IMPLICATIONS FOR CORPORATE PARENTING

N/A

7.10 ISSUES ARISING FROM PRIVACY IMPACT ASSESMENT

No issues arising.

8. NOT FOR PUBLICATION DOCUMENTS

None

9. OPTIONS

That Health and Wellbeing Board members consider the content of this report.

10. RECOMMENDATIONS

That Health and Wellbeing Board members consider the content of this report and provide feedback for further action.

11. APPENDICES

11.1 Connecting People and Place for Better Health and Wellbeing: Outcomes Report

11.2 JSNA Structure

12. BACKGROUND DOCUMENTS

The JSNA is available at: https://jsna.bradford.gov.uk/