Reducing Inequalities Alliance

Bradford District and Craven Health and Care Partnership

ACTasONE

Inclusion Health in Bradford District and Craven: *Health Needs Assessment - SUMMARY*

Myrte Elbers

October 2024

Get started >>

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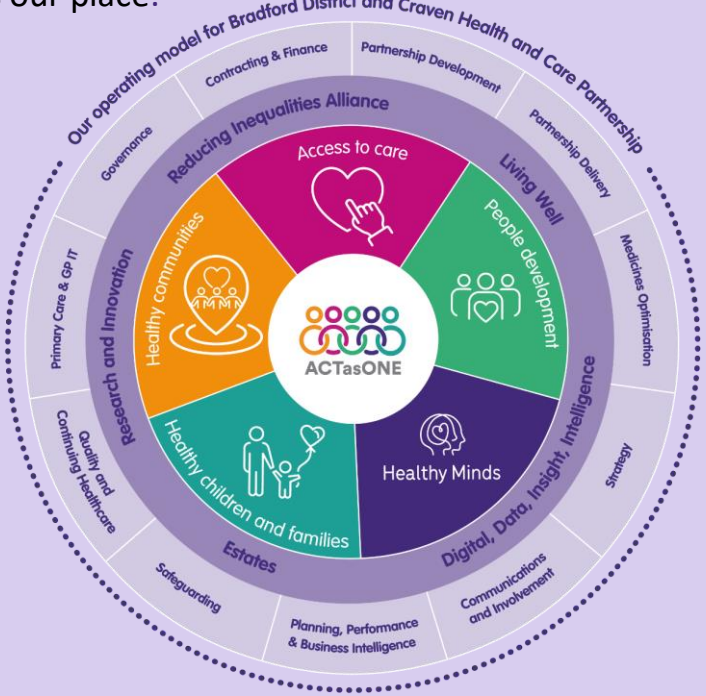
Introduction

- This Health Needs Assessment was carried out by the Reducing Inequalities Alliance (RIA) at Bradford District and Craven (BDC) Health and Care Partnership, part of West Yorkshire Integrated Care Board.
- Work commenced in October 2023 and finished July 2024.
- Extensive quantitative and qualitative data collection, analysis, interviews, presentations and consultations were completed with a wide range of stakeholders, partnerships and meetings across BDC, West Yorkshire as well as Yorkshire & the Humber.
- A long version of the Health Needs Assessment is available on the RIA website.

What is the Reducing Inequalities Alliance?

The Reducing Inequalities Alliance is an enabler programme within Bradford District and Craven Health and Care Partnership. It has been established to support and coordinate action to reduce inequalities across our place.



Acknowledgements

Bradford District & Craven Health and Care Partnership colleagues:

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- Communications and Involvement Team
- Community Partnerships Team
- Primary Care Team
- Data Quality Team

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- People/Public Health Commissioning
- Housing Strategy & Intelligence

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- Public Health Devon - Peter Mennear
- Colleagues across the voluntary and community sector in Bradford District and Craven, in particular VCS Alliance and Race Equality Network
- All other stakeholders attending the meetings where feedback on the draft HNA findings was received

Section 1: Context

What is Inclusion Health?
Why did we conduct a health needs assessment on Inclusion Health, and what was its purpose?

What is Inclusion Health?

- Inclusion Health (IH) is an umbrella term used to describe people who are **socially excluded**, who typically experience **multiple interacting risk factors for poor health**, such as stigma, discrimination, poverty, violence, and complex trauma.
- IH groups are recognised as part of the “PLUS” groups to be prioritised nationally within CORE20PLUS5. They include (but not limited to) homeless people, vulnerable migrants, Gypsies/Roma/Travellers, sex workers, victims of modern slavery, people in contact with criminal justice, people with alcohol/drugs dependency
- IH groups may belong to multiple disadvantaged groups within communities e.g. more likely to reside in Core20/most deprived 20% areas.
- IH groups can face mortality rates around nine times higher than the rest of the population.
- Poorer health outcomes and poorer access to health and care services among these groups contributes to worsening health inequalities.

Why a health needs assessment on Inclusion Health?

- NHS England's "National framework for NHS – action on inclusion health" outlines five principles for action on inclusion health [see diagram below]. Principle 2 is an understanding of the characteristics and needs of people in inclusion health groups.
- This health needs assessment (HNA) aims to contribute to the 2nd inclusion health principle.
- A HNA is a systematic approach to identifying the unmet health and care needs of a population and making recommendations to address those needs.

Figure 1: Principles for action on inclusion health

Purpose of health needs assessment (HNA)

- Look at health inequalities through an inclusion health lens
- Estimate the **size** of inclusion health groups from existing data i.e. no primary data collection (e.g. included findings from existing health needs assessments, service monitoring/evaluation reports etc)
- Map out the **scale** of health inequalities experienced by inclusion health groups
- Identify the preventative and primary healthcare needs of inclusion health groups, and gaps identified
- Assessment of evidence of effectiveness to reduce exclusion and health inequalities experienced
- Engage key stakeholders to feed into service planning and increase ownership and sustainability
- Inform commissioning decision making within the BDC Health & Care Partnership, and regionally where relevant, both short term (opportunistic) and longer term (strategic).

Section 2: Findings

Health Needs Assessment emerging findings: What are populations and health needs? What works, what do we currently do? What did stakeholders say?

What is the Population – summary of all groups

NB. [Bradford District] + [Craven] numbers

2680 + 60 (assessed as statutory homeless per year)

~1400 Asylum Seekers as of Dec 23 (BD only)

1100 + 50 (Gypsies & Travellers) Census 2021

1600 + 13 (Roma) Census 2021

85 service users, engaged in street-based sex work (BD only)

140 + 2 (Modern Slavery offences per year)

3800 + 55 (on Probation as of Nov 23)

>10,000 alcohol, opiate, cocaine dependency (BD only)

112 in drug treatment (Craven) 2021-22

What is the Population – summary of all groups

- The total size of *known* Inclusion Health groups exceeds 20,000 but this does not account for intersectionality and under-recorded populations such as vulnerable migrants, hidden homeless, modern slaves.
- Homelessness in Bradford District is significantly worse than the England average, whilst Craven has one of the lowest rates of homelessness compared with other districts in North Yorkshire.
- The absolute number of Asylum Seekers and Refugees accommodated in the Bradford District is the highest in the Yorkshire and Humber region, but in relative terms the second highest 'per 200 of the population', after Calderdale.
- There is no publicly available data on refugees other than those on 'Resettled Refugee' Home Office programmes.
- Roma Strategy indicates the actual (Eastern European) Roma population in the Bradford District may be between 8 and 12 times higher compared to official ethnicity counts such as from the Census (2021).

What is the Population – summary of all groups

- Similarly, the Gypsy and Traveller (G&T) Strategy estimated that the actual British/Irish G&T population was estimated to be 2-3 times higher compared to what's reported through the Census (2021).
- Little is known about the size of the indoor sex working population in BDC as these are less known to services. Around 85 on-street sex workers engage with the Lotus Project in Bradford District.
- Modern slavery figures only count victims that are on WY/NY Police's radar and are therefore a huge underestimate compared to the overall size.
- Bradford District's Probation Local Delivery Unit works with second highest number of people in Yorkshire & Humber, after Leeds but before Sheffield, Hull etc.
- Estimates for alcohol and drugs (opiate and/or crack cocaine) dependency are available at Local Authority level but not 'locality' level i.e. there are prevalence estimates for Bradford District but not for Craven.
- Around 10% of people who are homeless, offending, or substance users are estimated to have all three of these risk factors for exclusion (38% have two or more).

What are the health needs – summary of all groups

Asylum Seekers and Refugees –

Untreated communicable diseases

Poor mental health (1 in 5) – under-reporting in primary care

Poorly controlled chronic conditions

Maternity care

Eastern European Roma

Maternity care;

Poorly controlled long-term conditions.

Less engagement with preventative interventions

Lack of knowledge of UK healthcare system

People that experience **homelessness** –

Life expectancy more than 30 years less than general population

Tri-morbidity: physical, mental, and substance use issues

Diagnosed mental health conditions doubled since 2012

Gypsies and (Irish) Travellers

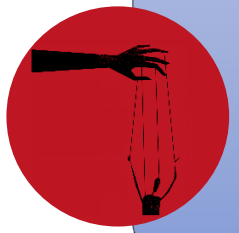
Self-report the highest levels of "bad or very bad health" compared to people of other ethnic backgrounds

On-street **sex work**, substance misuse and enduring mental health problems go hand in hand

What are the health needs – summary of all groups

57% of people on Probation, report that they have a physical and/or mental health condition – this figure is better than anywhere else in Yorkshire & Humber but twice the Bradford District average (based on similar question in Census 2021).

Similar to homelessness, substance misuse increases the risk of suicide



There is fragmented knowledge of the health needs of prison leavers, victims of modern slavery, sex workers (except on-street), as this does not systematically get flagged on healthcare systems, nor disclosed due to fear or stigma.

For women in Craven, the rate of alcohol hospital admissions was the highest in Yorkshire and Humber.

63% of people in substance use treatment in Bradford District are opiate users, which is higher than England (49%), and 18% of people are in treatment for alcohol dependency, which is lower than England (29%).

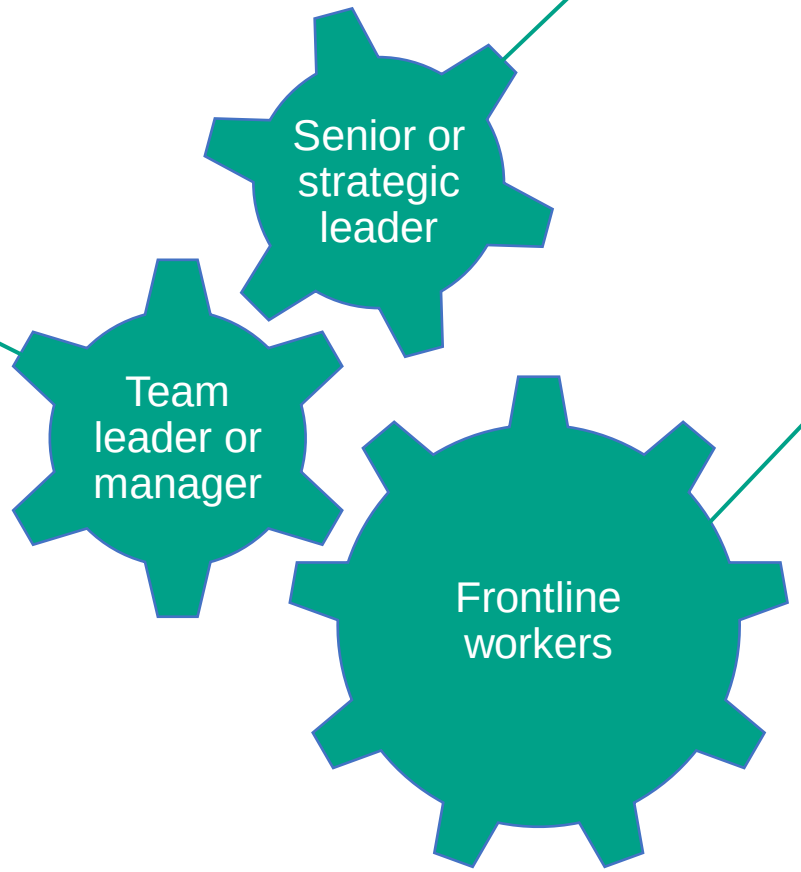
What works? Principles for inclusion health

Provide leadership and support services
raise the profile of inclusion health, ensure it is included in JSNAs, promote a coherent approach, challenge current ways of working

Collaborating with local services
identify need, build protocols, develop pathways, offer integrated services

Offer the highest quality standards
audit against key criteria, work with local partners, ensure nobody is excluded, involve people with lived experience

Ensure your team has the right training



Building trusting relationships
- non-judgemental attitudes, good communication

Accessible services
- don't refuse access, outreach

Ensuring other needs are met
- holistic assessments, ask and record social issues

Connecting people to other services
- help with GP registration, using windows of opportunity, challenge barriers

Use community assets
- be aware, collaborate and support access

Professional development
- cultural sensitivity, trauma informed approaches, entitlements

Slide produced by Office for Health Improvement and Disparities (OHID)

What works - for *all* IH groups

- Generic approaches do not work - a place-based approach recognising local needs is required.
- Targeted, co-ordinated approach in planning / multi-disciplinary approach in delivery - to address all needs
- Co-ordination and continuity of care and support
- Support for staff to meet range of needs and recognising they go 'above and beyond'
- Involvement of inclusion health groups in planning and delivery of services is crucial
- Adopting person-centred approach and trauma informed practice throughout
- Flexible attitude and approaches in delivery – e.g. longer contact times, sensitive approach to eligibility, no-linear recovery
- Ease of access is key for all groups (outreach/walk-in/in-reach). Outreach works particularly well for homeless, G&T, sex worker populations. Assertive outreach for those who struggle to engage
- Maximise opportunities for health protection interventions

Slide adapted from Public Health Devon, Devon County Council (2022)

What works - for specific groups

Homeless:

- Focus on housing and intervention to support effective discharge
- Provide specialist services, in Places/localities where there are high numbers of people experiencing homelessness

Gypsies, Roma, Travellers (GRT):

- Accommodate for literacy and language barriers, the latter is a particular barrier for Eastern European Roma.
- Outreach, building trust, and culturally aware approach
- People from a Gypsy/Traveller/Roma background to act as advocates and providers

Vulnerable Migrants

- Peer mentors helpful
- Specialist primary care where possible, incentivise where specialist provision is not possible
- Actively seek to offer care
- Translation and interpretation

Sex workers

- Non-judgemental approaches
- Specialist outreach – focus wider than sexual health, include mental health support
- Criminal justice as opportunity for engagement

Slide adapted from Public Health Devon, Devon County Council (2022)

BD = Bradford District
BDC = Bradford District & Craven

3.4 Bradford & Craven Strategic Leadership/Governance for Inclusion Health – as of July 2024

Gypsies and Travellers Strategy Group [under review]

Roma Strategy Group [under review]

BDC Healthy Communities Board [under review]

RIA/BD Public Health Inclusion Health Forum

BD Multiple Needs System Change Strategy Group; BD Street Based Lives Group [under review];

Vulnerable migrants

North Yorks Strategic Migrant Health Partnership

BD Stronger Communities Partnership Board [under review]

People experiencing homelessness and rough sleeping

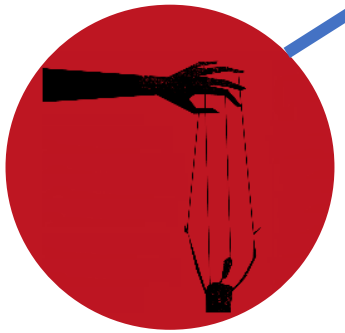
North Yorks Homelessness Forum [in development]
BD Housing People Group [under review];
BD Housing, Health and Care Forum

Sex workers

No strategic group for sex work specifically

Gypsy Roma and Traveller communities

BD Combating Drugs Partnership



Victims of modern slavery and human trafficking

BD Modern Slavery Board ; Community Safety Partnership (BD / North Yorks) Safeguarding Adults/Children Board (BD / North Yorks)

People in contact with the criminal justice system

Community Safety Partnership (BD / North Yorks)

Alcohol and/or Drugs Dependency

BDC Healthy Minds Board

North Yorks Drug and Alcohol Partnership Board ;
BD Alcohol & Drugs Strategy Group [under review]

What do we do, compared to what works?
Emerging findings

Local good practice examples have service delivery models that adopt the "what works" evidence.

Organisations such as Project 6, The Bridge, Race Equality Network (REN), Bevan Healthcare have long-standing knowledge and experience of supporting people with multiple and complex needs, as well as acknowledging and addressing (where possible) the multiple underlying risk factors such as poverty, violence, trauma, discrimination.

For example:

- Ease of access is key for all groups (outreach/walk-in/in-reach) – **e.g. Bevan Healthcare**
- Support for staff to meet the range of needs and recognising they go 'above and beyond' – **e.g. The Bridge**
- Involvement of inclusion health groups in planning and delivery of services is crucial – **e.g. REN**
- Flexible attitude and approaches in delivery – **e.g. ASIST at Project 6, Wellbeing Hubs**

Similar to national findings, there are 'pockets of excellence' at Place. Our local provision of support for IH groups is dependent on specialist services (and works within a complex system-wide governance and funding framework). This fragmentation means that IH groups will always be at risk of re-organisational change and funding cuts.

Section 3

Consultation and engagement
Emerging data gaps
Summary of recommendations

Consultation and engagement with stakeholders and communities

- Community insight was drawn from existing Health Needs Assessments, a ‘Listen in’ involvement cycle, as well as through various ad hoc communication with those with lived experience.
- Stakeholder feedback was gathered between March-July 2024, with summary versions of the HNA presented at over 10 multi-agency meetings.
- Comments in relation to specific IH groups were received such as the need to engage with Youth Service and Youth Justice re: people in contact with criminal justice and health(care) literacy barriers for vulnerable migrants.
- General comments were made regarding complex and fragmented governance and strategic leadership, better intelligence sharing, increasing profile of IH in the Health & Care Partnership’s Priority Programmes, importance of collaboration with other Places and Regional forums, IH to be included in Quality and Equality Impact Assessments, improve recording on clinical information systems, clarify the role of the IH Forum and strengthen governance, ‘seldom heard’ voices as part of decision making including through children’s forums, more easy read or audio/video info needed for those with poor English literacy including White British.

Emerging data gaps

Healthcare Provider data – limited to Bevan Healthcare, primary healthcare data is indicative but does not include all localities and IH groups
Homelessness – health data in Housing Options assessment is an untapped resource
Gypsies, Travellers, Roma – poor recording of ethnicity on healthcare records (national issue)
Alcohol/drugs dependency – no locality estimates i.e. for Craven, limited physical health data
People engaged with sex work – limited data on needs of indoor, migrant, and trans sex workers
Modern slavery - little known about health needs of Modern Slavery victims in Bradford District and Craven.
Criminal justice – more detail needed on 57% of people on Probation that self-report a “physical or mental health condition”, no Youth Justice data included.

Recommendations

These are an aspirational set of recommendations based on extensive data analysis and consultation. The Inclusion Health Forum (joint Public Health/RIA led) will work with partners to implement these:

- Awareness
  - Promote “what works” and existing online self-assessment tools
  - Feed into Public Sector Equality Duty (PSED)
  - Workforce development such as Adversity, Trauma, Resilience programme
- Action
  - Address data gaps such as coding of IH groups on clinical information systems
  - Review resources for vulnerable migrants, to increase healthcare literacy
  - Connect criminal justice and neurodiversity into the LD/ND Programme
- Advocacy
  - Ensure IH groups’ voices are incorporated in existing engagement, decision-making, and evaluation structures.
  - Embed IH focus into Digital Inclusion and Workforce programmes e.g. ‘Enhance’
  - Increase physical health focus as part of continuity of care in criminal justice
- Leadership and Governance
  - Due to complex governance, ensure close working between RIA & priority boards (Healthy Communities, Healthy Minds) to support IH groups
  - Inclusion Health Forum to refocus on capacity building e.g. funding applications and strengthen accountability through feeding up to Healthy Communities Board

Appendix

Definitions

Definitions 1/3

People sleeping rough: People sleeping, about to bed down (sitting on/in or standing next to their bedding) or bedded down in the open air or in buildings or other places not designed for habitation. The definition **does not include** people in hostels, shelters, campsites etc.

Homelessness: those households which meet specific criteria of priority need set out in legislation, and to whom a homelessness duty has been accepted by a local authority. Such households are rarely homeless in the literal sense of being without a roof over their heads, but are more likely to be threatened with the loss of, or are unable to continue with, their current accommodation.

- Prevention duty: if the person is threatened with homelessness, and eligible for assistance, the local authority has a duty to prevent them becoming homeless.
- Relief duty: if the person is already homeless, and eligible for assistance, the local authority has a duty to help them secure accommodation for at least six months.

A migrant has moved to another country, for example to work, study or join family members. They may be living there temporarily or permanently depending on their situation.
***Vulnerable* migrants** living in the UK include:

- asylum seekers and refugees
- unaccompanied children
- people who have been trafficked
- undocumented migrants (those who are living in the UK with no legal status)
- low paid migrant workers

Definitions 2/3

A person seeking asylum:

- flees their home
- arrives in another country, whichever way they can
- makes themselves known to the authorities
- submits an asylum application
- has a legal right to stay in the country while waiting for a decision

A refugee:

- has proven that they'd be at risk if returned to their home country
- has had their claim for asylum accepted by the government
- has permission to stay in the UK either long term or indefinitely.

Gypsies and Travellers:
A recognised Ethnic Minority population under the Race Relations Act as amended in 2000, with 'protected characteristics' according to the 2010 Equality Act. The population includes several smaller communities with varying ethnic origins, such as Romany Gypsies as well as Irish and Scottish Travellers.

Eastern European Roma:
A recognised Ethnic Minority population under the Race Relations Act as amended in 2000, with 'protected characteristics' according to the 2010 Equality Act. Roma are a people without a homeland, spread through a wide range of Central and Eastern European countries.

Definitions 3/3

Sex worker: a person who on at least one occasion and whether or not compelled to do so, offers or provides sexual services to another person in return for payment or a promise of payment to A or a third person.

Modern slavery encompasses:

- Slavery, servitude, forced or compulsory labour
- Human trafficking: the recruitment, transportation, transfer, harbouring, or receipt of persons by improper means (e.g. coercion) for an improper purpose including forced labour or sexual exploitation. Trafficking does not have to be from one country to another, it can be from one area to another within a country or region.

People in contact with criminal justice: those convicted of a crime through the courts system.

Alcohol dependence: persistent drinking despite harmful consequences, a strong and often overwhelming desire to drink, and the prioritisation of drinking over other activities or obligations. Sheffield Alcohol Research Group based data on Adult Psychiatric Morbidity Survey 2014 findings, which in turn was based on respondents with AUDIT scores of 20 or above.

Opiate and/or crack cocaine use (OCU) estimates are based on drug treatment, probation, police, and prison data, for persons aged 15 to 64.

Reducing Inequalities Alliance

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