Reducing Inequalities Alliance

Bradford District and Craven Health and Care Partnership

ACTasONE

# Inclusion Health in Bradford District and Craven: *Health Needs Assessment*

Myrte Elbers

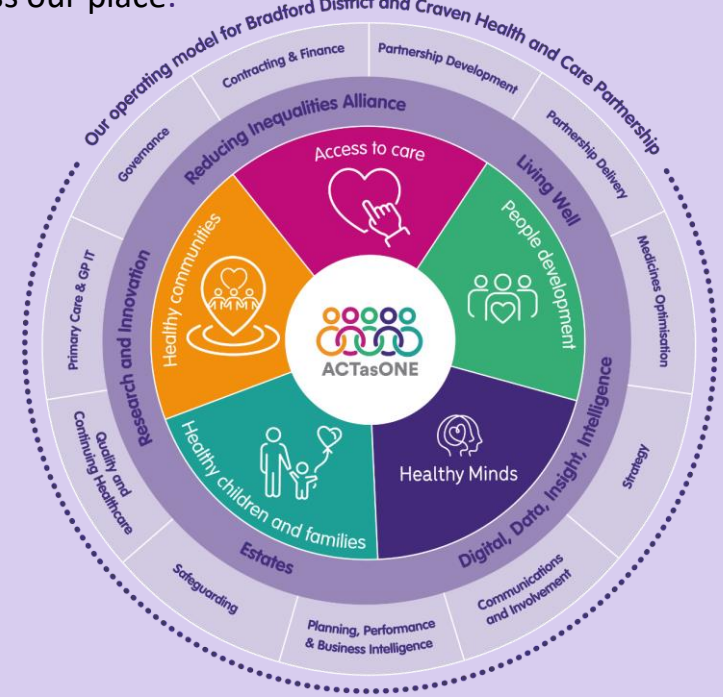
October 2024

# 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, Yorkshire & the Humber (see slides 74, 85).
- A summary 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.



# Contents



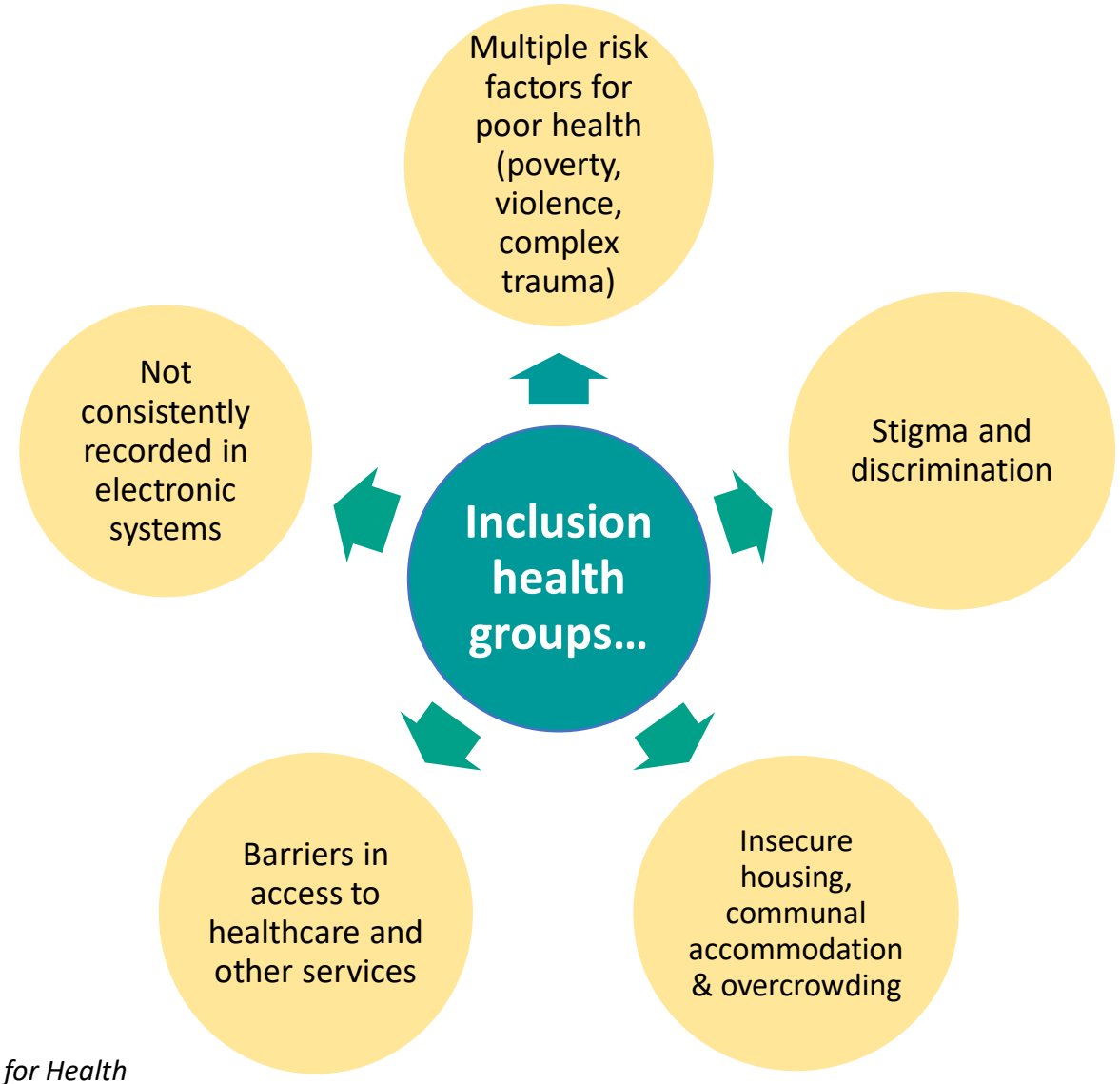
# Section 1: Context

## What is Inclusion Health? Why a health needs assessment?

# 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 [1].
- IH groups are recognised as part of the “PLUS” groups to be prioritised nationally within CORE20PLUS5.
- 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 [2].
- Poorer health outcomes and poorer access to health and care services among these groups contributes to worsening health inequalities.

# Interacting risk factors and vulnerabilities

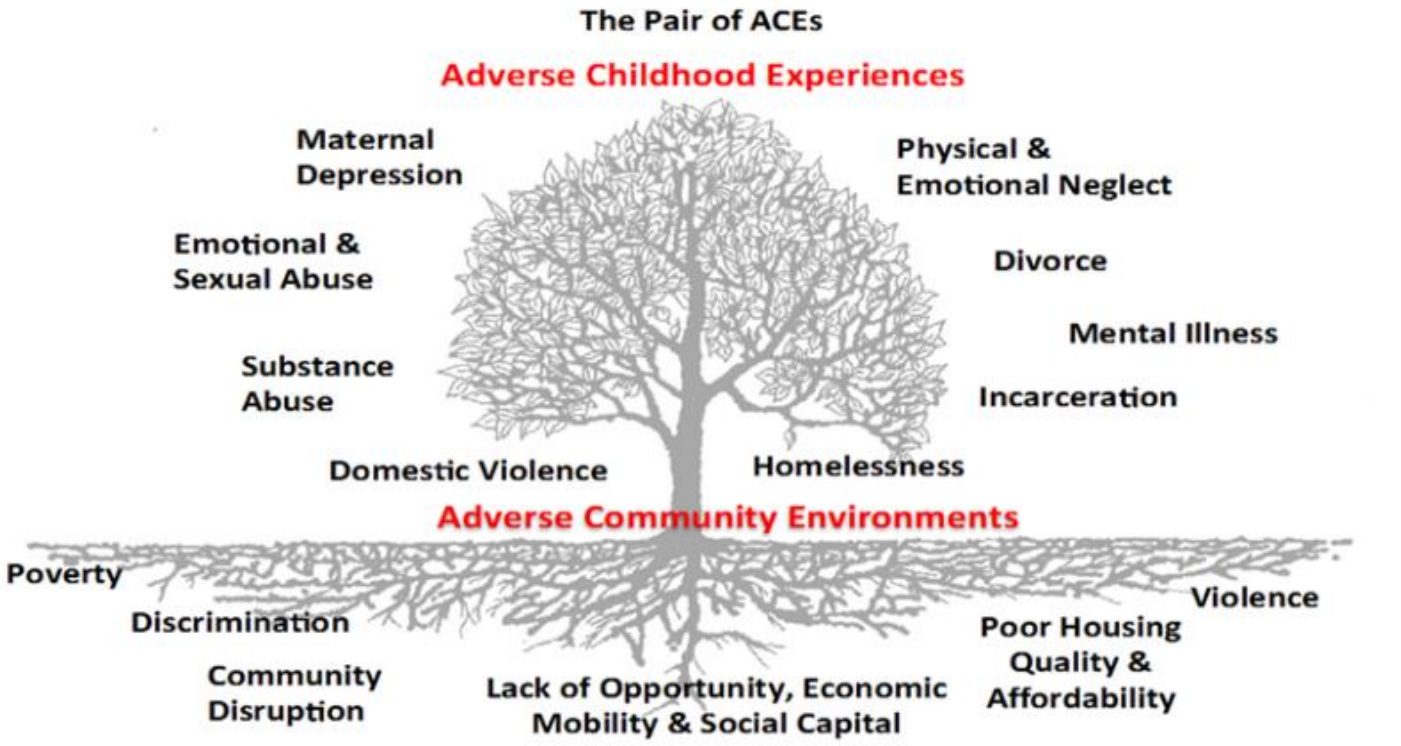



Multiple overlapping and interacting risk factors and vulnerabilities can lead to social exclusion, poor mental / physical health and addiction

Extremely poor health outcomes (‘cliff edge’)

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

# **“The Pair of ACEs”:** Adverse Childhood Experiences and Adverse Community Environments




Ellis, W., Dietz, W. (2017) A New Framework for Addressing Adverse Childhood and Community Experiences: The Building Community Resilience (BCR) Model. Academic Pediatrics. 17 (2017) pp. S86-S93. DOI information: 10.1016/j.acap.2016.12.011

Adverse Childhood Experiences (such as neglect and abuse) are exacerbated by Adverse Community Environments (poverty, poor housing). Bradford’s high level of deprivation puts its population at increased risk of ACEs [54].

Both “ACEs” significantly increase the risk of people becoming part of Inclusion Health groups (e.g. engaged in substance misuse, offending, sex work) in their adult lives [44].

# Inclusion Health Groups* include (but not limited to):

The groups below were prioritised for this HNA, to align to national and regional programmes.



People experiencing homelessness and rough sleeping

Vulnerable migrants

Gypsy Roma and Traveller communities

Sex workers

** See Appendix 1 for definitions*

Victims of modern slavery and human trafficking

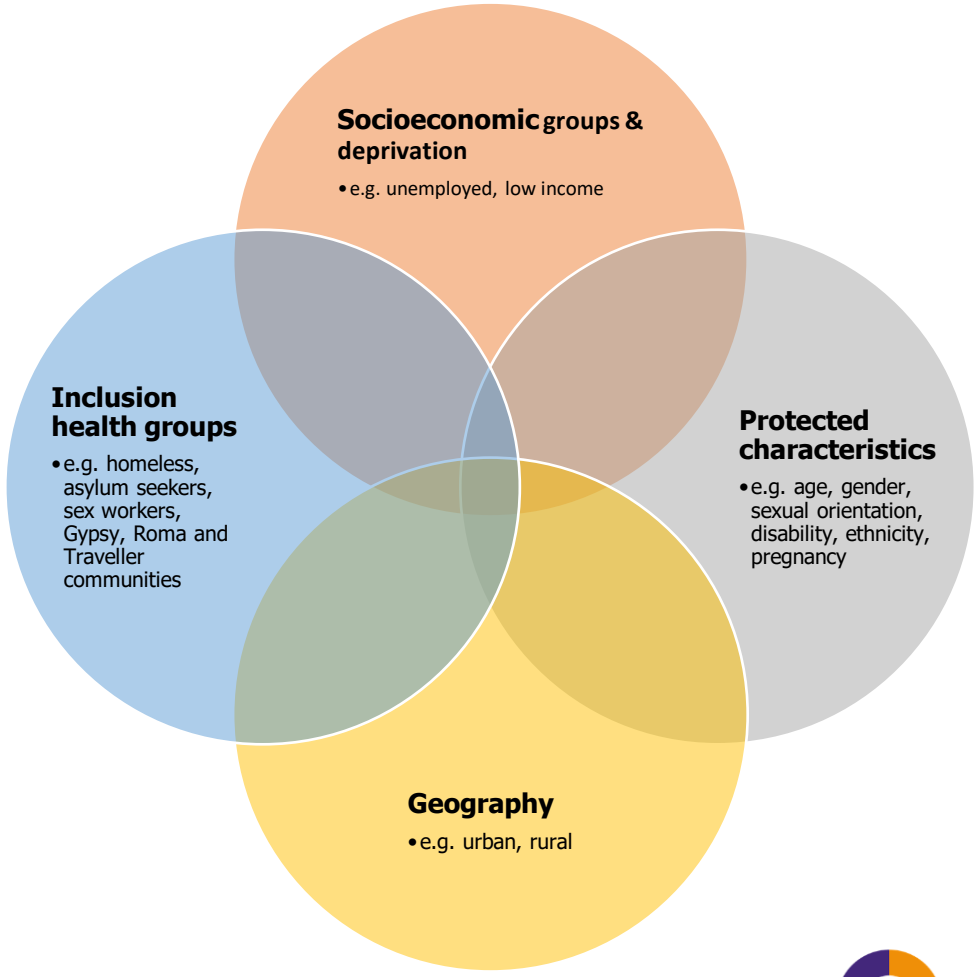
People in contact with the criminal justice system

People with alcohol and/or drugs dependency

*Slide adapted from Office for Health Improvement and Disparities (OHID)*

# Intersectionality and the role of local systems

- It is important we recognise overlapping 'domains of inequalities' (see diagram on the right) to be truly inclusive
- Not just about health service access
- Looking 'upstream' is crucial to address health inequalities – housing, education, employment, social networks, access to green space – are existing programmes addressing the needs of Inclusion Health (IH) groups?
- Integrated Care Systems, by their integrated multi-sectoral nature, are well placed to address multiple health inequalities experienced by IH groups.




*Slide adapted from Office for Health Improvement and Disparities (OHID)*

# Why a health needs assessment on inclusion health?

- NHS England's "National framework for NHS – action on inclusion health" [1] 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 aims to contribute to the 2nd inclusion health principle.

**Figure 1: Principles for action on inclusion health**

# What is a health needs assessment (HNA)?

Systematic approach to identifying the unmet health and care needs of a population and making recommendations to address those needs [3].

Epidemiology:
- What is the population?
- What is the health need?
- Emerging findings

Comparative:
- What works?
- What do we currently do?
- Emerging findings

Corporate:
- What do stakeholders and community think?

Emerging gaps

Recommendations

# Purpose of health needs assessment (HNA)

- Look at health inequalities through an inclusion health lens
- Estimate **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: Epidemiology

**What is the population? What are the health needs?**

# 2.1 Epidemiology: What is the Population – summary of all groups 1/3

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

# 2.1 Epidemiology: Emerging Findings – Population – summary of all groups 2/3

- 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 England average, whilst Craven has one of the lowest rates of homelessness compared with other districts in North Yorkshire.
- Absolute number of Asylum Seekers and Refugees accommodated in Bradford District highest in Yorkshire and Humber region, but relatively the second highest 'per 200 of population' (after Calderdale).
- There are no publicly available data on refugees other than those on 'Resettled Refugee' Home Office programmes.
- The Roma Strategy indicates the actual (Eastern European) Roma population in Bradford District may be between 8 and 12 times higher compared to official ethnicity counts such as the Census 2021.
- 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.

# 2.1 Epidemiology: Emerging Findings – Population – summary of all groups 3/3

- Little is known about the size of the indoor sex working population in Bradford District and Craven (BD&C) as these are less known to services. Around 85 on-street sex workers engage with the Lotus Project.
- Modern slavery figures only count victims that are on West & North Yorkshire Police's radar and therefore there is a huge underestimate compared to the overall size.
    - These risks overlap with Vulnerable Adults Exploitation e.g. Albanian, Vietnamese nationals and cuckooing
    - Overlap with Sex Work and Vulnerable Migrants, which involves coercion and trafficking, as analysis from Birbeck University of London suggests that migrants make up the majority of indoor workers
- 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 no estimates for Craven.
- Alcohol and opiate and/or crack cocaine dependency in Bradford District are higher than the England average.
- 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).

# 2.1 Epidemiology: Emerging Findings – Population:
## Intersectionality and Multiple Disadvantage

Figure 1: Overlap of SMD disadvantage domains, England, 2010/11


SMD 3
**58,000**

SMD 2
**164,000**

SMD 1
**364,000**

TOTAL
**586,000**

Around 10% of people who are homeless, offending, or substance users are estimated to have all three Severe and Multiple Disadvantage (SMD) domains (38% have two or more) [21]. Intersectionality or overlap between IH groups means we cannot simply add numbers up.

# 2.1.1 Homelessness - national

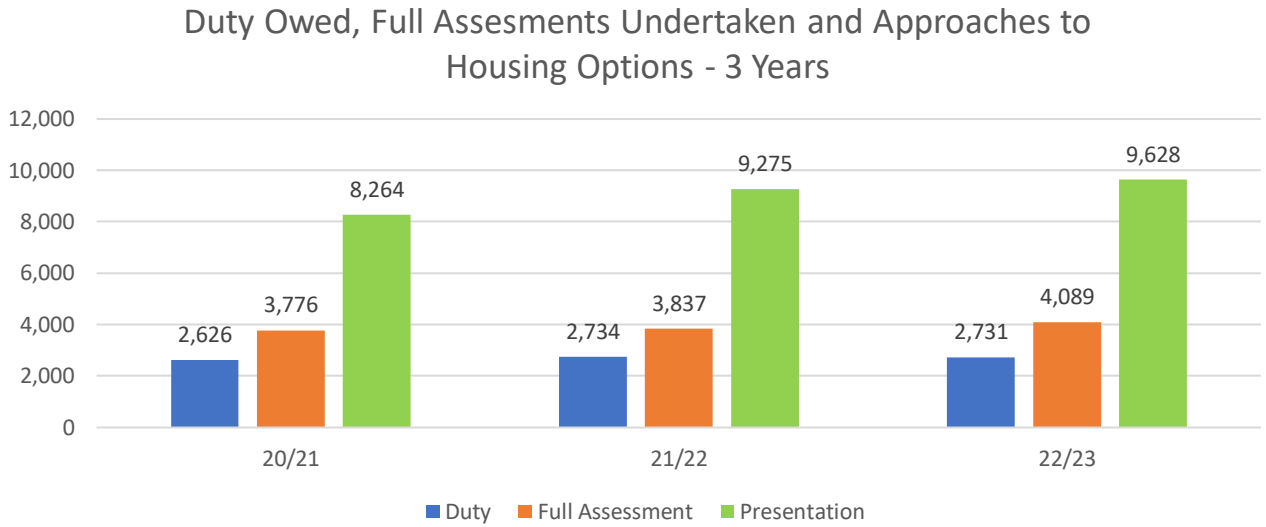
- It is not possible to estimate "hidden" homelessness across the UK because of known complexities in reaching this population group.
- Evidence suggests that some population groups, such as women, young people and ethnic minority groups, are more likely to experience "hidden" homelessness than others.
- Office for National Statistics (ONS) [4] definition includes people who are experiencing homelessness or housing difficulties, regardless of legal definitions or entitlement, but who are not supported by their local authorities or counted in official statistics. This could include people who:
    - choose to not approach local authorities for assistance
    - approach local authorities but do not receive a response that meets their needs
    - find an alternative solution outside of the formal system of housing support and provision
    - do not necessarily identify as homeless

Estimates are based on the following data sources: rough sleeping, sofa surfing, overcrowded households, concealed households, non-permanent or non-standard structures (e.g. caravan, tent), squatting.

# 2.1.1 Homelessness – local (Bradford)

***What is the population?***

- 2680 households were owed a Prevention or Relief duty between April 2021 and March 2022 [5].
- Of these:
  - 1790 (67%) were owed a Prevention duty
  - 890 (33%) were owed a Relief duty
- 'Prevention or Relief Duty owed' has risen slightly between 20/21 and 22/23 – see bar chart on the right [6]
- Presentations to Housing Options continue to rise year-on-year, i.e. 17% between 20/21 and 22/23

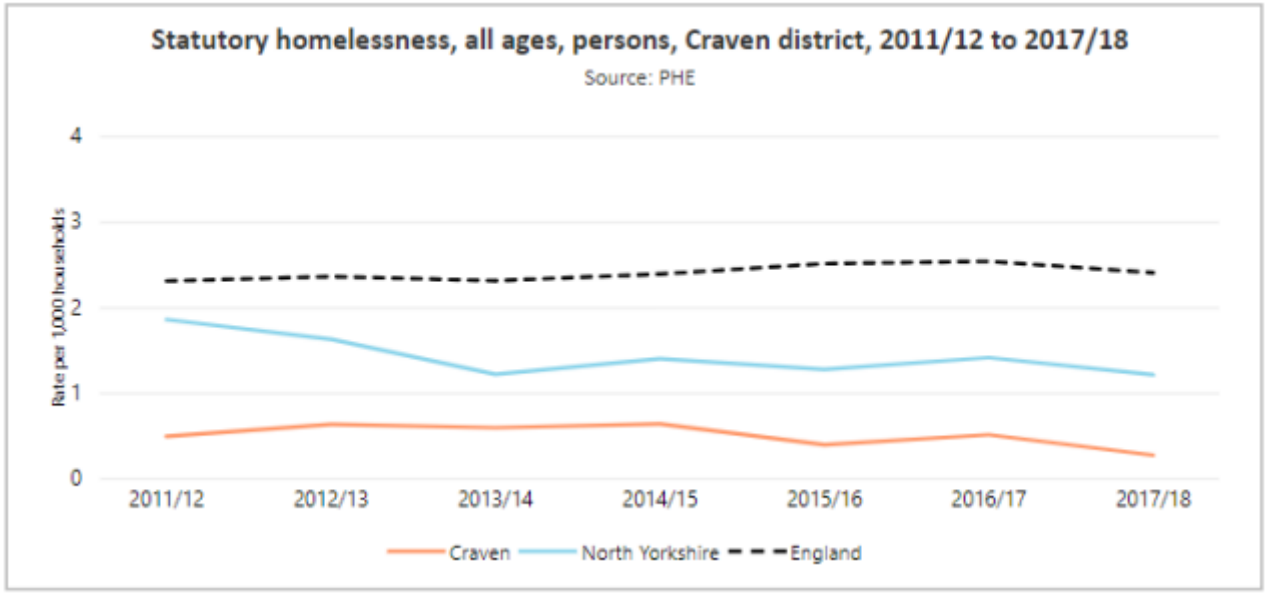



- Top reasons for loss of settled accommodation is that 'friends or family are unable or unwilling to accommodate', or 'end of private rented tenancy'

- Rough sleeping: Latest snapshot in February 2024, counted 40 rough sleepers in Bradford (including 10 with No Recourse to Public Funds)

# 2.1.1 Homelessness - local (Craven)

- The rate of households who are homeless has decreased in Craven since from 2015/16 and 2017/18 and is below both England and county averages.
- Craven has one of the lowest rate of homelessness compared with other districts in North Yorkshire.
- 59 households assessed as homeless April 2022 – March 2023.
- Reasons for loss of settled accommodation are 'family and friends no longer willing to accommodate' (32%) and 13 'domestic abuse' (22%).
- On a single night in Autumn 2022, there were an estimated 9 rough sleepers in Craven.




*Slide produced by RIA in 2023, for Craven Community Partnership*

# 2.1.2 Migration overview - local

Bradford District [7]:

- In 2021, 18.7% of Bradford's population was born outside the UK.
- Bradford has the lowest proportion of UK born residents of all local authorities within Yorkshire & Humber, but only marginally less than the figure for England as a whole.
- All wards (except Worth Valley) saw an increase in the percentage of residents born in the Middle East or Asia
- 6.5% of Bradford's population had arrived in the UK in the 10 years prior to the 2021 census.
- This inflow positions Bradford in 4th place within Yorkshire & Humber, behind Leeds, Hull (both 7.5%) and Sheffield (7.3%), with the proportion nationally at 7.3%

Craven [8]:

- In 2021, 5% of Craven's population was born outside the UK
- 2.8% of the population is from Black, Asian and minority ethnic group (same as North Yorkshire overall but significantly lower than England 15%)

# 2.1.2 Vulnerable Migrants: Asylum Seekers, Refugees (AS/R), Unaccompanied Children - local

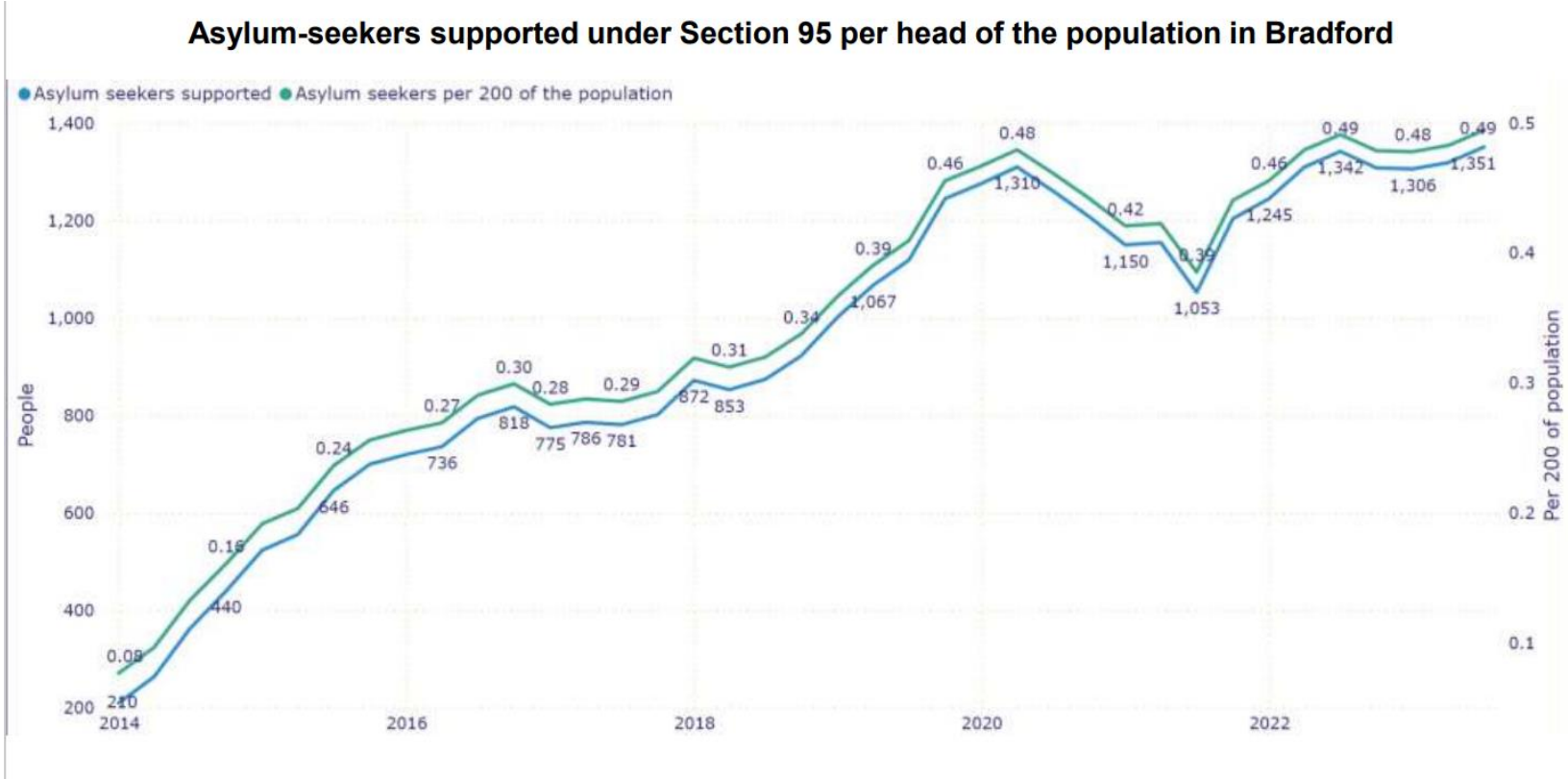
*What is the population?* [9, 10]

| | Bradford District (at end of Dec 2023) | Craven |
|---|---|---|
| Looked after unaccompanied asylum-seeking children | 52 | Not listed |
| Asylum seekers supported under Section 95 and Section 4 | 1,896 | 0 |
| Asylum seekers in dispersed accommodation | 1300 | 0 |
| Asylum seekers in contingency accommodation | 532 | 0 |
| Resettled refugees | 795 | **Not listed** |

North Yorkshire County Council has stats on resettled refugees e.g. around 100 Ukrainian, 12 Afghan, 18 Syrian. These are not available via Home Office dashboards.

NB. There is no publicly available data on number of people that have received their refugee status/right to remain.

# 2.1.2 Vulnerable Migrants – Asylum Seekers Supported - local (Bradford) [7]




- The number of Asylum Seekers supported in Bradford District has risen 7-fold in the last 10 years.
- The rate of Asylum Seekers per 200 of population has increased from 0.08 (1 in 2500) in 2014 to 0.49 (1 in 408) in 2024.
- Bradford accommodates the highest *number* of supported asylum seekers in the Yorkshire & Humber Region (2nd highest as 'per 200 of population')

# 2.1.3 Gypsies and Travellers - local

*What is the population?*

- 0.2% (~1100) self-reported Gypsy or Traveller as ethnicity in Bradford District, as per 2021 Census [11]
- In addition, 50 people from Craven indicated that their ethnicity was “White: Gypsy or Irish Traveller”
- Real figures most likely to be 2-3x higher [12]

- Gypsy and Traveller communities are identified for protection under the Equality Act 2010.

- Historically, Gypsy and Traveller groups largely followed a nomadic lifestyle in the UK, however around three-quarters of the population now live in settled accommodation, with around one-quarter living in caravans or mobile homes.

# 2.1.4 Eastern European Roma - local

*What is the population?*

- 0.3% (~1600) self-reported Roma as ethnicity in Bradford District, as per 2021 Census [11]
- In addition, 13 people from Craven indicated that their ethnicity was “White: Roma”
- The Roma Strategy estimated that between 13,000-20,000 Eastern European Roma reside in Bradford District.

- The Roma population of Bradford is not a single community. Roma from different countries and regions have cultural differences. Most Bradford Roma are of Slovak origin but there are also Czech, Hungarian, Latvian, Polish and Romanian Roma [13].

- Roma communities are identified for protection under the Equality Act 2010.

- Roma communities are no longer nomadic and usually live in conventional housing.

# 2.1.5 People in contact with criminal justice - local

*What is the population?*

- For the purpose of this HNA, only those supervised by Probation have been included, serving a community sentence, in custody, or those on license. Figures do not include Police or Youth Justice statistics.

- 3824 for Bradford District and 55 for Skipton is the total number of people Probation is responsible for in the Bradford & Craven area (as of Nov 2023).

- The table below shows that 30% of those on Probation in Bradford District are in custody, with the remaining 70% on Community Sentence or Released on License [14].

| Bradford LDU Cases - Order Category | Total Cases | Oasys Found No | Oasys Found Yes | | %Oasys Found No | %Oasys Found Yes |
|---|---|---|---|---|---|---|
| Community Sentence | 1770 | 513 | 1257 | | 28.98% | 71.02% |
| Released On Licence | 911 | 131 | 780 | | 14.38% | 85.62% |
| In Custody | 1143 | 622 | 521 | | 54.42% | 45.58% |
| Bradford Total | 3824 | 1266 | 2558 | | 33.11% | 66.89% |

# 2.1.6 Sex workers - local

*What is the population?*

- Nationally, it is unclear how many people are engaged with sex work. Estimates range from 105,000 to 72,800 and it is widely thought that up to 88% of these are women [15].
- The Lotus Project in Bradford have 85 clients on their case load but see around 130 women. These are primarily on-street sex workers [16] Case load between 2020-23 was consistently around the high 60s and low 70s.
- Little is known about numbers of people engaged in indoor/remote sex work – some engage with Lotus, some are picked up through human trafficking investigations etc.
- No data has been available on sex workers in the Craven area.

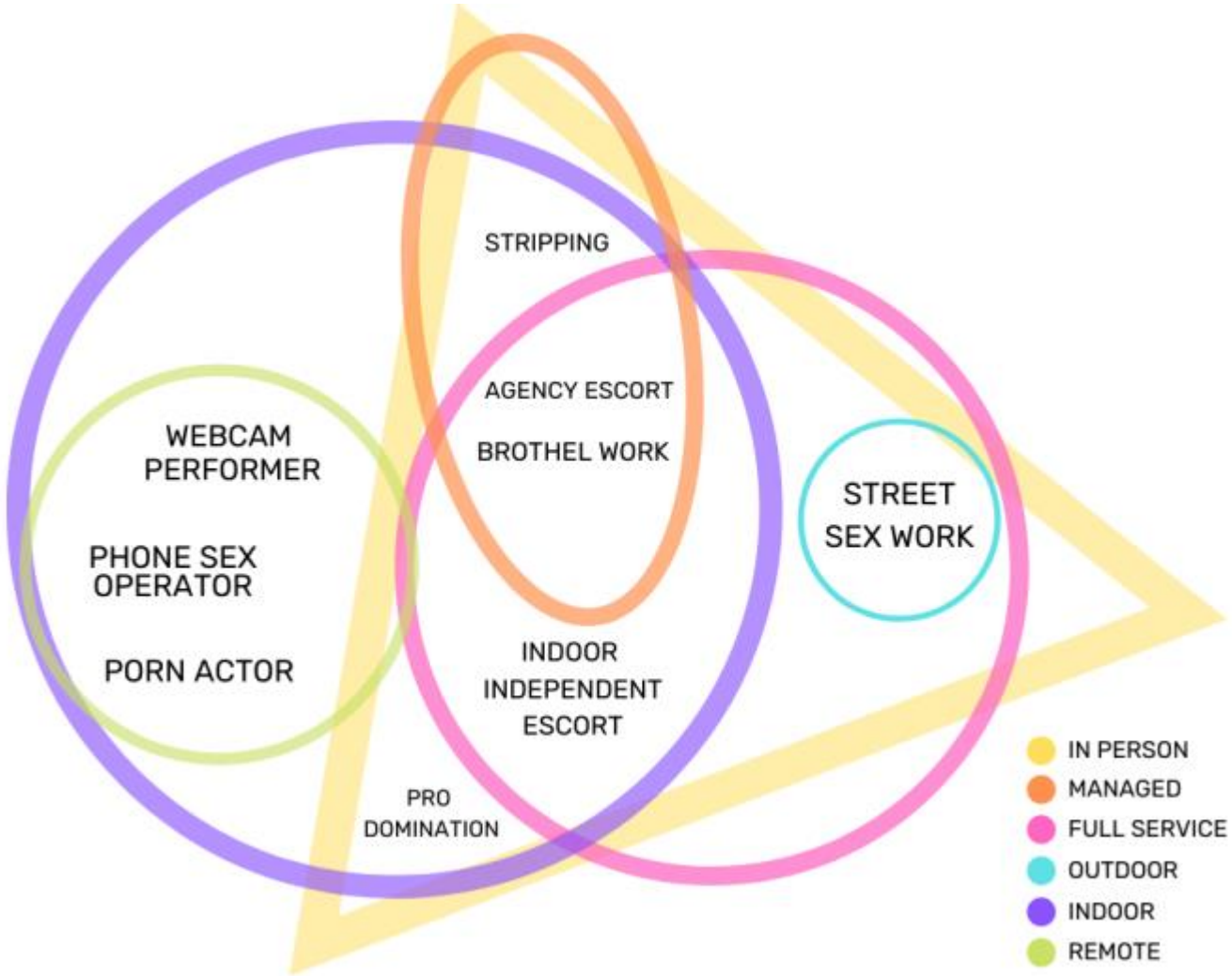
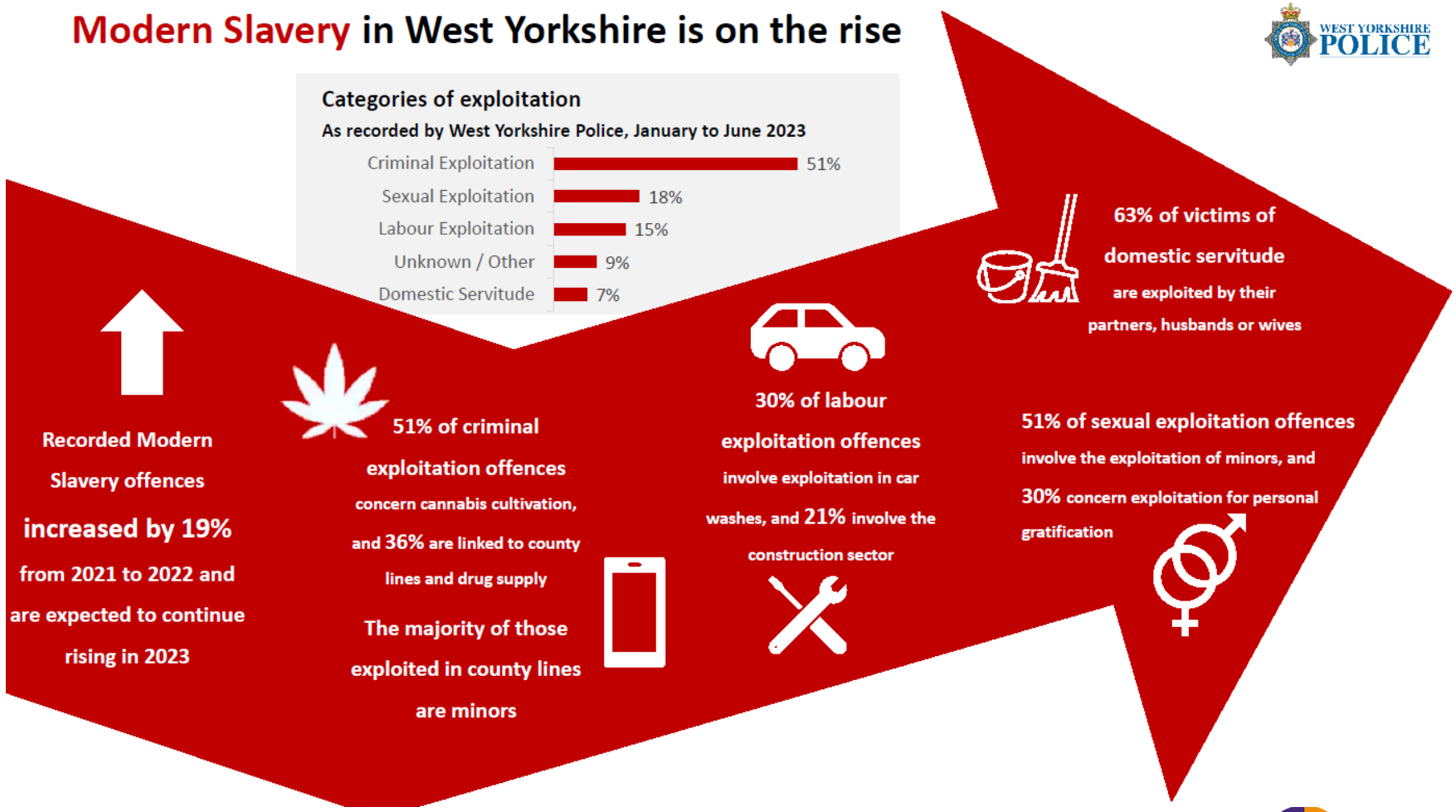



Diagram representing various 'sectors' of sex work [17]

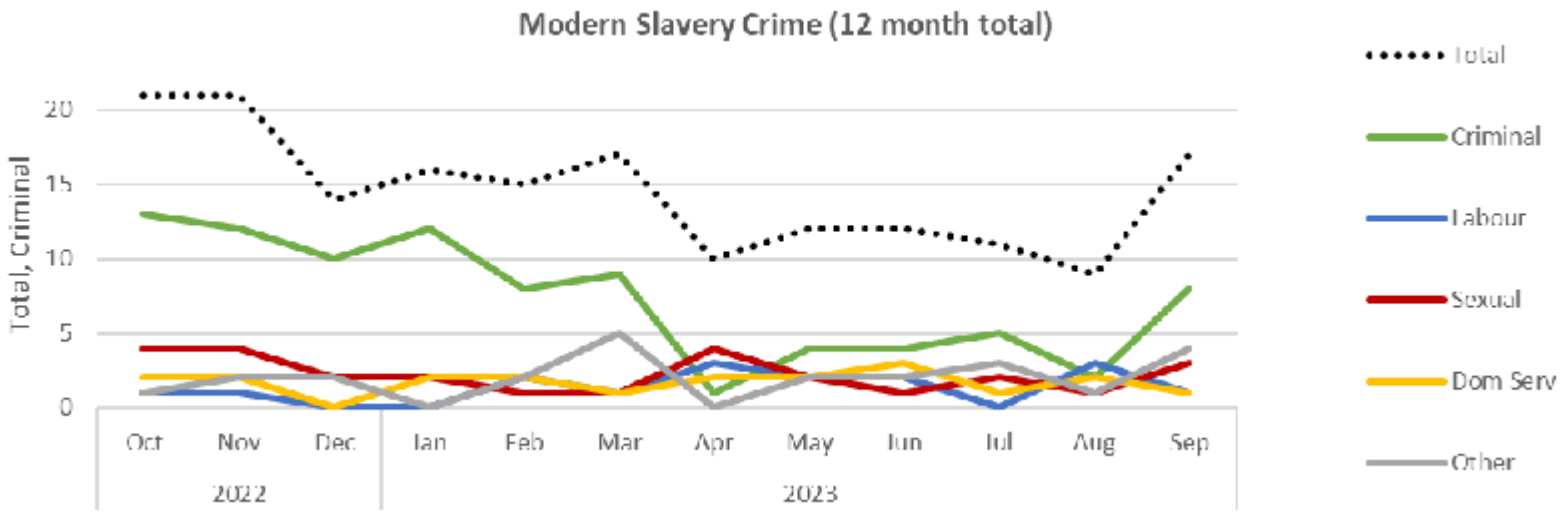
# 2.1.7 Modern Slavery and Human Trafficking - regional

Main types of modern slavery (MS) are:

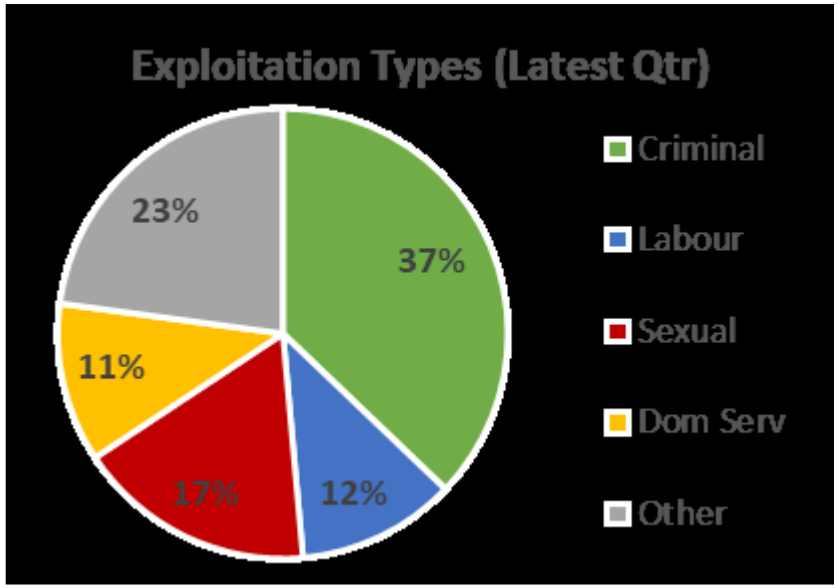
1. Criminal exploitation (e.g. shop lifting, begging, County Lines (drug running)
2. Sexual exploitation (commercial sex industry)
3. Labour exploitation (work for little or no pay)
4. Domestic servitude (working in a household where they are ill-treated)
5. Removal of organs (organ harvesting)



# 2.1.7 Modern slavery – local




Graph (above) and pie chart (right) representing West Yorkshire Police MS offences for Bradford District




*What is the population?*

- 37 MS offences recorded in Bradford District (24% out of 152 offences in West Yorkshire) during Quarter 3 (excluding CSE-related crime) [18]
- Criminal exploitation was most common (37%), followed by 'other' (23%), and sexual exploitation.
- Criminal exploitation offences have increased, with cannabis cultivation, county lines and drug supply continuing to be the most recorded type of offending.

- North Yorkshire Police recorded 2 MS offences in Craven during 2023, no details on type of exploitation.

# 2.1.8 Drugs and Alcohol Dependency - local

*What is the population?*

Alcohol and drugs dependency estimates are not available for Craven as these figures are included in North Yorkshire estimates. The data below only relates to Bradford District.

- Alcohol dependency estimate [19] was 5744 people
- 1.45% based on adult population of 395,168
- Higher than England estimate which was 1.37%
- Alcohol dependency is slightly decreasing, when comparing to data from previous years.

- Opiate and/or crack cocaine use (OCU) estimate [20] was 4868 people
- 1.44% based on population of people aged 15-64: 338,353
- Higher than England estimate which was 0.95%
- OCU dependency is slightly decreasing, when comparing to data from previous years.

There are no local estimates for other drug use such as cannabis, legal highs etc. These are only available at national level through the Crime Survey for England and Wales, published on the Office for National Statistics website.

# 2.2 Epidemiology: Emerging Findings – Health Needs – summary of all groups 1/2

- Life expectancy of the Homeless population is more than 30 years less than that of the general population. This is largely down to 'tri-morbidity' of (a multitude of) physical and mental health issues as well as substance misuse.
- Diagnosed mental health conditions in the homeless population have almost doubled since 2012, according to the Homeless Health Needs Audit.
- Asylum seekers and refugees' health needs relate to untreated communicable diseases, poor mental health (e.g. 1 in 5 will have depression, anxiety, post-traumatic stress disorder, bipolar disorder or schizophrenia), poorly controlled chronic conditions and maternity care.
- Mental health issues among asylum seekers and refugees appear to be under-reported, according to a snapshot of local GP practice data.
- People identifying as Gypsies or Irish Travellers self-report the highest levels of "bad or very bad health" compared to people of other ethnic backgrounds
- Lack of knowledge of the UK healthcare system is a common theme for Asylum Seekers and Refugees as well as Vulnerable Migrants such as Roma.

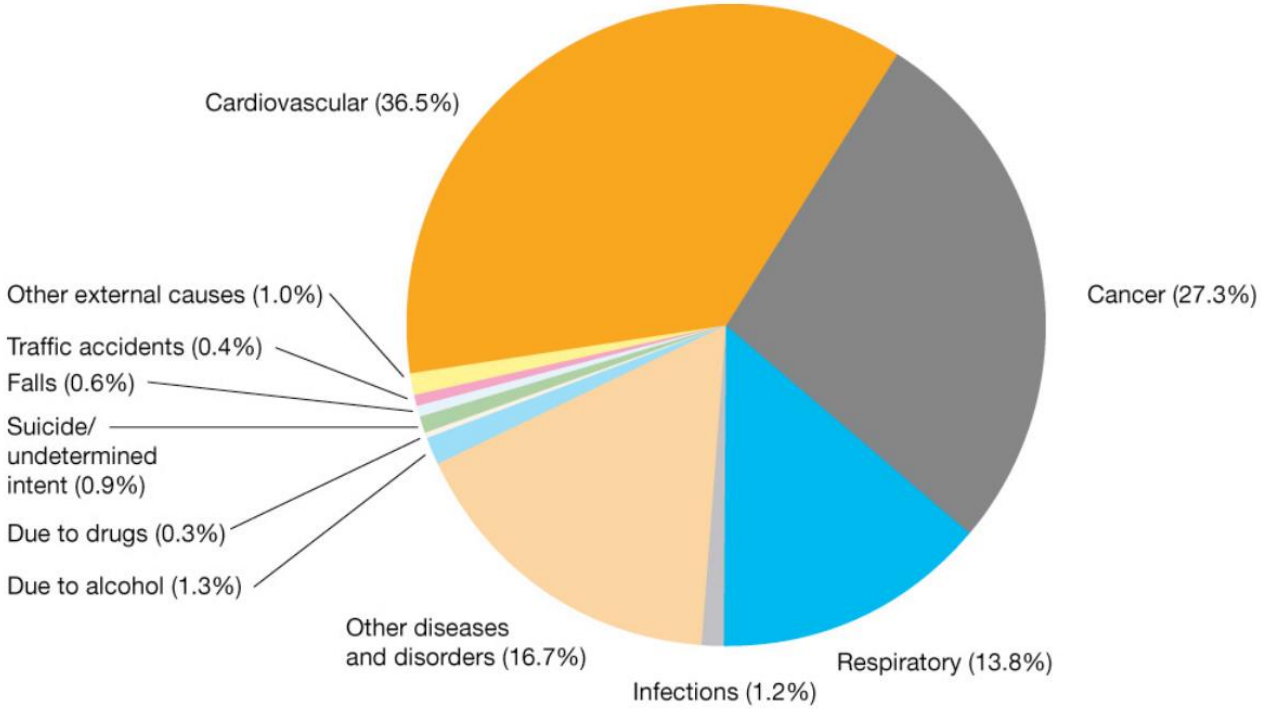
# 2.2 Epidemiology: Emerging Findings – Health Needs – summary of all groups 2/2

- On street sex work, substance misuse and enduring mental health problems go hand in hand.
- 57% of people on Probation self-report that they have a physical and/or mental health condition – this is better than anywhere else in Yorkshire & Humber but twice the Bradford District average (based on similar question in Census 2021).
- 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.
- Similar to homelessness, substance misuse increases the risk of suicide.
- 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%).
- For women in Craven, the rate of alcohol hospital admissions was the highest in Yorkshire and Humber.

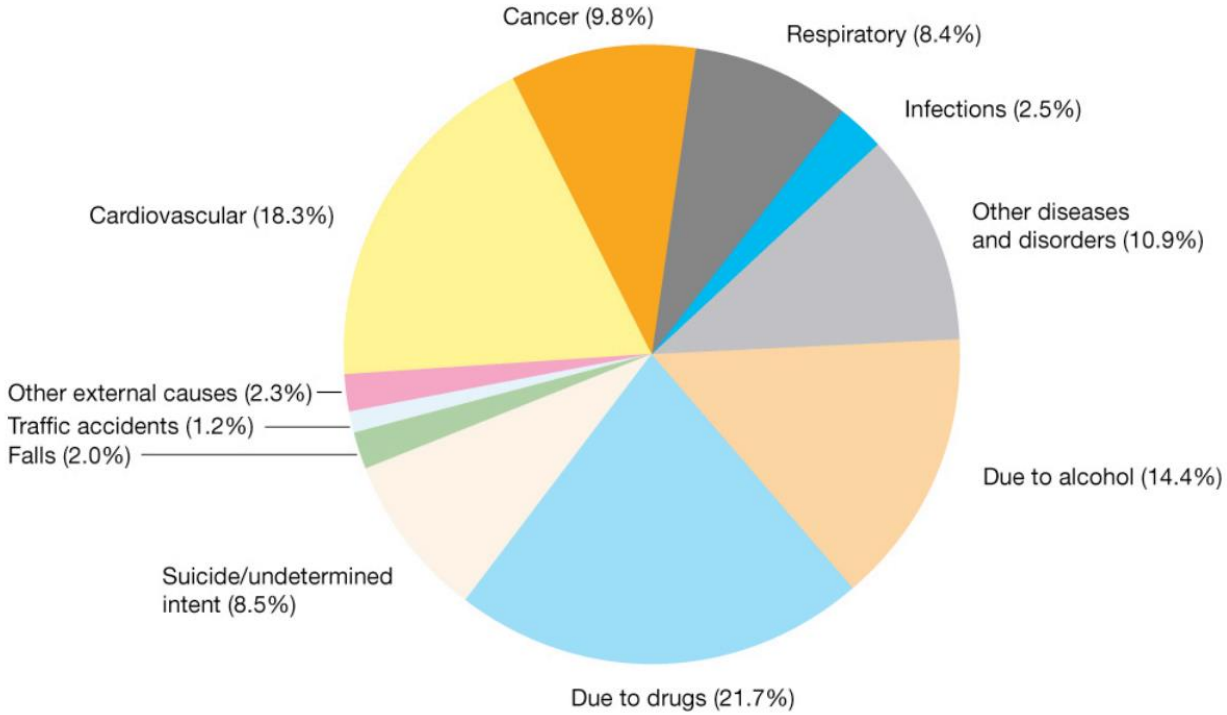
# 2.2.1 Homelessness – national

Between 2013 and 2020, the mean age of death was 45.9 for males, 41.6 for females. **This is a more than 30 years difference to the general population** (ONS 2020)

This group is at greater risk of CVD, respiratory and digestive disease [22,23] compared to those in lowest socio-economic group with a home, and a third of deaths may have responded to timely health care (e.g. infections, ulcers).




Causes of death for general population (Crisis 2011)




Causes of death for homeless people (Crisis 2011)

*Slide produced by Public Health Devon, Devon County Council (2022)*

# 2.2.1 Homelessness – national

Homeless Health Needs Audit (2022) [24]:

- 73% reported having a physical health condition:
    - 37% joint aches/problems with bones and muscles
    - 36% dental/teeth problems
    - 24% asthma
    - 22% difficulty seeing/eye problems
- Comorbidities: 29% reported between 5 and 10 different physical health diagnoses
- 44% of deaths in homeless people were caused by substance use or suicide, compared to 2.5% in the general population [23].

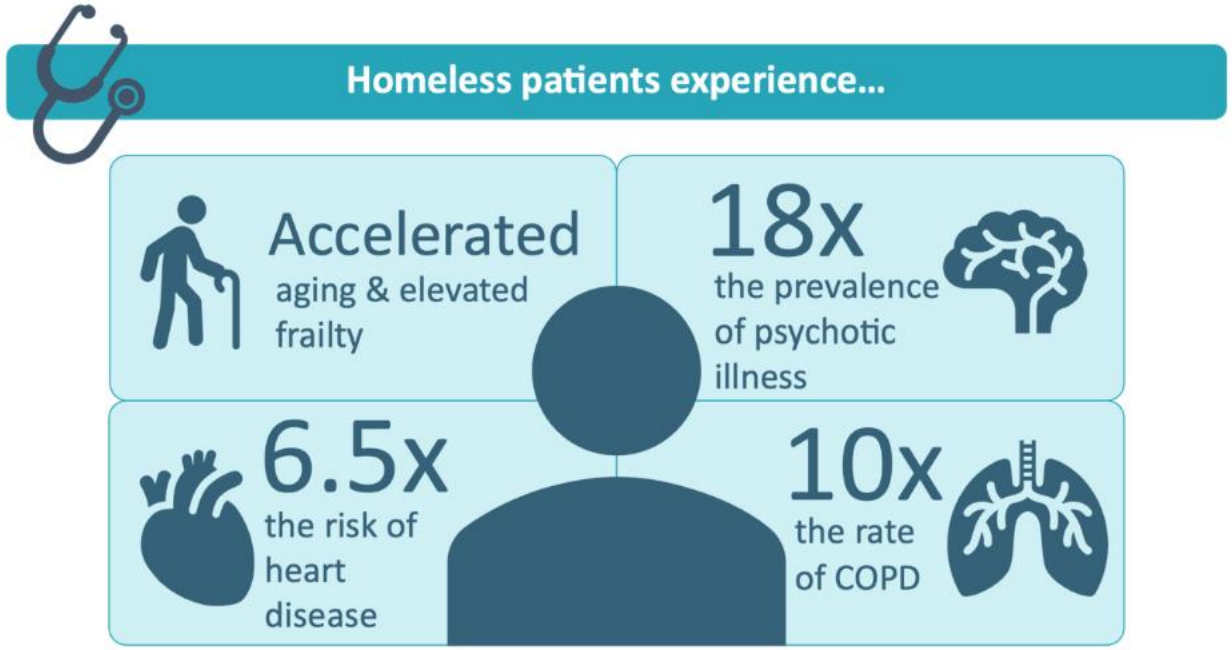


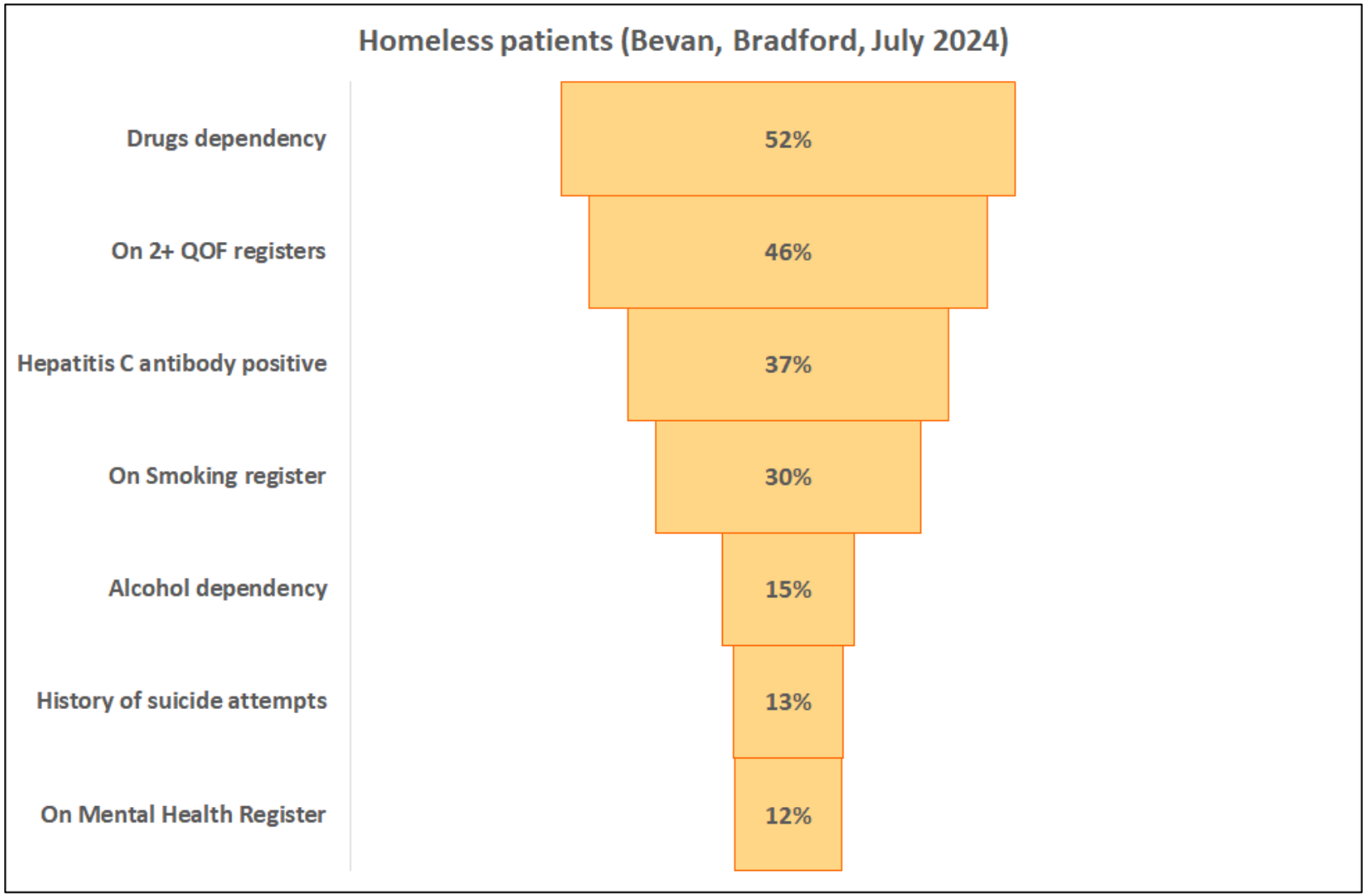

**Figure 1 Common conditions and homelessness**
Government guidance for hostels and day centres not helping, Pathway, 17 March 2020

- People experiencing homelessness are at a higher risk of ending their lives by suicide than the general population [25].

# 2.2.1 Homelessness - national [24]

- 82% had a diagnosed mental health condition (compared to 45% for the first audit in 2012-14) and compared to 12% in the national population
  - 72% depression; 60% anxiety disorder or phobia; 25% dual diagnosis with drug or alcohol problem; 22% PTSD, often caused by Adverse Childhood Experiences (ACE).
  - Comorbidities – 81% experiencing comorbidities, mostly 2 or 3
  - 45% said they self-medicating with drugs or alcohol to help them cope with their mental health
  - 38% self-identified as having, or recovering from, a drug problem; self-reported problematic alcohol use was 29%
- 76% smoke tobacco (versus 14% of adults in general population) and 50% want to quit.
- 33% only eat one meal a day, on average
- Only 6% fully vaccinated against Hep B; 53% had never received a flu vaccine
- Women are much less likely to access cervical or breast screening (37% versus 62% general population)
- In relation to primary and acute healthcare e.g. GP or dental practice registration refusal, high use of emergency healthcare services are issues
- Public Health Devon highlighted a gap regarding data on neurodiversity and acquired brain injury among the homeless population [22].

# 2.2.1 Homelessness - local




Caveat: this is data from one GP practice, Bevan Healthcare CIC, a specialist in Inclusion Health. It represents those that were coded homeless without a more recent code that said they are housed. Homelessness status fluctuates so it can quickly become out of date. In practice, it does not tend to be frequently checked and updated on patient records. This data should therefore be interpreted with caution and it cannot be interpreted as prevalence of health conditions among the entire homeless patient population in Bradford District and Craven.

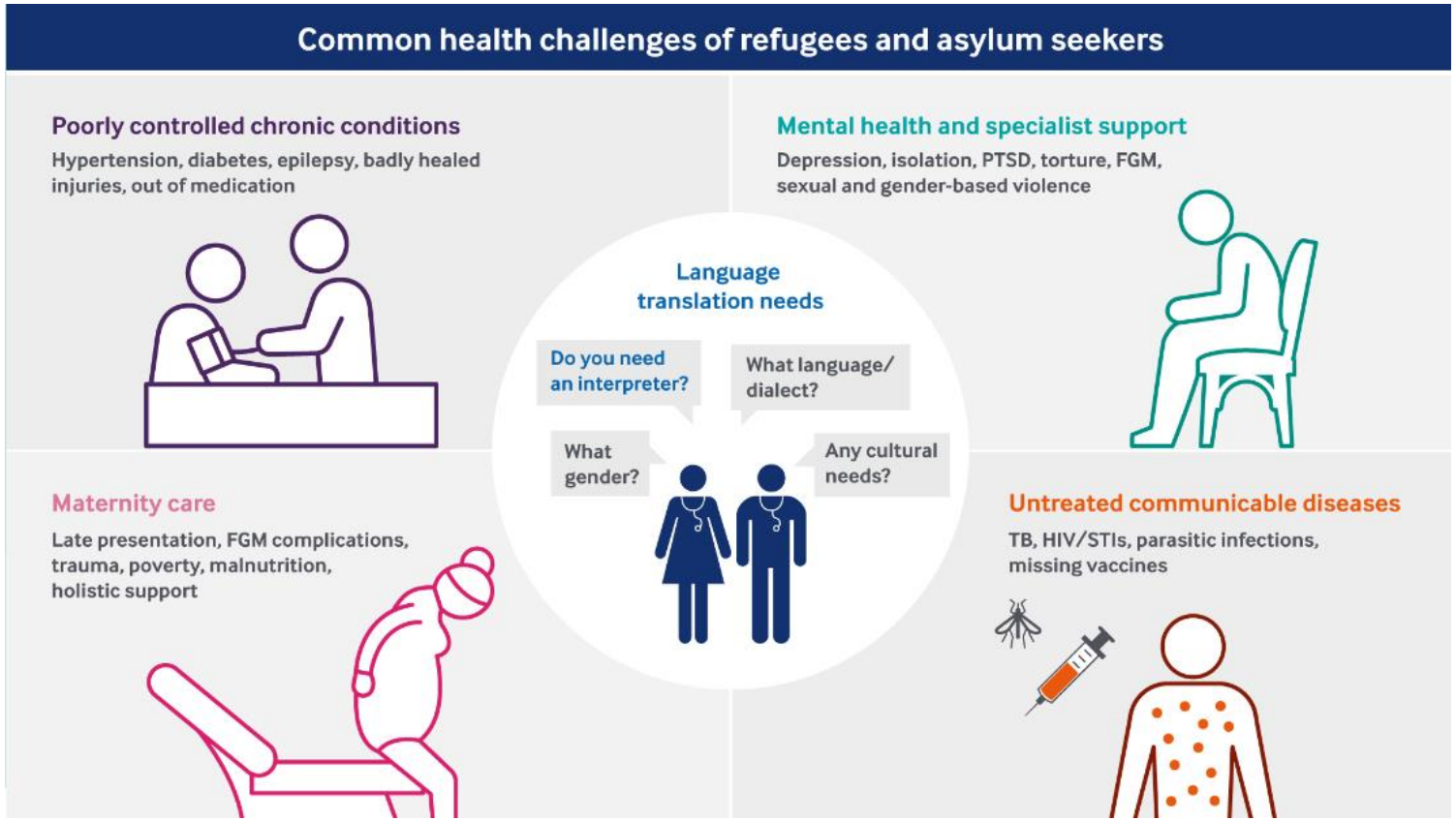
- High prevalence of drug dependency and other addictions
- High prevalence of multimorbidity
- 29% of homeless people also coded as asylum seeker or refugee
- 12% on Mental Health register (1% in general population)

# 2.2.2 Vulnerable migrants: Asylum seekers and refugees - international

*What are the health needs? International data*

- Refugees and asylum seekers may have been exposed to traumatic events such as conflict, loss or separation from family, a life-threatening journey to safety, long waiting periods, and complexities with acculturation [27], which all contribute to 'migration trauma'.
- Almost all people who have been affected by emergencies (for example, war and conflict, environmental disasters) will experience psychological distress [26].
- Among those who have experienced war or conflict in the past 10 years, 1 in 5 will have depression, anxiety, post-traumatic stress disorder, bipolar disorder or schizophrenia. 1 in 11 will have a moderate or severe mental health disorder. [26]
- Estimated prevalence of PTSD and Depression for adult asylum seekers and refugees is 31-32%. [27]

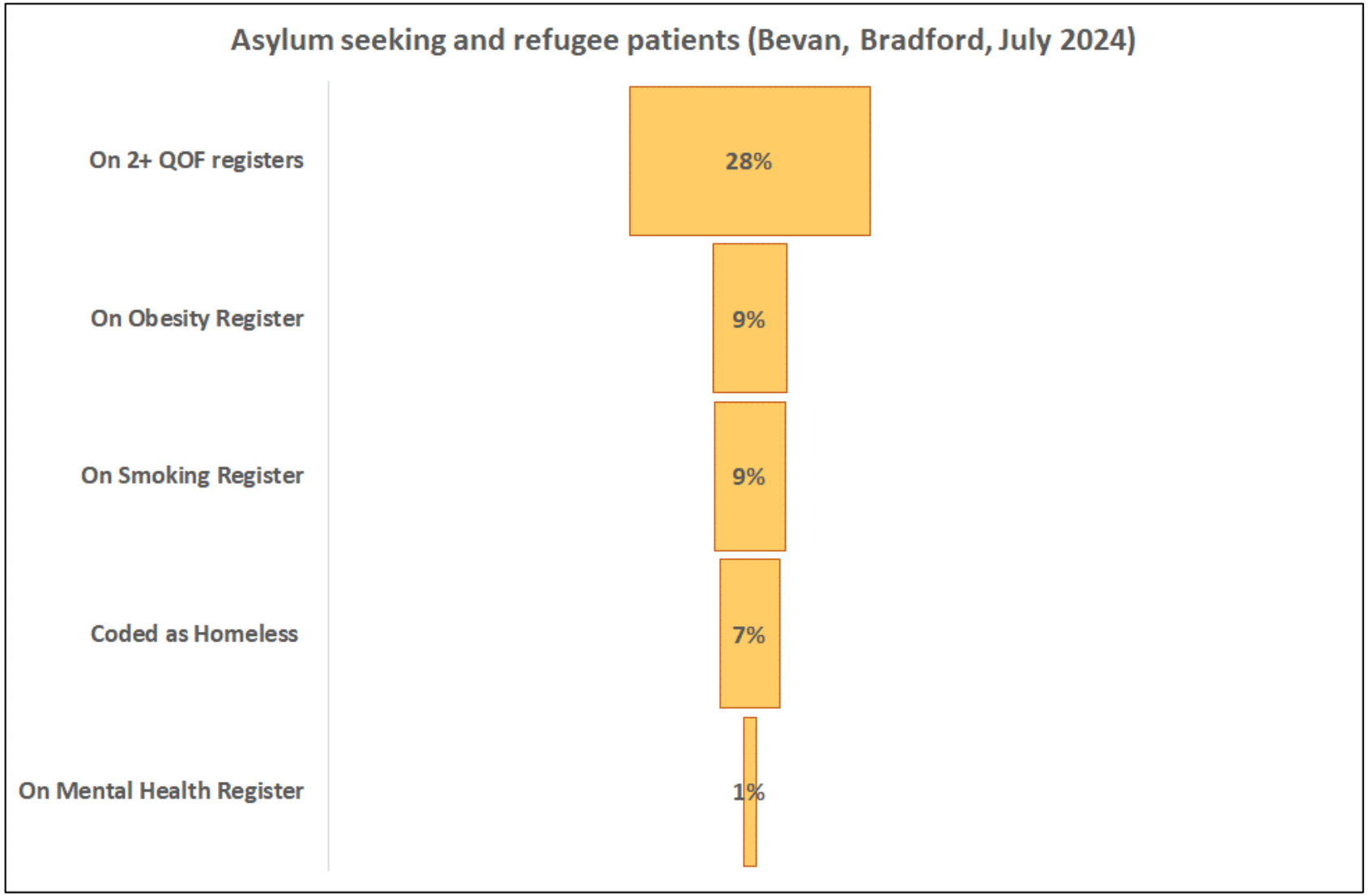
# 2.2.2 Vulnerable migrants: Asylum seekers and refugees – national [28]




For children, additional physical and mental health needs were identified [55]:
- Malnutrition
- Obesity
- Anaemia
- Musculoskeletal complaints
- Oral disease
- Adolescent pregnancy

Restrictive immigration policies, health system challenges and service provider barriers to care are having a negative impact on children's health [55].

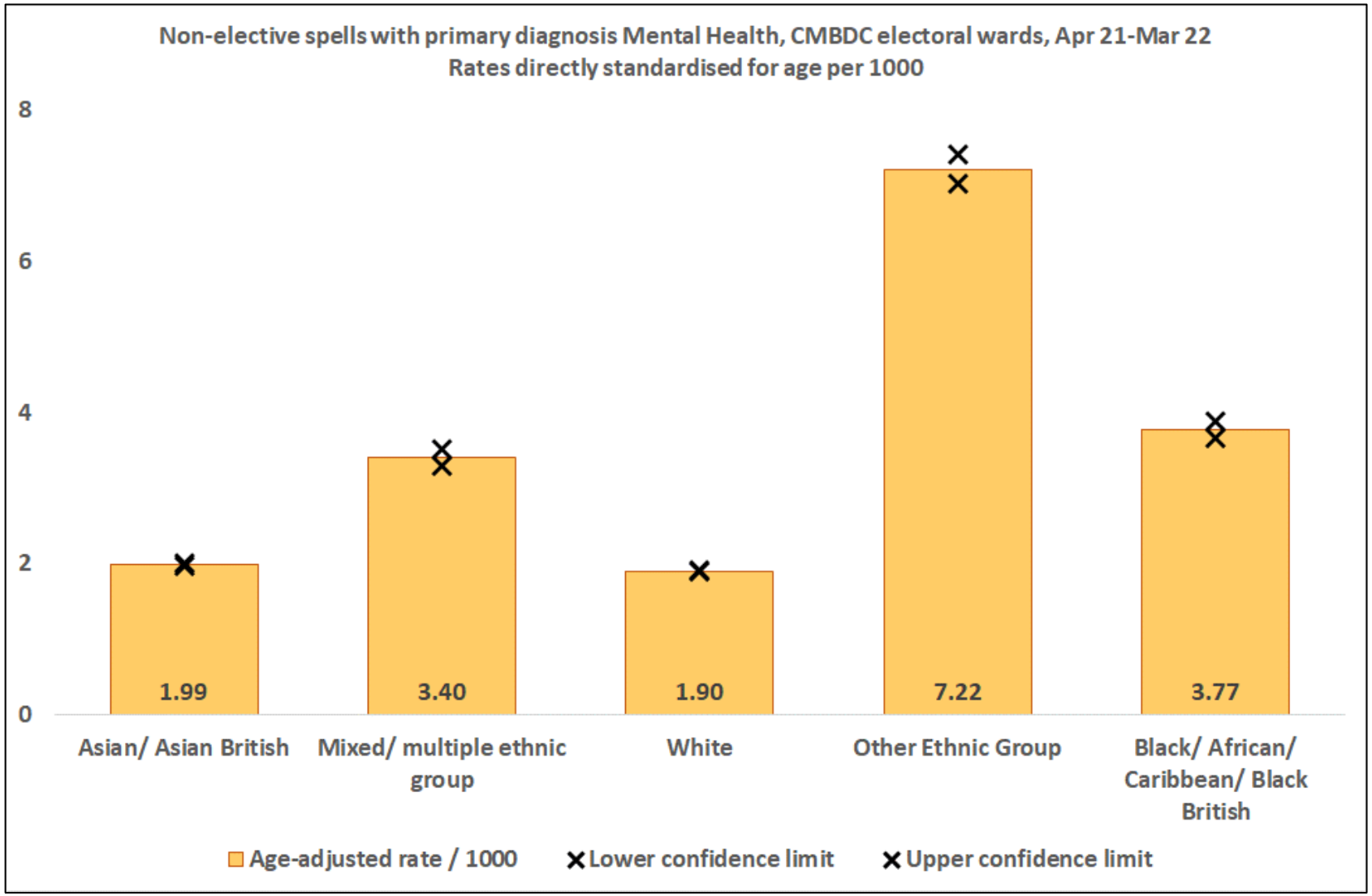
# 2.2.2 Vulnerable migrants: Asylum seekers and refugees - local




Caveat: this is data from one GP practice, Bevan Healthcare CIC, which is a specialist in Inclusion Health. Some relative assumptions can be made based on this data, but it cannot be interpreted as prevalence of health conditions among the entire asylum seeker and refugee patient population in Bradford District and Craven.

- Diagnosed prevalence of multimorbidity similar to general population (estimated 25% in England)
- Obesity and smoking appears less than general population (Obesity 13.4%, Smoking 17.6% in Bradford and Craven)
- 7% coded as Homeless
- 1.4% (45/3235) on MH register and 0% (1 person) on Depression register (estimated prevalence of PTSD and Depression for adult asylum seekers and refugees is 31-32%) [27]

# 2.2.2 Ethnicity and non-elective mental health spells - local




- Graph shows significantly high rate of non-elective spells with primary diagnosis Mental Health for Other Ethnic Group (very high), Black / African / Caribbean / Black British and Mixed / Multiple ethnic group
- Many asylum seekers and refugees are from backgrounds classified as Other Ethnic Group and Black African

# 2.2.3 Gypsies and Travellers - national

The Gypsy and Traveller population faces the lowest life expectancy of any ethnic minority group, between 10-25 years less than the English average.

*What are the health needs? National evidence* [12]*:*

- Poorer general health and higher rates of limiting long-term illness, pain and disability
- Higher reported miscarriage rates and child death
- Higher self-reported anxiety, depression, and suicide
- Higher self-reported rates of respiratory, chest and musculoskeletal symptoms (including asthma, bronchitis, chest pain and arthritis)
- Lower reported registration with GPs, but higher reported interactions with health visitors, midwives and social workers, who may be more likely to visit the home setting.

# 2.2.3 Gypsies and Travellers - local

There is no data available on the Gypsy and Traveller population in Craven as numbers are estimated to be very small and people tend to live in settled housing, there are no sites. Data below relates to Gypsies and Travellers in Bradford District.

Figure 1: Common mental and physical health issues among the gypsies/travellers in Bradford District [12]

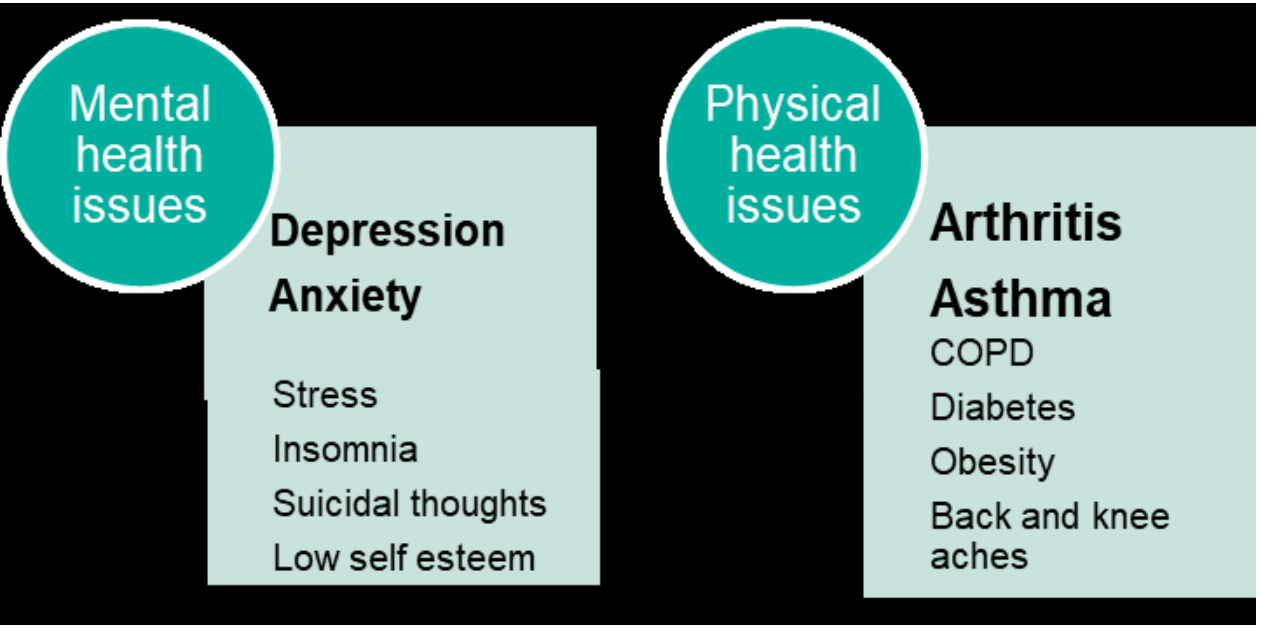
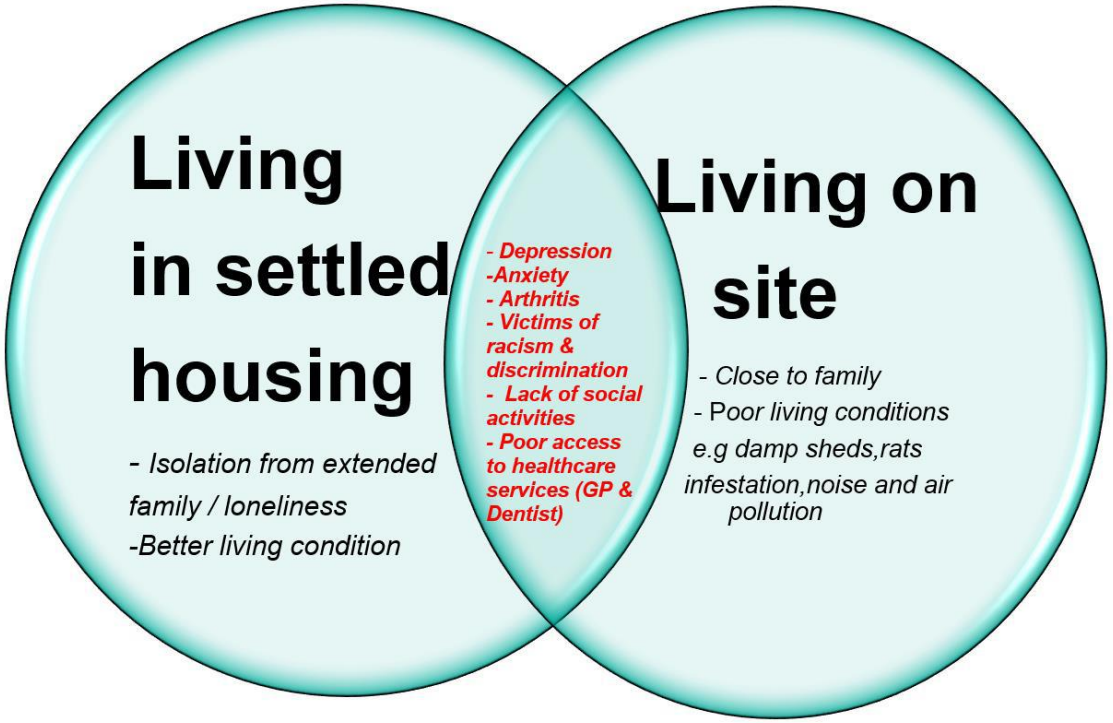



Figure 2 : Common themes among Gypsies and Travellers living on site and those living in settled housing in Bradford District [12]



# 2.2.3 Gypsies and Travellers – local [12]

- In Bradford district, people identifying as Gypsies or Irish Travellers self-report the highest levels of "bad or very bad health" compared to people of other ethnic backgrounds [10] – see table:

| Ethnic category | % of people reporting bad or very bad health |
|---|---|
| White: Gypsy or Irish Traveller | 11.0% |
| White: Irish | 8.7% |
| Black, Black British, Black Welsh, Caribbean or African: Caribbean | 7.5% |
| White: English, Welsh, Scottish, Northern Irish or British | 6.2% |
| Asian, Asian British or Asian Welsh: Pakistani | 5.2% |
| Other ethnic group: Arab | 5.0% |
| Asian, Asian British or Asian Welsh: Bangladeshi | 5.0% |
| Other ethnic group: Any other ethnic group | 4.7% |
| White: Roma | 4.0% |

- Poor access to healthcare:
  - 71% mentioned it was difficult to get a GP appointment
  - 85% mentioned it was difficult to get access to a dentist.

- A major barrier to accessing healthcare was either lack of access to internet or inability to read and understand.

- Some do not drive, which can make access for face-to-face appointments at the GP or hospital, or reaching the pharmacy very difficult.

# 2.2.4 Eastern European Roma - national

Life expectancy up to 10 years less that of non-Roma communities in the UK [29].

*What are the health needs? National data* [30]

- Higher risk of frailty through having multiple or long term conditions at an earlier age.
- Higher rates of diabetes, hypertension and coronary heart disease at a much earlier age than normally observed – obesity is a contributory factor.
- Higher rates of obstructive airways disease (COPD), pneumonia and lung cancer – higher smoking prevalence is closely correlated.
- High rates of stress, anxiety and depression reported but low uptake of mental health services for fear of institutionalisation etc.
- Cultural conceptions of cleanliness and purity impacting on uptake of antenatal care, childbirth and postnatal care e.g. baby's immunisations and other tests.

# 2.2.4 Eastern European Roma - local

*What are the health needs? Local data* [13]

There is no data available on Roma people in Craven as numbers are estimated to be very small, the info below relates to Roma in Bradford District only.

- Smoking levels are higher than the UK average and alcohol consumption is above advised levels.
- Poor diets and obesity, linked to low income and dependency on food bank distributions.
- Fire and Rescue partners are concerned by home safety understanding e.g. fire safety.
- National research, confirmed locally, shows that failure to understand how the UK healthcare system works and how it differs from that in origin countries is a source of friction between health services and Roma patients.
- Access problems to health care in the UK, for various reasons (e.g. lack of knowledge of available services, lack of information in appropriate forms, cultural sensitivities around certain areas of health, language barriers).
- Reluctance to maintain routine contact for screening and checking, possibly due to different practice in accessing care in other countries of origin.

# 2.2.5 People in contact with criminal justice - national

*What are the health needs? National data*

- People who commit offences often have multiple and complex health needs, alongside social disadvantages such as persistent unemployment and housing problems. [31]
- Few studies have examined the health of community offenders, research indicates that their health is more similar to that of prisoners rather than that of the general population. [32]
- The risk of suicide was six times higher between 2011 and 2021 in all offenders in the community compared with the general population, which remained constant over time. [25]
- Mental health, drug dependency and chronic social exclusion are often inter-related problems of offending.
- An increased likelihood of children with special educational needs entering the criminal justice system is seen in local and national data [33]. These needs include neurodiversity, as it is estimated that up to half of the adult prison population is neurodivergent [56].
- Prisoners generally receive worse primary care than that delivered in the community [34].

# 2.2.5 People in contact with criminal justice - local

*What are the health needs? Local data* [14]

Prison and Probation services use the Offender Assessment System (OASys) to complete a risk and needs assessment. It contains one question about general health "Any physical or mental health conditions?" that people are asked to answer.

The table below outlines the 'general health' of offenders engaged with Bradford Probation's Local Delivery Unit (NB. this data is only available for North Yorkshire, not Craven alone): **57%** of people self-reported a physical and/or mental health condition.

| Local Delivery Unit | Yes | No | Answer Not Supplied | Total | Yes % | No % | Answer Not Supplied % |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| Bradford | 1457 | 1052 | 48 | 2557 | 56.98% | 41.14% | 1.88% |

# 2.2.5 People in contact with criminal justice - local

*What are the health needs? Local data* [14]

- Factors linked to offending behaviour:
  - Lifestyle 82%
  - Relationships 69%
  - Emotional Wellbeing 55.5%
  - Thinking & Behaviour 98.5%

- Drugs was a factor linked to offending – 42%
- Drug use and obtaining drugs a major activity – 11% had “significant problems”

- Alcohol: Current use a problem – 27% had “some/significant problems”
- Binge drinking/Excessive alcohol over past 6 months – 14% had “significant problems”

Unable to obtain local healthcare data as people’s offending history does not get flagged on clinical systems. The code ‘On Probation’ appears to be used by GP practices sporadically.

# 2.2.5 People in contact with criminal justice - local

*What are the health needs? Local data* [35]

During March and April 2024, the Health & Care Partnership carried out an involvement cycle, visiting groups, team meetings etc to help us understand what matters most to inclusion health groups, with specific intention to hear from those with experience of the criminal justice system, when it comes to health and care.

Key findings:

- Mental health and substance use – intersectionality and the need for both issues to be addressed concurrently and holistically
- Access to healthcare services – challenges with access and navigating services, and feeling misunderstood or judged by staff
- Support for families of prisoners – more support groups and services needed
- Stability and consistency in support services – building relationships and trust
- Community engagement and peer support – fostering hope and belonging
- Housing and reintegration challenges – navigating complexities back in the community, after having been incarcerated, and challenges posed by temporary accommodation

# 2.2.6 Sex workers - national

Sex workers often face multiple disadvantages, some pre-existing and some exacerbated by sex work itself. These include homelessness, drug and/or alcohol misuse, sexual abuse, domestic violence, coercion, and exploitation at the hands of those known to them and others. [16]

The type of sex work impacts on their health and wellbeing needs e.g. those working on-street tend to experience far worse health inequalities and disadvantage than those working indoors. [15]

*What are the health needs? National data* [36,37]

- Increased use of health services, but lower uptake of preventative care including screening
- Mental health issues (e.g. 68% meet criteria for PTSD; stress-related)
- Addiction (e.g. up to 95% of London female sex workers misuse drugs)
- Sexually transmitted infections (STIs)
- Vein abscesses
- Respiratory diseases
- Fatigue
- Acute pain (e.g. 58% of trafficked sex workers reported tooth pain)
- Unplanned pregnancy

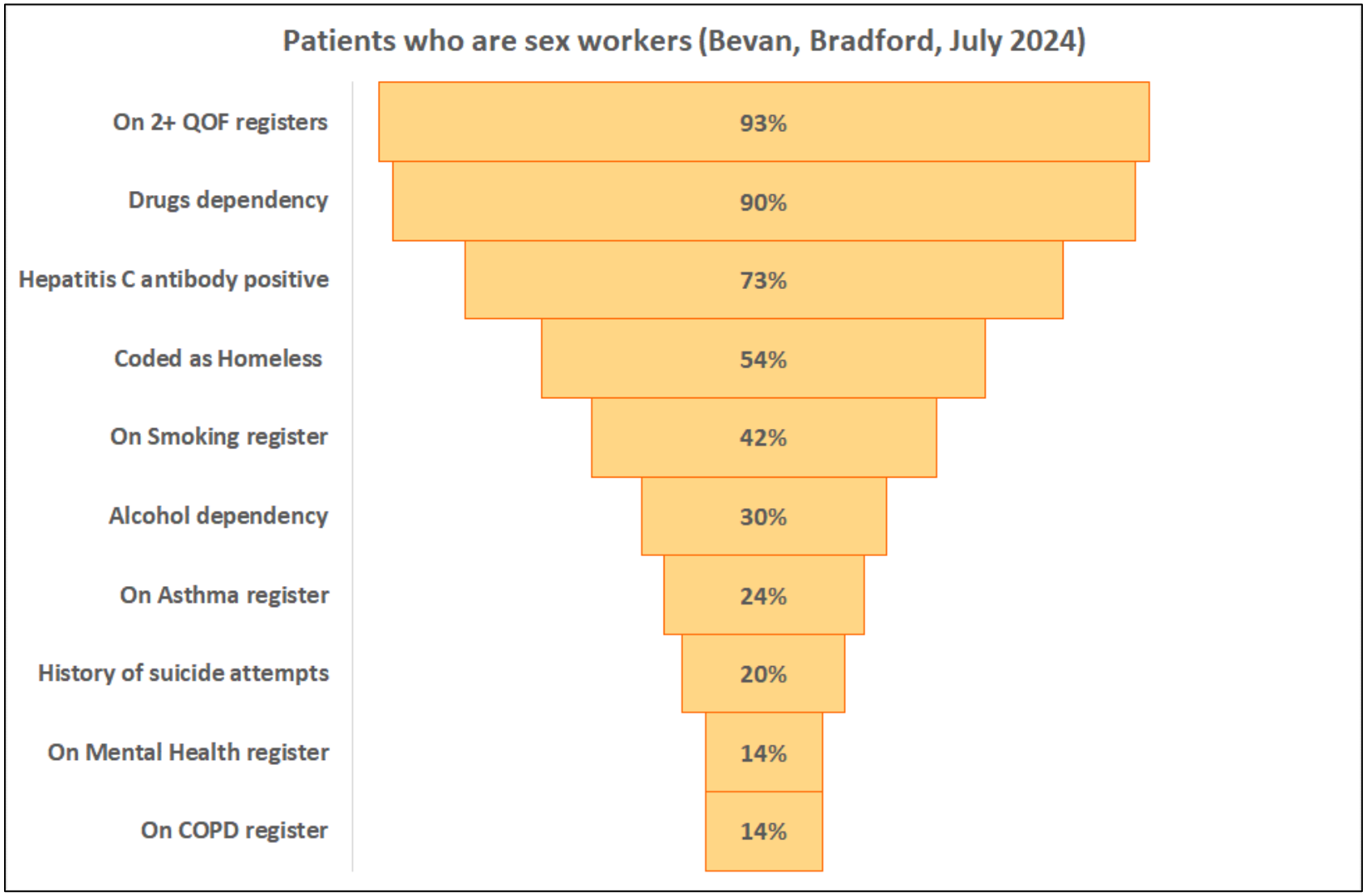
# 2.2.6 Sex workers - local

*What are the health needs? Local data*

There was no data available on people from Craven that were engaged in sex work, the info below relates to on-street sex workers from Bradford District only.

- On-street sex workers rarely access mainstream sexual health services but instead engage with outreach e.g. only 20 people attended a GUM clinic in Bradford at least once in 2019. [15]
- The majority of individuals accessing the Lotus Project reported physical and mental health issues. [16]
- Most individuals accessing the service report drug/alcohol issues - In 2022-23, 72% of individuals on caseload with a drug/alcohol problem were engaging with alcohol and/or drug treatment services.
- Those deemed to be “at risk to self or others” increased by 77% in 2022-23 which suggests the mental health needs of those on Lotus Project’s caseload are increasing.
- A higher percentage of individuals reported an improvement to their mental health compared to physical health across both 2021-22 and 2022-23.
- The largest decrease was observed for physical health improvements, reporting 50.5% in 2021-22 compared to 39.8% in 2022-23.
- For mental health, the percentage decreased from 57.6% in 2021-22 to 51.3% in 2022-23.

# 2.2.6 Sex workers - local




Caveat: this is data from one GP practice, which is a specialist in Inclusion Health. Some relative assumptions can be made based on this data, but it cannot be interpreted as prevalence of health conditions among the entire BDC patient population engaged in any type of sex work. Also, coding is based on those who have "ever" been engaged in sex work, as it is a fluctuating state.

- Very high prevalence of multimorbidity
- Very high prevalence of drug dependency and other addictions
- More than half coded as homeless
- 14% on Mental Health register, 20% (1 in 5) have history of suicide attempts
- Very high prevalence of respiratory conditions

# 2.2.7 Modern slavery - national

*What are the health needs? National data* [38]

- The nature of exploitation and their contexts result in a range of consequences e.g. physically demanding forced labour combined with long working hours (such as domestic, agriculture, manufacturing) resulting in high incidence of physical injury; sexual exploitation brings with it high prevalence of sexually transmitted infections.
- Trafficked people commonly experience poor mental health with high prevalence of post-traumatic stress disorder (PTSD), anxiety and depression.
- Survivors experienced high levels of unmet health needs and poor access to health services.

# 2.2.7 Modern slavery - local

*What are the health needs? Local*

- West Yorkshire Police hold no data on victims/subjects' health needs or access to healthcare. Salvation Army 'Victim Care' and sub-contractors such as Palm Cove Society support people to access mainstream healthcare.

- There is little local healthcare data available as history of modern slavery or human trafficking does not tend to get flagged on clinical systems of NHS providers.

- Some GP practice data appears to point to the intersectionality between modern slavery, human trafficking and specific IH groups such as vulnerable migrants, with asylum seekers being most at risk.

# 2.2.8 Drugs and Alcohol Dependency – international and national

*What are the health needs? International and national data* [39]

- Mental health -
  Comorbidity with alcohol and substance use disorders (AUD/SUD) vastly increases vulnerability to suicidal ideation, attempts, and deaths.

- Physical health -
  Increased risk for developing many types of chronic illness, including cardiovascular disease, respiratory disorders, hepatitis C and diabetes.
  Oral disease and nutritional deficiencies are also disproportionately higher among this population.

# 2.2.8 Drugs and Alcohol Dependency – local (Bradford)

*What are the health needs? Local data* [40]

- Estimates of unmet treatment need:
  - approximately 51% for drugs (opiate and/or crack cocaine)
  - 84% for alcohol misuse.

- The proportion of people leaving prison and referred for substance use support into New Vision Bradford varied between 71 and 88% between July and December 2023.

- In 2022-23, 34.9% of people leaving prisons and engaged in community treatment within 3 weeks of release this is lower than England Average (42.6%) and regional (43.0%). The data reported on NDTMS does not reflect the data reported at service level.

- The majority of individuals in treatment (63%) are opiate users with 18% in treatment for alcohol dependency. Nationally, this is 49% and 29% respectively.

- Bradford has a similar proportion of non-opiate only service users when comparing to national.

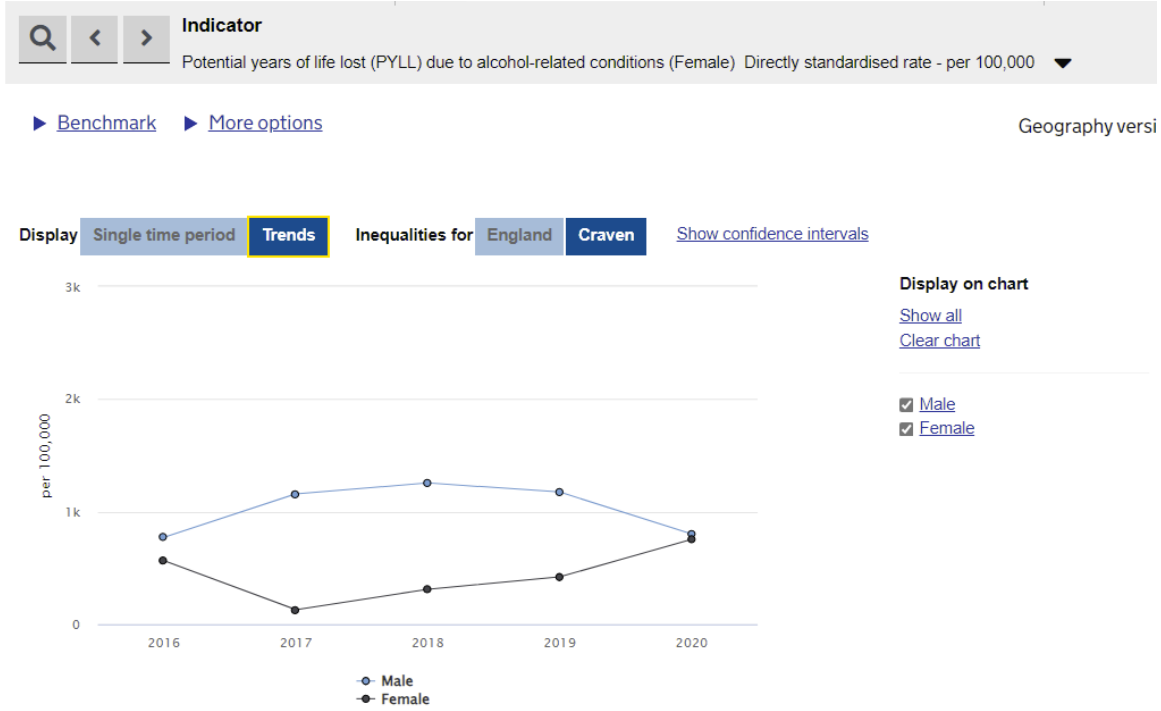
# 2.2.8 Drugs and Alcohol Dependency – local (Bradford)

*Local data [continued]* [40]

- Most of Bradford's substance use indicators (such as Hepatitis B treatment completion, waiting times) are not significantly different than England averages.
- Deaths from drugs misuse are rising both in Bradford District and nationally, whilst successful treatment completion for opiates is falling and below the national average.
- Plans are underway to address the significant mismatch between those ethnicities presenting in hospital with alcohol/drugs related issues, those receiving treatment, and the numbers in the wider Bradford district e.g. 11% Asian/Asian British versus 32% of Bradford population.

# 2.2.8 Drugs and Alcohol Dependency – local (Craven)

- Internationally, most studies have found that rural, relative to urban, residence is associated with an increased likelihood of hazardous alcohol use and alcohol-related harm [41].
- Alcohol admissions (narrow definition) 115.7 (DSR, per 100,000) in Craven, compared to Bradford's 116.8.
- For women in Craven, alcohol admissions (narrow) was highest rate in Yorkshire and Humber [42].



# 2.2.8 Drugs and Alcohol Dependency – local (Craven) [43]

North Yorkshire Horizons case load trends by Locality:

- 112 people accessed structured drug treatment (8.3% of North Yorkshire total) at the Skipton Hub in 2021/22.
- The substance using profile of people in treatment varies considerably by locality. In Craven (as well as Harrogate and Northallerton) most people engage for support for alcohol, whereas in Scarborough and Selby most engage for support with opiates.

Case load by substance group and locality 2021/22

- At the Skipton Hub, 77 people received support with opiates, 18 for non-opiate only support, and 17 for alcohol and non-opiate support.

Referrals into RISE (Young People in Structured Treatment) 2021/22

- 11 appropriate referrals (7.5% of North Yorkshire total) were received from the Craven area.

# Section 3 Comparative:

## What works, what do we currently do?

# **3.1 What works?** Overall values

‘the values that should underpin services—expressed by people with experience of exclusion—include providing ample time and patience to really listen, striving to develop trust and acceptance, providing supportive, unbiased, open, honest, and transparent services in inclusive spaces and places, encouraging clients to accept personal responsibility for health, allowing clients to take ownership and participate in decisions, and above all, promote accessibility, fairness, and equality for all.’

*(What works in inclusion health: overview of effective interventions for marginalised and excluded populations,* 2017*)* [44]

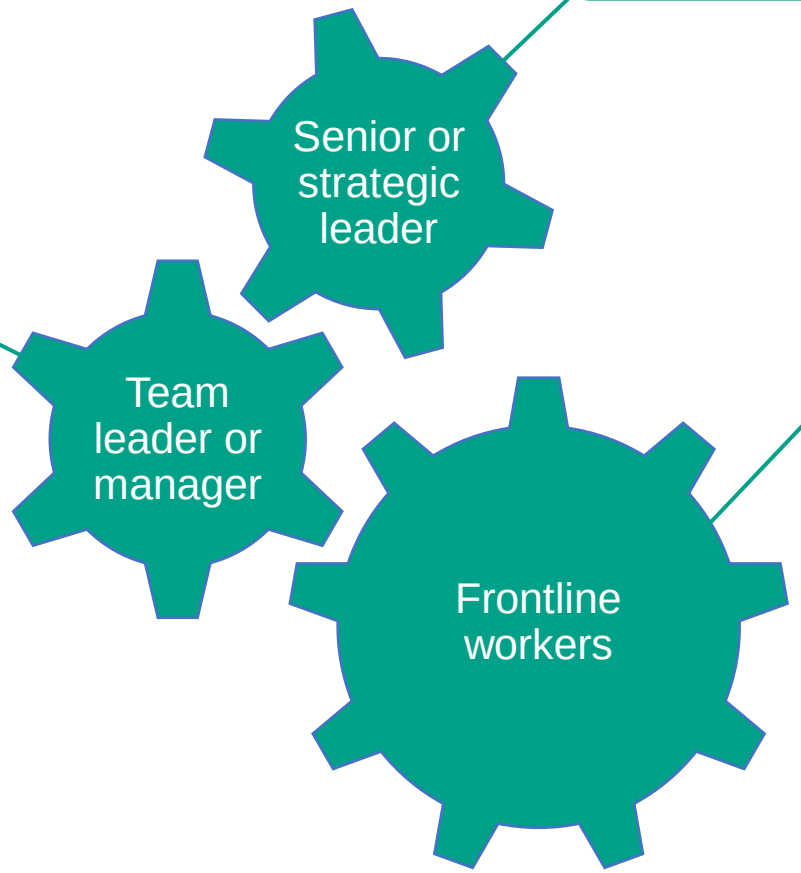
# 3.1 What works? Principles for inclusion health

**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)*

# 3.1 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 (between different organisations and staff)
- 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 produced by Public Health Devon, Devon County Council (2022)* [22]

# 3.1 What works - for specific groups [22]

**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)* [22]

# **3.1 What works?** Local evidence: "ACEs HNA (2019)" and the Bradford District Adversity, Trauma and Resilience (ATR) Programme

- The Adverse Childhood Experiences Health Needs Assessment (HNA) [54] for Bradford District concluded that primary, secondary and tertiary prevention approaches needed to be adopted, as well as a whole system family-orientated approach to commissioning and delivering services.
- The HNA informed the development of the Bradford District Adversity, Trauma and Resilience Programme in 2020, overseen by the Bradford ATR Partnership.
- The Bradford District ATR strategy [57] was launched in 2021, providing a framework for the district's vision on prevention and mitigation of Adverse Childhood Experiences. This includes buffering the impact of adversity and trauma, intervening early and developing services that are building resilience against long term harm of adversity and trauma, particularly supporting those with multiple and complex vulnerabilities.
- The ATR Partnership offers free evidence-based training and resources available to anyone working in the District.

# **3.1 What works?** Local evidence: “Bradford for Everyone Programme Evaluation (2022)” [45]

- Vulnerable migrants accessing English language classes: ESOL can be seen as critical ‘warm up’ tool coupled with other life skills such as mental health and wellbeing to employability skills.
- Vulnerable migrants accessing web-based information: ‘Welcome to Bradford’ website increased number of migrants accessing information on health and wellbeing provision.
- Befriending Service, the Bridge Project – cost saving to mental health services
- CCG involved in development of Roma Strategy using a strategic asset approach. Focus on prevention and early intervention.
- Covid Community Champions project, by REN and Equality Together, increased trust in health services e.g. champions sat in GP reception to help with bookings, using language skills
- Funding directed at the preventative stages of integration frictions and challenges can save large amounts of money spent on mental health, policing, court proceedings and prisons down the line.

# **3.1 What works?** Local evidence: “Roma Strategy 2021-2025” [13]

- Services need to pro-actively engage with the Roma communities, building bridges and reaching out, not waiting for community members to walk through the door or read the website.
- While information campaigns in appropriate formats would help, some of these issues would be best tackled by community-based health initiatives, working with people from the Roma communities to understand how issues are perceived within the community and how best to move health and wellbeing messages through the community via community champions, engaging with the community at events and getting the correct messages spreading via word-of-mouth.
- Trust is not gained simply by qualification and position, however, but by building a working relationship with individuals and families.
- Liaison staff in schools and colleges, of public engagement and social prescribing staff in GP surgeries and pastoral work in churches play an important role in communicating and engaging with Roma communities. These liaison roles should be protected or, where absent, created.

# **3.2 What do we currently do?** Local good practice example – "PIE"

**People experiencing homelessness:**
Psychologically-Informed Environments for people experiencing homelessness (PIE) hosted by Bevan Healthcare

PIE incorporates the provision of a low-threshold, accessible and flexible psychological therapy service, with a concomitant emphasis on system change through staff training, multidisciplinary co-working and the provision of reflective practice groups across a range of service providers.

**Key outcomes** [46]:

- Patients have exceeded expectations in terms of their readiness for and ability to engage in psychological therapies.
- Increased engagement with homeless patients and increased delivery of psychological input to care of homeless people.
- Improved adoption of psychologically informed thinking and practices throughout the organisation.
- Improvement in mental health and social functioning.

# 3.2 What do we currently do? Local good practice example – “Lotus”

**On-street sex workers**

Lotus Project implements the following international evidence of ‘what works’ [15] in Bradford District:

- Interventions that are focused on education and empowerment or those that are multicomponent are likely to be effective.
- Coproduction - where services were developed and delivered in collaboration with sex workers there were better outcomes.

The Lotus Project, hosted by the Bridge, is a specialist support service for anybody who is involved, or at risk of being involved in, sex work. Lotus Project has strong engagement with on-street sex workers e.g. through joint working with Locala and Bevan Healthcare, utilising their outreach bus. Lotus Project also supports women with ‘safe secure housing’ and a housing management officer.

# **3.2 What do we currently do?** Local good practice example – "MARRS"

**People in contact with criminal justice:**
CBDMC Public Health has undertaken a quantitative and qualitative evaluation of the Multi-Agency Reducing Re-Offending Service (MARRS) and Perpetrator Pilot delivered by the Bridge Project, commissioned by Probation.
The projects use a trauma-informed Navigator and Peer Mentor model and are based on learning from the West Yorkshire Findings Independence (WY-FI) pilot.

**Key findings** [47]:

- 81% reduction in offending, with none going back to Prison.
- 54% had an unmet mental health need at programme start and 100% of individuals had their mental health needs met via their GP.
- 45% had unmet physical health needs at start and 100% of individuals had their physical health needs met.
- Unmet substance misuse treatment need was not an issue for this cohort: 100% were already engaged with treatment and were retained in treatment. This was highly unusual compared to other Bridge Navigation models.
- Overwhelming positive feedback from service users e.g. "I am guided and supported".

# 3.2 What do we currently do? Local good practice example – "ASIST"

**People experiencing alcohol and/or drugs dependency**

- Alcohol Specialist Intervention Support Team (ASIST) at Project 6 Keighley
- ASIST carry out the pre- and post-discharge support to people who have been in hospital (BRI, Airedale) due to problematic alcohol use. They work closely with other specialist hospital-based teams, attend High Intensity Users (HIU) meetings, as well as working with agencies that provide community support.
- Personalised care plan created to manage alcohol dependence alongside addressing key needs such as housing and benefits. ASIST work with people for 6-12 months until they are ready to access mainstream treatment or enter recovery services.

**Key findings** (April 2023 – March 2024, BRI only) [48]:

- 43% of new referrals were engaged in treatment (68/158) with 21% being referred to other, more appropriate services
- Following discharge, 10% of service users abstained from alcohol and a further 40% reduced their alcohol use
- Self-reported reductions in hospital and primary care visits

# **3.3 Emerging findings -** What do local good practice examples have in common, compared to what we know works?

Local good practice examples have service delivery models that adopt the "what works" evidence (**slide 62**) – 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:

- Support for staff to meet 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**
- Adopting person-centred approach and trauma informed practice throughout – **e.g. PIE**
- Flexible attitude and approaches in delivery – e.g. longer contact times, sensitive approach to eligibility, no-linear recovery **– e.g. ASIST, Wellbeing Hubs**
- Ease of access is key for all groups (outreach/walk-in/in-reach) – **e.g. Bevan Healthcare**

Similar to national findings [49], 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 (see slides 70/71). This fragmentation means that IH groups will always be at risk of re-organisational change and funding cuts.

# **3.4 Strategic Leadership and Governance** - for Inclusion Health across Bradford District & Craven

- The governance of inclusion health across Bradford District and Craven was mapped out, as an extension of the "what do we currently do" section of this health needs assessment, but also to inform local implementation of Principle 1 "Commit to action on IH" in NHS England's Framework. [1]
- Mapping suggested a complicated, fragmented and (in places) stagnant governance structure across Place, with different boards/groups representing IH groups and no clear overarching governance or reporting.
- The Inclusion Health Forum (jointly led by RIA and Bradford Council's Public Health) provides a support network for inclusion health as a whole, through adopting the King's Fund's three 'As' model i.e. Awareness, Action and Advocacy.
- The purpose of the Inclusion Health Forum is to help reduce inequalities within socially excluded groups that are experiencing multiple disadvantage and unmet needs through:
    - Providing a space for local partners and stakeholder to meet regarding IH
    - Facilitating the sharing of best practice and learning that can be utilised across the District
    - Building and strengthening partnership across the District to improve health and wellbeing of IH groups
    - Informing the system of endemic, emerging, or unmet needs/issues within the IH groups that we service and/or represent
- The Forum reports up to the Healthy Communities Board (NHS) and Public Health Leadership Team (Council).

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

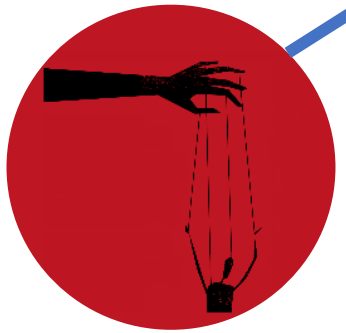
North Yorks Homelessness Forum [in development]
*BD* Housing People Group [under review];
BD Housing, Health and Care Forum

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)

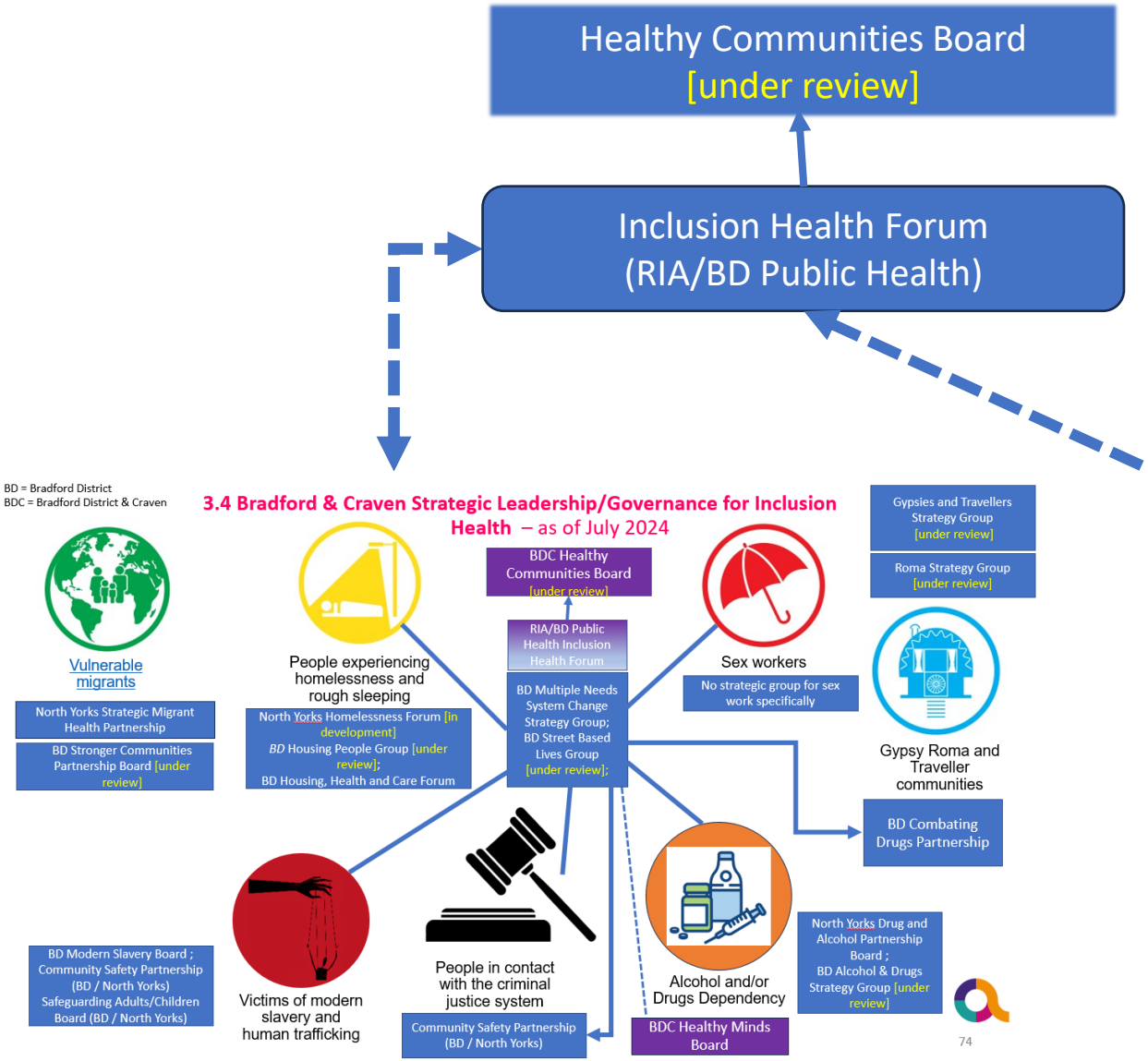
Alcohol and/or Drugs Dependency

BDC Healthy Minds Board

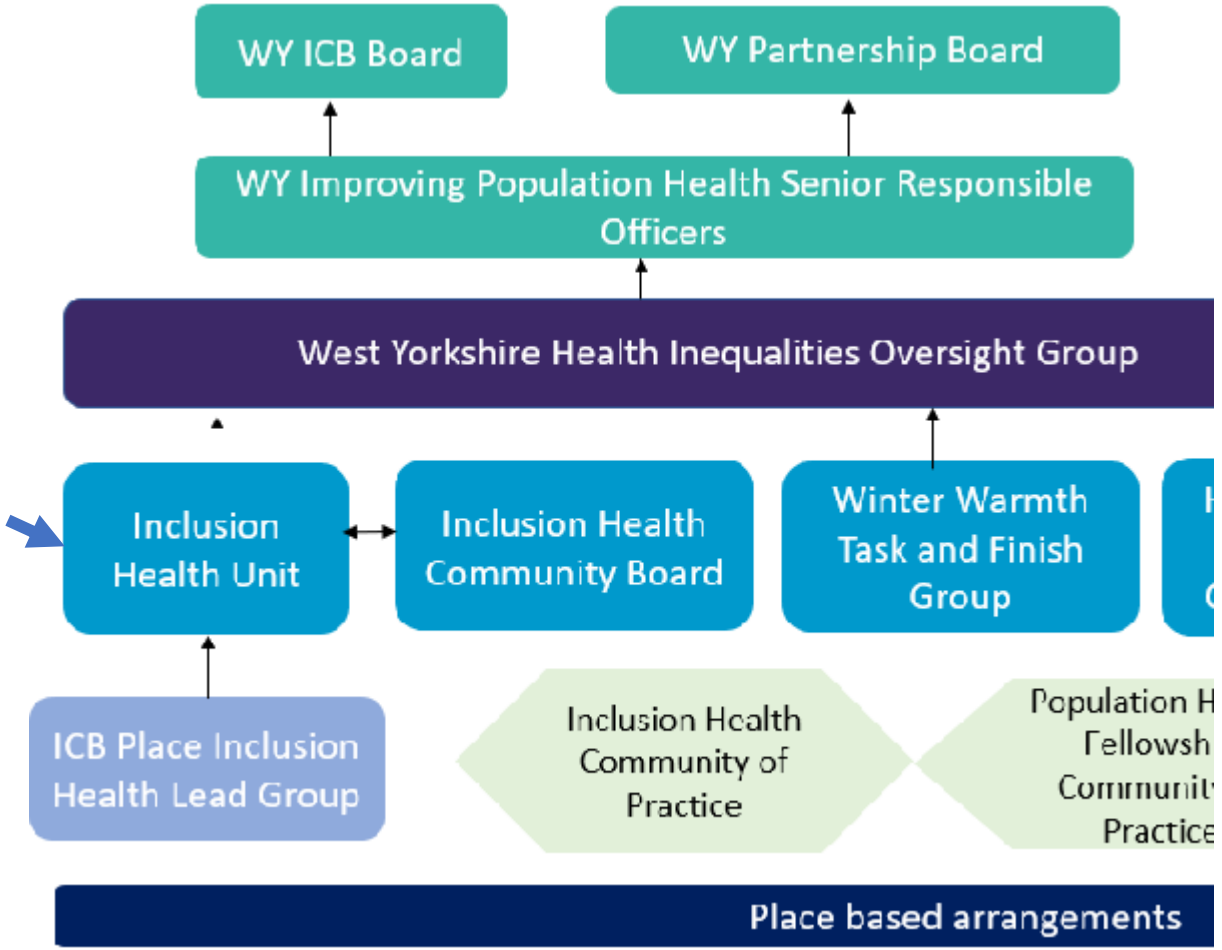
North Yorks Drug and Alcohol Partnership Board ;
BD Alcohol & Drugs Strategy Group [under review]

# 3.4 Strategic Leadership and Governance for Inclusion Health – as of July 2024

## Bradford District and Craven (BDC)




## West Yorkshire structure



# 3.4 Strategic Leadership and Governance - West Yorkshire ICB Inclusion Health Unit (as of July 2024)

Feeds up to the Health Inequalities Oversight Group (Population Health Programme) and West Yorkshire Voice partnership (to be developed 2024/25).

✓ Support and strengthen WY's 5 Places in their inclusion health work
✓ Respond to key 'at scale' priorities, designing and implementing collective solutions to challenges
✓ Act as a critical friend to other programmes/mainstream provision

3 ways of operating:


6 priorities:

1. Influence condition-specific programmes to meet the needs of IH groups
2. Review and improve the effectiveness of IH across WY
3. Embed lived experience in the WY approach, and promote it within Places
4. Improve what we know about IH groups (population size and health needs) and build a 'what works' evidence base for service design
5. Support improved quality in commissioning for inclusion health
6. Support a representative workforce across WY who are supported, skilled and capable

# Section 4
# Corporate:

## What do stakeholders and communities think?

# 4.1 Consultation and engagement process: which stakeholders and communities did we engage with and how?

Community insight was drawn from existing Health Needs Assessments, 'Listen in' involvement cycle (see section 1.2.5) as well as through various ad hoc communication with those with lived experience, such as:

- Connecting Roma
- European Drom
- Leeds Gypsy and Traveller Exchange (GATE)
- Create Strength Group/LEEP
- The Growth Company
- Peer Mentors from Liaison and Diversion service

Other stakeholders that provided input were:

- VCS Alliance
- The Bridge Project e.g. Lotus
- Project 6
- Staying Put
- Race Equality Network
- Refugee Action
- Bradford District & Craven Mind
- Millside Centre
- Bradford City of Sanctuary
- Palm Cove Society
- Homeless and New Arrivals team (BDCFT)
- Alcohol Care Team (BRI)
- Bevan Healthcare
- Solace
- SkillsHouse
- Health and Justice Team (Probation)
- North Yorkshire Public Health, Localities, Community Safety
- Bradford Council's Stronger Communities team, EDI, Access to Housing Strategic Policy team, Immigration and Asylum Unit, Living Well Community Health Development team, Commissioning team (Public Health/People), Housing Strategy & Intelligence

# 4.1 Consultation and engagement process: which stakeholders and communities did we engage with and how?

Stakeholder feedback was gathered between March-July 2024, summary versions of the HNA were presented at the following meetings:

- Reducing Inequalities Alliance team
- Community Partnerships Team
- CORE20Plus5 Steering Group
- Primary Care Team
- Healthy Communities Board
- Extended Public Health Leadership Team (CBMDC)
- West Yorkshire ICB Inclusion Health Place Leads
- Yorkshire & Humber Inclusion Health Community of Improvement (CoI) (hosted by OHID)
- Wellbeing Hubs Network
- Community Partnerships Network
- Health Protection Committee (CBMDC)

# **4.2 Consultation findings** – Inclusion Health group specific

- Asylum seekers and refugees - more local data needed on the population sizes and health needs
- Roma – concerns were echoed around health literacy, vaccine hesitancy, sexual exploitation
  - Difficulty with translating info automatically e.g. there is no word for ‘stress’ in Roma
- Gypsies and Travellers – perception of lip service paid to supporting the community whilst the bigger (often more politically sensitive) issues such as housing conditions and environmental health concerns get ‘kicked into the long grass’.
- Criminal Justice
  - Engagement with Youth Service is needed, as they work with people up to the age of 25 if they are registered as SEND. They may be at higher risk of cuckooing, for example.
  - Information on NEET (not in education, employment or training) or Youth Justice has not been included.
  - Improve collaboration with Yorkshire & Humber Health & Justice Team.
- Homeless/insecurely housed
  - Data to inform bid to Yorkshire Cancer Research on improving cancer pathway for IH groups.
  - Learning from Covid when rough sleepers were put in hotels, Bevan went out to see them – what were the benefits?
- Substance use – IH principles to be incorporated in Bradford Council’s Alcohol & Drugs governance structure.
- Sex work - People working remote/online may not see themselves as sex workers but working in ‘entertainment business’.
  - Exploitation versus conscious choice, having control over their earnings etc.

# 4.2 Consultation findings – general 1/3

- Intelligence sharing -
  - Community Partnerships and Wellbeing Hubs have intelligence on specific Inclusion Health groups as well as common themes that can be fed into the system e.g. hidden homelessness and implications for healthcare.
- Interface with BDC Priority Programmes -
  - What is the interface with Healthy Minds targeted services?
  - Access to Care – data could feed into the new Wellbeing Hubs contract
  - Workforce – raise awareness of IH data at Workforce Programme Board
  - How to influence procurement of services?
- Collaboration with other Places and West Yorkshire -
  - Collaboration with other Places/WY/Y&H to understand, learn and share. The transient nature of IH populations makes this even more important.
  - Workforce/capability – link to WY ICB Inclusion Health Unit workforce development plans
  - WY Adversity Trauma and Resilience (ATR) programme – does it include modern slavery?
- Quality and Equality Impact Assessments –
  - For new programmes/initiatives (or those under review) targeting IH groups in any way, QEiAs can be requested from the programme lead/director to see what the direct outcomes have been. Where are QEiAs held, they should sit with the needs assessments.
  - Opportunity to include IH in CBMDC Equality & Health Inequalities Impact Assessment.

# 4.2 Consultation findings – general 2/3

- Clinical systems, recording, and access -
  - Barriers in access to electronic systems are in Health & Care Partnership's control. Others such as housing are within Local Authorities' remits.
  - Improve ethnicity recording – standardise which READ codes to use, through working with Primary Care and Data Quality. WY Inclusion Health Unit can support this work across Places.
- Governance:
  - Stakeholders agreed the governance picture is complex.
  - Healthy Communities Board agreed to provide governance for the Inclusion Health remit and Inclusion Health Forum.
- Inclusion Health Forum/Group:
  - The Forum needs to be clearer on its role and how/where it feeds up. For example, could it support Return on Investment work, gather data re: total system cost etc? Also, can the Forum help demonstrate how IH groups have been impacted as result of budget cuts?
- Primary Care -
  - Mapping of operational partners that support IH groups is welcomed so Primary Care Team know who to go to when asked a question.
  - Onus on GP practices to get people in but they don't have capacity. There is an (NHS) perception that outreach (e.g. to increase vaccine uptake) is poor value for money.

# 4.2 Consultation findings – general 3/3

- Representation and lived experience –
  - Increase workforce volunteer development and community workforce
  - ‘Seldom heard’ voices should be reflected in work. Continued commitment to increase IH group’s influence as part of decision-making.
  - Work with Child Friendly Bradford as accessibility to children and young people from IH groups is arguably easier than adults.
- Inclusion Health work needs to be more closely aligned to suicide prevention.
- CBMDC internal investments e.g. Neighbourhood Teams -
  - What is the role and contribution to IH? What standards have been agreed re: IH, and are they included in a Memorandum of Understanding (MOU)
  - Quality assurance could take place as part of a staff survey.
- Poor literacy or English language – there is very little ‘simple’ ‘easy read’ (not aimed at Learning Disabilities) information out there e.g. housing, healthcare.
- If dental care needs are not met, it leads to knock-on effects on physical and mental health.
- Wellbeing Hub model reflects all the evidence on ‘what works’ for IH.

# Section 5:

## Emerging data gaps

# 5. Emerging data gaps 1/3

Local NHS data:

- Due to limited capacity, large-scale collation of data from various local NHS Providers was not pursued. However, Bevan Healthcare data was extracted for patients who were coded as homeless, asylum seekers/ refugees, and sex workers. This gives an indication of health issues experienced by these IH groups but it cannot be interpreted as prevalence of these issues for all IH groups across Bradford & Craven.

Hate Crime Alliance data

- Suggested as local source of information on discrimination, violence etc directed at IH groups.

Alcohol/drugs dependency:

- No locality estimates available e.g. Craven
- Little data on physical health and neurodiversity from treatment providers

Vulnerable migrants:

- More data needed on population sizes (e.g. refugees) and health needs

# 5. Emerging data gaps 2/3

Homelessness

- Housing Options assessments collate a wealth of information on customers' health issues however this is currently not reported anywhere and is therefore an untapped resource. The Health Determinants Research Centre (HDRC) is exploring how this data can be utilised/shared most effectively.

Sex workers – raised through Regional Sex Work Steering Group:

- Further explore the needs of indoor, migrant and trans sex workers to inform future work.
- Work with local authorities to identify opportunities to influence work around adverse childhood experiences (ACEs). There is a need to establish a joint approach on this in relation to sex work and sexual exploitation.

Gypsy, Roma, Travellers:

- The availability of healthcare data for these groups is very limited due to poor recording of ethnicity in primary care records. This is a national issue and relates to the measurement of health inequalities across all ethnic groups.

# 5. Emerging data gaps 3/3

Modern Slavery victims:

- Little is known about health needs of Modern Slavery victims in our area. It may be possible to follow up with victim support provider such as Palm Cove Society, with the caveat that the sample is relatively small.

Criminal justice

- More detail is needed on 57% of people on Probation that self-report a “physical or mental health condition”, what those conditions are and what support options are available to them etc. There are opportunities to follow up with Health and Justice colleagues at Probation Y&H. It is unknown whether neurodivergence, where diagnosed, is consistently recorded by Probation.
- Currently no data is included from Youth Service re: 18-25 with SEND, or Youth Justice.

# Section 6:

## Recommendations

# 6. 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 recommendations:

**Awareness:**

- Summarise HNA content onto a briefing note.
- Present HNA at relevant strategic boards (within Act as One partnership covering Local Authority, NHS and VCSE and police forums).
- Encourage VCS, PCNs etc to self-assess engagement with IH groups using tools such as IH online self-assessment tool, through joint working with VCS Alliance, Community Partnerships/Localities Team etc.
- Promote evidence of 'what works' in useable format e.g. checklist.
- Promote Bradford's and WY ICB's Adversity, Trauma and Resilience (ATR) programmes with NHS commissioners and Providers/services that work with IH groups.
- Promote learning from OHID's IH Community of Improvement and Pathway's ICS IH Programme at Place.
- Support prevention across the life course, including a family/community-orientated approach, to reduce ACEs, increase health literacy in IH groups, and embed healthy lifestyles and supportive social structures.

# 6. Recommendations

**Awareness** (continued)

- Source and promote good practice examples of EQIA e.g. on RIA website.
- Input relevant HNA findings into the PSED reporting, through working with EDI Lead(s).
- Develop the workforce for IH:
    - Working with providers that deliver good practice and people with lived experience
    - Using a variety of mediums such as webinars and quality-assured e-learning
    - Working closely with WY ICB Inclusion Health Unit and BDC Workforce programme.

**Action:**

- Address emerging data gaps (see section 4), through collaboration with WY Inclusion Health Unit and relevant (Place based) stakeholders.
- Work at Place, WY, and with OHID and NHSE to improve ethnicity recording and use of flags on clinical systems (e.g. homeless, refugee or asylum seeker, engaged in sex work, on probation).
- Review existing resources to improve healthcare literacy for vulnerable migrants and new arrivals e.g. with REN Community Champions.
- Connect criminal justice work with neurodivergent offenders into BDC Learning Disabilities/ Neurodiversity Delivery Plan (Health Inequalities section).
- Work with VCS Alliance, CP Team and others to promote self-assessment against ‘IH good practice’ guidelines.

# 6. Recommendations

**Advocacy:**

- Ensure IH groups' voices are incorporated in existing engagement, decision-making, and evaluation structures.
- Work with primary care to explore the suggested under-recording and under-reporting of mental health issues among asylum seekers, refugees, and other vulnerable migrants.
- Work with Digital Inclusion programmes to ensure that IH groups benefit from tailored interventions and support.
- Work with BDC Workforce programme to help frontline services to adopt trauma-informed approaches and for workforce to access relevant CPD, written into specifications and workforce development plans.
- Work with WY Inclusion Health Unit, OHID and NHSE to encourage criminal justice to expand continuity of care beyond mental health and substance use to wider (physical) health and wellbeing needs.
- Lobby for parity of healthcare quality between incarcerated and community populations.

# 6. Recommendations

**Governance and leadership:**

- Strategic direction and governance of Inclusion Health across the system is fragmented and in flux, due to reorganisation and staff changes, financial pressures, political changes, and shifting national targets. Stability, consistency, and possibly rationalisation in governance is needed, to ensure that progress against existing action plans can be made.
- The Inclusion Health Forum (joint Public Health/RIA) will focus on:
    - Expanding and solidifying membership, representing all Inclusion Health groups
    - Clarifying and communicating its purpose e.g. quarterly themes by clinical priority area)
    - Seeking out, applying for, and influencing additional funding and partnership opportunities
    - Providing regular feedback to Healthy Communities Board and Public Health Leadership Team.
- Inclusion Health principles are to be embedded in Alcohol and Drugs governance structures. Opportunities to replicate this for other strategic boards (such as Poverty, Domestic Abuse and Sexual Violence, Adversity Trauma and Resilience, Urgent Care, Healthy Minds) will be explored.

# Acknowledgements


Bradford District & Craven Health and Care Partnership colleagues:

- Reducing Inequalities Alliance (RIA) in particular Dr Duncan Cooper, Anna Smith, Sophie DiMauro, Dr Sohail Abbas
- Communications and Involvement Team
- Community Partnerships Team
- Primary Care Team
- Data Quality Team

Bradford Metropolitan District Council colleagues:

- Public Health in particular Nasar Ahmed, Jo Holt, Toshal Patel Bhatia
- Zahra Niazi – former Strategic EDI Lead
- People/Public Health Commissioning
- Housing Strategy & Intelligence

- North Yorkshire County Council colleagues – Localities, Public Health

- Bevan Healthcare CIC
- West Yorkshire ICB Inclusion Health Unit - Beth Kirby (WY ICB)
- Yorkshire & Humber OHID - Cathie Railton
- 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

# References


1. NHS England (2023) A national framework for NHS – action on inclusion health. https://www.england.nhs.uk/long-read/a-national-framework-for-nhs-action-on-inclusion-health/
2. Aldridge et al (2018). Morbidity and mortality in homeless individuals, prisoners, sex workers, and individuals with substance use disorders in high-income countries: a systematic review and meta-analysis. The Lancet.
3. Health Knowledge - Faculty of Public Health. The uses of epidemiology and other methods in defining health service needs and in policy development | Health Knowledge (accessed November 2023)
4. Office for National Statistics (ONS) "Hidden" homelessness in the UK: evidence review https://www.ons.gov.uk/peoplepopulationandcommunity/housing/articles/hiddenhomelessnessintheukevidencereview/2023-03-29 (accessed May 2024)
5. Department for Levelling Up, Housing and Communities. Statutory homelessness flows analysis for households owed a duty in 2021-22 Microsoft Power BI (accessed March 2024)
6. CBMDC (2024). 2022/23 Housing & Homelessness Statistics.
7. Rifet, S (2024) Equality Diversity and Inclusion data pack – City of Bradford District Metropolitan Council. Internal document, not published.
8. North Yorkshire Joint Strategic Needs Assessment 2021 – Craven District Summary Profile. https://hub.datanorthyorkshire.org/dataset/7bd880b4-4bc1-42da-b87c-20bb1f7838f2/resource/88a58a92-1f4e-4457-8ebb-d3b37ffbc344/download/craven-2021.pdf (accessed June 2024)
9. Migration Yorkshire. Refugee and asylum seeker dashboard | Migration Yorkshire (accessed April 2024)
10. Home Office. section-95-support-local-authority-datasets-mar-2023.xlsx (live.com) (accessed April 2024)
11. Office for National Statistics. Census 2021. https://ubd.bradford.gov.uk/about-us/2021-census/
12. Strategy: Gypsy and Traveller Communities in Bradford District (CBMDC, January 2022). Available through CBMDC Public Health.
13. European Roma Communities: A Strategy for the Bradford District 2021-2025 (C-net/CBMDC, 2021) Roma Strategy | CNet Bradford
14. Offender Assessment System (OASys), a national tool that Probation & Prisons use for assessing people on probation, extracted on 06/11/23
15. OHID/UKHSA (2022) A scoping to understand the health and wellbeing needs of sex workers in Yorkshire and the Humber yorkshire-humber-sex-work-scoping-report-nov-2022-summary.pdf (yhphnetwork.co.uk)
16. Bridge Project (part of the CBMDC Domestic Abuse, Sexual Violence (DASV) and Sex Workers Needs Assessment 2023). Internal document, not published.
17. Basis Leeds (2021) Sex-Workers-A-Guide-for-Professionals-2021.pdf (basisyorkshire.org.uk)
18. West Yorkshire Police - Modern Slavery Human Trafficking Quarterly Statistics (accessed November 2023)
19. https://www.gov.uk/government/publications/alcohol-dependence-prevalence-in-england
20. https://www.gov.uk/government/publications/opiate-and-crack-cocaine-use-prevalence-estimates
21. Lankelly Chase Foundation (2015). Hard Edges: Mapping severe and multiple disadvantage: England. https://lankellychase.org.uk/wp-content/uploads/2015/07/Hard-Edges-Mapping-SMD-2015.pdf


# References


22. Devon Public Health/Devon County Council (2022). Inclusion Health – Health Needs Assessment Northern Devon. Emerging Findings. https://onenortherndevon.co.uk/inclusion-health-presentation/
23. Crisis (2011). Homelessness: A silent killer. A research briefing on mortality amongst homeless people. https://www.crisis.org.uk/media/237321/crisis_homelessness_a_silent_killer_2011.pdf
24. Homeless Link (2022). The Unhealthy State of Homelessness 2022: Findings from the Homeless Health Needs Audit. https://homelesslink-1b54.kxcdn.com/media/documents/Homeless_Health_Needs_Audit_Report.pdf
25. Suicide Prevention West Yorkshire. https://suicidepreventionwestyorkshire.co.uk/ (Accessed December 2023)
26. World Health Organisation (WHO). Mental health of refugees and migrants: risk and protective factors and access to care. https://www.who.int/publications/i/item/9789240081840
27. Blackmore et al (2020). The prevalence of mental illness in refugees and asylum seekers: A systematic review and meta-analysis. https://pubmed.ncbi.nlm.nih.gov/32956381/#full-view-affiliation-2
28. British Medical Assocation (2023). Refugee and asylum seeker patient health toolkit. https://www.bma.org.uk/advice-and-support/ethics/refugees-overseas-visitors-and-vulnerable-migrants/refugee-and-asylum-seeker-patient-health-toolkit/unique-health-challenges-for-refugees-and-asylum-seekers
29. Improving Roma health: a guide for health and care professionals - GOV.UK (www.gov.uk)
30. Roma Support Group website https://www.romasupportgroup.org.uk/common-health-problems-and-vulnerable-groups.html (accessed June 2024)
31. Revolving Doors (2017) Rebalancing Act: A resource for Directors of Public Health, Police and Crime Commissioners, the police service and other health and justice commissioners, service providers and users. https://revolving-doors.org.uk/wp-content/uploads/2017/01/Rebalancing-Act.pdf
32. Derbyshire County Council (2018) Derbyshire and Derby City Offenders HNA https://observatory.derbyshire.gov.uk/wp-content/uploads/reports/documents/health/specialist_reports_and_assessments/2018/Derbyshire_and_Derby_City_Offenders_HNA_2018_Full_report.pdf
33. City of Bradford District Metropolitan Council (2024) Bradford District Children and Young People's Mental Health Needs Assessment 2024 https://jsna.bradford.gov.uk/media/dwbpzyvs/children-and-young-peoples-mental-health-needs-assessment-2024.pdf
34. McLintock et al (2023) The quality of prison primary care: cross-sectional cluster-level analyses of prison healthcare data in the North of England. eClinicalMedicine. https://www.thelancet.com/journals/eclinm/article/PIIS2589-5370(23)00348-6/fulltext
35. Bradford District and Craven Health and Care Partnership (2024). Listen In involvement project with Inclusion Health groups. https://engagebdc.com/listen-in-bdc
36. Hewett et al. (2018) Homeless and Inclusion Health standards for commissioners and service providers. Faculty of Inclusion Health and Pathway. https://www.pathway.org.uk/faculty/standards/

# References


37. UCL Institute of Health Equity (2014). A review of the literature on sex workers and social exclusion (publishing.service.gov.uk)
38. Modern slavery and public health - GOV.UK (www.gov.uk)
39. Osborne et al (2022). Systematic review of guidelines for managing physical health during treatment for substance use disorders: Implications for the alcohol and other drug workforce. Drug and Alcohol Review.
40. City of Bradford Metropolitan District Council (2023) Combatting Drugs Partnership Needs Analysis. Not in the public domain.
41. Friesen et al (2021) Hazardous alcohol use and alcohol-related harm in rural and remote communities: a scoping review. The Lancet Public Health.
42. Fingertips website https://fingertips.phe.org.uk/search/alcohol%20admissions
43. North Yorkshire County Council (2023) North Yorkshire Drugs Needs Assessment - Jan 2023 - Datasets - Data North Yorkshire
44. Luchenski et al (2017). What works in inclusion health: overview of effective interventions for marginalised and excluded populations. The Lancet. https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(17)31959-1/fulltext
45. Bradford for Everyone (2022) A Bradford for Everyone - Programme Evaluation Report. Bradford-for-Everyone-Programme-Evaulation-Report.pdf (bradfordforeveryone.co.uk)
46. Bradford District and Craven Health and Care Partnership (2023) Reducing Inequalities in Communities – Psychologically Informed Environments (PIE) for people experiencing homelessness Implementation Report (internal).
47. City of Bradford Metropolitan District Council (2024) Evaluation of the Multi-Agency Reducing Re-Offending (MARRS) and Domestic Abuse Offender Manager Team Perpetrator Pilot services (internal).
48. Project 6 Keighley (2024) Alcohol Specialist Intervention Support Team Bradford Royal Infirmary (BRI) 12 Month Report, April 2023 - March 2024 (internal).
49. Pathway (2023) https://www.pathway.org.uk/resources/beyond-pockets-of-excellence-integrated-care-services-for-inclusion-health/
50. City of Bradford Metropolitan District Council (2020) Bradford Homelessness and Rough Sleeping Strategy 2020-2025 https://www.bradford.gov.uk/media/5755/bradford-homelessness-strategy-2020-to-2025.pdf
51. Vulnerable migrants: migrant health guide - GOV.UK (www.gov.uk) (Accessed October 2023)
52. British Red Cross https://www.redcross.org.uk/about-us/what-we-do/how-we-support-refugees/find-out-about-refugees (Accessed October 2023)
53. Alcohol Change UK https://alcoholchange.org.uk/policy/policy-insights/how-do-we-talk-about-alcohol (Accessed January 2024)
54. Stevens (2019) Health Needs Assessment of Adverse Childhood Experiences in Bradford. ACEsHNA (bradford.gov.uk)
55. Stevens (2019) How can we meet the health needs of child refugees, asylum seekers and undocumented migrants? British Medical Journal.
56. Criminal Justice Joint Inspection (2021). Neurodiversity in the criminal justice system: a review of evidence (justiceinspectorates.gov.uk)
57. City of Bradford Metropolitan District Council (2021). Adversity, Trauma & Resilience Strategy, 2021-24. Strategy - Bradford ATR (bradfordatrpartnership.co.uk)

# Appendix 1 – Definitions 1/4

**People sleeping rough [50]**: 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 [50]**: 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.

# Appendix 1 – Definitions 2/4

**A migrant [51]:**

- has moved to another country, for example to work, study or join family members
- 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

**A person seeking asylum [52]:**

- 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 [52]:**

- 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.

# Appendix 1 – Definitions 3/4

**Gypsies and Travellers [12]:**
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 [13]:**
Roma is 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.

**Sex worker:** the term encompasses diverse groups and there is no one agreed definition. From a service/vulnerability perspective, often distinction made between 'on street' or 'indoor' [15]. Bradford Council's DA/SC Review [16] has quoted '*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*'.

# Appendix 1 – Definitions 4/4

**Modern slavery** [38] 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:** people convicted of a crime by the courts, supervised by Probation, who are serving a community sentence, who are in custody, or those released on license.

**Alcohol dependence** [53]: 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 [20].

Reducing Inequalities Alliance

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