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Report of the Director of Public Health, Interim Strategic Director of Adult and Community Services and Director of Children's Services to the meeting of the Health and Wellbeing Board to be held on 8th February 2016.

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Subject:

Update on work to address Health Inequalities through housing, employment and health improvement

Summary statement:

This report for the themed session of the Board is focused on the wider factors such as housing and employment issues that impact on the health and wellbeing of the population.

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Portfolio:

Health and Social Care

Overview & Scrutiny Area:

Health and Social Care

1. SUMMARY

This report provides an overview of background documents that together inform the February 2016 themed session of the Board. This session focuses on the broader, social and economic factors that influence the health and wellbeing of the population.

The report focuses on where we live – the impact of housing supply and conditions on health, on how we live - outlining work to reduce high levels of unhealthy behaviours and increase health-giving behaviour, and on what we do - highlighting issues relating to high levels of unemployment and low wage and skill levels.

Background information is provided to update the Board on the overall pattern and levels of health inequalities across the District.

2. BACKGROUND

Health inequalities can be summarised as the differences in the health of different parts of the population. For example people in more deprived areas may have a shorter life expectancy than in more affluent areas. Differences may also occur between groups of people related to other factors such as gender, disability, ethnicity or those with caring responsibilities. Recent information published by Public Health England (PHE) defines health inequalities as:

"Preventable and unjust differences in health status experienced by certain population groups. People in lower socio-economic groups are more likely to experience chronic ill-health and die earlier than those who are more advantaged. Health inequalities are not only apparent between people of different socio-economic groups – they exist between different genders and different ethnic groups. Health inequalities are often observed along a social gradient. This means that the more favourable your social circumstances such as income or education, the better your chance of enjoying good health and a longer life. While there is a significant gap between the wealthy and the poor, the relationship between social circumstances in health is in fact a graded one"

The District's Health Inequalities Action Plan (HIAP) supports the local Joint Health and Wellbeing Strategy 2014-17. The strategy is shaped around the six key areas of focus in the influential Marmot Review (2010) *Fair Society, Healthy Lives*:

- Give every child the best start in life
- Enable all children, young people and adults to maximise their capabilities and have control over their lives
- Create fair employment and good work for all
- Ensure healthy standard of living for all
- Create and develop healthy and sustainable places and communities
- Strengthen the role and impact of ill health prevention

Progress on health inequalities depends heavily on partnership arrangements and joint working across different organisations and council departments. The Health and Wellbeing Board has ownership of the Joint Health and Wellbeing Strategy 2014-17 and the shared

Health Inequalities Action Plan and has the strategic lead for the partnership work to address health inequalities and leads the integrated working to improve health outcomes. The transfer of Public Health from the NHS back to the Local Authority in 2013 has provided greater opportunity to work closely with other departments across the council and to harness their contribution to partnership working on health outcomes and health inequalities.

The November 2014 Local Government Association (LGA) 'peer review' of health and wellbeing work streams examined planning and delivery structures in health and social care; the health of staff; management and leadership; strategic policy and documentation and joint planning systems. One of the key recommendations was specifically to reduce the number of priorities within the HIAP. In response six priorities were recommended to Council Executive to be adopted as specific 'areas of action' due to their wide ranging nature and the District's poor performance in comparison to national performance data.

These 6 are:

1. Infant Mortality
2. Healthy Ageing
3. Smoking
4. Alcohol and Violence
5. Excess Winter Deaths and Fuel Poverty
6. Tuberculosis

Each of the six affect the most deprived areas of our community and contribute to health inequalities overall. They were also highlighted by the Public Health Outcomes Framework (PHOF) monitoring as ones of particular concern for Bradford, and are considered to be best tackled by a partnership approach; working across the council and its broader partners. See Appendix 1 for a full overview of the six. Section 3.1 of this report highlights activity in relation to smoking and air quality in general, alcohol and obesity.

The Board has commissioned a review of the Joint Health and Wellbeing Strategy to ensure consistency with other key documents such as the *Five Year Forward View (2014-19) Bradford District and Craven Health and Care Economy.* However, both the HIAP and the Joint Strategic Needs Assessment will continue to inform the Strategy.

3. REPORT ISSUES

The Health and Wellbeing Board adopted a themed approach to Board meetings midway through 2014-15. Themes to date have included mental health, child health and wellbeing, whole system working and joint approaches to safeguarding. This report for the Board's themed session responds to the annual update on key priorities from the Health Inequalities Action Plan by focusing on the broader factors that shape our health and wellbeing.

The 'wider determinants' of health are the social, economic and environmental conditions that influence the circumstances and conditions in which people live, work and earn. Addressing these can improve health and wellbeing and help to prevent health problems from arising.

Presentations and discussion will focus on:

- **How we live** - how our behaviour – what we eat, our levels of physical activity, our use of tobacco and alcohol - is affecting the local population's health?

- **Where we live** - how does the supply of housing and the condition of the housing stock, our neighbourhoods and the built environment influence the population's health and wellbeing?

- **What we do** - what is our current jobs and skills profile, what are the trends in relation to wages and unemployment, and what will we need for the future?

In each case the report gives a brief indication of the work that is going on across the District, and provides links to background papers and information at section 12.

3.1 How we live – shifting the balance towards healthy behaviours

3.1.1 Tobacco use

Smoking prevalence in adults aged 18 years and over in Bradford is now 20.2%, (down from the 22.8% reported in 2012) compared to a rate of 20.1% across Yorkshire and Humber and 18% across England. The percentage of pregnant women smoking at time of delivery in Bradford is 15.1%, compared with 15.6% across Yorkshire and Humber and 11.4% nationally.

Breathe 2025 is the overarching campaign for work and aspirations to eliminate tobacco-related harms and health inequalities across the Yorkshire and Humber region. The vision is to see the next generation of children born and raised in a place free from tobacco, where smoking is unusual. To support and drive this vision all Children's Centres have been provided with training and resources to raise awareness of the danger to children's health caused by second hand smoke exposure. Each Children's Centre has identified a smoke free champion to sustain this work. To reduce exposure to smoke amongst unborn babies and protect the health of mothers- to-be, the stop smoking team work with midwives and local hospitals to ensure pregnant women who smoke get the best support to quit.

The trade in cheap, illegal tobacco - with cigarettes sold at half or even a third of retail prices - makes it easier for children to smoke and brings crime into local communities. To create economies of scale and ensure a consistent approach the PH department works in partnership with the other West Yorkshire local authorities and together the authorities have commissioned trading standards to address the trade in illegal tobacco. Support to quit is available at a range of times and venues across the district including GP practices and Pharmacies.

3.1.2 Air Quality

Air quality is now recognised as a key determinant of health. Associations have been

demonstrated between concentrations of air pollution and a number of significant health impacts including low birthweight, adverse birth outcomes, cardiovascular disease, respiratory disease, and certain cancers. Aire pollution is currently estimated to account for around 5-6% of Bradford district's mortality.

As a region, West Yorkshire has some of the worst air quality in the country with 28 designated air quality management areas (AQMAs) and European 'safe' air pollution levels regularly exceeded. Air pollution costs the region around £524 million in annual health costs; however this figure is likely to increase as evidence of health impacts grows.

Air quality has also been identified as a key area for reducing health inequalities in the region. The vast majority of AQMAs are situated in urban areas and as a result those living in deprived urban communities are most likely to experience the highest levels of pollution and greatest health risk.

There is strong commitment amongst all five West Yorkshire authorities to tackling high pollution levels. Work has been undertaken and is ongoing to develop a regional Low Emissions Strategy, with input from Public Health England and the West Yorkshire Combined Authority, and from this other strategic work streams have been developed.

Led by Bradford Public Health, the West Yorkshire Air Quality and Health Strategy project is a collaborative research project which aims to develop strategies to reduce ambient air pollution using behaviour change methodology. The project combines local authority, NHS and academic expertise and looks to harness the collaboration of key stakeholder groups to translate health research outputs directly into municipal policy making. To date fieldwork has been completed as part of two research studies relating to school active travel. Further development work is planned and a third research study relating to air quality policy is expected to be completed in 2016.

3.1.3 Obesity

Obesity and overweight remains an issue across all age ranges in the district. The economic implications are substantial. The NHS costs attributable to overweight and obesity are projected to double to £10 billion per year by 2050, equating to roughly £80 million for Bradford district. The wider costs to society and business are estimated to reach £49.9 billion per year, which would equate to roughly £400 million for Bradford and Airedale.

In Bradford, it is estimated that 14% of 2-15 year olds are obese and 18% are overweight. If no action is taken, evidence suggests that by 2050, 25% of children in Bradford district will be obese and 30% overweight. Proportions of children with excess weight are higher in the Bradford District than nationally in both Reception and Year 6 with levels of obesity higher in Year 6 than in Reception. The prevalence of obesity is closely linked with socio-economic deprivation. In Bradford, in 2013/14 12.8% of reception children in the most deprived quintile were obese, compared with 6.2% in the least deprived quintile. In Year 6, 27.4% of children in the most deprived quintile were obese, compared with 12.9% in the least deprived quintile. Childhood obesity poses a serious threat to both direct and indirect costs, as obesity in childhood increases the risk of obesity and morbidity in adulthood and will therefore increase the burden.

The estimated prevalence of overweight and obesity amongst adults in Bradford is 67.7%, which is above the national average of 63.8%. Approximately 25.8% of these adults are obese, 1.6% above the national average. Just under a quarter (24.3%) of the population of Bradford district eat a healthy diet, whilst nearly half (49.4%) of Bradford adults are physically active, achieving 150 minutes of activity per week.

Amongst both sexes there is a trend of obesity prevalence increasing with age until 60 years, with a higher prevalence of morbidly obese patients (BMI>40) amongst women (3.4%) than men (1.7%). This differs from the national picture where men are more likely to be morbidly obese. Obesity prevalence is associated with ethnicity. The White British population has a lower prevalence of obesity than other ethnic groups. However, Black Minority Ethnic (BME) groups have higher levels of deprivation; therefore confounding effects have to be taken into consideration. National studies have shown that Pakistani boys and girls are up to 50% more likely to be overweight than the general population.

Whilst acknowledging that Bradford's statistics are high in comparison with national and regional figures there is positive activity. A range of organisations commission interventions, particularly the Clinical Commissioning Groups (CCGs) and the council's Public Health and Sport and Environment departments - working together to provide support programmes around healthy eating and exercise and raising awareness of the impact of obesity, including to raise awareness of the link between obesity and diabetes, and to reduce the risk of developing diabetes through the Bradford Beating Diabetes Programme.

Delivery of the various initiatives is through schools and educational establishments, community services and in partnership with NHS providers, GPs and importantly the voluntary not- for- profit sector.

3.1.4 Alcohol

Alcohol affects our community in a variety of ways including health, the economy, crime and fear of crime, families and relationships. In 2013-14 there were 3,700 hospital admissions due to alcohol related conditions in Bradford district. Admission rates have been increasing slightly and have been above the national and regional average. In 2013-14 there were 787 admissions per 100,000 of population compared to the England average of 645 admissions per 100,000 of population.

As of October 2015 there were 1,345 people in alcohol treatment in Bradford. Of these, 39.3% had successfully completed treatment, there is an improving trend in successful completion of treatment - above the target of 37% and slightly exceeds the national average of 39.1%. A partnership approach is also being taken to address the on-going problems of street drinking in the City Centre.

There remains a strong commitment from local partners to ensure that the negative impacts of alcohol use are addressed. A district wide review of the district's Drug and Alcohol system has been conducted in response to the changing landscape of drug and alcohol misuse. The review identified that Alcohol services will need to be responsive to changes in drinking behaviours within the district, and to focus on both prevention of

harmful drinking and recovery from dependency. Based on the findings of the review a new drugs and alcohol service is being designed by Council and CCG leads.

3.2 Where we live

3.2.1 Housing issues and the impact on health

Housing is widely recognised as a key determinant of health and the causal link between poor housing and serious long-term health conditions such as heart disease and stroke is generally accepted by both the health and housing sectors. Also, the risk of falls – a major cause of injury and hospital admission – is significantly affected by housing characteristics and results in direct costs to the NHS. Living in poor quality housing therefore has serious detrimental impacts on people's health and wellbeing, and can impact on educational attainment for children. We also know that poor quality housing can result in people becoming homeless or experiencing acute housing difficulties with the attendant impact on health and life expectancy.

The Joint Housing Strategy, A Place to Call Home, agreed by the Council in 2014, sets out four key objectives which link to health outcomes, namely, More Housing; Affordable Housing; Safe and healthy homes; and Supporting independence and tackling homelessness.

Objective 3, Safe and Healthy Homes, in particular, displays a direct link with health outcomes and seeks to: Ensure all housing is free from the worst hazards; Make sure homes support people to stay healthy; Adapt homes so people can stay independent; Encourage landlords and lettings agents to provide safe and healthy homes with decent management of tenancies; Tackle the blight of empty homes.

The context within which we face the challenges include the high level of pre-1920 stone terraced housing stock in many of our inner-urban areas, including around 10,000 back-to-back houses. These are difficult to insulate and heat, and often have steep stairways. Where terraced houses have been extended through loft conversions with dormer windows, this often creates constraints to heating and insulating properties effectively, and the solutions required are more costly. Household needs can change over time, and many properties in the district are not suitable for disabled people or those with long-term health problems. Poorly managed Houses of Multiple Occupation (HMOs) are known to form housing of the highest risk, and work to improve standards in this sector needs to continue. Long-term empty homes can affect the safety and quality of neighbouring properties, particularly where they are adjoining, and we therefore need to continue to tackle the worst cases.

3.2.2 Key Health & Housing Facts:

- In terms of housing tenure, property in the District breaks down into 32,500 social rented, 39,500 private rented and 142,500 owner-occupied properties.
- Reflecting a national trend over the last 10 years, the number of households renting from a private landlord has increased significantly. There are now about an extra 15,000 households renting from a private landlord than in 2001. In total 18% of

households now rent from a private landlord in the district. This is a higher proportion of private renting than many of the West Yorkshire districts.

- There are over 214,000 properties in the district, of which over 30,000 (18%) have serious health and safety hazards at category 1. The highest concentrations of these properties are located in City, Bowling, Barkerend and Bradford Moor wards.
- The highest concentrations of homes with fuel poverty issues are located in City, Bowling, Barkerend and Bradford Moor wards.
- Wards with the highest concentrations of excess cold are in the City, Worth Valley and Craven areas
- The estimated cost of mitigating the hazards within the private housing sector has been calculated at £67.4million. In the private rented sector only the cost has been calculated at £23.5million.
- In the private sector stock there are an estimated 50,000 dwellings with un-insulated cavity walls and about 30,000 dwellings with less than 100mm of loft insulation
- It is estimated that poor housing conditions are responsible for over 1600 harmful events that require medical treatment each year.
- The estimated cost to the NHS to treat accidents and ill health is £6.6 million annually. If the wider costs to society are considered, this figure rises to £16.4 million.
- The main hazards have been identified as damp, excess cold and falls. Combined, these account for over 1200 instances which require medical attention and add to the cost of NHS services.

3.2.3 Actions and achievements:

- The number of long term empty homes reported for 2015/16 is 4154, which is 3,148 fewer than for the baseline year of 2009. The number of long term empty homes has increased in the last year, but this is largely accounted for by a general increase in the number of the properties in the District, a number of new housing developments that are showing as vacant at the moment and a slight change in the way some empty properties, such as flats are counted. A new measure has been introduced that shows that in the year up to December 2015, 5,231 formerly long term empty properties ceased to be classed as empty. The Council is continuing to successfully encourage owners to bring their empty properties into use which not only improves the appearance and safety of neighbourhoods but also increases the overall housing stock.

- The Council has used domestic Energy Performance Certificate (EPC) information to inform domestic energy efficiency schemes such as the Better Homes Yorkshire Central Heating Fund scheme using funding from central Government. The Council has delivered domestic energy efficiency measures to 655 private sector homes between April 2014 and March 2015 with a further 86 private sector homes receiving measures in Q1 & Q2 of 2015/16. These figures include successful ‘hard to treat’ external wall insulation projects in Holme Wood and Thorpe Edge.

- The partnership-based Warm Homes Healthy People (WHHP) programme addresses fuel poverty and excess winter deaths. The programme is governed and provided by a broad body of agency representatives who work together to direct and co-ordinate resources and to provide a single point of referral to a range of cold weather initiatives including practical support – warm clothes and bedding - home energy checks, fuel

debt advice, links to emergency food supplies, local snow-clearing initiatives, repairs and insulation. This has until this year been seasonal - delivered only during the winter months from November through to the end of March each year. Investment from Public Health and two CCGs in 2015-16 means that a new approach is being taken to develop a more sustainable future for WHHP, linking with the Self Care programme to support greater sustainability – developing joint messages to reduce health risks, and to promote personal responsibility, neighbourliness and community activity.

- The Fuel Poverty Framework for Action was adopted by the Executive committee of the Council on 15 September 2015. This secures a multi-agency approach to these issues for Bradford. The Council has used domestic Energy Performance Certificate (EPC) information to inform domestic energy efficiency schemes such as the Better Homes Yorkshire Central Heating Fund scheme and to deliver domestic energy efficiency measures to 655 private sector homes 2014-15, plus 86 private sector homes in Q1 & Q2 of 2015/16. These figures include successful 'hard to treat' external wall insulation projects in Holme Wood and Thorpe Edge.

- In 2014/15 the work of Housing Standards, Empty Homes and Loans, Adaptations and Energy and Climate Change teams have contributed to improvements in 2,167 properties. This was a significant increase on the figure for the preceding year (1,393) although this is partly accounted for by improved data collection and also better than expected performance around home energy efficiency improvements through the BWarm scheme

- 4091 statutorily defined hazards were identified and dealt with by the Housing Standards team in 2014/15 (1,880 in the first two quarters of 2015/16)

- Over the last year, a total of 14 different supported living schemes have been procured, which have enabled 52 people with either learning disabilities or mental health needs to move into their own homes with the right package of support for their needs. This helps to prevent much higher costs of residential care or hospital admission, and more importantly, enables those clients to live as independent lives as possible.

- The Council's Housing Options service provides advice and assistance to approximately 8000 people a year in housing need, are homeless or at risk of becoming homeless and is in the process of developing a new 'single gateway' to housing related support, which will mean that all vulnerable clients will have a full holistic assessment of their support needs, at the same time their housing needs are being assessed. This will enable more appropriate and timely placements into the right kind of supported accommodation.

- In 2014/15 236 major adaptations were completed to enable disabled people to retain independent living in their homes through the use of disabled facilities grants (DFGs)

- There was a further decrease in the use of bed and breakfast accommodation for homeless households over 2014/15, down to 369 households which was a reduction of 39% compared to the previous year.

- The Council has commissioned a new No Second Night Out service, which opened in October 2015. This service provides street outreach, emergency accommodation and move-on support to people who are sleeping rough or at serious risk of sleeping rough.

- Bradford Cyrenians have established a new specialist service providing support and accommodation for men fleeing domestic abuse – Men Standing Up, to add to the complement of provision for women and children within the District.

- A Housing Options officer has been appointed in the Housing Options team to work closely within Bevan Healthcare's Street Medicine Team to meet the needs of vulnerable clients identified at food banks, those sleeping rough etc.

- A Housing Social Worker was appointed recently, located at Lynfield Mount who works closely with the Housing Options Service to ensure that the housing needs of people who also have mental health needs are effectively met

- The Council has completed the first stage of new temporary accommodation facilities at Clergy House and is in the process of completing the second phase, Jermyn Court. These facilities will provide 18 units of additional good quality temporary units for homeless singles, couples and families when completed.

- A private rented housing options team has been established to widen choice to customers in housing need and to maximise the use of the private rented sector working with private landlords to ensure good quality private rented accommodation is sourced for clients

- In 2014/15 306 new affordable homes were constructed in the district, 81 of which by the Council

3.2.3 Ongoing Challenges and gaps:

- The District is not keeping up with the supply of housing needed of 2200 per annum and only provided well under 1000 dwellings per year between 2009/10 and 2013/14. While there has been a noticeable increase in 2014/15 (provision of 1134 properties) this still indicates an ever widening gap between supply and demand.
- Housing costs including the costs of paying for fuel and housing repairs (for owner occupiers) is a real issue for many households particularly due to the combined effect of low incomes and poor stock condition - fuel price increases are a big concern for many households as is the impact of welfare benefit cuts, and, as a consequence, getting into debt
- Not enough public investment into ageing private sector housing stock, the majority of which is in private ownership (owner occupied or privately rented) as this is exorbitantly costly
- Need to do more to tackle empty homes and bring them back into use despite recent investment and successes
- Better co-ordination of resources between health and housing agencies in recognition of the positive impact on health and well-being that housing can have
- Whilst use of inappropriate temporary accommodation (B&B) has been reduced significantly, the work needs to continue to completely eliminate its use

- Although major investment has been placed into insulating homes over recent years, there is still many homes which need to be brought up to acceptable standards
- Increase the use of private landlords by the Councils Housing Options Service to meet the gap in housing provision (ie by size, location etc) left by social housing-quality accommodation and good management are the challenges
- Demand for major adaptations (DFGs) to enable disabled people to continue to live independently continues to increase (the Council has received an average of 50 new cases/month over the last 18 months)
- A range of welfare, benefits and social housing reforms are being rolled out by the Government which may result in greater poverty and hardship and/or increased pressure on social landlords and supported housing providers. This will be a particular challenge if the pace of these reforms outstrips growth of the economy, jobs and programmes to enhance the skills and work-readiness of vulnerable people.

3.2.4 Safe and healthy neighbourhoods, active communities

The District's Community Safety and Stronger Communities Partnerships have recently come together as a single partnership in recognition that both contribute to improving the wider environment in which people live. The Stronger Communities Partnership plan has contributed to a number of HIAP actions & priorities, working closely with health and community partners to achieve these, in particular:

1. Create the economic, social and environmental conditions that improve quality of life for all
2. Reduce harm from preventable disease caused by tobacco, obesity, alcohol and substance abuse
3. Deliver a healthier and safer environment.

Just as the condition and specification of the housing stock can support health and wellbeing, or have a negative impact on people's health, so the condition and safety of neighbourhoods will influence our health and wellbeing.

The condition of streets, parks and other open spaces will shape whether people are willing to walk and exercise locally. The presence of local community amenities and an open, inclusive and welcoming community vibe will influence whether people are willing to be social and active in their communities, helping .

Joint working between residents and services can lead to the most effective use of public sector resources to support and enhance neighbourhoods and the local environment, as both communities and services can deliver what they each do best. There are many initiatives where service resources are delivered jointly with community action to deliver positive outcomes for communities. For example, Dementia Friendly Communities, Street clean ups/ Litter picks and Winter Warmth projects.

Small grants have been a cost-effective way to support local initiatives and neighbourhood based activities, but such funds have been significantly reduced, meaning that initiatives will need to build on and enhance existing appeals and local funding routes such as the

Lord Mayors' Appeals and Bradford District Community Fund. The Community Fund has distributed nearly £1 million within the District to date.

A year long Active Communities campaign (People Can) is being planned by the New Deal outcome group: Safe, Clean and Active Communities. The group is seeking ways to develop strong communities, as a way of filling the gap created by significant reductions in public sector funding. The 'People Can' campaign aims to highlight the contributions of communities within the Bradford District and build on these strengths, as part of the New Deal. It will focus on four priority themes during the year:

- Neighbourliness
- Joint Local Action
- Formal Volunteering
- Fundraising for Community Activities.

Activity will be themed month by month for the following impacts:

- A District where more people behave in a neighbourly way
- Community action is well supported by public services
- Volunteer opportunities developed and more volunteers are active

Activities that will be encouraged will include the following:

- Highlighting existing community activity that demonstrates the strengths of the Bradford District
- Networking opportunities that bring people together to share different strengths from both the Bradford District and outside.
- Learning events that will share innovation and creativity from other places that could be taken up within the District
- Pilots to trial different approaches

Statutory sector organisations could increasingly consider where volunteers can support the delivery of existing services in relation to a broader range of needs and issues. Increasingly with reduced public sector funding we will need to recruit volunteers to support, enhance and help to provide neighbourhood level services, for example Special Constables and Libraries.

3.3 What we do – Work and worklessness, skill and wage levels and the impact on health and wellbeing

There has long been an identified link between poor health and well-being and worklessness. The nature of work and wage levels also impact on health and wellbeing, particularly on mental health where these result in insecurity and stress.

Low pay, whether resulting from under-employment (not enough hours work to reach a decent standard of living) or employment in low-skilled, low paid work impacts on ability to meet the costs of eating well, keeping warm, affording leisure activities. Insecure working

conditions mean that income levels can fluctuate.

This section provides details of the demographics, local and national solutions to unemployment, barriers to getting into or returning to work after health problems, and future work planned to support individuals with health conditions, including mental health conditions, into work.

3.3.1 Wage and skill levels

Low skills are reflected in lower than average earnings. In 2015 median weekly gross full-time earnings for District residents were £451.60, below the regional average of £480.50 and the UK average of £527.70.

However, the gap is narrowing. Since 2010 gross median earnings have increased by 6.9% which is higher than the regional increase of 3.9% and the national growth of 5.9%.

Wage levels reflect the occupational profile of Bradford's residents. Bradford has more people than average employed in the lower paid elementary occupations and fewer managers and directors than average. Elementary occupations account for 13.3% of Bradford's employed residents.

At the other end of the occupation profile there are 19,800 or 8.8% of Bradford's employed residents who are employed as managers, directors or senior officials. The number has increased by 3,400 or 21% since 2005.

3.3.2 Unemployment profile

The number of working age people who were unemployed at June 2015 was 21,200.

Bradford's unemployment rate remains higher than regional and national rates. Bradford's unemployment rate at June 2015 was 8.7% compared to a UK rate of 5.7%.

Youth unemployment remains a key issue particularly given Bradford youthful population profile. 4.1% of all 18-24 year olds in Bradford are claiming JSA. This is more than twice the UK youth claimant rate of 1.9%.

Long term unemployment is usually defined as individuals who have been claiming benefits for more than 12 months. The November 2015 figures for Bradford show that there were 2,720 long-term claimants. These claimants formed 30.2% of the District's JSA claimants.

An analysis of long-term claims by age groups shows people in older age groups are more likely to be long-term claimants. 42% of claimants aged 50-64 have been claiming for more than 12 months, compared with 34% of people aged 25-49 and 15% of people aged 16-24.

In Bradford 23,680 individuals are claiming Employment Support Allowance or Incapacity Benefit. This represents 7.2% of the total population. These individuals have significant health barriers to work.

3.3.3 Local Solutions to unemployment

In response to high unemployment Bradford Council invested in ***Get Bradford Working (GBW),*** a major Employment Investment Programme for the Bradford District. It draws together key initiatives which tackle the issues and barriers facing Bradford's residents in the labour market and has provided specific local solutions for people with health conditions to support them into work. To date Get Bradford Working programmes have supported 2146 individuals into employment. Through GBW the Council has worked in partnership with the LEP, DWP, local providers and VCS organisations and housing associations to ensure programmes meet the needs of local people. The programme has seven strands which include:

- ***The Employment Opportunities Fund (EOF***) is a partnership between CBMDC, Incommunities, Jobcentre Plus and associated partners. The fund targets Bradford claimants who have been out of work for at least six months and supports them towards sustainable employment. One of the target groups for this programme was people with work limiting health conditions. To date 10% of the people who have gained employment through the fund have been disabled.
- ***Routes into Work (RIW***) fund is a commissioned fund that seeks to meet the gaps in the Employment and Skills provision identified in the Employment and Skills Strategy and offer additionality to National and Regional Programmes. RIW contracts target those furthest away from the labour market such as individuals with a disability, mental ill-health and drug and alcohol dependency. Through these specific contracts 22% of people who have gained employment through RIW have been disabled.
- ***SkillsHouse*** has been established to support retail, hospitality and visitor economy businesses to recruit and up skill their staff and to help local people find jobs within these sectors.
- ***Bradford Apprenticeship Training Agency (ATA) & Apprenticeship Hub****.* The ATA acts as a recruitment agency and allows organisations to employ apprentices on an agency basis, minimising the risk associated with employing staff more permanently. The Hub works to promote and co-ordinate the apprenticeship offer in the District.
- ***Industrial Centres of Excellence (ICE****)* are discrete vocationally based centres within existing schools or colleges. The centres have their own management Board and comprise of business partners alongside 14-19 education and training providers and a Higher Education partner. Each ICE aims to address the future strategic workforce needs of local businesses through learning, training and work experience.

Data relating to individuals who have gained worked through GBW shows that the largest disability groups are mental-ill health and physical disabilities.

The District has commissioned a specific intervention through Centre for Mental Health funding to support people with mental health needs back into employment, this is being delivered through health and VCS providers.

3.3.4 National Solutions

As part of the government's welfare to work provision, DWP commissions national

contracts to support individuals into work. The current contracts are detailed below:

- Work Choice – is a voluntary scheme for people who are disabled and need additional support to gain employment. The programme can provide long term specialist support to ensure that individuals sustain work long term.
- Work programme – is a mandatory scheme for people who are long term unemployed. The programme is a payment by results model and does not have specific support built in for people with disabilities. There has been significant criticism of the low numbers of disabled people who have gained employment through the work programme. However some individual providers have found successful solutions.

3.3.5 Future

As part of the LEPs ESIF programme two employment support programmes will be commissioned, both of which we expect will include people with health conditions within the eligibility. Bradford Council plans to submit tenders for both contracts in partnership with Leeds City Council to ensure that programmes are delivered to meet local need. However, the launch of these programmes has been delayed significantly.

The Government will be re-commissioning its welfare to work programmes later this year with contracts likely to commence in spring/summer 2017. One of the asks within the LEPs devolution deal is that the successor to the work programme will be co-commissioned locally. Officers from Employment and Skills will work alongside the LEP to ensure this is fit for purpose and meets local need. The initial information from DWP points to the programme prioritising the long-term unemployed and people with health conditions.

3.4 Summary

The Board is asked to consider how and to what extent the range of issues considered through the paper are enabling or constraining the choices people can make about their own health and whether the health and wellbeing system is doing as much as it can to use the ‘wider determinants’ of health’ to support the population to become and stay healthy?

4. FINANCIAL & RESOURCE APPRAISAL

Tackling health inequalities requires long term commitment and investment. Much of this already exists and is directed towards HIAP priorities. This includes internal Council investment, partner investment and resources as well as external funding from central government departments such as the Homes and Community Agency, the Department of Health, Public Health England and NHS England.

5. RISK MANAGEMENT AND GOVERNANCE ISSUES

The HIAP and its priorities have been formally endorsed and adopted by the Council and its key partners in a variety of different multi-agency settings. The responsibility for delivering change and the actions designed to mitigate health inequalities have been interwoven into the Bradford District Partnership and its main strategic partnership groups. This ensures accountability across all agencies.

6. LEGAL APPRAISAL

Section 194 Health and Social Care Act 2012 (the Act) required the Council to establish a Health and Wellbeing Board (HWBB) for the district, which functions as a committee of the local authority under section 102 of the Local Government Act 1972.
Its primary function is to encourage integrated working between commissioners of NHS, public health and social care services for the advancement of the health and wellbeing of the local population. It is in pursuance of this objective that the HIAP was considered and has now been brought to the attention of this Committee.

6.2 Part 1 of 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. The Public Health department in the Local Authority supports the performance of this duty. However systems need to be devised to ensure that this duty is delivered in partnership and that other parts of the Council fulfil their role within the HIAP, particularly in relation to the wider determinants of health.

6.3 Section 31 of the Act requires local authorities to pay regard to guidance issued by the Secretary of State for Health when exercising their public health functions and in particular local authorities are required to have regard to the Department of Health's Public Health Outcomes Framework.

7. OTHER IMPLICATIONS

7.1 EQUALITY & DIVERSITY

7.1.1 The Public Sector Equality Duty under the Equality Act 2010 requires the Council when exercising its functions to have due regard to the need to:
a) Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Equality Act 2010;

b) Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
c) Foster good relations between persons who share a relevant protected characteristic and persons who do not share it; including due regard to tackling prejudice and promoting understanding.

Relevant protected characteristics include age, disability, gender, sexual orientation, race, religion or belief.

There is an important difference between this duty and the responsibility to tackle Health Inequalities. As noted earlier, Health inequalities are defined as the differences in the health of different parts of the population, and this brings into consideration a wider range of factors than those identified as 'protected characteristics' within the Equality Act 2010.

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

7.1.3 There are health inequalities which affect protected characteristic groups more than others. This is acknowledged and reflected in the HIAP, and specifically priorities 1 through to 10. These outline health impacts for specific groups such as older people, young people and children, people with disabilities and/or mental health problems.

7.1.4 It is important to acknowledge however that there are also health inequalities which affect people from all the diverse communities in Bradford. The joint effort of working together to improve the housing stock for instance would make material difference to those experiencing fuel poverty and therefore also meet the actions in priority 15.

7.2 SUSTAINABILITY IMPLICATIONS

The HIAP and the Joint Health and Wellbeing strategy are an integral part of health and social care systems. As such they underpin all the work programmes and services delivered across the health and social care systems.

7.3 GREENHOUSE GAS EMISSIONS IMPACTS

7.3.1 Some of the major programmes which the Council fosters under wider determinants in relation to Health Inequalities have a direct impact on reducing the impacts of climate change. Fuel poverty plans aim to improve housing and heat/light and power systems for vulnerable householders. 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 health outcomes will largely reduce greenhouse gas emissions.

Active travel is a good example, achieving multiple outcomes for the environment and the health of the population. However it is 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

The health and wellbeing of communities includes perception of safety and security within the household and wider society. One of the priorities (Alcohol and Violence) has been specifically performance managed by the Community Safety partnership and will continue to be overseen by its replacement.

7.5 HUMAN RIGHTS ACT

By virtue of the Human Rights Act 1998 all public bodies (including local government) carrying out their public functions have to comply with the rights set out in the European Convention on Human Rights. Developing priorities of the type set out in the HIAP and promoting their effective delivery means that the Council will be supporting the principles behind the Convention, in particular respect for private and family life, the right to marry and start a family, the right to an education, the right to life and the right to be protected from the effects of discrimination. Action taken to reduce health inequalities is likely to have a positive impact on human rights issues across all aspect of the framework.

7.6 TRADE UNION

None.

7.7 WARD IMPLICATIONS

Health Inequalities are complex and bought about by economic, cultural and social differentials across populations and communities. Through the Area and Neighbourhoods services there are ward plans developed in partnership with services and householders which detail local concerns; including those which are health and social care related. These are then worked up to identify the actions which can be taken to tackle and/or mitigate these.

8. NOT FOR PUBLICATION DOCUMENTS

None.

9. OPTIONS

No options are provided

10. RECOMMENDATIONS

10.1 That the Board continues to receive regular updates on health inequalities in the

District and to oversee activity to reduce health inequalities.

10.2 That the Board works with other District partnerships to harness their influence over the wider determinants of health to make the maximum difference possible to health inequalities and health outcomes.

10.3 That Board members work within their individual organisations to ensure that all commissioning activity and service provision under their influence has regard to the reduction of health inequalities and to seek opportunities to work in partnership and with communities to make maximum impact on health inequalities.

11. APPENDICES

Appendix 1 - Progress Report – Health Inequalities - Report of the Director of Public Health, the Interim Strategic Director Adult and Community Services to the meeting of the Health and Social Care Overview & Scrutiny Committee to be held on 21st January 2016.

Appendix 2 - 2015 Marmot indicators.

12. BACKGROUND DOCUMENTS

12.1 Housing and Homelessness Strategy and associated papers
http://www.bradford.gov.uk/bmdc/housing/strategies_policies_plans_and_research/housing_and_related_strategies.htm

12.2 Joint Health and Wellbeing Strategy 2014-17 including the Health Inequalities Action Plan
http://www.observatory.bradford.nhs.uk/Documents/Bradford%20and%20Airedale%20Joint%20Health%20and%20Wellbeing%20Strategy%202013.pdf

City of Bradford MDC
www.bradford.gov.uk

Appendix 1
Report of the Director of Public Health, the Interim Strategic Director Adult and Community Services to the meeting of the Health and Social Care Overview & Scrutiny Committee to be held on 21st January 2016

AI

Subject: Progress report: Health Inequalities

Summary statement:
The following report updates the Health & Social Care Overview and Scrutiny committee on progress in relation to the main priorities of the Health Inequalities Action Plan (HIAP)

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Portfolio:

Adult Social Care and Health

1. SUMMARY

1. Summary

The following report will update the Health and Social Care Overview and Scrutiny Committee (H&SC O&S) with regards to progress against the Health Inequalities Action Plan's (HIAP) strategic priorities. This includes the detail of changes made as a result of reports relating to the HIAP being considered by the Council's Executive committee; the H&SC O&S and the Health and Wellbeing Board (HWBB) during 2014-15 & 2015-16.
It also incorporates the Public Health (PH) department's performance in relation to the Council's internal equalities performance management systems; the Equalities Action Plan (EAP). This is in accordance with the decision of the Corporate Overview and Scrutiny Committee taken on 4 November 2015.

2. BACKGROUND

2.1 In 2013 the Council, Health and other key partners - through the Health and Wellbeing Board (HWBB), the CCG's clinical governance systems and the Council's Executive committee - agreed the Joint Health and Wellbeing Strategy for the Bradford district. This outlined the broad strategic priorities for health and wellbeing in the area. It is from these that the detailed HIAP priorities were drawn. (See background document 1)

2.2 A report introducing the HIAP was taken to the HWBB on the 14 May 2013. This established 18 strategic priorities and agreed the performance management framework to be used to manage and deliver them. It was agreed that the Bradford District Partnership (BDP) and their already established strategic planning structures would lead this (See appendix 1)
The initial priorities were:

1. Reduce and alleviate the impact of child poverty
2. Reduce infant mortality
3. Promote effective parenting and early years development
4. Ensure young people are well prepared for adulthood and work with a focus on ensuring that children with disabilities to maximise their capabilities
5. Reduce childhood obesity and increase levels of physical activity and health eating in children and young people
6. Improve oral health in the under 5's
7. Improve the mental health of people in the Bradford district
8. Improve health and wellbeing for people with physical disabilities; learning disabilities; sensory needs and long term health conditions
9. Improve diagnosis, care and support for people with dementia and improve their carers quality of life
10. Promote the independence and wellbeing of older people
11. Increase employment opportunities and training
12. Promote healthier lifestyles in the workplace
13. Create the economic, social and environmental conditions that improve quality of life for all
14. Deliver a healthier and safer environment
15. Increase the number of decent homes and ensure affordable warmth
16. Enhance social capital and active citizenship

17. Reduce harm from preventable disease caused by tobacco, obesity, alcohol and substance abuse
18. Reduce mortality from cardiovascular and/or respiratory disease; diabetes and cancer

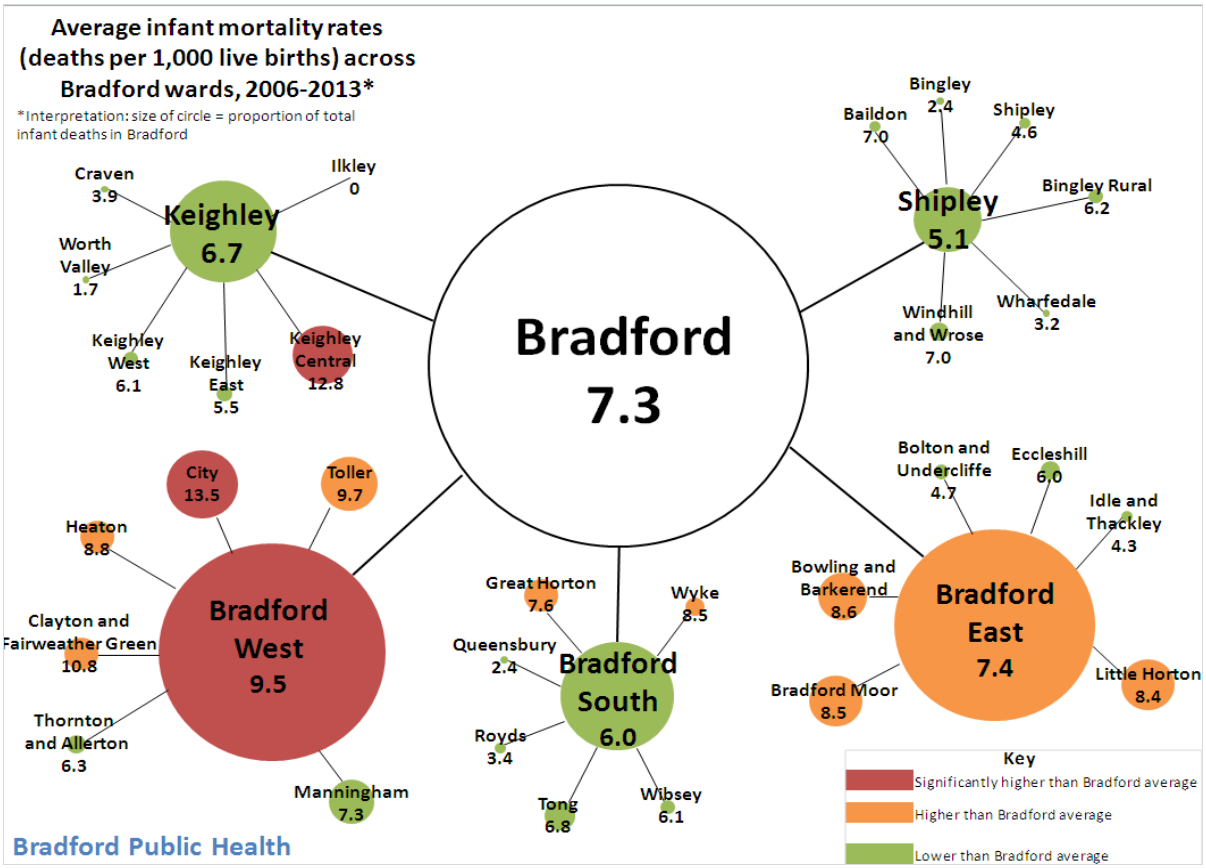
2.3 In the year that followed (2014) further reports were prepared on the HIAP for two key partnerships and decision making bodies. The first was delivered to the HWBB meeting on 29 July 2014. The main purpose of this was to update members on progress in relation to the action plan.
The second report was delivered to the H&SC O&S (on 2 October 2014). This introduced the complexities of 'health inequalities'; the new responsibility of the Council in relation to these in the light of the shift of PH into Council management from the NHS in April 2013; and detailed performance information on each of the 18 priorities. (See background documents 2 &3)

2.4 The H&SC O&S October 2014 report defined health inequalities as the differences in the health of different parts of the population. For example people in more deprived areas may have a shorter life expectancy than in more affluent areas. Differences may also occur between groups of people related to other factors such as gender, disability, ethnicity or those with caring responsibilities. Recent information published by Public Health England (PHE) defines health inequalities as:

"Preventable and unjust differences in health status experienced by certain population groups. People in lower socio-economic groups are more likely to experience chronic ill-health and die earlier than those who are more advantaged. Health inequalities are not only apparent between people of different socio-economic groups – they exist between different genders and different ethnic groups. Health inequalities are often observed along a social gradient. This means that the more favourable your social circumstances such as income or education, the better your chance of enjoying good health and a longer life. While there is a significant gap between the wealthy and the poor, the relationship between social circumstances in health is in fact a graded one"

2.5 The discussion and awareness of health inequalities is of major importance for the area. Bradford district is one of continuing contrasts; with rural and urban landscapes, populations across differing ethnic, social, religious and cultural backgrounds and of increasing populations of both older people and younger people. Within it are some of the most deprived wards and super output areas in the country. With this in mind, raising awareness of health inequalities with decision makers and service providers has been a vital first step to tackling inequalities for the future.

The topic of infant mortality serves as an example of health inequalities in Bradford. Although Bradford's infant mortality rate is improving, at a ward level there are still large inequalities across the district. Higher infant mortality rates are confined to the more deprived wards; to the South East of the district and lower rates occur in the less deprived wards, in the North of the district.



2.6 In November 2014 a 'peer review' of health and wellbeing work streams was conducted by the Local Government Association (LGA) across the Bradford district. This examined planning and delivery structures in health and social care; the health of staff; management and leadership; strategic policy and documentation and joint planning systems. The outcome of the review was very positive. However, one of the key recommendations was specifically to reduce the number of priorities within the HIAP. (See background document 4)

2.7 On 13 January 2015 a report on the HIAP was presented at the Council's Executive committee. This gave detail on progress in relation to all 18 priorities and recommended that from these, 6 be adopted as specific 'areas of action' due to their wide ranging nature and the District's poor performance against tackling them in comparison to national performance data. (See background document 5)
It was acknowledged within the recommendation that all 18 priorities remained, but that 6 would be used to focus increased activity. These 6 are:

7. Infant Mortality
8. Healthy Aging
9. Smoking
10. Alcohol and Violence
11. Excess Winter Deaths and Fuel Poverty
12. Tuberculosis

Each of the six affect the most deprived areas of our community and contribute to health inequalities overall. They were also highlighted by the Public Health Outcomes Framework

(PHOF) monitoring as ones of particular concern for Bradford, and are considered to be best tackled by a partnership approach; working across the council and its broader partners.

2.8 A report on the performance of the Council in relation to its wider equalities duties is presented to Corporate Overview and Scrutiny every year; this year this was received on 19 March 2015. The report looks at how the organisation has delivered and managed its services during the year; across each separate directorate; in relation to communities of interest and those listed under the 'protected characteristic' categories within the legislative framework. The main vehicle for this is the Equalities Action Plan (EAP). At this meeting it was resolved that a further report would be referred to the relevant scrutiny committee on these performance outcomes. In the case of PH this is H&SC O&S.

2.9 The EAP actions have been concurrent with those in the HIAP with a focus on delivery mechanisms internal to the service rather than externally provided services. PH's performance against their priorities has benefited from the service being embedded within the Council. Many of the priorities with these plans are cross cutting and are more effectively dealt with participation from a range of services. An example of this is the key role that Housing and Environmental health can play in reducing fuel poverty, when managing retrofit and/or small-scale programmes to tackle homes where heating costs are unaffordable for householders.

2.10 The HWBB is in the process of changing its role and redefining its reach. Discussions at recent meetings have explored mechanisms by which the board can assume wider, more comprehensive, financial and performance management responsibility for aspects of the health and social care economy. One area being considered as part of this is the HIAP.

3. REPORT ISSUES

3.1 The following paragraphs will update the committee on progress against the main 6 areas for action of the HIAP. In each section, the corresponding Public Health Outcomes Framework (PHOF) indicators are noted, together with their position within the wider HIAP.

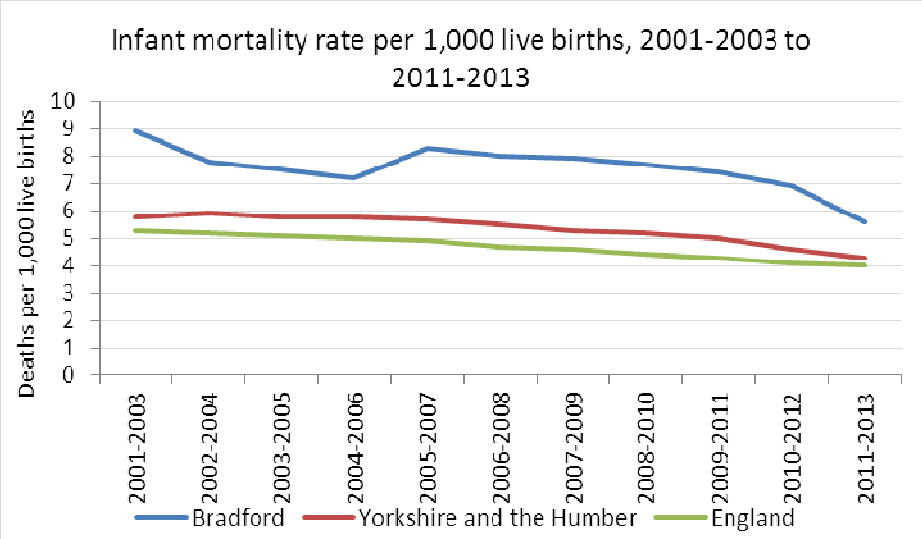
3.2 Infant Mortality

HIAP Priority 2 Reduce Infant Mortality

The survival rate for babies under one year of age has improved across the Bradford district for the sixth year in a row according to the latest published data; the infant mortality rate is now 5.6 per 1,000 live births in 2011-13. This is down from 7.5 in 2009-11 and 8.3 in 2005-07. It is also the lowest rate across the Bradford district for the last decade and the figures are ahead of projected targets agreed in 2011 for reducing infant mortality in the district. The Every Baby Matters steering group is chaired by PH and this group oversees the implementation of the Action Plan, reporting to the Children's Trust Board and the HWBB as required. The Every Baby Matters Action Plan and dashboard is based on 10 key priority areas. A detailed report on these 10 areas and the dashboard will be presented to H&SC O&S in April 2016.

The following chart shows how Bradford's infant mortality rate has improved over the last

10 years and how the gap with the national rate has narrowed over time, with the gap between Bradford's infant mortality rate and the rate for England falling from 3.6 deaths in 2001-2003 to 1.6 deaths in 2011-2013.



Source: Public Health Outcomes Framework

3.3 Healthy Aging

HIAP Priority 9 Improve diagnosis, care and support for people with dementia and improve their and their carers' quality of life; HIAP Priority 10 – promote the independence and wellbeing of older people)

3.3.1 A detailed report on regarding Dementia in the district was read at the H&SC O&S at the October meeting. (See background document 6). The report confirmed that the Dementia Strategy group has good engagement from stakeholders including the Council, the acute trusts, Bradford District Care Trust, the private sector, the Voluntary and Community Sector and all of the District's CCGs.

There have been a number of initiatives undertaken to address this priority over the past year: The Dementia Health Needs Assessment has been developed to stand as the District Dementia strategy for 2015-2020, and gives key information on the condition and related services.

The six key strategic priorities are:

- We should support people with dementia to stay in their own homes as long as possible
- We should raise the strategic profile of dementia in care homes
- Around 20% of dementia in our district is vascular in nature and therefore preventable in the same way that heart attacks are through lifestyle changes such as stopping smoking
- We need to look more closely at the development and delivery of palliative care services for people with dementia
- Helping people to live well with dementia
- An action plan is being led by the Dementia Strategy Group to address the strategic recommendations.

In respect of inequalities, the two key issues are:

1. Access to diagnosis – all three CCGs are performing above the government target of 66% of patients diagnosed
2. Vascular dementia – this form of dementia is related to lifestyle, particularly smoking and diet. As such it would be expected that its prevalence will follow smoking and obesity prevalence to a degree.

3.3.2 Supporting and promoting the broader objectives of independence and well-being of older people is led by the Older People's Partnership. This multi-agency body is made up older people together with key partners who commission and deliver services including, the NHS, Local Authority and the VCS and has been in existence since 2005.

The Partnership's main aims are to look at older people as a positive asset to the district and sets out the things that they consider most important to their lives, these include:

- Getting and staying healthy
- Living where and how I want
- Being involved in and feeling safe in my community / neighbourhood
- Having economic independence
- Having the opportunity for learning, faith, spirituality and sexuality
- Getting around

In delivering on these elements the partnership ensures that;

- The voices of older people are heard
- Information is accessible and understandable

All projects overseen by the Partnership will involve older people in their delivery – from project initiation to completion.

3.4 Smoking Prevalence

HIAP Priority 17 – reduce harm from preventable disease caused by tobacco, obesity, alcohol and substance abuse

3.4.1 Smoking prevalence in adults aged 18 years and over in Bradford is now 20.2%, (from the 22.8% reported in 2012). This compares to a rate of 20.1% across Yorkshire and Humber and 18% across England. The percentage of pregnant women smoking at time of delivery in Bradford is 15.1%, which compares with 15.6% across Yorkshire and Humber and 11.4% nationally. The PH team has a key role in reducing the prevalence of smoking across the Bradford district.

Breathe 2025 is the overarching campaign for work and aspirations to eliminate tobacco-related harms and health inequalities across the Yorkshire and Humber region. The vision is to see the next generation of children born and raised in a place free from tobacco, where smoking is unusual.
To support and drive this vision all Children's Centres have been provided with training and resources to raise awareness of the danger to children's health caused by second hand smoke exposure. Each Children's Centre has identified a smoke free champion to sustain this work. To reduce exposure to smoke amongst unborn babies and protect the health of mothers- to-be, the stop smoking team work with midwives and local hospitals to

ensure pregnant women who smoke get the best support to quit. The trade in cheap, illegal tobacco - with cigarettes sold at half or even a third of retail prices - makes it easier for children to smoke and brings crime into local communities. To create economies of scale and ensure a consistent approach the PH department works in partnership with the other West Yorkshire local authorities and together the authorities have commissioned trading standards to address the trade in illegal tobacco. Support to quit is available at a range of times and venues across the district including GP practices and Pharmacies.

3.4.2 Obesity remains an issue across all age ranges in the district. The estimated prevalence of overweight and obesity amongst adults in Bradford is 67.7%, which is above the national average of 63.8%. Approximately 25.8% of these adults are obese, 1.6% above the national average. Just under a quarter (24.3%) of the population of Bradford district eat a healthy diet, whilst nearly half (49.4%) of Bradford adults are physically active, achieving 150 minutes of activity per week. Amongst both sexes there is a trend of obesity prevalence increasing with age until 60 years, with a higher prevalence of morbidly obesity patients (BMI>40) amongst women (3.4%) than men (1.7%)2. This differs from the national picture where men more likely to be morbidly obese, 3% compared to 1% of women.
The economic implications are substantial. The NHS costs attributable to overweight and obesity are projected to double to £10 billion per year by 2050, equating to roughly £80 million for Bradford district. The wider costs to society and business are estimated to reach £49.9 billion per year, which would equate to roughly £400 million for Bradford and Airedale.

In Bradford, it is estimated that 14% of 2-15 year olds are obese and 18% are overweight. If no action is taken, evidence suggests that by 2050, 25% of children in Bradford district will be obese and 30% overweight.
Proportions of children with excess weight are higher in the Bradford District than nationally in both Reception and Year 6 with levels of obesity higher in Year 6 than in Reception. The prevalence of obesity is closely linked with socioeconomic deprivation. In Bradford, in 2013/14 12.8% of reception children in the most deprived quintile were obese, compared with 6.2% in the least deprived quintile. In Year 6, 27.4% of children in the most deprived quintile were obese, compared with 12.9% in the least deprived quintile.

3.4.3 Obesity prevalence is associated with ethnicity. The White British population has a lower prevalence of obesity than other ethnic groups. However, Black Minority Ethnic (BME) groups have higher levels of deprivation; therefore confounding effects have to be taken into consideration. National studies have shown that Pakistani boys and girls are up to 50% more likely to be overweight than the general population.

3.4.5 National Child Measurement Programme (NCMP) figures for Bradford 2013/14 show that all of the children measured had their ethnicity recorded. However numbers from the 'Black', 'Chinese' and 'Other' ethnic categories were too small to make comparisons of prevalence. Out of the remaining ethnic categories (White, Asian and Mixed), the highest prevalence of overweight in reception children was amongst the White ethnic group and the highest prevalence of obesity was among the Asian ethnic group. In year 6 children, the highest prevalence of obesity and overweight was among the mixed ethnic group.

Childhood obesity poses a serious threat to both direct and indirect costs, as obesity in childhood increases the risk of obesity and morbidity in adulthood and will therefore

increase the burden.

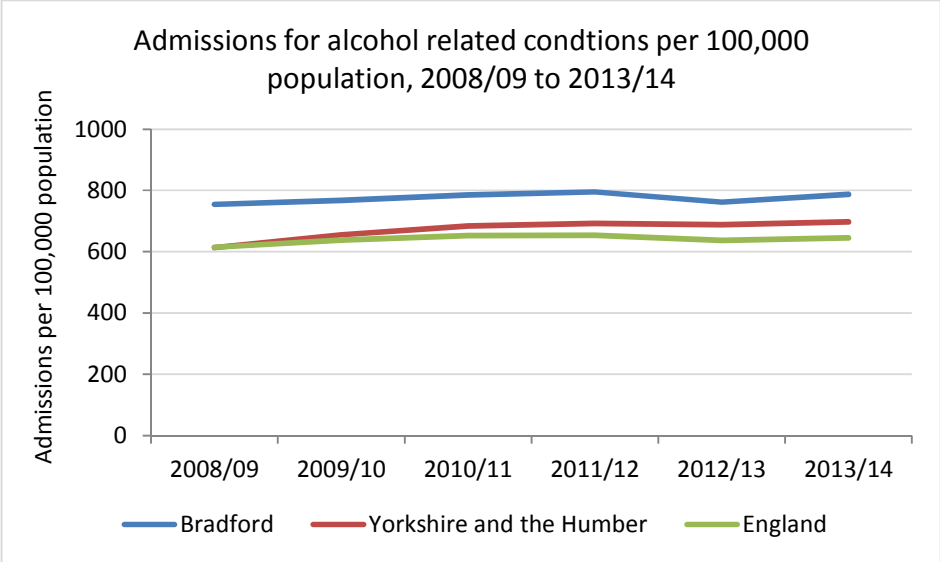
3.4.6 Whilst acknowledging that Bradford's statistics are high in comparison with national and regional figures there is positive activity and a range of services and agencies working together to tackle this. The Council and PH in particular support programmes around healthy eating, exercise and raising awareness on the impact of obesity in a variety of settings. These range from schools and educational establishments through to community services and in partnership with NHS providers, GP's and importantly the voluntary not-for- profit sector.

3.5 Alcohol and Violence

HIAP Priority 17 Reduce harm from preventable disease caused by tobacco, obesity, alcohol and substance abuse; HIAP Priority 14 – Deliver a healthier and safer environment

There remains a strong commitment from local partners to ensure that the negative impacts of alcohol use are addressed. Alcohol affects our community in a variety of ways including health, the economy, crime and fear of crime, families and relationships.
A district wide review of the district Drug and Alcohol system has been conducted due to the changing landscape of drug and alcohol misuse. The review identified that Alcohol services need to be responsive to changes in drinking behaviours within the district, and need to focus on both prevention of harmful drinking and recovery from dependency. A new drugs and alcohol service is now being designed by Council and CCG leads.
A partnership approach is also being taken to address the on-going problems of City Centre Street drinkers. District performance for alcohol is improving. As of October 2015 there were 1,345 people in alcohol treatment in Bradford. Of these 1,345 people, 39.3% had successfully completed treatment. This is above the target of 37% and above the national average of 39.1%.

In 2013-14 there were 3,700 hospital admissions due to alcohol related conditions in Bradford district. Apart from a reduction in 2012-13, admission rates due to alcohol-related conditions have been increasing slightly and have been above the national and regional average. In 2013-14 the admission rate for alcohol related conditions in Bradford district was 787 admissions per 100,000 populations compared to the England average of 645 admissions per 100,000 populations.



Source: Public Health Outcomes Framework

3.6 Excess winter deaths and fuel poverty

HIAP Priority 15 – Increase the numbers of decent homes and ensure affordable warmth

One of the main programmes aimed at reducing the number of 'excess winter deaths' across our district is the Warm Homes Healthy People (WHHP) programme. This has until this year been seasonal and delivered only during the winter months from November through to the end of March each year. Investment from PH and two CCG's in 2015-16 means that a new approach is being taken to develop a more sustainable future for WHHP. The programme is governed and provided by a broad body of agency representatives who work together to support multiple service options through an internet-based single point of referral route. The multiplicity of interventions allows for a targeted approach for vulnerable households who may otherwise suffer through exposure to weather extremes. To support greater sustainability, WHHP has been twinned with the Self Care project this year, and together the projects incorporate a range of messages for the general public, services users and providers alike. These messages aim to reduce health risks, and to promote personal responsibility, neighbourliness and community activity. Additionally, Adult and Community Services support two separate but linked programmes aimed at rough sleepers and homeless households. Both of these groups are vulnerable to inclement weather conditions. The 'No- Second –Night –Out' project has joined up a range of voluntary not for profit providers and the Local Authority's statutory housing options service to try to reduce repeat homelessness. This is a new service commenced at the end of 2015 and early results are promising. Coupled with this is the emergency cold weather services offered every year, which are now formalised via the supported housing contract let in 2015. Both these work programmes are linked into WHHP via provider agencies and close working partnership arrangements.

Through WHHP a Warm Homes Officer has been employed in the voluntary not for profit sector. The Warm Homes Officer is knitting together the range of support that is becoming available to tackle fuel poverty locally. The district has been successful in attracting a range of funding into this area of work including short term small interventions, through to retrofitting poor housing and funding for a range of community outreach sessions to support larger scale energy provider switching and surgeries to support those struggling

with energy bills.
The Fuel Poverty Framework for Action was adopted by the Executive committee of the Council on 15 September 2015. This secures a multi-agency approach to these issues for Bradford.

The stock condition survey completed in July 2015 identified 23,547 households in the area at risk of fuel poverty. PH is working with colleagues in planning and housing to support house building which meets new, more appropriate standards and does not increase a lack of affordable warmth for the future. Outputs for 2015/16 are not completed as yet however in 2014/15 an additional 306 affordable homes were built in the district (including 81 by the Council). All of these that were built as part of the 2011/15 Affordable Homes Programme met the 'Code for Sustainable Homes' which set standards for levels of insulation and heating efficiency making them less likely to make occupants 'fuel poor'. In the same period, the Council was directly involved in bringing 312 long term empty properties back in to use and also dealt with approximately 4000 housing hazards in private rented and owner occupied properties, of which around 10% related to excess cold. This is positive progress when considering the additional hurdles faced by the district in respect the local housing stock profile and the high number of older properties (pre 1920's) which are particularly difficult to heat efficiently.

Between August 2010 and July 2013 there were 899 excess winter deaths in Bradford District compared to 749 between August 2009 and July 2012 (Source: PHOF)
The Excess Winter Death Index (the extra deaths from all causes that occur in the winter months compared with the average number of non-winter deaths) for Bradford District between August 2010 and July 2013 was 22.1, compared to 17.4 for England and 17.2 for Yorkshire and the Humber. The Excess Winter Death Index in Bradford is the highest within the region. With this in mind the work of the WHHP partnership and the formal extension of this to a two year programme is particularly important.

3.7 Tuberculosis (TB)

HIAP Priority 18 – Reduce mortality from cardiovascular disease, respiratory disease

The Health and Social Care Overview and Scrutiny Committee took a full report on Tuberculosis in the district at their last meeting held on 10 December 2015. (See background document 7) The report noted that for over a decade Bradford has had the highest rate of TB within West Yorkshire. However, recent analysis of the 2014 data shows that Bradford had 96 cases of TB notified to the national Enhanced Surveillance system (ETS) in 2014. This gives the TB rate for Bradford and Airedale in 2014 of just over 18 per 100,000. This is a decline from 2013 (29.45 per 100,000) and the lowest number of cases reported in recent years. This decline reflects a national trend in declining cases as total of 6,520 cases of TB were notified in England in 2014, a rate of 12.0 per 100,000 population, which is a further reduction since the peak of 8,276 cases in 2011 (15.6 per 100,000). Although Bradford has seen a decrease in case numbers and incidence in the past two years, it is too early to tell whether this is the beginning of a sustained downward trend. Work continues to tackle TB across the district coordinated by the TB Network. Regionally the newly formed TB Control Board offers an overview on national strategy taking forward the implementation of the Collaborative Tuberculosis Strategy for England 2015-2020

3.8 Contribution to Corporate Priorities

New Deal is the name of the change programme which Bradford Council has adopted in order to develop a new relationship and narrative with the citizens of the district in the light of the changing role of the public sector. There are four main priorities:

- Safe clean and active communities
- Good Schools and a great start for all our children
- Better skills, more good jobs and a growing economy
- Better Health better lives

All 18 priorities in the HIAP, contribute to and support all 4 priorities, and it is acknowledged that PH has a specific lead role to play in relation to the 'Better Health Better Lives' priority. Public sector organisations in the district are working on creating a community plan and a council plan. Both of these plans are likely to see health and social care as key platforms. In a wider context PH has developed a Health Impact Assessment process for use on key strategic policy. This has been used to influence the new Core Strategy and it is hoped to extend this in the future.

4. FINANCIAL & RESOURCE APPRAISAL

Tackling health inequalities requires long term commitment and investment. Much of this already exists and is directed towards HIAP priorities. This includes internal Council investment as well as external funding from central government departments such as the Homes and Community Agency, the Department of Health and Public Health England.

5. RISK MANAGEMENT AND GOVERNANCE ISSUES

The HIAP and its priorities have been formally endorsed and adopted by the Council and its key partners in a variety of different mutli-agency settings. The responsibility for delivering change and the actions designed to mitigate health inequalities has been interwoven into the Bradford District Partnership and its main strategic partnership groups. This ensures accountability across all agencies. The HWBB is also a key contributor and partner in relation to the HIAP. Across all, the expectation is an annual report.

6. LEGAL APPRAISAL

6.1 Section 194 Health and Social Care Act 2012 (the Act) required the Council to establish a Health and Wellbeing Board (HWBB) for the district, which functions as a committee of the local authority under section 102 of the Local Government Act 1972. Its primary function is to encourage integrated working between commissioners of NHS, public health and social care services for the advancement of the health and wellbeing of the local population. It is in pursuance of this objective that the HIAP was considered and has now been brought to the attention of this Committee.

6.2 Part 1 of 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. The Public Health department in the Local Authority supports the performance of this duty. However systems need to be devised to ensure that other parts of the Council fulfil their

role within the HIAP, particularly in relation to the wider determinants of health. The setting of strategic policy objectives and the way services are delivered might both have an influence in this respect and those involved in these processes across the Council need to be made aware of their responsibilities in this respect.

6.3 Section 31 of the Act requires local authorities to pay regard to guidance issued by the Secretary of State for Health when exercising their public health functions and in particular local authorities are required to have regard to the Department of Health's Public Health Outcomes Framework.

7. OTHER IMPLICATIONS

7.1 EQUALITY & DIVERSITY

7.1.1 The Public Sector Equality Duty under the Equality Act 2010 requires the Council when exercising its functions to have due regard to the need to:
a) Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Equality Act 2010;
b) Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
c) Foster good relations between persons who share a relevant protected characteristic and persons who do not share it; including due regard to tackling prejudice and promoting understanding.

Relevant protected characteristics include age, disability, gender, sexual orientation, race, religion or belief.

There is an important difference between this duty and the responsibility to tackle Health Inequalities. As noted earlier, Health inequalities are defined as the differences in the health of different parts of the population, and this brings into consideration a wider range of factors than those identified as 'protected characteristics' within the Equality Act 2010.

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

7.1.3 There are health inequalities which affect protected characteristic groups more than others. This is acknowledged and reflected in the HIAP, and specifically priorities 1 through to 10. These outline health impacts for specific groups such as older people, young people and children, people with disabilities and/or mental health problems.

7.1.4 It is important to acknowledge however that there are also health inequalities which affect people from all the diverse communities in Bradford. The joint effort of working

together to improve the housing stock for instance would make material difference to those experiencing fuel poverty and therefore also meet the actions in priority 15.

7.2 SUSTAINABILITY IMPLICATIONS

The HIAP and the Joint Health and Wellbeing strategy are an integral part of health and social care systems. As such they underpin all the work programmes and services delivered across the health and social care systems.

7.3 GREENHOUSE GAS EMISSIONS IMPACTS

7.3.1 Some of the major programmes which the Council fosters under wider determinants in relation to Health Inequalities have a direct impact on reducing the impacts of climate change. Fuel poverty plans aim to improve housing and heat/light and power systems for vulnerable householders. 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 health outcomes will largely reduce greenhouse gas emissions. Active travel is a good example, achieving multiple outcomes for the environment and the health of the population. However it is 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.

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7.4 COMMUNITY SAFETY IMPLICATIONS

The health and wellbeing of communities includes perception of safety and security within the household and wider society. One of the priorities (Alcohol and Violence) has been specifically performance managed by the Community Safety partnership and will continue to be overseen by its replacement in time to come

7.5 HUMAN RIGHTS ACT

By virtue of the Human Rights Act 1998 all public bodies (including local government) carrying out their public functions have to comply with the rights set out in the European Convention on Human Rights. Developing priorities of the type set out in the HIAP and promoting their effective delivery means that the Council will be supporting the principles behind the Convention, in particular respect for private and family life, the right to marry and start a family, the right to an education, the right to life and the right to be protected from the effects of discrimination. Action taken to reduce health inequalities is likely to have a positive impact on human rights issues across all aspect of the framework

7.6 TRADE UNION

None

7.7 WARD IMPLICATIONS

Health Inequalities are complex and bought about by economic, cultural and social

differentials across populations and communities. Through the Area and Neighbourhoods services there are ward plans developed in partnership with services and householders which detail local concerns; including those which are health and social care related. These are then worked up to identify the actions which can be taken to tackle and/or mitigate these.

8. NOT FOR PUBLICATION DOCUMENTS

None

9. OPTIONS

That members examine and comment on the report content

10. RECOMMENDATIONS

- That the committee recognise the breadth and complexity of the work undertaken in relation to Health Inequalities and support its continuation

- That a further report is made to this committee in 12 mths time

11. APPENDICES

Appendix 1 HIAP

12. BACKGROUND DOCUMENTS

Background paper 1 Health and Wellbeing Strategy
Background paper 2 Report for HWBB re HIAP 2014-07-29
Background paper 3 Report for HSC O&S 2014-10-02-HIAP
Background paper 4 HWB peer review outcomes
Background paper 5 Executive report HIAP 2015-01-13
Background paper 6 Report for HSC O&S 2015-10-10 Dementia
Background paper 7 Report Tuberculosis Incidence in Bradford District-2015-12-10

Appendix 2

Marmot Indicators 2015 – Bradford