The Health and Wellbeing needs of the People of Bradford and Airedale

Joint Strategic Needs Assessment 2008
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Appendix 1 JSNA Data Sources.
PREFACE

This first Joint Strategic Needs Assessment (JSNA) for Bradford & Airedale draws together the key data and information which give a picture of the health and well-being needs of the population of the Bradford Metropolitan District. Health is viewed in its widest social context. We acknowledge throughout this document and the philosophy of the JSNA that health means more than just physical health. There are significant wider determinants of health, and we do not view health as just the absence of disease, but as ‘a state of complete physical, mental and social well-being’\(^1\). The intention is that the JSNA will help planning over the next 3-5 year period, with the aim of maximising the potential for health and well-being across Bradford and Airedale by reducing inequalities and considering the impact of well-being in decision making.

The JSNA identifies the position Bradford & Airedale tPCT and the City of Bradford Metropolitan District Council currently occupy, according to a wide range of statistics and data, and where possible compares them with the situation across Yorkshire and Humber and the country as a whole. We have tried to determine where our progress is in line with national and regional indicators, and where there is a significant gap between what is happening in Bradford and the rest of the region and the country. We recognise that so much we do has an impact upon our health, from having a job we enjoy and feel happy in; to living in a pleasant environment with friends and neighbours around us and feeling safe in, and part of, our local community.

The JSNA identifies where gaps exist in data collection and the process of creating a JSNA will be significantly supported and strengthened through the creation of a Bradford Observatory. The key challenges facing Bradford in the next 3-5 years include supporting our ageing population, and the significant number of people who provide paid and unpaid care. We need to extend our current levels of progress to counter significant inequalities in health and well-being. We face significant challenges in reducing the levels of infant mortality, childhood obesity and teenage pregnancy, and improving the aspirations and educational achievement for children and young people. We need to significantly increase people’s general level of health and improve their understanding of their own health needs. We also need to plan for those with mental health problems and for the increasing number of people experiencing dementia, as our population grows and life expectancy increases.

In this JSNA, we have begun a process of identifying the health and well-being needs of the local population, in order to inform a strategic approach to meeting these needs. We invite the people of Bradford and Airedale to join us to ensure that we continue to focus on people’s needs - both now and the future.

Anita Sims, Director of Public Health, Bradford and Airedale Teaching PCT

Moira Wilson, Strategic Director, Adult Services, Bradford Council

Kath Tunstall, Strategic Director, Children and Young People’s Services, Bradford Council

\(^1\) The World Health Organisation (WHO) definition of health.
1. BACKGROUND

Aims and Objectives of the JSNA

1.1 The aim of this Bradford & Airedale JSNA is to bring together data and information in a way which is accessible to local commissioners, local communities and other stakeholders. The JSNA identifies the health and well-being needs of the local population of the Bradford District. Producing a JSNA is a legal requirement which feeds into World-Class Commissioning and into the strategic planning of the PCT and Council. Further details are given later in this chapter.

1.2 The JSNA will help to improve the targeting of services which aims to reduce health inequalities that exist between Bradford & Airedale and other areas and to narrow the gap in the health and wellbeing experienced by different communities within Bradford & Airedale.

1.3 It is a framework for annual commissioning cycles, providing evidence of need. It will focus attention on longer-term service development and on identifying the capacity required to deliver a reduction in health inequalities. Therefore better planning, and better resource allocation decisions, will be made as a result. The JSNA will change the way services are commissioned in the future.

1.4 It is intended that this JSNA will provide a platform to engage stakeholders – including partner agencies, clinicians, and communities - in the continuing development of appropriate services.

1.5 The key objectives of the JSNA are to inform:

- What we are doing
- What we should we be doing
- What we should be doing differently.

The JSNA is envisaged as a ‘live’ document that will be updated regularly in the light of economic, social or other change arising nationally or locally, or in the light of outcomes from a previous year’s initiatives. This, the first JSNA, acknowledges there are significant gaps in the data currently held, particularly at below-district level, and filling these gaps will be an important element in our work in the next 12 months.

Content of this JSNA

1.6 This document collects together information about our current local priorities from local plans and the data which is available to support decision making in these areas. The report format is as follows:

- This background chapter provides the context for the report, outlining the purpose and the function of the document. It also places the JSNA within the existing strategic environment.
The detailed technical Appendix contains the data sources and baseline information used to populate the JSNA. Chapters 2 – 4 draw out the key issues emerging from this data. In particular:

- Chapter 2 provides a demographic profile of the population, looking particularly at issues of deprivation and inequalities within the population.
- Chapter 3 provides details of the key health and well-being issues for adults, including the wider determinants of health, such as housing, economic activity levels and social networks/isolation.
- Chapter 4 provides details of the key health and well-being issues for children and young people.
- Chapter 5 draws on the information provided and looks at prioritisation and commissioning.
- Chapter 6 contains the next steps which have been agreed by the PCT and the Council to take this JSNA forward.

1.7 Alongside the JSNA, a statutory report, the report of the Director of Public Health Annual Public Health Report for Bradford (APHR), is also being published by the tPCT in September 2008. This report provides a picture of the health of the people of Bradford and highlights specific issues for those at higher risk of ill health. The APHR, like the JSNA, is especially aimed at the local NHS and the Council but could be used by anyone in Bradford to understand local health issues. As well as describing the actions and approaches that are underway to improve health, it covers the role of public health in risk management and surveillance of specific public health related areas (e.g. communicable disease control, vaccination and immunisation, screening and emergency planning).

**What is a JSNA?**

**A Statutory Duty - to Improve Local Services**

1.8 The Local Government and Public Involvement in Health Act 2007 placed a statutory duty on Local Authorities (LA) and Primary Care Trusts (PCT) to complete a Joint Strategic Needs Assessment (JSNA). A JSNA will:

- Enable the PCT, LA and their partners to develop health and social care commissioning plans which are designed to meet future needs and achieve better outcomes
- Inform existing and potential service providers about potential service change
- Provide an opportunity to look ahead three to five years and identify the change that needs to happen in local services so that positive outcomes are maximised at minimum cost
- The JSNA must drive strategic planning in two ways:
(a) the range of needs in the district, identified through the assessment must be taken into account by the local authority and its partners in preparing the sustainable community strategy, and inform the priorities of the local area agreement

(b) it must shape commissioning strategies and plans of local authority, PCT and practice based commissioners.

1.9 A JSNA is a central element of the Government’s Commissioning Framework for Health and Well-Being (2007), which provides guidance on commissioning services for primary care, social care, public health and well-being. The framework suggests that health and well-being services should be:

- focussed on the needs of the individual
- orientated towards improving wellbeing and preventing ill-health
- developed in partnership, with organisations working together to improve outcomes for the local population.

1.10 These three particular attributes - being person centred, focussed on prevention and working in partnership - are echoed by other national policy documents such as ‘Our Health Our Care Our Say’, ‘Every Child Matters’, ‘Putting People First’ and ‘Strong & Prosperous Communities’ which stress the need to ensure services are outcome-focussed and based on evidence of need.

**A Support Tool for World Class Commissioning**

1.11 These principles are reinforced by the Department of Health’s recent vision for world class commissioning, to deliver better health and well-being for all so that we can add life to years and years to life, and specifically:

- People will live healthier and longer lives
- Health inequalities will be dramatically reduced
- Services will be evidence-based and of the best quality
- People will have choice and control over the services that they use, so they become more personalised
- Investment decisions will be made in an informed and considered way, ensuring that improvements are delivered within available resources
- PCTs will work with others to optimise effective care

1.12 The vision for world class commissioning requires that organisations develop skills and knowledge within 11 commissioning competencies. These require that commissioners:

<p>| | |</p>
<table>
<thead>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Are recognised as the local leader of the NHS</td>
</tr>
<tr>
<td>2</td>
<td>Work collaboratively with community partners to commission services that optimise health gains and reductions in health inequalities</td>
</tr>
<tr>
<td>3</td>
<td>Proactively seek and build continuous and meaningful engagement with the public and patients, to shape services and improve health</td>
</tr>
<tr>
<td>4</td>
<td>Lead continuous and meaningful engagement with clinicians to inform strategy, and drive quality, service design and resource utilisation</td>
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</table>
5. Manage knowledge and undertake robust and regular needs assessments that establish a full understanding of current and future local health needs and requirements

6. Prioritise investment according to local needs, service requirements and the values of the NHS

7. Effectively stimulate the market to meet demand and secure required clinical, and health and well-being outcomes

8. Promote and specify continuous improvements in quality and outcomes through clinical and provider innovation and configuration

9. Secure procurement skills that ensure robust and viable contracts

10. Effectively manage systems and work in partnership with providers to ensure contract compliance and continuous improvements in quality and outcomes

11. Make sound financial investments

The JSNA is a crucial vehicle to support the delivery of this vision.

**Defining Health**

1.13 The JSNA is based on a holistic, social model of health – which recognises the impact of a wider range of influences on health. Health has often been perceived as simply the absence of disease. However, the World Health Organisation (WHO) has defined health as, “*a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity*”. This broader definition implies that:

- Health is a positive concept to which governments, statutory agencies, voluntary organisations, businesses, communities and individuals can all contribute
- People’s sense of well-being can be poor even where there is no “identifiable disease” (WHO, 1999).

1.14 The WHO also states: “*the policies that are the most successful in sustaining and improving the health of the population are those which deal with economic growth, human development and health in an integrated way.*” (WHO, 1999). A wide range of factors can contribute to good and/or poor health, for example:

- The environment
- Income
- Employment
- Education
- The organisation of transport
- The design and condition of houses
- Crime and anti-social behaviour
- The social and physical condition of local neighbourhoods.
1.15 These factors have been labelled as the “wider determinants of health”. These determinants interact to create the health status of a community. A representation of the inter-relationship of these factors is demonstrated by the Dahlgren & Whitehead “rainbow model” (Dahlgren and Whitehead, 1991) shown below:

**The Rainbow Model of Health**

(Dahlgren & Whitehead, 1991)

1.16 The five layers, moving from the core outwards, are:

**Fixed biological factors** – age, sex, racial group, genetics
- e.g. Being Chinese, 80 years of age, from a family with a history of coronary heart disease.

**Individual lifestyle factors**
- These are personal factors an individual can control.
- e.g. choosing not to practice safe sex; choosing inactive leisure pursuits. This is often an issue of a lack of correct information regarding lifestyle choices.

**Social and community influences**
- These are peer influences and social pressures, which can influence the personal factors mentioned above.
- e.g. interaction with friends and relatives, support from the immediate community, in some communities it is the norm to have children in teenage years. The norm of parents driving children to school instead of walking or cycling.
Living and Working Conditions
Factors which person encounters in their daily life, at home, work or leisure.
e.g. access to relevant health services (i.e. family planning) communication (lack of
information about contraception); poor public transport or leisure services.

General socio-economic, cultural and environmental factors
This layer takes into account the roles of Government, laws, treaties, religions,
global economic status and physical geography, and has a bearing on all the other
layers e.g. economic status of country, cultural/religious beliefs, and international
policy on pollution.

Partnership Working to provide Information and Intelligence

1.17 A fundamental principle of this JSNA is the development of a partnership which
brings together the information and intelligence of the individual agencies
encompassed by the partnership. It provides a vehicle for sharing data and
information in order to commission services in the most effective way. It brings
together known data, facts and figures into one source, to be interpreted and used
by local commissioners to target resources.
1.18 The JSNA not only draws on information held by the Bradford District Partnership, but will provide information and analysis to partnership groups to inform priorities and work programmes:

**Analysing the Health and Well-Being of the Population**

1.19 The JSNA provides an analysis of the health and well-being status of the population. It provides details of the demography of the area (e.g. age and ethnicity profiles), health indicators (such as disease prevalence and lifestyle behaviours, e.g. smoking rates) and also indicators for the wider determinants of health (such as housing conditions, worklessness or educational attainment). This data can be used to project and predict health and well-being needs of the future local population. It can also be used to consult the community and service providers, to commission appropriate services, and to monitor the success of services commissioned. The JSNA is a ‘live’ document, and information from monitoring of outcomes and community consultation will inform future JSNAs.

**How the JSNA contributes to Key Local Strategies and Plans**

1.20 The Local Area Agreement (LAA) is the delivery plan for the Sustainable Community Strategy, and sets out short term targets and measures to help achieve the high-level community strategy vision. It contains the cross-cutting targets which need a multi-agency approach, working together in order to make an impact. This is underpinned by more detailed themed work – housing strategy, children’s plan, adult wellbeing strategy, supporting people etc.

1.21 The JSNA, although primarily concerned with health and wellbeing outcomes, is also relevant to all the LAA themes – wider determinants of health, neighbourhoods,
social capital, crime, work, regeneration and deprivation. It therefore confirms and informs the strategic vision and connects to other key plans, including:

- ‘The Big Plan’ – Bradford’s Sustainable Community Strategy (2008-2011)
- Citizens First – Bradford Council's Corporate Plan 2007 – 2010
- Bradford LAA – Connecting People and Places to Economic Prosperity (SCS Delivery Plan)
- tPCT Strategic Plan 2008-2011
- Delivery, Responsibility and Accountability – Patient and Public Involvement
- PCT Local Delivery Plans
- Bradford and District Children and Young People Needs Analysis, June 2008
- Children and Young People’s Plan 2008-2009
- Bradford District Health in Mind Strategy 2008-11
- Strategic Review of Adult Mental Health Services in Bradford and Airedale 2008
- ‘Emerging from the Shadows – A strategic framework for services for older people with mental health difficulties 2008-11’
- ‘Changing Lives Through Real Partnership – Commissioning Framework for Learning Disability Services – a Model’
- ‘Thinking about Tomorrow: Taking Action Today – The Bradford Older People’s Partnership renewed strategy 2007-10’
- Adult Service 5 year Strategy 2007-12
- Carers’ Strategy
- Bradford Supporting People Needs Analysis
- Bradford Supporting People Strategy
- Supporting Independence – Bradford’s accommodation strategy for older people 2006-2010
- Bradford Homelessness Strategy 2008

**Using the JSNA to inform future strategies**

1.22 The JSNA will be the cornerstone of the planning process for commissioners of health and wellbeing services. It will inform and amend the Sustainable Community Strategy (‘The Big Plan’), the Local Area Agreement, the Strategic Commissioning Plan and Practice Based Commissioning Plans. It will support the PCT, the Council and other partners in identifying performance targets and will underpin the achievement of LAA targets.

**What do we learn from the JSNA? Does it tell us anything new?**

1.23 Whilst there are no surprises in the JSNA, it brings together, in one place, data and information from many different sources. This information is held by various partners and organisations, and the JSNA places these indicators and information into a nationally agreed framework which we can use to measure and improve quality of life, and the quality of health and healthcare, for the population of Bradford and Airedale. The evidence contained within the JSNA, and the detailed Appendix, should confirm and reinforce our existing strategic priorities, and support our decisions on where interventions are required to meet national and regional targets.
Our Data Selection Rationale

1.24 We have selected data which provides us with evidence of the needs of the population, drawing on the JSNA Core Data Set\(^2\). We have included data which reflects the needs in Bradford and Airedale, and have identified where data may not be available. We appreciate that the Bradford Observatory will be well placed to coordinate data in the future and fill these gaps. Identification of these gaps will be useful for strengthening the PCT and Local Authority health intelligence function, developing the Observatory and planning future year’s JSNA.

Data Sources

1.25 In undertaking this JSNA, we accessed a wide range of data sources, including data from the Census 2001, NOMIS (DWP’s National Online Management Information Service) IMD 2007 (Indices of Multiple Deprivation), local health data, data from Council services and Bradford & Airedale TpCT, the Association of Public Health Observatories (APHO) and the Department of Health.

Developing a Bradford Observatory

1.26 The synthesis of data and information as described above must be a dynamic process. A part of the learning which results from a needs assessment of this scope is identification of what is not known, as well as what is known. This must be the first step in the process to refine and enrich our intelligence over time. Whilst the strategic drivers to improve partnership working are growing, the operational systems currently in place to access and share data in the right format and time are unable to meet the needs in this new environment. Although there is a willingness to find a solution to meet the data and information needs of local stakeholders, this will require considerable effort and energy to resolve.

1.27 Preliminary work on development of a Bradford Observatory is encouraging and has received strong support. This development has the potential to transform data-sharing and data analysis across multiple sources and multiple geographies, providing an infrastructure to meet information needs across the partnership, both operational and strategic. It has focused attention on finding a solution to meet the data and information needs of all key stakeholders. The challenge will be to channel this energy and the considerable experience and expertise existing within Bradford to develop the Bradford Observatory.

Consulting the Local Community to Commission the Right Services

1.28 It is essential that the quantitative data brought together in this report is combined with evidence gathered through community consultations to shape the appropriateness of services for the future. This will include an understanding of

\(^2\) The JSNA core dataset is available at http://www.ypho.org.uk/commissioning_JSNA.aspx.
those within the population getting a raw deal in terms of health and well-being outcomes that will be used to inform investment decisions to reduce health inequalities.

1.29 The JSNA will therefore be able to define achievable improvements in the health and well-being of the population, creating a solid foundation for commissioning priorities in the area and providing a clear message for commissioners of services about how to achieve better outcomes for the people of Bradford and Airedale. The JSNA looks forward three to five years to identify the changes needed in local services to ensure that positive outcomes and resource usage are maximised.

1.30 We are committed to engaging the local community actively, effectively and meaningfully through the local strategic partnership and its emerging structures. Building on our effective public-patient involvement work, we will publicise the JSNA and make it available through a series of community consultation and engagement events in the autumn. Our track record of community engagement and public consultation was recently evidenced in drawing up the Sustainable Community Strategy, ‘The Big Plan’. We will ensure the detailed JSNA guidance on community engagement is implemented effectively and robustly across Bradford. The ability to effectively engage the community will have a distinct and important impact on the effectiveness of the JSNA and its ability to tackle and reduce health inequalities.

Recent consultation work in Bradford: ‘The Big Plan’

1.31 All local authorities have a statutory duty to work with partner organisations to produce a Sustainable Community Strategy, designed to demonstrate how local organisations and agencies will work together to improve the economic, social and environmental well-being of their area. This is the over-arching, high-level strategy that includes the vision for the area, covering the period from 2008-2020. It is ‘owned’ by the Council and the local strategic partnership and, as a result, all members of the LSP sign up to help deliver its vision and objectives.

1.32 Bradford District’s Sustainable Community Strategy is called ‘The Big Plan’ and is organised around five themes - Health and Well-being, Safer & Stronger Communities, Prosperity and Regeneration, Environment, and Children & Young People - with each theme identifying a number of priority areas for action.

1.33 Development of ‘The Big Plan’ involved the district’s strategic partnerships, the participation of key partners and stakeholders, and extensive public consultation to cover the period 2008-2011. The partnerships were the focal point for drawing up an evidence-based assessment of the critical issues that need to be addressed across the district, engaging with their constituent partners and stakeholders as appropriate. This assessment was set out in ten “theme profiles” which set out the challenges, aspirations and proposals for intervention:

- Children & Young People
- Safer Communities
- Stronger Communities
- Health & Wellbeing
- Older People
The challenges, aspirations and critical issues were subject to detailed discussions at a partnership conference on 11th July 2007 attended by about 200 people representing the District’s key partners and partnerships.

Two elected Member conferences gave councillors the opportunity to shape the theme profiles and the challenges set out in them, to assess the evidence, and to interrogate the actions.

During October/November 2007, an extensive public consultation programme was carried out, reaching over 3,000 people. It was designed to harvest a statistically significant response to quantitative surveys, supported by qualitative methods for hard to reach groups. Participants were provided with information before being asked for their views. Fact sheets were available electronically and widely distributed through libraries and other contact points. These were used to ask people about priorities for the district through:

- On-line and hard copy survey questionnaire (promoted via local media, Community Pride, Neighbourhood Forums and email) resulting in 1,343 responses
- A parallel questionnaire using the Council’s SpeakOut! Panel (1,337 responses)
- Focus groups, in-depth interviews and other qualitative research approaches with representatives of communities of interest and hard to reach groups (e.g. low income families; BME groups; people with learning difficulties, disabilities and mental illness; the LGBT community; residents with literacy problems. In total there were more than 40 events involving 377 people
- Consultation/resource packs were also available for organisations to run their own consultation events, for instance Bradford Older People’s Alliance ran a conference for older people

Overall, analysis of the findings demonstrated widespread support for the priorities that emerged through this year-long partnership process: economy, skills, children, and crime and environmental issues at neighbourhood level.

Bradford and Airedale Teaching PCT: Patient Consultation and Engagement

As the local leader of the NHS, Bradford and Airedale Teaching PCT (tPCT) wants to ensure that NHS services used by local people are of the best possible quality.

The tPCT is working to improve the patient experience from four perspectives:

- Learning from patients’ actual experiences and responding to those through the commissioning, service redesign and contracting processes;
o Providing information to patients and the wider public to enable them to make choices about their healthcare and give them assurance that their local healthcare commissioner and its providers are responding to their needs as patients;

o Engaging patients and the public appropriately in the development of strategy and service changes;

o Through a programme of community development work, identifying and addressing the needs of local communities/communities of interest, opportunities for developing sustainable social capital, and the needs of those in the community who do not access services.
2 THE POPULATION OF BRADFORD AND AIREDALE

The Local Population

2.1 Some 493,100 people live in the Bradford and Airedale district – 242,600 men and 250,500 women (49.2% and 50.8% respectively). The working age population is around 303,100, or 61.5% of all residents. This compares with 62.2% of the total population of Great Britain, (NOMIS, 2006). The chart below shows the projected population growth in the district, which is expected to reach nearly 600,000 by 2030.

Projected population growth of Bradford District (2004-2028)

Source: ONS Population Projections (2005)

2.2 The population pyramid below shows that Bradford’s population growth is being driven by higher than average birth rates. Young people therefore make up a larger proportion of the district’s population than the national average: 23% of residents were under 16, compared with 19% nationally.

2.3 Bradford’s population, like that of Britain as a whole, is also ageing. We are forecast to have a total of over 80,000 residents aged 65+ by 2020 (from a figure of 68,600 today).

3 Source – the figures in this section are based on 2001 Census, and/or ONS estimates
Our district contains a rich mix of ethnic groups and cultures. Whilst 77% are White British (compared with 92% in Yorkshire and Humberside and 87% nationally) 15% are Pakistani and 3% Indian, with the remaining 5% from other Asian, Caribbean, Chinese, Mixed or Other backgrounds:

Source: Nomis web.co.uk
The Local Geography

2.5 Bradford District covers an area of approximately 400 square km. In addition to Bradford city, there are also a number of smaller centres, towns and villages and two-thirds of the District is rural. Most of the industrial and residential development has taken place alongside the rivers Aire and Wharfe, with the majority of the 493 thousand population living in the urban centres of Bradford, Shipley, Bingley, Keighley and Ilkley.

2.6 All these areas have their own identity and challenges will be posed to both service providers and commissioners of services to ensure that the needs of populations residing in these parts of the district are both identified and met.

2.7 Bradford District has defined number of geographic boundaries that are used to sub-divide and analyse the district at various levels. An example of the key sub-district geographies used are presented below:

<table>
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<tr>
<th>Geographic Boundary</th>
<th>Average Population</th>
<th>Number in Bradford District</th>
</tr>
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<tbody>
<tr>
<td>Lower Super Output Areas</td>
<td>Minimum population 1000; mean 1500. Built from groups of OAs</td>
<td>306</td>
</tr>
<tr>
<td>Middle Layer Super Output Areas</td>
<td>Minimum population 5000; mean 7200. Built from groups of</td>
<td>61</td>
</tr>
<tr>
<td></td>
<td>Lower Layer Output Areas.</td>
<td></td>
</tr>
<tr>
<td>Wards</td>
<td>Average 15,000 population</td>
<td>30</td>
</tr>
<tr>
<td>Constituencies</td>
<td>Average total population 90,000 Each constituency contains</td>
<td>5</td>
</tr>
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<td></td>
<td>6 Wards</td>
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</table>
Wards and Localities

2.8 Each of the Council's 30 Wards has a population of around 15,000 people. The Ward boundaries were established in 1991, with changes occurring in Keighley and the east of the district during 2004. The Ward list and map below incorporate these changes.

Index of Wards

1. Baildon
2. Bingley
3. Bingley Rural
4. Bolton & Undercliffe
5. Bowling & Barkerend
6. Bradford Moor
7. City
8. Clayton & Fairweather Green
9. Craven
10. Eccleshill
11. Great Horton
12. Heaton
13. Idle & Thackley
14. Ilkley
15. Keighley Central
16. Keighley East
17. Keighley West
18. Little Horton
19. Manningham
20. Queensbury
21. Royds
22. Shipley
23. Thornton & Allerton
24. Toller
25. Tong
26. Wharfedale
27. Wibsey
28. Windhill & Wrose
29. Worth Valley
30. Wyke

Indices of Deprivation

2.9 A key characteristic of Bradford District is a significant variation in the levels of deprivation, both between Bradford and other areas and between different neighbourhoods and communities within the district. There is a clear link between deprivation and differing experiences of health and wellbeing which presents Bradford District with the challenge of narrowing this gap in experience.
2.10 In 2007, Communities and Local Government published the “Indices of Multiple Deprivation 2007” (IMD 2007), which are a means of measuring levels of deprivation in areas of England. The Index assesses deprivation by seven different ‘domains’ and provides an overall deprivation score for small geographical areas, known as ‘Lower Super Output Areas’. Summary measures of the IMD 2007 are also produced at Local Authority District Level.

2.11 Bradford ranks 32nd (out of 354) in the Department for Communities and Local Government (DCLG, now CLG) Index of Multiple Deprivation (2007). This places it squarely in the most deprived 10% of local authorities nationally. Its position is worse than other West Yorkshire authorities:

<table>
<thead>
<tr>
<th>LA Name</th>
<th>Rank of Average Score (ID 2007)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bradford</td>
<td>32</td>
</tr>
<tr>
<td>Wakefield</td>
<td>66</td>
</tr>
<tr>
<td>Kirklees</td>
<td>82</td>
</tr>
<tr>
<td>Leeds</td>
<td>85</td>
</tr>
<tr>
<td>Calderdale</td>
<td>107</td>
</tr>
</tbody>
</table>

Source: Neighbourhood Statistics

2.12 Some 42% of people in Bradford district live in the 20% most deprived areas of the country and 5% (over 20,000 people) in the 1% most deprived. Looking at individual aspects of deprivation, Bradford ranks 4th and 6th nationally for income and employment deprivation respectively (IMD data). More than 32,000 people experienced income deprivation in the Bradford District.
Nearly 3 in 10 Bradford LSOAs fell into the 10% most income deprived in England. This amounts to 90 Bradford LSOAs, where typically at least 34% of the population were on very low incomes. This rose to 75% of people in the most deprived area of Undercliffe.

Some 16% of Bradford’s LSOAs are in the 10% most employment deprived nationally. In these 49 LSOAs typically 1 in 5 (19%) of the population are claiming key benefits such as Job Seekers Allowance (JSA), Incapacity Benefit, (IB), Severe Disablement Allowance, (SDA) or are on New Deal programmes. An area of Little Horton ward (ranked 69th nationally) was the most employment deprived in the District, where 39% of its population are on benefits.

**PCT GP Practice Based Alliances – summary of key health data**

The PCT groups GP practices into 4 Alliance areas across the Bradford district. The table below provides a breakdown of key health data by these Alliance areas, together with a cross-Bradford average and the national average for comparison. The figures in the top half of the table show the differences in mortality and life expectancy rates across the 4 alliance areas, demonstrating a link between deprivation and health outcomes (2004-2006 figures).

The data in the lower half of the table on disease prevalence across the district comes from the Quality and Outcome Framework (QOF) which records the % of cases of a disease in each GP practice (2007-2008 figures). Whilst these QOF indicators provide a means of predicting the local burden of disease on the health service, they should not be used as a true measure of prevalence in the community. The Health Survey for England found that they under-estimate certain risk factors and diseases, possibly due to under-recording of patients known to GPs but diagnosed previously in other practices or hospitals.

The figures illustrate that, within Bradford, the Citycare Alliance has the most deprived population, the highest premature mortality rates (particularly from coronary heart disease), and the lowest overall life expectancy. However, they also show the Citycare Alliance with the lowest recorded prevalence of registered coronary heart disease, suggesting that additional effort may be required to target treatment in that Alliance area.
<table>
<thead>
<tr>
<th>Indicator</th>
<th>Airedale Alliance</th>
<th>Citycare Alliance</th>
<th>South and West Alliance</th>
<th>Yorkshire Primary Care Alliance</th>
<th>Bradford</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of the registered population living in the most deprived 20% (fifth) of England</td>
<td>31%</td>
<td>78%</td>
<td>59%</td>
<td>25%</td>
<td>44%</td>
<td>20%</td>
</tr>
<tr>
<td>All cause (all age) mortality rate per 100,000</td>
<td>576.9</td>
<td>738.0</td>
<td>732.0</td>
<td>735.9</td>
<td>698.2</td>
<td>612.5</td>
</tr>
<tr>
<td>Cancer mortality rate (&lt;75yrs) per 100,000</td>
<td>106.2</td>
<td>108.8</td>
<td>139.6</td>
<td>142.5</td>
<td>125.7</td>
<td>117.5</td>
</tr>
<tr>
<td>Coronary Heart Disease mortality rate (&lt;75yrs) per 100,000</td>
<td>50.0</td>
<td>83.5</td>
<td>62.7</td>
<td>58.8</td>
<td>61.9</td>
<td>48.9</td>
</tr>
<tr>
<td>Stroke mortality rate (&lt;75yrs) per 100,000</td>
<td>16.0</td>
<td>19.9</td>
<td>19.8</td>
<td>13.0</td>
<td>17.3</td>
<td>16.0</td>
</tr>
<tr>
<td>Life expectancy (males)</td>
<td>77.7</td>
<td>75.3</td>
<td>75.7</td>
<td>75.1</td>
<td>75.5</td>
<td>77.2</td>
</tr>
<tr>
<td>Life expectancy (females)</td>
<td>82.5</td>
<td>79.6</td>
<td>79.1</td>
<td>80.1</td>
<td>79.8</td>
<td>81.5</td>
</tr>
<tr>
<td>A&amp;E attendances per 1,000</td>
<td>268.7</td>
<td>331.4</td>
<td>238.8</td>
<td>214.8</td>
<td>281.7</td>
<td>264</td>
</tr>
<tr>
<td>% patients on coronary heart disease register*</td>
<td>4.3</td>
<td>2.6</td>
<td>4</td>
<td>4</td>
<td>3.7</td>
<td>3.5</td>
</tr>
<tr>
<td>% patients on stroke and TIA register*</td>
<td>2</td>
<td>0.9</td>
<td>1.8</td>
<td>2.1</td>
<td>1.7</td>
<td>1.6</td>
</tr>
<tr>
<td>% patients on hypertension register*</td>
<td>12.7</td>
<td>8.4</td>
<td>12.3</td>
<td>13.5</td>
<td>11.6</td>
<td>12.8</td>
</tr>
<tr>
<td>% patients on diabetes register*</td>
<td>4.1</td>
<td>5.3</td>
<td>4.5</td>
<td>4.1</td>
<td>4.5</td>
<td>3.9</td>
</tr>
<tr>
<td>% patients on cancer register*</td>
<td>0.9</td>
<td>0.3</td>
<td>0.9</td>
<td>1.3</td>
<td>0.8</td>
<td>1.1</td>
</tr>
<tr>
<td>% patients on asthma register*</td>
<td>6</td>
<td>5.6</td>
<td>6.2</td>
<td>6.4</td>
<td>6</td>
<td>5.8</td>
</tr>
<tr>
<td>% patients on chronic kidney disease register*</td>
<td>2.7</td>
<td>1.7</td>
<td>2.9</td>
<td>3.5</td>
<td>2.6</td>
<td>2.9</td>
</tr>
<tr>
<td>% patients with BMI recorded and ≥ 30*</td>
<td>7.9</td>
<td>6.7</td>
<td>8</td>
<td>8.3</td>
<td>7.6</td>
<td>7.5</td>
</tr>
<tr>
<td>% patients who are smokers*</td>
<td>19.7</td>
<td>20.7</td>
<td>25.6</td>
<td>21.8</td>
<td>22.1</td>
<td>21.2</td>
</tr>
<tr>
<td>% coverage measles mumps, rubella vaccine (5 year olds)</td>
<td>89.2</td>
<td>88.3</td>
<td>83.4</td>
<td>88.9</td>
<td>87.2</td>
<td>83.1</td>
</tr>
<tr>
<td>% coverage influenza vaccine 65+ years</td>
<td>74</td>
<td>71.9</td>
<td>75.7</td>
<td>77.4</td>
<td>75.2</td>
<td>73.5</td>
</tr>
</tbody>
</table>

* Recorded prevalence (% Patients on registers)
WIDER DETERMINANTS OF HEALTH

Housing Conditions and housing needs

2.18 National research\(^4\) has highlighted the relationship between housing and health. Poor housing conditions have been shown to be linked to increased risk of illness and accidents. In addition:

- Housing conditions were seen to affect health through such things as heating the home, and hazardous stairs or steps.
- Conditions in the neighbourhood (such as street cleanliness and green space) affect health through increased mental well-being.
- Poor housing and homelessness affects children as well as adults

Housing Tenure

2.19 In Bradford:

- 31.2% of people own their own home outright
- 38.8% own their own home with a mortgage
- 9.4% rent from BCHT (now InCommunities)
- 5.9% rent from another Housing Association
- 13.9% rent from a private landlord and
- 0.8% have other arrangements

2.20 The 2001 Census indicated that 23% of houses in Bradford had no central heating at that time. The overwhelming majority of these involved people over age 65 - nearly 11% of 65-74 year olds, 7% of 75-84 year olds and 2.5% of those aged 85+ were without access to central heating. These figures and those from the Private Sector Housing Condition survey (see next section) are relevant in considering possible links between housing conditions and excess winter deaths, reported on page 45 below.

2.21 2001 Census data also indicated that just over 8% of houses in the district (i.e. 1 in

12) were overcrowded.

Private sector housing stock

2.22 The Council’s latest Private Sector Housing Condition Survey (2008) assessed stock under the Housing Health and Safety Rating System, which provides a good link between housing condition and the health and well-being of its residents.

Key features of Bradford’s private housing stock were:

- It is significantly older than the national average: 40% was built before 1919 compared to 25% nationally, and 21% between 1919 and 1944 compared to 18% nationally. House building in Bradford after 1944 was at lower than national levels, particularly between 1965 and 1980 (11% against 21% nationally);
- The stock is dominated by small and medium/large terraced houses and semi-detached houses;

The report found that:

- A high proportion (40.5%) of Bradford housing fell below the Decent Homes Standard\(^5\), compared with 27.1% nationally. This involves some 65,100 houses across the district;
- Primary reasons for failure in Bradford are Excessive Cold together with Falls on Stairs, Falls on the Level, and Fire;
- These hazards are strongly associated with older dwellings occupied by those on lower incomes and benefit receipt;
- These hazards are strongly associated with privately rented dwellings;
- The level of Excess Cold hazard is an issue for Bradford, given the numbers of older residents;
- Pre-1919 properties are the less energy efficient dwellings, along with converted flats and private rented dwellings;
- The incidence of fuel poverty is much higher than the national average. It is estimated to affect 25,900 (16%) dwellings in Bradford compared with approximately 10% in England as a whole. If the price of fuel continues to rise this figure will increase. The occupiers of a property are considered to be in fuel poverty if more than 10% of their net household income would need to be spent on heating and hot water to give an adequate provision of warmth and hot water.

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\(^5\) To meet the standard, a property should:

- Be above the legal minimum standard for housing
- Be in a reasonable state of repair
- Have reasonably modern facilities (e.g. kitchens and bathrooms) and services, and
- Provide a reasonable degree of thermal comfort (i.e. effective insulation and efficient heating)
The map below shows the distribution of non-decent housing across the district. The map is based on the 2001 Census Wards.

Non-decent dwellings by Ward

[Image of the map showing the distribution of non-decent housing by Ward.]

Source: BMDC Private Sector Housing Condition Survey 2007, June 2008

Housing support needs of vulnerable people

2.23 The Supporting People programme helps vulnerable adults to live independently in the community. The programme pays for housing-related support to help someone to manage in their home. It aims to improve people’s quality of life and provide support to prevent problems that can lead to hospitalisation, institutional care or homelessness.

2.24 This section draws on the detailed “Bradford Supporting People Needs Analysis 2008-9” which highlighted the need for services to respond to the diversity of the Bradford district, and identified a number of key strategic gaps. There is currently a large shortfall in service provision for socially excluded groups and an imbalance between the needs of the community and the pattern and locality of services on offer. There is also currently a concentration on accommodation-based services.

2.25 The Analysis estimated that overall there were probably 15,000 to 20,000 people in need of support at any one time, and a much larger group who would benefit from an increased level of preventative services, beginning with monitoring–only services via Community alarms. This implies a shortfall of between 2,050 and 3,370 units that could be met by floating support, both generic and specialist.

2.26 A key finding was therefore the need for greater use of floating support services that could respond to vulnerable users across all housing tenures and areas of the district, providing a range of services. As just 3% of organisations providing floating support are currently funded by Supporting People in Bradford, over the next 3 years there will be a significant shift to increase that provision in line with the outcomes of the Needs Analysis. There was also a need for additional supported accommodation.
2.27 The range of client groups is outlined below, with the numbers identified in surveys to support the Needs Analysis shown in brackets.

**Socially excluded groups**

2.28 The report indicated that the largest gap between needs and supply was in **Substance and Alcohol misuse** (450 people with this as a main need). Drugs (209) were slightly more prevalent than alcohol (164) and a further 77 experienced difficulties with both.

2.29 **Offenders** were probably the second largest group (314, of whom 212 had an alcohol or substance-misuse problem).

2.30 Almost three quarters of **Homeless** acceptances were from **families**. 337 were identified by the surveys, some of whom had complex needs that would need support after they moved into ordinary housing. There was also a need to increase preventative services to further reduce the numbers losing their homes. The most recent **Rough Sleeper** count suggested that about 50 people were sleeping rough, although an unknown number beyond that will be ‘sofa-surfing’. 199 single people were accepted as homeless in 2006/7.

**Young people** (90 identified in the surveys), nearly 80% of whom were homeless, included young offenders, care leavers and teenage parents.

2.31 Victims of **Domestic Violence** are now more prepared to report incidents, but this does not translate directly into numbers needing support. Around 9000 people were thought to be victims of abuse and some were fleeing forced marriages. There are currently 72 units of support, mainly accommodation-based.

2.32 There are an estimated 230 people with **HIV/AIDS** in the district (thought likely to be an under-estimate), but no specialist support for them.

2.33 In the case of Travellers there are about 70-80 caravans in Bradford at any one time, of whom only 28 occupy official pitches. Bradford also has a long history as host to **BME communities** and the numbers accessing support services are comparatively large. A range of culturally specific services is needed, especially given the likely growth in these communities.

2.34 A key factor addressing needs across the entire Socially Excluded client group relates to access to stable accommodation. Again, the lack of affordable “move on” accommodation, together with effective floating support services, results in silting up of service. The council is currently developing a new homelessness strategy, which will also include a focus on the socially excluded and vulnerable people.

**Independence with support**

2.35 By far the largest current unmet need in terms of numbers is **Older people**, a population that is also projected to grow in the foreseeable future and, significantly, the numbers of over 85s that will be most in need of support. There is a rapid increase in the numbers of owner-occupiers falling into old-age, a group who in the past have not received many services, and the growth in BME communities will also be important in future service development. An estimated 1,000-2,000 units of additional
Extra Care are needed as a starting point. The lack of these services impacts on the strategic decision to support more older people living in their own homes.

2.36 A new 5-year Supporting People Strategy has just been completed (2008-2012) that aims to fill gaps identified by the Needs Analysis. Supporting People also determines its priorities through the Local Strategic Partnerships as set out in the ‘Big Plan’.

2.37 In order to address the needs outlined in its 5 year strategy, Supporting People will carry out a 3-year programme of sector reviews and commissioning of new services, recognising the need for more flexible support solutions to all client groups. To this end the 3-year programme incorporates the introduction of the personalisation agenda through individual budgets.

**Economic Activity rates**

2.38 Economic activity rates, together with rates of pay from employment, are critical factors in the wellbeing of the local population and are inextricably connected with the economic welfare of the district as a whole. They also underlie inequalities and relative deprivation across the district.

2.39 Bradford has a lower proportion of economically active residents than Y+H and the country as a whole. In 2006/7 73.9% of all working age residents in the District were economically active. This compares to 78.5% nationally and 77.6% in Yorkshire and the Humber (Y+H).

<table>
<thead>
<tr>
<th></th>
<th>Bradford (numbers)</th>
<th>Bradford (%)</th>
<th>Y+H (%)</th>
<th>GB (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Economically active</strong></td>
<td>222,100</td>
<td>73.9</td>
<td>77.6</td>
<td>78.5</td>
</tr>
<tr>
<td>In employment</td>
<td>206,400</td>
<td>68.7</td>
<td>73.2</td>
<td>74.3</td>
</tr>
<tr>
<td>Unemployed</td>
<td>14,400</td>
<td>6.5</td>
<td>5.5</td>
<td>5.3</td>
</tr>
<tr>
<td><strong>Economically inactive</strong></td>
<td>75,700</td>
<td>26.1</td>
<td>22.4</td>
<td>21.5</td>
</tr>
<tr>
<td>Wanting a job</td>
<td>19,400</td>
<td>6.7</td>
<td>5.3</td>
<td>5.3</td>
</tr>
<tr>
<td>Not wanting a job</td>
<td>56,200</td>
<td>19.4</td>
<td>17.2</td>
<td>16.2</td>
</tr>
</tbody>
</table>

2.40 There are some differences in the types of employment available in Bradford compared to Y+H and GB. For example, we have a lower proportion of professional occupations, a slightly higher proportion of personal service occupations and a higher proportion of plant and process machine operatives.

**Qualifications**

2.41 Bradford has a high proportion of residents with no qualifications (21.8%, compared to 15.3% in Y+H and 13.8% in GB). The District also has a lower proportion of residents with higher qualifications (NVQ4 and above) – 19.6% of Bradford’s

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6 Source: Nomis web.co.uk
working age population have NVQ4 and above, compared with 22.7% in Y+H and 27.4% nationally.

**Earnings**

2.42 Average weekly earnings in the District are lower than Y+H and the national average. For full-time workers, average gross weekly pay in 2007 was £381.50, compared with £425 in Y+H and £459 in GB. There is also a difference in earning between men and women:

<table>
<thead>
<tr>
<th></th>
<th>Bradford</th>
<th>Y+H</th>
<th>GB</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gross weekly pay</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All full-time workers</td>
<td>£381.5</td>
<td>£425.0</td>
<td>£459.0</td>
</tr>
<tr>
<td>Males</td>
<td>£423.8</td>
<td>£470.0</td>
<td>£500.7</td>
</tr>
<tr>
<td>Females</td>
<td>£345.1</td>
<td>£355.5</td>
<td>£394.8</td>
</tr>
<tr>
<td><strong>Hourly pay</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All full-time workers</td>
<td>£9.71</td>
<td>£10.53</td>
<td>£11.50</td>
</tr>
<tr>
<td>Males</td>
<td>£10.35</td>
<td>£11.15</td>
<td>£12.17</td>
</tr>
<tr>
<td>Females</td>
<td>£9.19</td>
<td>£9.49</td>
<td>£10.48</td>
</tr>
</tbody>
</table>

**Working-Age Benefits**

2.43 Bradford also has a higher proportion of residents claiming Jobseekers Allowance (JSA) which is payable to people under pensionable age who are available for, and actively seeking work. Some 9,286 residents (3.1% of residents of working age) were claiming JSA in April 2008. This is a higher proportion than Y&H or nationally. The rate is higher for males (4.4% in Bradford) than for females (1.6%).

2.44 Young people comprise just over 3% of those claiming JSA – some 2,840 18-24 year olds were claiming in April 2008.

2.45 In Bradford, over 24,000 residents were claiming Incapacity Benefit in May 2007. This is 7.9% of the resident working age population – higher than Y&H (7.3%) and nationally (7.2%).

2.46 The table below shows the Wards with the highest numbers of working-age people living on working-age benefits (by sex and those age 50 and over), and a breakdown by the specific benefit claimed. These data are based on 2001 Census Wards:

- Wards with over 3,000 claimants were Bowling and Little Horton

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7 Source: Nomis web.co.uk
Those with over 2,000 claimants were University, Bradford Moor, Toller, Tong, Undercliffe, Heaton and Great Horton (in descending order).

<table>
<thead>
<tr>
<th>Ward</th>
<th>Total claimants</th>
<th>Male</th>
<th>Female</th>
<th>aged 50+</th>
<th>Incapacity benefits</th>
<th>Carers Allow.</th>
<th>Disabled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baildon</td>
<td>810</td>
<td>430</td>
<td>380</td>
<td>385</td>
<td>455</td>
<td>60</td>
<td>70</td>
</tr>
<tr>
<td>Bingley</td>
<td>955</td>
<td>495</td>
<td>460</td>
<td>355</td>
<td>510</td>
<td>65</td>
<td>60</td>
</tr>
<tr>
<td>Bingley Rural</td>
<td>925</td>
<td>455</td>
<td>470</td>
<td>385</td>
<td>510</td>
<td>75</td>
<td>95</td>
</tr>
<tr>
<td>Bolton</td>
<td>1,080</td>
<td>515</td>
<td>565</td>
<td>415</td>
<td>540</td>
<td>90</td>
<td>95</td>
</tr>
<tr>
<td>Bowling</td>
<td>3,165</td>
<td>1,530</td>
<td>1,635</td>
<td>830</td>
<td>1,435</td>
<td>230</td>
<td>130</td>
</tr>
<tr>
<td>Bradford Moor</td>
<td>2,735</td>
<td>1,345</td>
<td>1,390</td>
<td>780</td>
<td>1,110</td>
<td>330</td>
<td>165</td>
</tr>
<tr>
<td>Clayton</td>
<td>1,555</td>
<td>730</td>
<td>825</td>
<td>540</td>
<td>795</td>
<td>125</td>
<td>105</td>
</tr>
<tr>
<td>Craven</td>
<td>745</td>
<td>385</td>
<td>360</td>
<td>350</td>
<td>440</td>
<td>75</td>
<td>70</td>
</tr>
<tr>
<td>Eccleshill</td>
<td>1,545</td>
<td>715</td>
<td>830</td>
<td>485</td>
<td>735</td>
<td>100</td>
<td>110</td>
</tr>
<tr>
<td>Great Horton</td>
<td>2,020</td>
<td>940</td>
<td>1,080</td>
<td>640</td>
<td>945</td>
<td>200</td>
<td>135</td>
</tr>
<tr>
<td>Heaton</td>
<td>2,105</td>
<td>1,010</td>
<td>1,095</td>
<td>630</td>
<td>145</td>
<td>255</td>
<td>145</td>
</tr>
<tr>
<td>Idle</td>
<td>1,170</td>
<td>600</td>
<td>570</td>
<td>455</td>
<td>650</td>
<td>75</td>
<td>85</td>
</tr>
<tr>
<td>Ilkley</td>
<td>430</td>
<td>215</td>
<td>215</td>
<td>185</td>
<td>210</td>
<td>40</td>
<td>55</td>
</tr>
<tr>
<td>Keighley North</td>
<td>1,310</td>
<td>640</td>
<td>670</td>
<td>500</td>
<td>610</td>
<td>140</td>
<td>90</td>
</tr>
<tr>
<td>Keighley South</td>
<td>1,970</td>
<td>1,000</td>
<td>970</td>
<td>600</td>
<td>1,005</td>
<td>145</td>
<td>90</td>
</tr>
<tr>
<td>Keighley West</td>
<td>1,895</td>
<td>915</td>
<td>980</td>
<td>565</td>
<td>915</td>
<td>165</td>
<td>110</td>
</tr>
<tr>
<td>Little Horton</td>
<td>3,165</td>
<td>1,595</td>
<td>1,570</td>
<td>790</td>
<td>1,395</td>
<td>225</td>
<td>145</td>
</tr>
<tr>
<td>Odsal</td>
<td>1,910</td>
<td>905</td>
<td>1,005</td>
<td>645</td>
<td>910</td>
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<tr>
<td>Queensbury</td>
<td>1,500</td>
<td>720</td>
<td>780</td>
<td>515</td>
<td>785</td>
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<tr>
<td>Rombalds</td>
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<td>300</td>
<td>270</td>
<td>275</td>
<td>290</td>
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<tr>
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<td>865</td>
<td>525</td>
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<tr>
<td>Shipley West</td>
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<td>580</td>
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<tr>
<td>Thornton</td>
<td>1,560</td>
<td>750</td>
<td>810</td>
<td>540</td>
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<tr>
<td>Toller</td>
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<td>790</td>
<td>1,140</td>
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<tr>
<td>Tong</td>
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<td>University</td>
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<tr>
<td>Wibsey</td>
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<td>465</td>
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<td>115</td>
</tr>
<tr>
<td>Worth Valley</td>
<td>845</td>
<td>405</td>
<td>440</td>
<td>390</td>
<td>495</td>
<td>70</td>
<td>70</td>
</tr>
<tr>
<td>Wyke</td>
<td>1,695</td>
<td>785</td>
<td>910</td>
<td>550</td>
<td>875</td>
<td>120</td>
<td>120</td>
</tr>
<tr>
<td>Totals</td>
<td>50,515</td>
<td>24,780</td>
<td>25,735</td>
<td>16,325</td>
<td>24,420</td>
<td>4,425</td>
<td>3,290</td>
</tr>
</tbody>
</table>
Young people not in Employment, Education or Training (NEET)

2.47 NEET data show that there were 1203 young people (16-18 yr olds) not in education, employment, or training. This is an average of 7.6% of the 16-18 yr old population across the district compared with a national average of 9.4% as at the end of December 2007 (Dept. of Children, Schools & Families). Wards with higher than average % of NEETs were:

- Tong 13.3%
- Royds 12.5%
- Wyke 11.6%
- Keighley Central 11.4%
- Little Horton 10.8%
- Eccleshill 9.7%
- Windhill & Wrose 9.6%
- Bowling & Barkerend 9.3%

Social Capital, Isolation and Social Networks

2.48 The projected increase in the elderly population in Bradford and Airedale will entail an increase in the number of single older people. Figures taken from POPPI (Projecting Older People Population Information) using data supplied in the 2004 General Household Survey indicate that there are currently 9,010 people aged 65-74 living alone in Bradford, and 15,713 over-75 year olds. These figures are
projected to rise to 11,597 and 20,328 respectively by 2025 (see appendix for a full breakdown).

2.49 The council’s Adult Services 5-Year Strategy estimate that 11% (7,700) of Bradford’s 68,600 older people (i.e. 65+) experience difficulties with Instrumental Activities of Daily Living (IADL), for example doing housework, or non-core IADL such as bathing of climbing stairs.

2.50 Furthermore, data taken from POPPI estimated that by 2008 there would be some 10,792 older people in Bradford unable to manage at least one mobility activity on their own. These activities include going out of doors and walking down the road; getting up and going downstairs; getting around the house on the level; getting to the toilet and getting in and out of bed. This figure is predicted to rise to 14,448 by the year 2025 (see appendix for a full breakdown).

2.51 A systematic review of health promotion interventions found that, nationally, educational and social activity groups were most effective at alleviating social isolation and loneliness amongst older people. In contrast, one-to-one social support, advice, information and health needs assessment were found to be less effective. It is important that the JSNA looks closely at the wider determinants of health and wellbeing and takes into account the significance of feeling alone and loneliness can have on health and mental health and wellbeing. This is an important factor and consideration for all vulnerable groups.

Summary

2.52 Bradford’s population is currently 493,000 and its above-average birth rate is driving projected population growth in the district close to 600,000 by 2030. The high birth rate also entails an above-average proportion of young people (23% : 19% nationally). As elsewhere in the country, Bradford also has an increasing elderly population that will entail greater numbers of single older people living alone.

2.53 The district has a rich mix of ethnic groups, with 23% of the population from minority ethnic groups compared to 13% nationally.

2.54 Bradford as a whole ranks 32\textsuperscript{nd} (out of 354) in the CLG Index of Multiple Deprivation, placing it firmly in the bottom 10% nationally. Within the district there is inevitably disparity between Wards in terms of deprivation, 42% of residents living in areas that fall into the 20% most deprived nationally, and 5% living in areas that are among the 1% most deprived.

2.55 Economic activity rates in the district are lower than average (73.9% : 78.5% nationally) and there are a high proportion of people without qualifications (21.8% : 13.8% nationally). Average weekly earnings are also below average at £381 compared to £459 nationally.

2.56 Mortality and life expectancy data across the PCT’s four GP-based Alliance areas demonstrate a link between deprivation and poor health outcomes and also points

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up the need for closer merging of the Council and PCT geographies in order to tackle health inequalities across the district effectively.

2.57 In Bradford 70% of people either own their own houses or are buying them with a mortgage and a further 14% are renting privately. A recent stock condition survey found that 40% of Bradford’s private sector stock falls below the Decency Standard (compared with 27% nationally) and that this was particularly true of privately-rented stock. The 2001 Census also showed that, at that time, 23% of Bradford residents were without central heating, many of whom were elderly.

2.58 There is also a high incidence of fuel poverty in the district, affecting an estimated 16% of dwellings compared to 10% nationally. There is also a large shortfall in provision of supported housing for vulnerable groups.
3. ADULTS: KEY ISSUES FOR BRADFORD AND AIREDALE

Introduction

3.1 The population of adults, particularly older adults (age 65+) in Bradford is projected to increase significantly over time. By 2025, the total number of men over 65 in Bradford is expected to increase from 29,200 to 42,100 and the number of women over 65 from 39,400 to 48,700. The projections are derived from assumptions about births, deaths and migration based on trends over the last five years. They do not take into account any future policy change.

3.2 More people will be living alone, and there will be an increase in the numbers of people who find it difficult to undertake everyday tasks on their own.

3.3 As the number of older people increases, there will be an increase in the number of people providing unpaid care for a partner, family member or other person.

3.4 The following are key strategic issues for the health and wellbeing needs of the Bradford population.

Health Status

3.5 Health status is a general measure of the health of an area. It can be examined using a number of measures:

- Life expectancy
- Limiting long term illness
- ‘Feeling in poor health’, which is how 9.6% of residents described themselves in the 2001 Census, compared with 7.8% nationally.

3.6 Overall life expectancy in Bradford is just below the national average for both men and women (75.5 : 76.9 for men and 79.8 : 81.1 for women). However, when we take relative deprivation into account a different picture emerges. Men from the most deprived parts of Bradford District have over eight years shorter life expectancy than those in the least deprived areas (70.4 compared to 78.7). Although the difference is less for women there is still a 5 year gap in life expectancy between the most and least deprived (76.2 compared to 81.6).

3.7 Nationally, life expectancy is increasing. By 2051, projected life expectancy at birth will have risen to 84 years for men and 88 for women. Relative to England as a whole, life expectancy in Bradford and Airedale is not improving. A key priority will be social inclusion and services to support the mental well-being of older people.

3.8 Overall, a higher than average proportion of Bradford residents reported themselves as having limiting long term illness in the 2001 Census (18.5% compared with 17.9% nationally).

3.9 Amongst people aged 65+, some 33,236 are estimated (by ONS) to have limiting long term illness, i.e. 48.4%.
3.10 Bradford’s mortality rate for all causes of death (2004-2006) is 698 per 100,000, substantially higher than rate of 613 for England and Wales. Bradford also has higher mortality rates for Coronary Heart Disease, Cancer and Stroke than the England average.

In the most deprived fifth of Bradford’s population there has been a reduction in the all causes (all age) mortality rates from the 1995/1997 baseline of 17%, and 10% in the least deprived fifth. The rate for Bradford (698.2 per 100,000) remains above the rate for England and Wales (612.5). The map below is based on 2001 Census Wards.

**Life expectancy at birth for wards in Bradford District (2000-2004)**

![Map showing mortality rates in Bradford District](image)

**Ward legend**

<table>
<thead>
<tr>
<th>Ward</th>
<th>Wards</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baildon</td>
<td>1</td>
</tr>
<tr>
<td>Bingley</td>
<td>2</td>
</tr>
<tr>
<td>Bingley Rural</td>
<td>3</td>
</tr>
<tr>
<td>Bolton</td>
<td>4</td>
</tr>
<tr>
<td>Bowling</td>
<td>5</td>
</tr>
<tr>
<td>Bradford Moor</td>
<td>6</td>
</tr>
<tr>
<td>Clayton</td>
<td>7</td>
</tr>
<tr>
<td>Craven</td>
<td>8</td>
</tr>
<tr>
<td>Eccleshill</td>
<td>9</td>
</tr>
<tr>
<td>Great Horton</td>
<td>10</td>
</tr>
<tr>
<td>Heaton</td>
<td>11</td>
</tr>
<tr>
<td>Idle</td>
<td>12</td>
</tr>
<tr>
<td>Ilkley</td>
<td>13</td>
</tr>
<tr>
<td>Keighley North</td>
<td>14</td>
</tr>
<tr>
<td>Keighley South</td>
<td>15</td>
</tr>
<tr>
<td>Keighley West</td>
<td>16</td>
</tr>
<tr>
<td>Little Horton</td>
<td>17</td>
</tr>
<tr>
<td>Odsal</td>
<td>18</td>
</tr>
<tr>
<td>Queensbury</td>
<td>19</td>
</tr>
<tr>
<td>Rombalds</td>
<td>20</td>
</tr>
<tr>
<td>Shipley East</td>
<td>21</td>
</tr>
<tr>
<td>Shipley West</td>
<td>22</td>
</tr>
<tr>
<td>Thornton</td>
<td>23</td>
</tr>
<tr>
<td>Toller</td>
<td>24</td>
</tr>
<tr>
<td>Tong</td>
<td>25</td>
</tr>
<tr>
<td>Undercliffe</td>
<td>26</td>
</tr>
<tr>
<td>University</td>
<td>27</td>
</tr>
<tr>
<td>Wibsey</td>
<td>28</td>
</tr>
<tr>
<td>Worth Valley</td>
<td>29</td>
</tr>
<tr>
<td>Wyke</td>
<td>30</td>
</tr>
</tbody>
</table>

**Source:** Department of Health / Association of Public Health Observatories (2006)
Accidents

3.11 Bradford's rate of road injuries and deaths is lower than the England average, at 56.3 per 100,000 compared with 59.6. Locally, there were 2,466 road casualties in 2007 - 255 involved death or serious injury - a drop of 9% over the 2006 figure of 2,700.

3.12 Bradford and Airedale hospital admissions for fractured hip among those aged 65+ is lower, at 454, than the England average of 565.3 per 100,000 (2005/6).

Specific populations

Older People

3.13 Some 76,815 people in Bradford and Airedale are State Pension claimants. Over 18,000 of these are aged 80 or over (6,445 men and 12,345 women). Further details are included in Chapter 2 ‘The Population of Bradford & Airedale’ and in the appendix.

3.14 Estimates suggest that 30% of Bradford & Airedale’s older people have some form of dependency or functional impairment. The largest proportion of these (7,700 older residents) have difficulties with instrumental activities of daily living (IADL) which include housework, or non-core IADL such as bathing or climbing stairs (Bradford Council Adult Services Older People 5-year Strategy). Further details are included in the previous chapter and the appendix.

3.15 The number of older residents unable to manage at least one mobility activity on their own (e.g. going out of doors and walking down the road, getting around the house, getting in and out of bed, getting to the toilet) currently stands at just over 10,000 and is forecast to increase to almost 15,000 by 2025.

People aged 65+ Unable to Manage at Least One Mobility Activity on Their Own

Source: Projecting Older People’s Population Information System (POPPI).

3.16 The number of people aged 65+ with a Long Term Limiting Illness is projected to rise from 33,236 in 2008 to 44,144 in 2025. (Source: POPPI).

3.17 Key points in respect of delivering services to the elderly population of Bradford are that the rate of growth is higher amongst very elderly people than the 65+
population (the number of people aged 85+ is projected to grow by 5,700 between 2008 and 2025, POPPI), and there will be increasing numbers from ethnic minority groups.

Physical and Sensory Impairment

3.18 In Bradford, 24,090 people claim incapacity benefit, and of these, 3,230 are disabled. This represents 1.1% of the resident working age population, which is above Yorkshire and Humberside (1%) and the national figure of 0.9%. Nationally, DWP data shows just over 2 million people claiming Incapacity Benefit and Severe Disablement Allowance. These figures include people with a physical disability, learning difficulties, or sensory impairment.

3.19 There are over 3,000 people on the Bradford Council’s Visual Impairment Register, and approximately 2,200 on the Hearing Impairment Register. The table below breaks the overall figures for visual impairment down by severity of condition and by age group, and includes figures for new registrations. About half of all visually impaired residents are over age 75, but just over a fifth of the severely impaired/blind and 15% of the partially sight impaired are between 18-49 years old.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>18-49</td>
<td>291</td>
<td>14</td>
<td>216</td>
<td>6</td>
</tr>
<tr>
<td>50-64</td>
<td>227</td>
<td>8</td>
<td>197</td>
<td>7</td>
</tr>
<tr>
<td>65-74</td>
<td>210</td>
<td>12</td>
<td>271</td>
<td>10</td>
</tr>
<tr>
<td>75+</td>
<td>653</td>
<td>36</td>
<td>731</td>
<td>46</td>
</tr>
<tr>
<td>Total</td>
<td>1381</td>
<td>70</td>
<td>1415</td>
<td>69</td>
</tr>
</tbody>
</table>

Learning Disabilities

3.20 A joint Council/PCT Strategic Review of Learning Disability Services in 2007 identified an expected prevalence locally of 8,000 people with a learning disability. This is based on estimates from national-level data which suggests the incidence of learning disability in the general population is around 2%, about a quarter of whom will experience difficulties. Some 2,200 should therefore be known to Bradford services because of a level of disability significant enough to indicate the need for health/social care support. Only 1,385 people are known to services, however.

3.21 Learning disabilities figures include children as well as adults, and cover a significant range of needs from mild and moderate to more severe conditions. As well as providing services to meet learning needs, disabilities and health and wellbeing requirements, there is also a need for social care.
3.22 In general terms services need to plan for an increase in the number of people with learning disability:

<table>
<thead>
<tr>
<th>People with learning disability of 50 years plus</th>
<th>Estimated % increase for period 2001 to 2011</th>
<th>Estimated % increase for period 2001 to 2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>People known to Learning Disability services</td>
<td>28%</td>
<td>48%</td>
</tr>
<tr>
<td>“True prevalence” (known and not known to Learning Disability services)</td>
<td>31%</td>
<td>53%</td>
</tr>
</tbody>
</table>

3.23 However, these are not general, “across the board” increases. They are concentrated in specific groups, particularly those leaving school or of retirement age plus. The main reasons are:

- **Reduced mortality amongst older adults.** Overshadowing all other trends is the very marked increase in survival rates of older adults with learning disabilities.

- **Increased survival amongst young adults.** There is strong evidence to suggest that the number of children with severe/complex disabilities is increasing. In recent years there have been significant advances in the care of premature babies and young infants. Some of these children are now surviving in spite of profound learning and/or physical disability.

- **Prevalence of learning disability in South Asian minority ethnic communities.** There is a higher prevalence of learning disability amongst younger people, primarily from Pakistani and Bangladeshi minority ethnic communities. As noted earlier, the population profile of these communities is skewed towards the younger age groups. This will also contribute to the growth trend in the numbers of people with learning disabilities.

  Nationally, a 14% increase is predicted between 2001 and 2021 in the total number of adults with learning disabilities who are from minority ethnic communities.

3.24 The Joint review estimated that in 2007 some 890 people with a Learning Disability in Bradford would also have a mental health need, of whom:

- 10 would have ‘very severe mental health problems requiring in-patient admissions and care co-ordinated via CPA arrangements,
- 80-90 would have ‘severe mental health needs’ and
- 130 would have moderate mental health needs.

3.25 More generally, between 224 and 335 adults with a learning disability are likely to present with a challenging behaviour, of whom between 143 and 214 will present with more demanding needs requiring specialist clinical input.

**Carers**

3.26 Following up on the New Deal for Carers, in June 2008 the Government published "Carers at the heart of 21st century families and communities: a caring system on your side, a life of your own". The carers' strategy is underpinned by £255m to implement some immediate steps alongside medium and long-term
plans. It sets out the Government’s short-term agenda and long-term vision for the future care and support of carers as follows:

"by 2018, carers will be universally recognised and valued as being fundamental to strong families and stable communities. Support will be tailored to meet individuals’ needs, enabling carers to maintain a balance between their caring responsibilities and a life outside caring, whilst enabling the person they support to be a full and equal citizen."

3.27 The Bradford City Lifestyle survey (2005) found 16% of respondents caring for someone with a long-term physical or mental health problem. The proportion was higher among Bangladeshi and Pakistani residents. Of those providing care, a third were doing so on a full-time basis. Most carers were in the 45-64 age group but it is important to remember that some carers are children (further detail in next chapter on Children).

3.28 National statistics indicate that currently 7,353 people over 65 provide unpaid care to a partner, family member or other person in Bradford. This figure is projected to rise to 9,616 by 2025 (ONS/POPPI). The number of people of working age eligible for and claiming Carer’s Allowance in 2007 was 4,900. Bradford has a higher proportion of its working age population claiming this benefit than either the Yorkshire & Humber region or the nation as a whole (1.5%: 1.2% : 1.0% respectively). (DWP/NOMIS benefit claimants statistics, Nov 2007). The Wards with the greatest number of Care Allowance recipients were Toller (385), Bradford Moor (330), Heaton (255), Bowling (230), Little Horton (225) and Great Horton (200). For fuller information on the distribution of Care Allowance claimants by Ward, see table on p29 above.

3.29 National data and evidence from other areas points to unmet care and support needs for older people. These needs frequently focus around low-level support such as gardening, home maintenance and shopping.

3.30 Support to carers will be a key aspect of future service planning. The new national indicator for local government NI 135 (carers receiving needs assessment or review) will monitor progress in this area.

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9 Available to those age 16 or over who spend at least 35 hours a week caring for a person getting Attendance Allowance, Disability Living Allowance (at middle or highest rate), or Constant Attendance Allowance (at or above the normal maximum rate) and not in full-time education or earning more than £95 a week after tax.

10 NOMIS May 08
**Conditions**

**Mental Well-Being – Adults of working age**

3.31 The numbers of people of working age in Bradford currently claiming benefit for mental or behavioural disorders is significantly higher than the national average (35.4 : 27.4 per 1000).

3.32 Figures for prevalence are based on the ONS Psychiatric Morbidity survey. The incidence of probable psychotic, neurotic and personality disorders among the working age population are all expected to increase by 5-6% between 2006 and 2012, broadly in line with the projected general population increase. The estimated implications for Bradford’s working age population act is summarised below (‘Adult Mental Health Commissioning Strategy and Plan’ July 2008), although it should be noted that not all of these individuals are likely to present for treatment:

<table>
<thead>
<tr>
<th>Disorder</th>
<th>2006</th>
<th>2009</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any Neurotic disorder</td>
<td>59,897</td>
<td>61,974</td>
<td>63,525</td>
</tr>
<tr>
<td>Any personality Disorder</td>
<td>14,137</td>
<td>14,655</td>
<td>14,982</td>
</tr>
<tr>
<td>Probable psychosis</td>
<td>1,806</td>
<td>1,848</td>
<td>1,904</td>
</tr>
<tr>
<td>Eating Problems</td>
<td>1,405</td>
<td>1,435</td>
<td>1,464</td>
</tr>
<tr>
<td>Post natal psychiatric problems</td>
<td>817</td>
<td>836</td>
<td>850</td>
</tr>
</tbody>
</table>

3.33 The Incidence of mental health disorders is estimated to be highest in the Citycare Alliance area followed by the Bradford South and West Alliance area. (Alliance areas are based on GP practices).

3.34 The table below identifies the estimated distribution of disorders across the four Practice Based Commissioning Alliance. shaded figures show a higher share of incidence of the disorder than the share of the population, but none of these figures are sufficiently high to cause concern. These are the 4 Practice Based Commissioning Alliance areas. Yorkshire PCA covers approximately the old North Bradford PCT, pre-merger. The Airedale and Wharfedale Alliance covers 2 practices which are not part of the Alliance structure. This is not a Yorkshire comparison.
### Table

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Airedale and Wharfedale</th>
<th>Bradford South and West</th>
<th>Citycare</th>
<th>Yorkshire Primary Care Alliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any Neurotic disorder</td>
<td>19.7</td>
<td>31.0</td>
<td>27.3</td>
<td>22.0</td>
</tr>
<tr>
<td>Any personality Disorder</td>
<td>20.5</td>
<td>30.9</td>
<td>25.4</td>
<td>23.2</td>
</tr>
<tr>
<td>Probable psychosis</td>
<td>20.5</td>
<td>31.5</td>
<td>24.2</td>
<td>23.8</td>
</tr>
<tr>
<td>Eating Problems</td>
<td>16.5</td>
<td>29.8</td>
<td>33.9</td>
<td>19.8</td>
</tr>
<tr>
<td>Post natal psychiatric problems</td>
<td>18.0</td>
<td>30.9</td>
<td>29.1</td>
<td>22.0</td>
</tr>
<tr>
<td>% share of population</td>
<td>19.9</td>
<td>31.7</td>
<td>26.1</td>
<td>22.3</td>
</tr>
</tbody>
</table>

3.35 The only significant variation to general population growth figures relates to an anticipated increase in the incidence of some neurotic disorders amongst the South Asian population. Again, this will have most impact on areas, such as the Citycare Alliance, with a larger South Asian population.

3.36 National research suggests that people from South Asian ethnic origins are 42% more likely to have a depressive episode and 14% more likely to suffer from mixed anxiety and depressive episodes than the general population. The most significant difference was the rate for Obsessive Compulsive Disorders where the ONS survey reported a prevalence of 40 cases per 1,000 in the South Asian population compared to 11 per 1,000 for the general population, which is a difference of 264%. However, there was a reported 5% lower prevalence of Generalised Anxiety Disorder in the South Asian population compared with the general population.

3.37 There have been a range of investments in mental health related services over the last five years: Early Intervention in Psychosis, Crisis Resolution and Home Treatment, Assertive Outreach and alcohol interventions, and this is a clear priority within the supporting people strategy. The tPCT has also published a Commissioning Strategy for Adult Mental Health that sets out 26 Key Priorities for development. These include new investments that will result in significant change, with expansion in the range of primary and community mental health services.

### Dementia and Mental illness amongst older people aged 65+

3.38 Nationally, 10-15% of older people aged 65+ suffer from depression (POPPI) and the prevalence of schizophrenia, bipolar disorder and other psychoses is 0.7% both nationally and regionally, with Bradford’s only slightly higher, at 0.8%. Transforming mental health services is one of the 4 key priority areas identified in the tPCT strategic commissioning plan. It is predicted that the prevalence of most mental disorders will remain stable over the next 20 years (Kings Fund “Paying the Price”) but there is expected to be huge increase in dementia (61%) as the older population increases.
3.39 Reflecting the national trend, Bradford has an ageing population, and it is therefore expected that the number of people with dementia will grow. Current prevalence (2008) is around 5200, projected to increase to 7062 by 2025. Dementia affects about 25% of the over-85s, a third of cases being severe. This age group is expected to increase by 12% in the next five years. Among our 85+ population, women outnumber men by a factor of more than 2:1 (5704 : 2304).

3.40 A breakdown by Ward (based on post-2001 Wards) shows that Ilkley, Craven, Baildon, Wharfedale and Bingley have the highest proportions of residents over age 65, whilst City, Bradford Moor, Little Horton, Manningham and Toller have the lowest. An estimate of dementia\textsuperscript{11} by Ward, based on the age distribution of older residents, indicates that Ilkley, Craven, Bingley, Baildon and Shipley are likely to have the highest incidence of dementia.

\begin{table}[h]
\centering
\begin{tabular}{|l|c|c|c|c|}
\hline
\textbf{Ward} & \textbf{\% 65+} & \textbf{65-84 yrs} & \textbf{85+} & \textbf{Dementia} \\
\hline
Baildon & 19.1\% & 2529 & 364 & 226 \\
Bingley & 18.5\% & 2666 & 406 & 249 \\
Bingley Rural & 16.2\% & 2507 & 291 & 198 \\
Bolton & 15.5\% & 2148 & 286 & 191 \\
Bolton & 11.4\% & 1878 & 257 & 164 \\
Bradford Moor & 7.6\% & 1341 & 171 & 111 \\
City & 6.9\% & 1288 & 121 & 95 \\
Clayton & 14.4\% & 2019 & 317 & 189 \\
Craven & 20.2\% & 2795 & 438 & 256 \\
Eccleshill & 14.1\% & 2148 & 201 & 162 \\
Great Horton & 12.4\% & 1859 & 215 & 151 \\
Heaton & 13.1\% & 1752 & 327 & 184 \\
Idle & 15.8\% & 2131 & 309 & 191 \\
Thackley & 24.6\% & 2935 & 617 & 327 \\
Ilkley & 13.7\% & 2019 & 322 & 195 \\
Keighley Central & 16.2\% & 2252 & 285 & 199 \\
Keighley East & 15.2\% & 2207 & 244 & 179 \\
\hline
\end{tabular}
\caption{Over-65s and estimated dementia by Ward}
\end{table}

\textsuperscript{11} Health Care Needs Assessment Vol 2, Stevens and Raftery, Radcliffe Medical Press (1994)
<table>
<thead>
<tr>
<th>Location</th>
<th>Prevalence</th>
<th>Population</th>
<th>Women</th>
<th>Men</th>
</tr>
</thead>
<tbody>
<tr>
<td>Little Horton</td>
<td>8.1%</td>
<td>1400</td>
<td>140</td>
<td>103</td>
</tr>
<tr>
<td>Manningham</td>
<td>8.2%</td>
<td>1298</td>
<td>158</td>
<td>102</td>
</tr>
<tr>
<td>Queensbury</td>
<td>12.0%</td>
<td>1624</td>
<td>181</td>
<td>110</td>
</tr>
<tr>
<td>Royds</td>
<td>14.0%</td>
<td>2026</td>
<td>260</td>
<td>173</td>
</tr>
<tr>
<td>Shipley</td>
<td>18.1%</td>
<td>2166</td>
<td>387</td>
<td>222</td>
</tr>
<tr>
<td>Thornton &amp; Allerton</td>
<td>14.5%</td>
<td>2097</td>
<td>228</td>
<td>165</td>
</tr>
<tr>
<td>Toller</td>
<td>8.2%</td>
<td>1405</td>
<td>141</td>
<td>105</td>
</tr>
<tr>
<td>Tong</td>
<td>12.4%</td>
<td>1993</td>
<td>278</td>
<td>172</td>
</tr>
<tr>
<td>Wharfedale</td>
<td>18.6%</td>
<td>1917</td>
<td>216</td>
<td>157</td>
</tr>
<tr>
<td>Wibsey</td>
<td>16.4%</td>
<td>2124</td>
<td>242</td>
<td>176</td>
</tr>
<tr>
<td>Windhill &amp; Wrose</td>
<td>14.8%</td>
<td>2027</td>
<td>193</td>
<td>155</td>
</tr>
<tr>
<td>Worth Valley</td>
<td>14.2%</td>
<td>1750</td>
<td>218</td>
<td>147</td>
</tr>
<tr>
<td>Wyke</td>
<td>15.0%</td>
<td>1933</td>
<td>195</td>
<td>148</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>-</strong></td>
<td><strong>60234</strong></td>
<td><strong>8008</strong></td>
<td><strong>5207</strong></td>
</tr>
</tbody>
</table>

3.41 The QOF\(^{12}\) prevalence rate for Dementia in Bradford is 0.2%, lower than the national and Y&H prevalence of 0.4%.

### Circulatory Disease

3.42 The Bradford rate of circulatory disease is much higher than the national rate (100.5 : 84.9) although slightly lower than the Y&H Spearhead PCT rate (101.1). Mortality from circulatory disease (<75yrs) has reduced by 41% for both the most and least deprived fifths (quintiles) of Bradford’s population since 1996. However, since 2000 the relative inequality gap has widened for mortality in stroke and coronary heart disease across the Bradford population as a whole.

3.43 Although 21% of the registered population (c112,000 people) are estimated to have hypertension, only 12% (63,000) are on GP hypertension registers (to manage high blood pressure). Approximately 49,000 people in Bradford may therefore be hypertensive but not currently receiving appropriate treatment and control.

### Stroke

3.44 The incidence of Stroke in Bradford is slightly higher than the national rate (17.3 : 16.0) but lower than the Yorkshire & Humber Spearhead PCT (18.2). Figures for people on the Stroke and Transient Ischaemic Attack register support this picture, the QOF rate for Bradford being 1.6%, the national rate 1.6%, and the Yorkshire & Humber Strategic Health Authority rate 1.8% (2006-7).

\(^{12}\)The QOF (‘Quality and Outcomes Framework’) data used in the JSNA only represents those people known to their GPS to be suffering a specific condition, and will therefore, not represent actual rates, but an under-estimation of the real figure.
3.45 Mortality data for Bradford indicates that early death rate from Stroke has halved in the most and least deprived fifths of Bradford’s population (50% and 53% respectively) between 1995-7 and 2004-6.

Heart Disease

3.46 Mortality from heart disease in Bradford is much higher than the national rate (61.9 48.9) although slightly lower than the Yorkshire & Humberside Spearhead PCTs (62.1). A range of actions is identified within the tPCT Operating Plan to target this issue, including increasing statin prescribing, hypertension registers and improving access to primary care provision in under-resourced areas. The QOF prevalence for chronic heart disease in Bradford (% registered on a coronary heart disease register) is 3.7%, just above the national rate of 3.5% and below the Yorkshire & Humber Strategic Health Authority (SHA) average of 4.2%. Data suggests that premature death (under 75 years) from coronary heart disease is dropping across Bradford, with reductions of 43% and 44% respectively in the most and least deprived fifths of the population between 1995-7 and 2004-6, and now stands at 105.43 and 77.04 per 100,000 people respectively.

Diabetes

3.47 The DoH Bradford Health Profile 2007 estimated that some 21,163 local people have diabetes (4.2%). This is above the national and regional average, both of which were 3.7% (2005/6).

3.48 The registered prevalence of Diabetes for Bradford PCT is 4.4% compared to 3.85% nationally. Prevalence rises steeply with age and there is an increased risk in deprived areas and amongst Black (70% raised risk) and Asian (20% raised risk) sub groups. The true prevalence in the district is likely to be nearer an estimated value of 5.4% or 29,000 people (YHPHO). There is a substantial public health burden of diabetes associated with premature mortality and morbidity, and a heavy financial cost to the NHS and community.

Cancer

3.49 The absolute inequality gap in the premature death rate from cancer in Bradford has narrowed in the last ten years and rates have dropped across all quintiles of the population.

3.50 Whilst Cancer death rates in the district overall are reducing in line with national trends, the relative inequality gap for deaths from cancer, stroke and CHD has widened between the most and least deprived fifths of the population.
Target: By 2010, reduce mortality rates for cancers by at least 20% with a 6% reduction in the inequalities gap between the fifth of areas with the worst health and deprivation indicators and the population as a whole (1995-1997 baseline).

3.51 The current mortality rate for Bradford and Airedale PCT as a whole is 126, higher than the England and Wales rate of 117 but lower than the regional ‘spearhead’ PCT rate of 131.

3.52 Between 1995-7 and 2004-6 the mortality rate for all cancers fell to 155 from 210 and to 143 from 179 per 100,000 people in the most deprived two-fifths of Bradford’s population. There has been a reduction in the rate in the most deprived quintile of 24% from the 1995/1997 baseline, and in the least deprived quintile of 9% during this period. The tPCT has prioritised Investment in oncology, priority to reduce waiting times, increased screening and investment in smoking cessation.

3.53 The Cancer Local Area Network (CLAN) is a multi-disciplinary group, which works closely with the Yorkshire Cancer Network to plan, develop and deliver cancer services for patients.

Excess winter deaths

3.54 Fuel poverty, along with viral and bacterial infections, is a major cause of excess winter deaths in the England. There are well known links between poorly heated housing (often caused by fuel poverty) and health. Factors that may lead to fuel poverty are low income (38% of Bradford Households have an income of less than £15,000) and heating type (23% of Bradford’s households are without central heating). A third of Bradford residents, and half of its Bangladeshi residents, report having damp, condensation or mould in their homes. (Bradford Lifestyle Survey 2005) The local Bangladeshi ethnic group are also least likely to own their own home and have sufficient heat to keep them warm all winter.
3.55 However, the number of excess winter deaths in Bradford has fallen steadily from over 300 to under 200 per year since the 1990s and are below regional and national levels. About 90% of excess winter deaths are in people aged over 65 years, highlighting the need for the local multi-agency Affordable Warmth Strategy Group to reinforce key messages on an annual basis. The PCT also needs to develop and accurately maintain registers of the most vulnerable elderly, and their key workers in order to monitor those most at risk.

**Dental Health**

3.56 In Bradford there is a cohort of older adults that have no teeth and will require denture care for many years. In addition there is a growing cohort of middle aged adults who will retain their teeth and need advance restorative care often with complex medical conditions. Currently only half (51%) of all adults in Bradford are registered with a dentist.

3.57 The need for more detailed and timely local surveillance data to monitor the oral health of adults has been identified by the tPCT. The Yorkshire and the Humber adult dental health survey will provide the first PCT level information regarding adult oral health needs.

**Personal Behaviours**

**Smoking**

3.58 Smoking is the single greatest killer resulting in avoidable and early death, killing more than 106,000 people in the UK annually, or 17% of all deaths. Most die from lung cancer, chronic obstructive lung disease (bronchitis and emphysema) and coronary heart disease.

3.59 Estimates of smoking across the district, based on the Health Survey for England 2003-5) suggest that 23.9% of the population smoke, compared with 24.1% nationally. This is a key influence on incidence of coronary heart disease, chronic obstructive lung disease (bronchitis and emphysema) and cancer.

3.60 The Bradford City Lifestyle Survey\(^{13}\) carried out in 2005 found that 25% of the adult population smoked. This equates to an estimated 90,000 smokers across the district. Although this is similar to the national average of 24.1%, deaths in Bradford from smoking are significantly above the national average (279.2 compared to 234.4).

3.61 The DoH Health Summary reported 856 deaths in Bradford from smoking each year. Self reported smoking prevalence is as high as 50% in some deprived communities (e.g. (Neighbourhood Element Survey, BMDC 2008).

3.62 The overall smoking prevalence of 25% found by the Lifestyle survey hides high rates for some groups, notably white men aged 18-24 yrs (50%) and Bangladeshi

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\(^{13}\) As its name suggests, the Bradford City Lifestyle survey covered only city Wards and not the whole district. However, this year and in future, the survey will cover the whole district.
men (42%). Across all ethnic groups, the 45-64 age group are most likely to smoke. There is also considerable variation across Bradford’s Wards: in some Wards over a third of adults smoke.

3.63 Smoking in pregnancy locally is significantly lower than the national average (12.5% compared to 16%). This district-wide figure may hide large differences between ethnic groups as in deprived areas, smoking in pregnancy among south Asian women is likely to be considerably lower than among white women.

3.64 These results emphasise a need for both intelligent targeting of smoking cessation services, but also a need for action to prevent young people starting to smoke. This is particularly important for Bradford, with its larger than average population of young people.

3.65 Tackling smoking has a major impact on life expectancy targets. The London Health Observatory life expectancy tool indicates that much of the gap in life expectancy between areas is linked to circulatory disease. It has been suggested that doubling the capacity of ‘stop smoking’ services could reduce the gap by 1%.

3.66 Reducing the incidence of smoking is a clear priority within the Council’s Big Plan and LAA. Additional investment of £260K has been made in 2007/08 to enhance service provision. Social marketing techniques have been used to target hard to reach groups and to reduce health inequalities.

**Alcohol**

3.67 Data from the Local Alcohol Profiles for England (NWPHO 2007) shows Bradford's performance on a number of critical health indicators, the regional picture, and its ranking against all other English local authorities (354). Bradford is in the worst quartile on six indicators and in the next worst quartile for four more.

3.68 Alcohol-related mortality figures show a higher than average rate among men in Bradford and a higher rate of alcohol-related hospital admissions.

<table>
<thead>
<tr>
<th>Alcohol-related mortality</th>
<th>Bradford</th>
<th>England rank (out of 354)</th>
<th>Regional average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol specific – males</td>
<td>16.11</td>
<td>289</td>
<td>12.93</td>
</tr>
<tr>
<td>Alcohol specific – females</td>
<td>5.56</td>
<td>218</td>
<td>5.35</td>
</tr>
<tr>
<td>Alcohol attributable – males</td>
<td>58.90</td>
<td>315</td>
<td>51.35</td>
</tr>
<tr>
<td>Alcohol attributable – females</td>
<td>24.94</td>
<td>235</td>
<td>23.87</td>
</tr>
<tr>
<td>Alcohol-related hospital admissions</td>
<td>Bradford</td>
<td>England rank (out of 354)</td>
<td>Regional average</td>
</tr>
<tr>
<td>-------------------------------------</td>
<td>----------</td>
<td>--------------------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>Alcohol specific – males</td>
<td>388.11</td>
<td>265</td>
<td>335.02</td>
</tr>
<tr>
<td>Alcohol specific – females</td>
<td>159.29</td>
<td>203</td>
<td>159.39</td>
</tr>
<tr>
<td>Alcohol attributable – males</td>
<td>1042.15</td>
<td>280</td>
<td>937.71</td>
</tr>
<tr>
<td>Alcohol attributable – females</td>
<td>565.20</td>
<td>268</td>
<td>522.11</td>
</tr>
</tbody>
</table>
*(All rates per 100,000 population, annual average, 2003-5)*

3.69 The age for onset of liver disease is decreasing and this trend is likely to continue. The LAA contains a target to reduce alcohol-related hospital admissions, and a plan to commission alcohol treatment is being developed, involving action planning across all four tiers from prevention to acute services.

3.70 Nationally, Bradford is the 70th worst local authority area (out of 314) in England\(^\text{14}\) for binge drinking (8+ units for men/6+ for women, in one session). However, as around a quarter of under-25s are from Pakistani or Bangladeshi backgrounds (and almost entirely Muslim), the level of binge drinking amongst other groups (mainly whites) is likely to be significantly higher than this statistic suggests. The Council’s recent Alcohol Scrutiny, drawing on Yorkshire & Humber Public Health Observatory’s 2005 report ‘Over the limit’, found that:

- An estimated 15,000 people in the Bradford district are dependent on alcohol
- Estimates for both hazardous and harmful drinking for Bradford are both significantly above the national average
- Bradford has significantly worse alcohol-related death rates for men than both the national and the regional average
- It has significantly worse alcohol-related hospital admissions for both men and women, and levels of admissions are rising
- More than 1,000 people were admitted to the Bradford Royal Infirmary via A&E for alcohol-related illnesses in 2006/7\(^\text{15}\)

Work is on-going to develop baseline data for alcohol consumption and targets, and an Alcohol Harm Reduction Strategy is being developed by the Council and its partners.

**Drugs**

3.71 Home Office estimates of the prevalence of opiate use and/or crack cocaine use for the period 2004/05 indicate there were 4,582 problem drug users (PDUs) in Bradford – a rate of 14.8 per 1000 population aged 15 to 64. The more recently published prevalence estimates (for 2005/06) indicate this number to be higher, at 5,304 for the district. These estimates are reviewed and challenged year on year as part of the ongoing substance misuse needs assessment work through which a number of data sources are combined to contribute to evaluating and prioritising...
identified needs, gaps and harms and determining options for meeting those needs. The Health Profile for Bradford, produced by the Health Observatory, reports that the percentage undergoing treatment for drug misuse is well above the national and regional average.

**Obesity**

3.72 Obesity is a major public health issue due to the damaging effect it has on general health and life expectancy. After smoking, it is the second most important preventable cause of cancer. Nationally, the proportion of obese adults over 16 rose to 24% in 2005. Although men and women are equally likely to be obese, men are more likely to be morbidly obese (3% compared to 1%). If current trends continue it is estimated that a third of adults will be obese by 2020.

3.73 Data from the Bradford City Lifestyle survey 2003-5 suggests that 14% of men and 17% of women were obese, with 1% and 3% respectively very obese.

3.74 The QOF prevalence of obesity in Bradford & Airedale PCT is 7.3% (2006/7), similar to the national rate (7.4%) but lower than the 8% figure for the region.

3.75 Obesity is closely linked with poor diet (over-consumption) and inadequate exercise, (see next 2 sections). Initiatives to reduce obesity are:

- collaborative work with on a Physical Activity and Sports Strategy, and a Food Strategy, which outlines how we will tackle obesity and the broader food and physical activity agenda;
- a wide range of community-based initiatives to support the public to eat well and exercise;
- a training programme for community workers to develop skills in managing groups for obese individuals within the community sector;
- a tPCT exercise on referral service in conjunction with general practice Bradford Encouraging Exercising People (BEEP), and in collaboration with the Local Authority and others, to improve the range and quality of physical activity available to the public.

**Food and Nutrition**

3.76 Poor diet and nutrition are major contributory risk factors for ill health and premature death in general. In the last five years there is evidence of an increase nationally in the proportion of adults and children consuming five or more portions of fruit and vegetables per day, with 28% of men and 32% of women doing so in 2006/07. The proportion generally increased with age and income.

3.77 A PCT model (2003-5) estimated that 23.2% of adults in Bradford ate 5 or more portions of fruit and vegetables each day, an increase from 20.1% in 2001-2.

3.78 The 2005 Bradford City Lifestyle survey indicated that 31% of city residents consumed five portions per day. This proportion was broadly similar across the main ethnic groups (White and Pakistani) and for different age groups. However young White adults (18-24 years) were less likely to eat 5 portions of fruit and
vegetables a day, only one in four having done so, and 1 in 25 people (18+ years) had eaten no fruit and vegetables at all during the previous day.

3.79 Encouragingly, a third of residents reported having changed what they eat in the last year, demonstrating awareness of specific measures needed to improve diet. Changes largely involved reducing fat intake and increasing consumption of fruit and vegetables, the majority citing ‘health reasons’ or acting on medical advice. Reducing saturated fats intake across the population is also seen as an important way of reducing mortality from heart disease.

Physical Activity

3.80 A Sport England survey in 2005/6 found that in Bradford 21.2% of people over 16 years old were physically active, similar to the national and Yorkshire & Humber figures (21% and 20.1% respectively). The survey measured participation in moderate intensity sport and active recreation for 30 minutes, 3 times a week (i.e. 2 sessions less than the current recommended level). About 1 in 8 achieved the recommended 2.5 hours per week (5 x 30 minutes)16. Participation in sport and active recreation 3 times per week from lower social classes and black and ethnic minority groups was below the district average (25% compared to 35%).

Summary

3.81 Whilst life expectancy in Bradford is just below the national average for both men and women, relative to England as a whole, life is not improving. A key need is to reduce inequalities across the district: men from the most deprived areas have 8 years shorter life expectancy and women 5 years.

3.82 The mortality rate for all causes of death is substantially higher than national average (698: 613), with higher mortality rates for Coronary Heart Disease in particular (61.9 : 48.9), and for Cancer and Stroke.

3.83 In line with national trends, Bradford nevertheless has an ageing population, with a projected increase by 2025 from 68,600 to 90,800 in the over-65s: 29,200 to 42,100 men and 39,400 to 48,700 women. Alongside its ageing population, there are likely to be increasing numbers of adults living on their own and in those unable to carry out every day activities without support. As more people live into their 80s and beyond, the incidence of dementia is expected to increase from the current 5200 to over 7000 in 2025.

3.84 There are also projected increases in the numbers with learning disability, as older people with disabilities live longer, increased survival rates among young adults, and a higher prevalence of learning disability in the (increasing) South Asian population.

3.85 The numbers of people providing care to a partner, family member or other person in Bradford is therefore expected to grow. Currently some 7,300 people over 65 provide unpaid care and this is expected to rise to over 9,600 by 2025.

16 DoH Bradford Health Profile 2007
Bradford already has a higher than average proportion of its working age population eligible for and claiming Carer’s Allowance (1.5% : 1.0% nationally).

3.86 Other issues for the Bradford district are a higher than average rate of circulatory disease (100.5 : 84.9) and of diabetes (4.2% : 3.7% of the population). In order to target areas of greatest need and priority groups, there is an urgent need for more and better data, broken down to appropriate local levels. This is where the new Observatory will have a vital role to play. We are aware of many gaps in this first JSNA for the district, and expect to have filled a substantial number of these by the time of updated JSNA next year.
**4 CHILDREN AND YOUNG PEOPLE: KEY ISSUES**

*Introduction*

4.1 The population of children and young people is predicted to grow by one fifth between now and 2030, and much of this growth will take place in areas of Bradford which suffer the highest levels of deprivation. This will have a significant impact upon health, education, housing and care services, particularly because children and young people are already one of the largest population groups in Bradford. The findings of a recent review of Bradford’s ‘Children and Young People’s Plan 2008’ are reflected in this JSNA.

4.2 The JSNA is also informed by the Children and Young People’s Strategic Partnership’s recent and comprehensive Children and Young People Needs Analysis (June 2008), which found that those communities where children most under-achieve, where their health is poorest and their outcomes at 19 are lowest are those communities where levels of deprivation are highest.

Key points from the Analysis are:

- Teenage conception, infant mortality and childhood obesity rates (particularly at year 6) are significantly higher than the national averages.
- Breast feeding rates are lower than the national average.
- Higher rates of admissions to hospital for non-accidental injuries and for serious injuries than the national average.
- Over-representation of white and black African/Caribbean young people in the youth justice system/population.
- Higher rates of children becoming looked after among white communities.
- Educational attainment is behind the national average at all stages.
- Key stage 1 rates have fallen over last three years.
- Unauthorised absences at primary and secondary schools are twice the national average (based on 2006 data).
- Lower attainments rates amongst white and Bangladeshi pupils at Key Stage 1.
- Boys’ educational attainment is generally lower than girls’ at all key stages.
- Looked after children are achieving lower than the district average at all key stages.
- Lower school attendance rates of looked after children.
- Significantly lower rate of young people achieve full level 2 and 3 qualifications at aged 19 than nationally.
- High rate of young people who are NEET (not in Education Employment and Training) than the national position.
**Population Growth**

4.3 Bradford has relatively high numbers of children and young people within the local population, and further growth predicted within this group will increase demands upon services and resources. The proportion of BME groups within the population will also rise.

4.4 Bradford’s relatively large young population is what produces fewer deaths in relation to births and the strong natural population increase being experienced.

4.5 Nearly a quarter of the population, 23%, is under 16 years of age. This is higher than the UK average of 19%.
Infant Mortality

4.6 The district’s infant mortality rate of 7.2 per 1,000 is one of the highest in the country and is higher than other areas with similar levels of deprivation. The rate for England as a whole is 5.1 and the Y&H Spearhead PCT figure 6.3. Infant mortality has been consistently higher in the most deprived fifth of the population compared to the least. The graph below shows that although the rate in the most deprived areas is decreasing it is still 3 times higher than in the least deprived areas.

![Graph showing infant mortality rates](image)

Target: By 2010, reduce the gap in mortality by at least 10% between "routine and manual groups" and the population as a whole (1997-1999 baseline)

Factors which can impact upon infant mortality include low birth weight, age and ethnicity of the mother, and social deprivation.

4.7 The difference between the local and national infant mortality rate is most striking for post neonatal babies (aged between 28 days and 1 year). There are also large differences in infant mortality between ethnic groups with the rate in the Pakistani population almost double that of the white population. However, there are signs that infant mortality for the Pakistani population is beginning to decrease. Mortality rates for babies of second generation mothers are generally lower than for first generation (Bradford District Infant Mortality Commission – summary Report (2006)).

4.8 Reducing infant mortality remains a priority for the PCT, and is targeted with work to increase breast feeding and reduce smoking in pregnant women. A partnership approach to reducing the rates is being overseen by the Every Baby Matters implementation group.
Childhood Vaccinations

4.9 The data for childhood vaccinations shows a good level of primary immunisation (94-96%) before 2nd birthday for Diphtheria, Tetanus, acellular Pertussis, Polio, Haemophilus Influenzae type B (DTaP/IVP/HIB), Menigitis C (Men C), Pneumococcus (PCV), with Measles, Mumps and Rubella (MMR) at 91%. Most targets have been met or exceeded. However, there needs to be continued work in areas of deprivation to ensure high levels of immunisation and also in light of recent outbreaks of Measles. Although levels of immunisation were relatively high for vaccination against Meningitis C and Pneumococcus, targets have not been met.

4.10 Vaccination rates have been improving each year for booster immunisation by 5th birthday for Diphtheria, Tetanus, acellular Pertussis, Polio, Haemophilus Influenzae type B (DTaP/IVP/HIB) and Measles, Mumps and Rubella (MMR). Targets have also been exceeded for the number of children immunised by their fifth birthday for MMR, both first and second dose. The PCT provides a focus through the Immunisation and Vaccination Lead and a District Strategy Group and an Operational Strategy Group take forward any identified actions to the PCT.

The uptake of the childhood primary immunisation programme in under 2 year olds and under 5 year olds were as below in 2007/08 and compare favourably with the national picture:

<table>
<thead>
<tr>
<th>24 month cohort</th>
<th>DTaP/IVP/HIB</th>
<th>MMR</th>
<th>Men C</th>
</tr>
</thead>
<tbody>
<tr>
<td>B&amp;A tPCT</td>
<td>95 %</td>
<td>89 %</td>
<td>93 %</td>
</tr>
<tr>
<td>UK Oct-Dec 07</td>
<td>94 %</td>
<td>84 %</td>
<td>94 %</td>
</tr>
</tbody>
</table>
Road Accidents

4.11 4 children were killed and 54 seriously injured on Bradford roads in 2007. This total of 58 represents an increase over a record low of 32 in 2005 and 39 in 2006, and constitutes 23% of all killed and seriously injured on the district’s roads. The child KSI increase in 2007 is mainly due to the number of pedestrian casualties which has gone up by 26% in 2007 (Bradford District Road Casualties 2007).

Specific Populations: Young carers

4.12 Children and Young People who act in a caring role are classed as “young carers” and receive support from mainstream services as part of family and adult support. The service - Barnardo’s Bradford Young Carers Service, jointly funded since 1994 - currently works with 75 children and young people aged 5-18 years.

4.13 Services include: support from an individual caseworker; whole family assessment via Family Matters, a partnership between Bradford Young Carers, tPCT and Care Trust; time limited groups around issues and to promote self esteem; summer activities; information, advice and guidance, signposting and referral to other services; and work with schools, taking support to where young people are.

4.14 Major Issues involve identification of young carers and production of an updated needs analysis, resource requirements and funding implications. The District Carers Strategy will improve clarity about responsibility between adult and children’s services and we need to consider how individualised budgets can be used to minimise the negative impacts of inappropriate levels of caring for Young Carers.

Physical / Sensory Impairment and Learning Difficulties

4.15 Understanding the numbers of children with disabilities is problematic because of the number of definitions of disability in use by different agencies across the District.

4.16 According to the Disabled Children’s Information Service, in April 2008 there were 1541 registered disabled children and young people. The register is voluntary and as such does not represent every disabled young person in the district.

4.17 The three wards with the greatest number of disabled young people were Manningham, Toller and Bradford Moor with a total of 343 (22%) between them. The largest age group was 13-17. Two thirds were male. The largest ethnicity groups were English (716) and Pakistani (477).

4.18 The most common disability was Autistic Spectrum Disorder; (approximately 25% of the registered young people). The Child Development Centre suggests that disability is more prevalent within the South Asian community and that Bradford also has a
higher than national average population of disabled children with complex levels of need.

4.19 According to the January 2008 School Census there were 897 children in Bradford District’s Special Schools.

4.20 There are also 5,456 pupils in mainstream schools within the district at ‘school action plus’, (a request for help from external services when a child has been identified as having a special educational need) (February 2008). A breakdown of needs of these young people can be seen below:

<table>
<thead>
<tr>
<th>Need</th>
<th>Total</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Autistic Spectrum Disorder</td>
<td>126</td>
<td>2.30</td>
</tr>
<tr>
<td>Behaviour, Emotional and Social Difficulty</td>
<td>1502</td>
<td>27.54</td>
</tr>
<tr>
<td>Hearing Impairment</td>
<td>132</td>
<td>2.43</td>
</tr>
<tr>
<td>Moderate Learning Difficulty</td>
<td>2167</td>
<td>39.72</td>
</tr>
<tr>
<td>Other</td>
<td>202</td>
<td>3.70</td>
</tr>
<tr>
<td>Physical Disability</td>
<td>205</td>
<td>3.76</td>
</tr>
<tr>
<td>Speech, Language and Communication Needs</td>
<td>541</td>
<td>9.93</td>
</tr>
<tr>
<td>Severe Learning Difficulty</td>
<td>85</td>
<td>1.55</td>
</tr>
<tr>
<td>Specific Learning Difficulty</td>
<td>390</td>
<td>7.14</td>
</tr>
<tr>
<td>Visual Impairment</td>
<td>87</td>
<td>1.59</td>
</tr>
<tr>
<td>Profound and Multiple Learning Difficulty</td>
<td>19</td>
<td>0.34</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>5,456</strong></td>
<td></td>
</tr>
</tbody>
</table>

Some children have learning difficulties as well as other disabilities.

4.21 In Bradford’s mainstream schools 2.3% of pupils have a statement of special educational needs, which is lower than both our statistical neighbours and the national figure of 2.8%. The review of the Children and Young People’s Plan identified ensuring easy access for children and young people with learning difficulties and/or disabilities to the therapeutic services they require, as an area for action over the next 6 months. (Bradford & District Children and Young People Needs Analysis, June 2008).

**Educational Attainment**

4.22 Educational attainment in Bradford is significantly lower than the national average and unauthorised absences twice as high as the national average (2006 data). 51.2% of pupils in Bradford achieved the benchmark 5 or more GCSE grade C or above, well below the national figure of 60.3%. It is also below the statistical neighbour figure of 54.9%.
Challenges persist in achievement at Foundation stage, including a gender gap in boys’ achievement and in progression levels from key stage 2 to key stage 3. The recent review of the Children and Young People’s Plan recommended for immediate action a clear focus on improvement at Key Stage 1, where attainment by white and Bangladeshi ethnic groups in particular is low. We have failed to meet our targets in relation to GCSE achievement, and have not yet closed the gap between our achievement and national achievement rates. Furthermore, vulnerable groups, including looked after children, are not achieving as well as they should be.

Improving educational attainment in Bradford is one of the three top priorities in ‘The Big Plan’, the city’s Sustainable Community Strategy. Recent consultation results showed the top priorities among those consulted were increased educational achievement and skills, combined with providing more jobs.

**Lifestyle Behaviours: Food and Nutrition**

4.23 Nutrition problems, including obesity, failure to thrive and poor oral health are widespread among children and young people in Bradford District. Within inner city localities iron deficiency is common with up to 40% of children being affected and 363 children were identified with vitamin D deficiency over a 5 year period 2000-2004 in Bradford District. Breast feeding initiation rates are around 62% (2007/08) but the focus is on continued breast feeding at 6-8 weeks and beyond as this provides more health benefits for infants.

4.24 There is a continued focus on reducing iron deficiency and vitamin D in children who are at risk and promoting breast feeding through the Baby Friendly Initiative, breast feeding cafes and use of peer supporters. Programmes such as Mind, Body and Soul include nutritional guidance for teenage girls and a variety of nutritional support to Children’s Centres and training for staff working with families. Work in schools to support healthy lifestyles is encouraging, with 65% of schools achieving ‘Healthy Schools’ status, compared with a regional average of 63%.

4.25 Work in schools to support healthy lifestyles is encouraging, with 65% of schools achieving ‘Healthy Schools’ status, compared with a regional average of 63%.

**Physical Activity**

4.26 Currently, just over half of children and young people in Bradford (52%) walk to school (BMDC Travel to School Survey), and there may be room to increase the numbers who do so. Information for the new indicator set for physical activity is currently being established. However, under the old measure, 80% of children aged 5 to 16 achieved the target of participating in 2 hours of high quality physical education and school sport in academic year 2006-07.

**Obesity**

4.27 Between 1995 and 2005 the national incidence of obesity amongst children rose substantially - amongst those aged 2 to 10 from 9.6% to 16.6% in boys and from 10.3% to 16.7% in girls. If this trend continues, a fifth of all boys and a third of girls will be obese by 2020.
4.28 Within Bradford, as elsewhere, a whole-system approach is required to tackle overweight and obesity in children. We need to recognise that responsibility for preventing children’s obesity crosses organisational boundaries and includes the responsibilities of the parent or carer. Strong and effective partnerships between all partners are key to achieving this.

4.29 One of the measures introduced by the Government to halt the year on year rise in childhood obesity was the National Child Measurement Programme (NCMP). This initiative aims to record the height and weight of all children in reception year (4-5yrs) and year 6 (10-11 years).

4.30 Obesity levels in Bradford are higher than the national average. The NCMP results for 2006/2007 indicate that 10.7% for 4-5 year olds (9.9 nationally) and 19.5% of 10-11 year olds (17.5% nationally) are obese. Within Bradford District, however, there is significant variation in Obesity prevalence in Children. For example, for Year 6 the prevalence ranges from 10.1% in Wharfedale to 26% in Wibsey, for reception year from 4.9% in Bingley Rural to 15.6% in Keighley Central.


4.31 Child obesity figures for Bradford for the school year 2005/06

<table>
<thead>
<tr>
<th>Reception class</th>
<th>Year 6</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Under weight</td>
</tr>
<tr>
<td>Males</td>
<td>5% (120)</td>
</tr>
<tr>
<td></td>
<td>4% (118)</td>
</tr>
<tr>
<td>Females</td>
<td>4% (101)</td>
</tr>
<tr>
<td></td>
<td>5% (133)</td>
</tr>
</tbody>
</table>

Child obesity figures for Bradford for the school year 2006/07

<table>
<thead>
<tr>
<th>Reception class</th>
<th>Year 6</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Under weight</td>
</tr>
<tr>
<td>Males</td>
<td>4% (118)</td>
</tr>
<tr>
<td></td>
<td>5% (129)</td>
</tr>
<tr>
<td>Females</td>
<td>4% (108)</td>
</tr>
<tr>
<td></td>
<td>5% (127)</td>
</tr>
</tbody>
</table>

Child obesity figures for Bradford for the school year 2006/07 compared to regional and national rates.

<table>
<thead>
<tr>
<th>Bradford</th>
<th>Yorkshire and the Humber SHA</th>
<th>England and Wales</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>% Overweight</td>
<td>% Obese</td>
</tr>
<tr>
<td>Reception</td>
<td>12.6</td>
<td>10.7</td>
</tr>
<tr>
<td>Year 6</td>
<td>13.6</td>
<td>19.5</td>
</tr>
</tbody>
</table>

4.32 Progress made to tackle Obesity locally has included:
• An obesity champion appointed to implement recommendations of the Bradford Scrutiny obesity report (2006) employed by the PCT.
• Commissioning community based structured programmes (MEND and Body, Mind and Soul
• Working towards implementation of the recommendations of the Bradford District Infant Mortality Commission that include improving the nutrition of mothers and babies and addressing the wider obesity agenda.
• A review of physical activity interventions led by Bradford Education client team, reporting to the Be Healthy outcome group
• A Health Needs Assessment undertaken with all children in reception, year 7 and year 10 and BMI data obtained for reception and year 6 children
• Childhood obesity coach funded by the tPCT, Yorkshire Sport and the local authority working in partnership with Bradford Bulls
• Advice and consultancy work with Education Contracting Service (ECS) to improve school meals and their uptake.
• Fruit in schools scheme in place, all key stage I children are offered a piece of fruit daily
• Community coach (Walking) jointly funded by Yorkshire Sport, the Local Authority and tPCT to work with children
• District Breastfeeding Co-ordinator in post to manage and facilitate the implementation of the breastfeeding strategy.
• Social marketing approach to publicise the Health Start Scheme in partnership with the Local Authority and the Acute Trust

4.33 The next steps are to reassess nutritional guidelines, develop a local children’s Obesity strategy and effective weight management interventions, and progress the strategic alliance across partner to reduce childhood obesity.

Dental Health

4.34 Within Bradford District young children have very high levels of dental disease and inequalities exist. In 2006 five year olds in Bradford and Airedale tPCT had the highest levels of dental disease in the Yorkshire and Humber region, with a mean decayed, missing or filled teeth rate (dmtf) of 2.56 per child. This is significantly higher than the national figure of 1.5. Children living in the most deprived areas have nearly twice as much dental disease as those from the least deprived (see map on next page) and only 60% of children under 18 are registered with a dentist. South Asian children have significantly higher levels of disease than their white peers living in areas of similar socio-economic status.

4.35 In 2007 two key strategies were approved by the tPCT. Firstly, the Oral Health Strategy set out the specific actions and investments required to improve the oral health of Bradford and Airedale’s population. Secondly, the second, the Dental Commissioning Strategy, set out how, through local commissioning of dental services, the tPCT would secure better access to high quality dental services.

4.36 Also in 2007, the tPCT approved an investment plan to support the oral health and dental commissioning strategies. This investment will support:
• three new dental surgeries in the district, sited according to need.
• general oral health improvement programmes for children (e.g. tooth brushing schemes, education programmes children and their parents), and
• programmes specifically developed to address the poor oral health of young children.


**Smoking, drugs and alcohol**

4.37 Survey results indicate a lower incidence of alcohol use amongst children in Bradford than nationally. However, the high levels of young Muslims in the district are likely to be masking high levels across the non-Muslim population.

4.38 Results from the 2007 ‘Tellus2’ (school-based) survey of children aged 10-15 included:

- 28% of Bradford children stated admitted to having ever had an alcoholic drink, compared with 48% nationally;
- 9% said they had been drunk at least once in the last four weeks, compared with 19% nationally;
- 37% of children in Bradford wanted more/better information and advice on smoking, compared with 26% nationally;
- 41% of children wanted more/better information and advice on drugs, against 31% nationally;
- 37% say they needed more/better information and advice on alcohol, against 27% nationally.
4.39 A national survey into young people and alcohol commissioned by Positive Futures gives an important insight into the lives of young people from those backgrounds most associated with crime and anti-social behaviour, low educational attainment, teenage pregnancy, chronic worklessness and other social problems.

Key findings were:

- 15% reported drinking at levels classified as hazardous or harmful for adults: 3% were drinking 61-80 units a week; 4% were drinking 41-60 units a week; and 8% between 21 and 40 units a week;
- 39% drank up to 20 units of alcohol a week;
- 22% did not know how much they drank and there was widespread ignorance of the unit value of alcoholic drinks;
- 8% began drinking when they were 10 years old or younger, 7% at eleven, and 12% at twelve;
- 42% knew family and/or friends with alcohol related problems.

During 2007, on a national level, there has been increase of:

- 40% in new presentations (under 18s) to specialist drug services;
- 32.5% in the number of under 18s in treatment of 32.5%;
- 49% in the number of under 18s accessing treatment within a young persons specialist service;
- 190% in the number of planned discharges for under-18s.
- 83% of young people presenting for treatment in Bradford District were seen in a young person’s specialist service.

On a local level during 2007 the following can be evidenced:

- 86% of the treatment population defined themselves as White British. This compares to only 6% defining themselves as of Pakistani origin although there is a school population of 30%

4.40 This could be accounted for because a large majority of the young Pakistani population are Muslim, many of whom will not use substances due to religious belief. This could also explain the below national average drug and alcohol prevalence figures for the Tell Us 2 Survey

The majority of clients within specialist treatment are aged 15-18+:

- 24% aged 15yrs
- 22% aged 16yrs
- 18% aged 17yrs
- 18% aged 18yrs

4.41 Alcohol and Cannabis are the main substances used by young people. Although less young people are drinking alcohol, those that are drinking are drinking more. The THC content of Cannabis is now stronger and Skunk is the predominant form of Cannabis used. Treatment figures show that 15% of clients report Alcohol and 58% reported Cannabis as main presenting substances.

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4.42 Full treatment figures for main presenting substance include:
- Cannabis 58%
- Alcohol 15%
- Heroin 13%
- Amphetamine 5%
- Cocaine 4%
- Ecstasy 2%
- Crack 1%
- Solvents 1%
- Poly drug 1%

4.43 Over the last 13 months (until Q3 2007/08) the number of planned discharges has increased significantly to 72%. Minimum performance expectations for 2008/09 require that at least 80% of young people should leave treatment in an agreed and planned way. Young people’s specialist services continue to work towards this target.

4.44 Locally within the Bradford district there is no comparative data or survey available that provides information on smoking prevalence amongst its young people. The Stop Smoking Service for Bradford report that there has been an increase in the number of under 18 males and females setting a quit date with the service in 2007/2008, but that the quit rate at 4 weeks has dropped slightly. This demonstrates that an increase in both capacity and quality of treatment provision for under-18s is required.

4.45 Regarding drug misuse, presentations for Heroin, Amphetamine, Cocaine, Solvents and Poly Drug are down whilst there has been in increase in presentations for Ecstasy, Cannabis, and Alcohol. This is consistent with national trends of falling Class A drug use amongst under 18s and an increase in Cannabis and Alcohol use.

The next steps for the District are:
- Continued focus on increasing planned discharges
- Continued focus on Cannabis, Alcohol and Ecstasy through screening vulnerable young people, delivery of drug awareness work in various youth venues including schools.
- Continued focus on improving access to specialist services through new promotional materials
- Protocol for the use of Nicotine Replacement Therapy in 12-17 year olds developed for dissemination and implementation the PCT to GPs and stop smoking advisors and specialists.
- Continued provision of NRT via the NRT Pharmacy Access Voucher scheme, this will enable young people to access NRT from stop smoking advisors without the young person having to attend the GP for a prescription.
- Continue to build capacity district wide to provide support for young people who wish to quit smoking for e.g. school nurses to be trained to deliver level 2 stop smoking interventions for young

Teenage conception rates and sexual health

4.46 Bradford Council and the tPCT share the target of a 50% reduction in teenage conception rates by 2010, from a 1998 baseline. Currently Bradford has a higher teenage conception rate than the national average (44 compared with 41 per 1,000
for 15-17 year olds (2005) but below other areas in Yorkshire and the Humber with similar levels of deprivation. So far there has been a 22% reduction in the teenage pregnancy rate in Bradford between 1998 and 2006.

4.47 There has also been a significant increase in the number of conceptions leading to termination. The proportion of teenage pregnancies leading to termination has for many years been below 35% for the district but in 2006 increased to 41% (close to the national figure of 48%).

4.48 Across Bradford there are still areas where teenage pregnancy is double the national average and three quarters of teenage pregnancies occur in the most deprived 40% of the community. The highest teenage conception rates and teenage birth rates both tend to occur in deprived areas where with majority white populations (e.g. Tong, Wrose and Eccleshill wards).

4.49 Within the district young peoples sexual health and contraceptive services have been developed in hotspot areas and community settings such as school based TIC TAC services, the free EHC scheme, free pregnancy testing Chlamydia screening, condom distribution and the promotion of LARC.

4.50 Looking to the future work is ongoing to develop specialist foster care placements for pregnant teenagers both already in local authority care and those who enter care as a result of their pregnancy, supported by provision of a specific parenting group for teenage parents and pregnant teenagers both in and leaving care. The Good practice which has gone on in the district will continue with a capacity review for roll out. There is also a district wide review of the Young People’s Sexual Health strategy and the Partnership Board, and a needs assessment for Bradford to inform the strategy for sexual health is underway. Information from this assessment will be used to support targeted work for the YP’s Sexual Health Strategy.

4.51 Rates of Chlamydia are only available at the regional level, and are lower than the England average for both under-16s and 16-19 year olds:

- Under-16s: 56.4 against 64.7 per 100,000 nationally;
- 16-19 year olds: 826 against 941 nationally.

Caution should be used because an increase in the rate may be due to increased public understanding and successful awareness raising campaigns. The recent review of the Children and Young people’s plan identified ensuring all partners understand and carry out their responsibilities for improving sexual health, as a priority for action over the next six months.

**Mental Health**

4.52 The CAMHS (Child and Adolescent Mental Health Service) Needs Assessment (2004) – reviewed in 2007, largely bases its estimates of the size and distribution of the emotional/ mental health needs of young people on extrapolation of national studies to conclude on the size of the issue for Bradford.
4.53 In 2004, nationally one in ten children and young people (10 per cent) aged 5–16 had a clinically diagnosed mental disorder: 4 per cent had an emotional disorder (anxiety or depression), 6 per cent had a conduct disorder, 2 per cent had a hyperkinetic disorder, and 1 per cent had a less common disorder (including autism, tics, eating disorders and selective mutism). Some children (2 per cent) had more than one type of disorder (Green et. al. 2005b, p8).

4.54 The figure below shows the unadjusted prevalence estimates applied to Bradford’s population of children and young people.

4.55 ONS estimates that one in ten children and young people have a clinically recognisable mental disorder and locally the CAMHS Needs Assessment suggested that out of an under 18 population in the Bradford District of 136,000 between 20 and 40 per cent, up to 54,400 children and young people, could, at any one time, have a mental health ‘problem’.

4.56 The 2007 Review of the CAMHS Needs Assessment identified the following issues:

- continue development of services for 16 and 17 year olds. Joint approach to be agreed between CAMHS and adult mental health commissioners;
- ensure that all children and young people’s services are able to identify the mental health needs of BME populations and that issues regarding under-representation within specialist CAMHS caseloads are addressed;
- continue development of services to address mental health needs of looked after children, as a key part of the LAC Strategy, ensuring that needs are addressed systematically and incorporating any information gained by LAC Health Team;
- further work to develop an understanding of the mental health needs of adopted children, how well they are currently being met and to make recommendations regarding potential service development;
- continue development of integrated services for children with mental health problems and learning disabilities;
- further development of integrated services for children and young people with Autistic Spectrum conditions;
- specialist CAMHS and commissioners to identify ongoing and increasing requirements for in-patient care.

Priorities agreed in the Healthy Minds Strategy 2008-11 are:

- Prevention, early intervention and access to services
- Children and young people in BME communities
- Permanence for children in care and adopted children
- Children and young people with learning disabilities and autistic spectrum conditions
- Effective and evidence based specialist CAMHS provision

**Other Indicators**

4.57 Other indicators used in preparing the JSNA give a picture of Bradford with pockets of deprivation, where it is difficult to close the gap in health inequalities between national performance and improvement at a local level:

- significantly higher than average numbers of children eligible for Free School Meals, a traditional indicator of poverty:
  - primary: 23% against a national average of 15.9%, and
  - secondary: 24% against a national average of 13.1%.

- challenges to be met in secondary school attendance, where although there have been improvements year-on-year, targets have not been met in any year. The recent review of the Children and Young people’s plan identified improving school attendance of Looked After Children as a priority for action over the next six months.

**Summary**

4.58 The chapter provides a snap-shot of the challenges needed to tackle the strategic health needs for children and young people in Bradford. Improvements are being made, and progress is generally in the right direction. Bradford already has relatively high numbers of children and young people – nearly a quarter of its population (23%) is under 16 years of age, compared to the UK average of 19%. This population is predicted to grow by a further fifth between now and 2030, and much of this growth will take place in areas of Bradford that suffer the highest levels of deprivation.

4.59 The district’s infant mortality rate is one of the highest in the country (7.2 per 1,000 compared with 5.1 nationally) and is higher than other areas with similar levels of deprivation. Infant mortality is 3 times higher in Bradford’s most deprived areas than in its least deprived. Factors impacting on infant mortality include social deprivation, age and ethnicity of the mother and low birth weight.

The uptake of childhood primary immunisation programme in under 2 year olds and under 5 year olds compares favourably with the national picture, although continued work is needed in areas of deprivation to ensure levels remain high.

4.60 Educational attainment in Bradford is a major challenge for the district, with levels of achievement significantly lower than the national average and unauthorised absences twice as high as the national average (2006 data). Compared with 60.3% of pupils nationally, only 51.2% of Bradford pupils achieve 5 or more GCSEs at grade C or above. This is below the 54.9% achieved by statistical neighbours. Achievement is also low at Foundation stage, with particular problems among boys and Bangladeshi groups.
4.61 Nutrition problems, including obesity, failure to thrive and poor oral health are widespread problems among children and young people in the district. Iron deficiency is common in inner city areas (up to 40% of children) and some vitamin D deficiency. There is continued focus to reduce these among children at risk.

4.62 Breastfeeding initiation rates are around 62% and support is in place to support breastfeeding at 6-8 weeks and beyond.

4.63 Obesity levels among children and young people in Bradford are higher than the national average - 10.7% : 9.9% nationally for 4-5 year olds and 19.5% of 10-11 year olds compared with 17.5% nationally. There is considerable variation in obesity by Ward across the district.

4.64 Another challenge for the district is the very high levels of dental disease among young children, particularly in deprived areas. Only 60% of children under 18 across the district are registered with a dentist.

4.65 Survey findings indicating a lower than average incidence of alcohol use amongst children are likely to be skewed by the relatively high proportion of Muslims, who avoid alcohol for religious reasons. The result is likely to be an underestimate of use amongst non-Muslims.

4.66 Bradford’s teenage conception rate is also higher than the national average, and three-quarters of teenage pregnancies occur in deprived Wards with majority white populations.

4.67 The priorities for action from the data analysis suggest a focus on reducing levels of infant mortality, teenage pregnancy, obesity and poor oral health, and to close the performance gap against national levels. Again, in order to target areas of greatest need and priority groups, more and better data, broken down to more local levels is required. This need will be met by the new Observatory.
5 PRIORITISATION AND COMMISSIONING

Key Issues and Priorities

5.1 The JSNA has highlighted the need to address health inequalities as a priority, and reflects the philosophy and work already undertaken in the Bradford & Airedale tPCT Strategic Plan\(^{18}\) which states: “we must invest wisely and shift the focus towards health improvement, prevention and addressing health inequalities”. The commissioning strategy reiterates the focus within the Local Area Agreement on the six priority areas of the ‘Choosing Health’ White Paper, which are:

- Tackling health inequalities
- Reducing the number who smoke
- Tackling obesity
- Improving sexual health
- Improving mental health & well-being and
- Reducing harm from alcohol and encouraging sensible drinking

5.2 The commissioning strategy places a local focus on these priorities, and recognises that obesity, tobacco and infant mortality are also at the core of the ‘Big Plan’ (Bradford’s SCS) which addresses the broader range of priorities of Prosperity and Regeneration, Children and Young People, Safer Communities, Health and Wellbeing for All, Improving the Environment, and Strong and Cohesive Communities

Addressing Health Inequalities

5.3 In general, the issues to be tackled in Bradford are:

- Reducing worklessness, raising educational achievement, improving access to quality housing and creating a safer environment are major themes;
- Supporting the most deprived neighbourhoods and communities experiencing greater inequalities and exclusion; promoting earlier contact with antenatal services, particularly for mothers born outside of the UK;
- Reducing smoking during pregnancy, increasing breast feeding rates and reducing teenage pregnancy;
- Inequity in access to important services that can contribute to health inequalities. It is recognized that sometimes the quality of care provided is not equally high across the district and improvement plans for underperforming services, leading to inequitable access to care. The PCT is commissioning primary care to improve quality, access and environment, to improve patient experience;
- Health equity audits (HEA) are being carried out on a range of services to inform developments. HEAs include children, CHD and cancer,
- Greater use is being made of social marketing techniques to help us better understand our population in order to target and improve access to our services.

5.4 The following paragraphs identify key specific issues in terms of health inequalities.

5.5 Obesity is linked to lower socio-economic status and Bradford has a relatively deprived population. Some ethnic groups are more at risk of obesity and developing

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consequent health problems. Obesity is directly related to increased mortality and lower life expectancy as well as being an important risk factor for a number of chronic diseases such as heart disease, stroke, some cancers, and type 2 diabetes.

- We are supporting a wide range of evidence-based programmes aimed at promoting physical activity and healthier eating with the aim of halting the year-on-year rise of obesity in children by 2010. Part of this has involved developing a range of interventions aimed at increasing levels of physical activity and encouraging healthy eating in communities at risk of obesity. We are working strategically across a range of partnerships to make Bradford’s environment more conducive to enjoyable and safe physical activity outdoors. As evidence shows that breast feeding helps prevent obesity later on as well as being beneficial in many other ways, we are working to increase breast feeding rates. We will continue to provide a variety of health promotion programmes based on the best evidence which are tailored to meet the needs of differing groups by gender, ethnicity, age etc.

5.6 **Smoking** is the principal immediate cause of health inequalities in the UK, particularly for CHD, cardiovascular and respiratory diseases, and cancers. Disadvantaged people are more likely to smoke. Death rates from tobacco are two to three times higher among disadvantaged social groups than among the better off. Although many BME groups smoke less than the rest of the population, prevalence is high among the Bangladeshi and Irish. Other vulnerable population groups hard hit by smoking are: young people, single parents, those with mental health problems and homeless people.

- We are working to ensure services are acceptable and accessible to all vulnerable groups so that adult smoking rates are reduced. We are continuing to develop a range of proactive approaches to engage at-risk and marginalised groups such as people living on a low income, pregnant women, young people, and heavily dependent smokers. Pregnant women and new mothers who wish to quit receive specialist advice and support. We will work to configure services which are more effective in serving these groups.

5.7 **Alcohol** related morbidity and mortality is rising across all social classes. An individual with low socioeconomic status is likely to suffer more harm (through factors such as poorer nutrition, financial problems, less secure employment) than somebody of higher status who is drinking the same amount. People from many ethnic minority groups are more likely to be non-drinkers. Alcohol dependency is a particular problem for people with mental health problems as it complicates diagnosis and treatment. Deaths from diseases caused by alcohol show a clear gradient with socio-economic position, with a higher rate in unskilled working men. Alcohol is a contributory factor to deaths from accidents, which also show a pronounced socio-economic gradient. The abuse of alcohol is a contributory factor in crime and delinquency, domestic violence, drink driving, public disorder, assaults, accidents, the spread of STDs, teenage pregnancy, and death by injury and poisoning. All of these can impact adversely on more deprived neighbourhoods affecting the life of many other local people.

5.8 **Substance misuse** Young people are particularly at risk: the highest numbers of drug users are between 16-34 years of age. Vulnerable and disadvantaged children and young people under 25 who are at risk of misusing substances include: those
whose family members misuse substances; those with behavioural, mental health or social problems; those excluded from school, truants and young offenders; looked after children; those who are homeless; those involved in commercial sex work and people from some black and minority ethnic groups. Misuse of drugs can lock people into circles of disadvantage, social exclusion and physical ill-health. Drug use may cause or exacerbate mental illness and makes treating mental health problems difficult. Problematic drug use in adults undermines families and compromises the health and development of children. Drug use and drug dealing has wider social costs because of its disruption of the communities by nuisance and anti-social behaviour. Often the communities most affected are the most disadvantaged. Drug users who need money to fund their habit often turn to crime and criminality. Drug distribution harms communities.

5.9 **Sexual ill health** particularly affects teenagers and young people, gay men and black and minority ethnic groups. There is a strong link between social deprivation and sexually transmitted infections, abortion and teenage conceptions. The risk of teenage pregnancy is greater in young women experiencing disadvantage in terms of education or home life. Particularly at risk are the daughters of teenage mothers, young people ‘looked-after’ by the local authority or leaving care, school non-attendees – due to truancy or exclusion – and homeless or runaway teenagers. Teenage mothers and their children are more likely to have health that is worse than average; and poor social, economic and educational opportunities. Bradford has high numbers of teenage pregnancies despite recent improvements. The highest rates of STIs are in young people. Rates of new diagnoses in GUM clinics of Chlamydia in 20 to 24 year olds are ten times higher than that for 35 to 44 year olds and five times higher for Gonorrhoea. Sexually transmitted infections and HIV disproportionately affect men, especially men who have sex with men.

- We are working to reduce inequalities by ensuring that sexual health services are accessible to underserved and high-risk groups such as young people, gay men and some ethnic minorities. Groups of people who are at higher risk of STIs and HIV are particularly targeted for sexual health promotion work locally. Changes in service provision are being made so that users can access basic services in convenient and welcoming locations and to encourage larger numbers of at-risk groups to access screening services. We are working to ensure that services are not only ‘young people friendly’, but attract an increasing proportion of young men. We are working to strengthen the contribution that schools can make to promoting sexual health and reducing teenage pregnancy via effective sex and relationships education. We also provide a clear focus on those most at risk such as those from disadvantaged communities, men who have sex with men, and vulnerable young people, with an emphasis on prevention in one-to-one structured advice and discussion with health care practitioners.

5.10 **Mental health of working-age adults** - problems are extremely common, affecting one in six adults. The data indicates that many of the symptoms of mental health problems are more common in females than males. Among other things, mental health problems are associated with: unemployment, particularly amongst young men having a low level of educational qualifications, abuse of alcohol and drug use. There is also evidence that migration can have a negative affect on mental health, as it may expose individuals to considerable pressure and stress. The great majority of NHS mental health expenditure resources go to the one per cent of the population who has psychotic problems. Among people with depression only a half receive any treatment, only eight per cent have seen a psychiatrist, and only three per cent have seen a psychologist.
• In primary care, GPs diagnose and treat mild to moderate illness with a combination of medication and psychological therapies. The provision of psychotherapy services should be assessed for equitable access. Data describing the prevalence of these mental health conditions should be further analysed to improve and target services. Bradford continues to undergo substantial change that may impact adversely on the mental well being of individuals and communities. The potential effects of regeneration schemes and other projects affecting communities should be assessed both in terms of their promotion of mental well-being and for any potential detrimental effects on mental health.

5.11 **Mental health issues amongst people aged 65+** are very common and include both organic mental illnesses such as dementia, (Alzheimer’s Disease and vascular dementia are the most common), and functional mental illnesses such as depression and anxiety. The prevalence of dementia rises sharply with age across the whole 65+ population, but is also significantly more prevalent amongst people with learning disabilities as they get into their 50s and 60s. Depression too commonly is not recognised, diagnosed or treated amongst older people. Social isolation, the effects of ageing and events such as bereavement all put a strain on emotional well-being. There are also people who have experienced psychotic, neurotic or personality disorders throughout their lives, who have now reached older age and may have specific needs. Mental health needs amongst older people often co-exist with physical illnesses or disabilities.

• Following a strategic review of older people’s mental health services, partners are developing an integrated health and social care locality model. This includes early assessment and diagnosis, enhanced capacity for specialist services, liaison services in acute hospital settings, access to intermediate care and a range of rehabilitation and enablement, support to carers.

5.12 **Oral health** Socio-economic factors are recognised as being key determinants of oral health inequalities. This association is particularly strong amongst young children. Inequalities exist in Bradford with children in the more affluent parts of the district having better oral health than their counterparts in the City and South of the City. Older people are an increasing section of the population and present a particular public health challenge. This section of the population is increasingly retaining their natural teeth into old age and their risk of oral diseases increases. Vulnerable groups of society also have poorer oral health and less access to oral health care services. For example, children and adults with a learning disability and people with mental illness tend to have fewer teeth, more untreated decay and more periodontal disease than the general population. Other groups at risk of poor oral health include people with disability and those in long-term institutional care. Some minority ethnic groups may face an increased risk of oral disease because they are more likely to be living in areas of disadvantage, and some groups may encounter language and cultural barriers to accessing dental care.

• Partnership working is crucial, as poor oral health has risk factors such as poor diet, tobacco and excessive alcohol use. Much of the oral health promotion is targeted at preschool and school age children.
5.13 **Long term conditions** The causes of chronic diseases are largely preventable and well known. The most important risk factors are: socio-economic deprivation and its association with an unhealthy diet; physical inactivity; poor blood pressure control; tobacco consumption, and obesity. The absence of preventive actions and absence of equitable access are much more conducive to chronic diseases than the question of individual responsibility. Long term conditions cause poverty as they can lead to long term unemployment and difficulties in returning to the workplace. The prevalence of most long term conditions increases with age: in Bradford, however, we also have higher rates of long term limiting illness in younger people than more prosperous areas. Long-term conditions also impact on the lives of family members and friends who become carers.

5.14 **Cardiovascular diseases** We are not yet managing to close the mortality gap for cardiovascular disease between Bradford and the rest of England. Rates of coronary heart disease and premature death are higher in men, socially and economically deprived groups, some BME groups and in older people.

5.15 **Hypertension** Although the risk of high blood pressure increases with age, it is often under diagnosed in younger people, as it may not produce symptoms until damage has been done. Women are more likely to have their hypertension diagnosed and treated than men, although it is more common in men.

5.16 **Diabetes** People from BME groups are up to six times more likely to develop diabetes. People with a severe mental illness have an increased risk of diabetes. Complications of diabetes such as heart disease, stroke, kidney damage and retinopathy are substantially higher in more socio-economically deprived groups.

- With the right support, patients can learn to be participants in their own care and manage their own conditions. We are committed to developing programmes for health professionals and the public which empower people with long term conditions to lead healthier lives. We are supporting the establishment of risk registers for cardiovascular disease in general practices in the PCT. This will mean that individuals at higher risk will be identified at an earlier stage and treated appropriately, helping to prevent deterioration in health. We are working to use existing data more effectively to assess the needs of our patient population and to audit the health care utilisation of different groups.

5.17 **Practice-based commissioning (PBC)** gives practices real power to redesign services to meet local needs and tackle health inequalities. A more appropriate range of services can be commissioned, including a focus on prevention, early intervention and cooperation with partners in social care. It will encourage co-operation between the NHS and local partners to tackle the broad determinants of health using vehicles such as Local Area Agreements. It also offers the potential for engagement across the whole local health economy to ensure consistent messages and a coherent approach to improving health and tackling inequalities are adopted by all providers and all professional groups.

**Issues for Adults**

5.18 Specific issues relating to Adults include:
• Rising numbers of people aged 65+ and especially over-85s, changes in the ethnic mix of the population of our district, including increases in the numbers of older people from a South Asian background;
• Rising numbers of people with dementia
• Rising numbers of people with complex disabilities;
• Increased life expectancy of people with disabilities, including those with learning disabilities;
• Higher than national levels of poor mental health amongst adults in the Bradford district;
• These factors together indicate a projected significant rise in demand for services;
• Significant inequalities in health, well-being and social inclusion between different localities and communities within the district, with some areas of significant multiple deprivation;
• The Supporting People needs analysis indicates significant unmet need in long term housing related support, housing with care, support to socially excluded groups. This is particularly related to the increases in the numbers of people aged 85+ and is impacting on the strategic decision to support more older people living in their own homes. There are also shortfalls in housing support and “move on” accommodation for people with mental health needs, learning disabilities and physical disabilities.
• Rising expectations for individualised care, choice and control;
• The need for new and differentiated services to meet more diverse needs, responding to outcomes as identified by people using services, including carers;
• Unmet needs relating to support and tailored services for Carers.
• The need to target lifestyle interventions to the 45-64 year old population. Preventative activity is likely to produce benefits in the elderly in the mid-term (10-25 years);
• Life expectancy in our district is improving, but still falls behind national figures. It also varies across the wards of the district. Resources will need to continue to be targeted at neighbourhoods or communities with low life expectancy.
• Areas of significant deprivation, poor housing, low or unemployment and low skills impact negatively on the health and well-being of communities.
• Isolation and a lack of social networks is a major issue for many older people, adults with mental health needs or physical disabilities.

Priorities for Adults:

5.19

• Promoting independence and well-being. In partnership we need to continue to expand preventative and early intervention services, through Third Sector commissioning. The PCT has a priority on health improvement, prevention and addressing health inequalities, focussing on the key behaviours influencing poor health amongst adults, particularly in groups most at risk;
• Equal Access for all Adults. The NHS and Adult Services are primarily focussed on delivering health and social care outcomes, but cannot do this in isolation. These alone will not provide the life chances and opportunities that go towards creating the sense of well-being all adults strive for. We need to work with key partners to promote equal access and social inclusion for all to mainstream services and activities, increasing quality of life, choice and control;
• The PCT is commissioning primary care to improve quality, access and environment, with a focus on improving patient experience;
• A shift to home-based support and care for adults with more intensive needs. Key partners will need to develop and commission new models of integrated community services to secure health and well-being;
• These include housing support for vulnerable adults, (taking forward the significant programme of Supporting People,) the continued development of extra care housing and an extension of the use of Telecare and other assistive technology. There is a need to move from the provision of accommodation only, to housing related support services, including flexible floating support services;
• Provide support to enable people to enter or stay in employment;
• Provide a comprehensive and in depth Welfare Rights service, maximising the incomes of more people, working in partnership with key agencies;
• Choice and Control. A key priority for Adult Services is to deliver the “personalisation” agenda, putting people at the centre of the assessment process, moving towards individualised budgets, supported by improved information, advocacy and safeguarding;
• The Choice agenda in the NHS is part of a wider set of system reforms;
• Implementation of the Bradford Carers’ Strategy, in line with the national New Deal for Carers, will deliver improved individualised support to Carers;
• Modernisation of Services. The Council and the PCT share the priorities of transforming Mental Health Services for Adults, Mental Health Services for Older People, and Services for People with Learning Disabilities. Working with Bradford District Care Trust and other providers, commissioners will re-shape services in line with the three strategic reviews in these areas;
• Commissioners will also need to take forward the recommendations of the review of End of Life Care;
• The PCT has an additional commissioning priority of transforming Urgent Care, which again will be taken forward in partnership;
• Integrated delivery of health and social care in local networks, to provide co-ordination of the care of those with complex and longer term needs, working proactively to reduce risk, strengthen independence and optimise health and well-being;
• Continue to tackle abuse of older and disabled people, through the Safeguarding Strategy;
• There is also a need to invest in supporting infrastructure such as IT, and take forward joint workforce development, building the collective skill base and capability to deliver these priorities.
Issues for Children and Young People

5.20 Specific issues relating to Children and Young People include:

- It is anticipated that there will be a significant growth in the number of 0-19 years old by 2030, This will place increasing demands on all services.
- It is anticipated that the proportion of children within the overall population will rise.
- It is anticipated that the proportion of children from ethnic minority communities will rise;
- the anticipated increase in the child population will be highest in the existing deprived areas;
- teenage conception rates are falling but remain significantly higher than the national average;
- Infant mortality rates are falling slightly but remain significantly higher than the national average;
- childhood obesity rates are higher than the national average;
- the proportion of mothers known to have initiated breastfeeding has increased significantly but remains lower than the national average;
- poor oral health is more prevalent amongst children from south Asian communities;
- there is a higher rate of admission to hospital for unintentional serious injuries than the national average;
- there are higher rates of children having a Child Protection Plan and being looked after among white communities;
- children in Bradford have lower educational attainment than children nationally.
  Lower attainment levels of children are already apparent at ‘Foundation stage’. All Key Stage attainment levels are lower than those across the country. Young people have lower levels of attainment at GCSE and a lower proportion reach 19 with Level 2 / Level 3 qualifications
- There are significant variations in attainment levels across the District, and there is a significant correlation between attainment levels and deprivation
- there is an over representation of White and African Caribbean young people in youth justice system;
- The proportion of young people (16 – 19 years old) who are NEET (Not in Education, Employment or Training) has been falling but remains higher than national rates.

Priorities for Children and Young People

5.21

- The Children and Young People’s Partnership coordinates and commissions services to address the needs of children and young people across the District. Improving the well-being of children, young people and their families is most effectively addressed by agencies working together.

- Strengthening and improving services for the most disadvantaged children and young people will improve their outcomes, reduce social exclusion and address inequalities across the District. A key priority is to ‘narrow the gap’ and reduce these inequalities.

- A key priority for the district is implementing the ‘Big Idea’ to intervene early when a child or young person has needs, to prevent problems becoming more complex and
requiring more intensive interventions. Early intervention in addressing children’s needs helps develop resilience.

- Addressing the needs of children and young people is most effectively addressed by working in partnership with their parents. A key priority for the District is implementing “for parents”, the District’s Parenting Strategy to involve and engage parents, to provide them with timely social and emotional support, and to increase their capacity to parent effectively.

- To develop and achieve, their potential children need to be happy, resilient and feel good about themselves and have someone to talk to they can trust.

- A key priority is to ensure all children and young people feel safe at home and in the community.

- A key priority is for every child to enjoy school life to the full in order to achieve their potential.

- A key priority is to ensure that the Contribution of children and young people is recognised and appreciated by everyone.

- A key priority for the district is to ensure today’s children become tomorrow’s highly motivated and well educated young workforce.

- The Co-ordination and development of a strategy to reduce poverty for children and young people underpins the commitment to address the needs of vulnerable children young people and their families

- Commissioning priorities identified by the Primary Care Trust include development of a Maternity and Newborn Pathway and Children’s Pathway as outlined in healthy Ambitions, development of a commissioning strategy to improve access to health care in educational settings and improve transition arrangements across health services for young people with disabilities and /or complex health needs.

- Other key areas include the development of an Aiming High commissioning strategy for disabled children.
6. NEXT STEPS

The JSNA is envisaged as a live document which will be subject to regular update. It is acknowledged that there are significant gaps in the data that are currently available, especially at a below district level and filling these will be an important element of work over the next 12 months – this will be linked to the development of the Bradford Observatory in the longer term. It is also essential that evidence gathered through consultation, especially around shaping appropriate services for the future, is bought together and combined with the quantitative data in this assessment.

The following actions have been agreed by the Council and tPCT to take this forward.

Following publication of the first JSNA we will do the following:

- publicise and share the report with key partners and the public, as appropriate, and seek feedback from them;
- extend the range of robust data and analyses at a locality or agreed sub-district level to fill gaps in our JSNA dataset, enhancing our understanding of inequalities within the district. This will be achieved via development of the new Bradford Observatory;
- ensure that the JSNA informs commissioning, work programmes and workforce development, with a view to improving health and well-being outcomes and reducing inequalities across the district;
- bring together key stakeholders in a JSNA Stakeholder event in the Autumn to share and understand the implications of the Needs Assessment and how it will inform commissioning and service delivery.