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

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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.

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Portfolio:
Healthy People and Places

Overview & Scrutiny Area:
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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