Nottinghamshire County Joint Strategic Needs Assessment
Evidence Summary 2022

Current/old	File version	Change	Author	Date
current	1.4	Section added: - Substance misuse (2022)	LH	Oct 2022
old	1.3	Sections removed to archive/ maintain currency to the last 3 years: - Smoking (2015) - Excess weight (2016) - Diet and nutrition (2016) - Physical activity (2015) - Substance misuse (2018) - Infection prevention and control-healthcare associated infections (2015) - Air quality (2015) - Child Poverty (2016) - Youth Offenders (2014) - Teenage pregnancy (2017) - Mental health (adults and older people, 2017) - Suicide prevention (2016) - Carers (2016) - Sexual abuse (2016) - Stroke (2017) - Viral Hepatitis (2017) - Dementia (2017) - Falls and bone health (2016) - Excess winter mortality (2015) - Loneliness (2016) - End of life care for adults (2017) - Excess winter deaths (2014) Section added: The full historical list of all currently published JSNA chapters	MF	July 2021

CONTENTS

Introduction 3
Demography 3
Deprivation, socio-economic status and wider determinants of health 5
Lifestyle factors 6
Substance misuse (alcohol and drugs, 2022) 7
Sexual health and HIV (2019) 9
Oral Health (2020) 10
Life expectancy and healthy life expectancy 13
Health and wellbeing in our communities (wider determinants) 16
Self-harm (2019) 19
Children and Young People 20
1001 days: From conception to age 2 (2019) 21
Early Years and School Readiness (2019) 23
Emotional and Mental Health of CYP (2021) 25
Avoidable injuries in children and young people (2019) 28
Adults and vulnerable Groups 29
Autism (2019) 29
Learning Disabilities (2019) 30
Domestic abuse (2019) 31
Long term conditions and cancer 33
Cancer (2019) 34
Older People 36
The full historical list of all currently published JSNA chapters 37

INTRODUCTION

This evidence summary presents an overview of the health and wellbeing needs in Nottinghamshire County using the key findings from Nottinghamshire's Joint Strategic Needs Assessment and associated reports. This evidence summary will be regularly updated as JSNA chapters are published.

Joint Strategic Needs Assessments (JSNAs) are local assessments of current and future health and social care needs. The aim of the JSNA is to improve the health and wellbeing of the local community and reduce inequalities for all ages through ensuring commissioned services reflect need. It is used to help to determine what actions local authorities, the NHS and other partners need to take to meet health and social care needs and to address the wider determinants that impact on health and wellbeing. The evidence within the JSNA is used to inform the priorities within the Health and Wellbeing Strategy for Nottinghamshire.

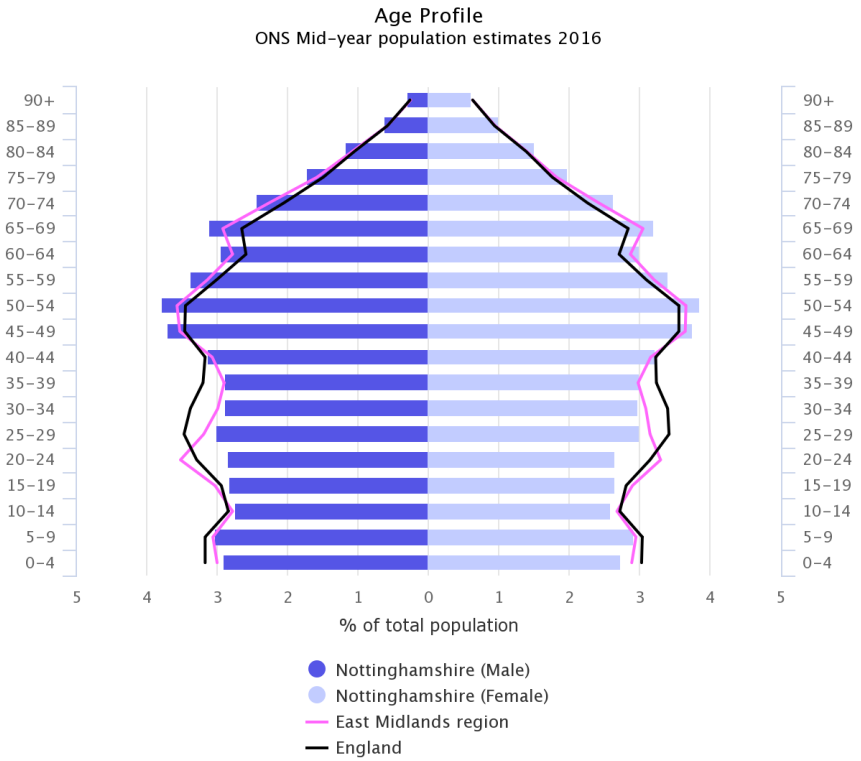
Nottinghamshire County's JSNA contains 40 chapters each considering a particular health and social care issue or the health and social care needs of specific groups. The full JSNA and related documents and data can be accessed at www.nottinghamshireinsight.org.uk. A brief overview of the newer chapters (completed within the past three years) as well as the list of older chapters are presented in this Evidence Summary. All supporting data and information for this evidence summary including references can be found in individual chapters or other reports (hyperlinks included).

DEMOGRAPHY

When broad sociological, demographic and health and wellbeing characteristics of Nottinghamshire County's population are compared to national figures, our population can appear somewhat average. However, more detailed information reveals that our population is diverse and has wide ranging health and wellbeing needs.

The latest estimate of the County's resident population is 817,900 (ONS mid-year estimate 2017). The number of people living in Nottinghamshire increased by 5% between the Census of 2001 and 2011 to 785,800 and is expected to increase to 840,700 by 2021. Projections estimate that this is due primarily to an increase in net migration of people from both other areas of the UK and abroad and an increase in life expectancy.

Figure 1: Nottinghamshire Age Profile (2016)



Source: Public Health England (PHE) Fingertips

Overall, the age structure of Nottinghamshire is slightly older than the national average, with 21% of the population aged 65+ in 2017 compared with 18% in England. Our population is predicted to continue to age over the next fifteen years with the number 65-84 year olds increasing by over 30% and 85+ year olds by over 76%. Older people are more likely to experience disability and limiting long-term illnesses. The majority of carers who provide 50 or more hours of care per week are aged 65+, often caring for a partner. Those carers themselves are more likely to experience poorer health than those of a similar age who do not provide care.

An increasing number of older people in Nottinghamshire are anticipated to live alone (increasing by 41% between 2015 and 2030). Older people living alone and without access to a car in the more rural areas of Nottinghamshire, which also have poorer access to public transport (notably Newark and Sherwood and Bassetlaw) are particularly vulnerable. Our aging and increasingly isolated population has implications for future planning and delivery of services in order to meet their health and wellbeing needs. This is considered in detail in the JSNA chapters Click here for all JSNA Chapters.

Children and young people make up 20% of the population. This population is expected to show a moderate increase of 9% by 2030, with the greatest increases in Broxtowe (15%) and Gedling (11%). In Nottinghamshire, localities where there are higher numbers of families on low incomes are those localities where children and young people are less healthy and do less well at school. Some children and young people may face particular disadvantages and so need more support to fulfil their potential. The needs of these young people are considered in more detail in the Children and Young People section of this report and individual JSNA chapters.

Disability affects a large proportion of our population. Approximately one in ten adults in Nottinghamshire aged 18-64 live with moderate/severe physical disabilities and approximately one in five people aged 65+ in Nottinghamshire are unable to manage at least one daily activity[i]. For older people the numbers are expected to increase from 29,000 in 2015 to 43,000 by 2030.

Although black and minority ethnic (BME) populations are relatively low in Nottinghamshire as a whole, 4% compared with 15% nationally, within the districts of Broxtowe, Gedling and Rushcliffe there are larger population groups (7% each district), mainly Asian and Mixed/Multiple Ethnic groups. BME populations in Nottinghamshire have a younger age profile than the general population. In Nottinghamshire a relatively low proportion of residents were born outside the UK, 5% compared with 10% in the region in 2011 but this varies across the County. A higher proportion of non-UK born residents live in Broxtowe (8%) and Rushcliffe (7%).

To access the latest population figures on Nottinghamshire Insight click here for area profiles and here for The people of Nottinghamshire (2017) chapter.

Annual Nottinghamshire health profiles produced by PHE fingertips can be found here.

DEPRIVATION, SOCIO-ECONOMIC STATUS AND WIDER DETERMINANTS OF HEALTH

Research shows that many health and wellbeing outcomes are linked to socio-economic factors and the 'wider determinants of health' (figure 1). It is therefore important to understand the socio-economic context of the County when trying to understand and improve health and health inequalities[i]. Health and wellbeing outcomes arise from the interaction of all the factors over time as people grow up, live their lives and grow old, rather than being directly attributable to any one factor.

Figure 1: The wider determinants of health. Source: Barton and Green (2006)



The Index of Multiple Deprivation (most recently published in 2015) gives a good summary measure of a range of wider determinants and allows comparison of the County with England and other areas, and also identification of inequalities[ii] within the County.

Deprivation levels for Nottinghamshire are comparable with England. However, within Nottinghamshire there are communities with both some of the highest levels of deprivation in the country and some of the lowest levels of deprivation.

In Nottinghamshire (excluding Nottingham City) there are 25 lower super output areas (LSOAs)[ii] in the 10% most deprived LSOAs in England. The most deprived LSOAs are concentrated in the districts of Ashfield (9 LSOAs), Mansfield (6), Bassetlaw (6) and Newark & Sherwood (3).

People living within the more deprived areas of Nottinghamshire have higher levels of unemployment, lower levels of qualifications, less healthy lifestyle choices and poorer health and wellbeing outcomes.

Claimant count unemployment rates in Nottinghamshire were 1.6% in March 2017 compared with 2.0% nationally and have fallen over the past 4 years from 3.4% in March 2013. For those aged 18-24 years, Job Seekers Allowance (JSA) unemployment rates have generally been higher than national levels for the past 10 years but were 1.1% in March 2017, the same as the national figure.

Wholesale and retail is the largest industry sector of employment in Nottinghamshire (18%), followed by health and social work and manufacturing with 14% of jobs in each sector. This compares with 8% of jobs in the manufacturing sector nationally. The manufacturing sector is a particularly important employer in the districts of Ashfield (20%) and Bassetlaw (17%). NOMIS – Official Labour statistics, 2015.

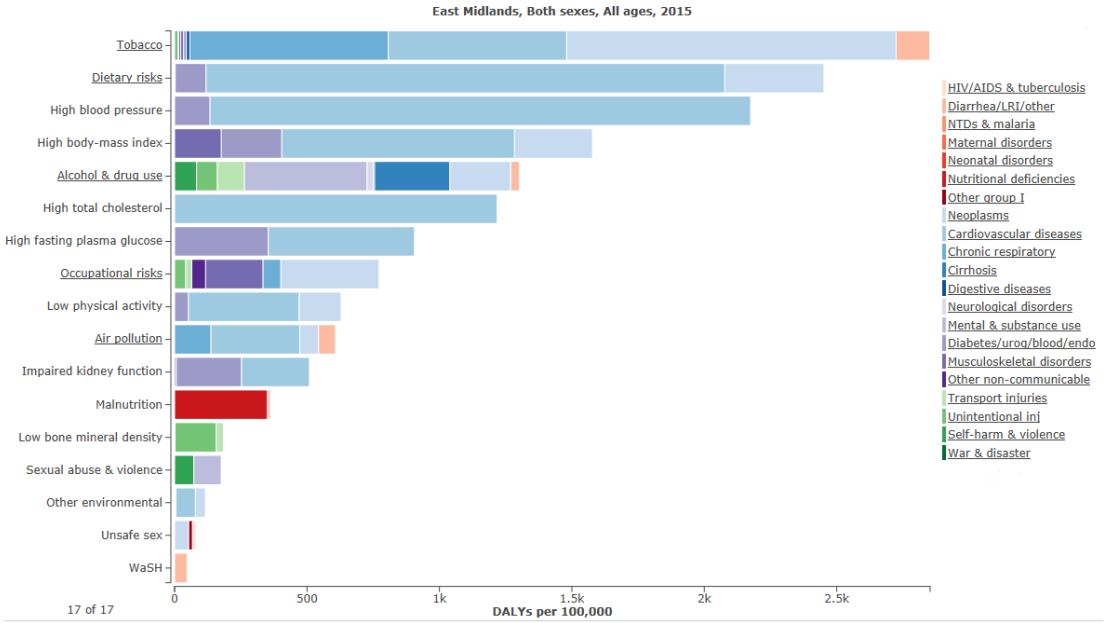
Levels of support within communities varies across Nottinghamshire. In the 2016 residents' survey the highest proportion of residents who felt that people from different backgrounds get on were from Rushcliffe (64%) and Broxtowe (58%). The lowest proportions were reported from people living in Newark and Sherwood (34%). Generally residents felt safer to go out during the day than the night time, particularly in Bassetlaw, Mansfield and Ashfield.

Click here for The people of Nottinghamshire (2017) chapter.

LIFESTYLE FACTORS

Individual lifestyle choices are shaped by a range of factors, including health awareness and the physical and social environment in which we live. They both cause and affect the consequences of many major illnesses (see figure below). More deprived groups are affected proportionally more by such risk factors than less deprived groups and they therefore represent a major driver of health inequalities. Supporting individuals and populations to maintain healthy lifestyles will result in both the primary and secondary prevention of disease improving both life expectancy and healthy life expectancy in the County.

Figure 1: Disability adjusted life years (DALY[iii]) by risk factors and causes, East Midlands



Source: Global Burden of Disease, Public Health England

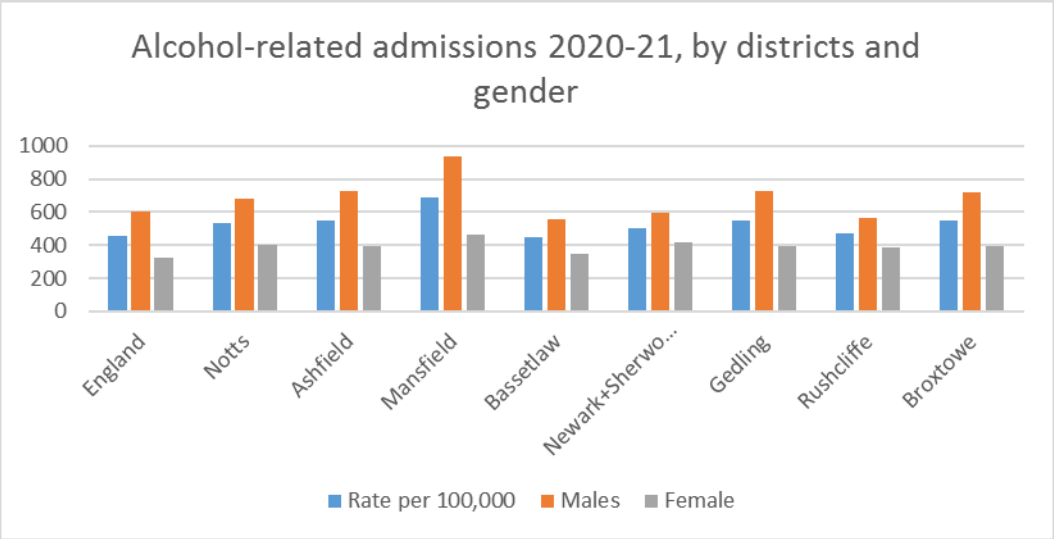
Substance misuse (alcohol and drugs, 2022)

'Substance misuse' is defined here as 'intoxication by – or regular excessive consumption of and/or dependence on – psychoactive substances, leading to social, psychological, physical or legal problems. It includes problematic use of both legal and illegal drugs'. Substance misuse is associated with a wide range of health and social issues and has enormous health and social care financial costs. Alcohol alone contributes to more than 60 diseases and health conditions and represents 10% of the burden of disease and death in the UK, placing it in the top three lifestyle risk factors after smoking and obesity.

Risk factors increase an individual's chances for substance misuse while protective factors can increase the resilience of an individual when faced with a risk factor, thereby reducing the risk of substance misuse. Some of the populations most at risk of substance misuse are young people exposed to Adverse Childhood Experiences (ACE's), people living in more deprived areas, those with mental health issues, offenders and those currently in recovery.

Estimated figures suggest that there could be in the region of at least 175,600 individuals in Nottinghamshire who use substances frequently (approximately 1 in 4 of the adult population), with 12,800 dependent on substances. Alcohol represents the greatest need (noting that a significant proportion of the drug using population are also likely to be drinking) with approximately 91% of the adult population drinking at levels that could be harming their health. Adult alcohol-related hospital admission episodes are higher than the national average across Nottinghamshire apart from in Bassetlaw, for both males and females and across all age groups.

Figure 1: Alcohol related admissions 2020-21 by districts and gender



After Covid-19 drug usage levels did not significantly change but for alcohol there appears to be more drinking at home, increased consumption by those who drink and referrals for treatment are increasing with individuals presenting with more complex needs.

Effectively addressing a community's substance misuse issues means addressing the wider determinants of health and considering substance misuse in the context of the causes of broader health and risk-taking behaviour.

Key JSNA recommendations include:

- To establish a Nottinghamshire Combating Substance Misuse Partnership. This will include Local Authority, Elected Members, Office of Police and Crime Commissioner, Police, Probation, NHS England, substance misuse providers, ICS, DWP.
- To implement locally the new national Drug Strategy (From Harm to Hope 2021 – which is a 10 year drug strategy).
- To enhance education and prevention with substance misuse considered in the context of broader risk-taking behaviour.
- Reducing the supply of substances into communities – for example, utilising the District licencing process to inform decisions regarding the concentration of licensed premises in any particular geographical area.
- Improving pathways for vulnerable individuals – such as those with co-existing mental health and substance misuse issues.
- Addressing data gaps and improving data and information sharing between agencies.

Click here to access the JSNA chapter for substance misuse

Sexual health and HIV (2019)

Sexual health is defined by the World Health Organisation as: 'a state of physical, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. Sexual health is a broader topic than sexually transmitted infections and includes areas such as contraception, abortion, sexual assault, healthy relationships and the wider reproductive health of men and women. Promoting good sexual and reproductive health, exploring healthy relationships, encouraging self-management and having the correct sexual health interventions can all have a positive effect on population health and wellbeing.

Some groups within the population are at higher risk of poor sexual health. The highest burden of sexually related ill-health is borne by groups who often experience other inequalities in health, including men who have sex with men, young people, black and minority ethnic groups, and people living in socio-economically deprived areas. They often experience additional stigma, discrimination and obstacles in accessing services.

Nottinghamshire County is similar to the rest of the country when considering key sexual health outcomes. In Nottinghamshire there has been a slight increase in new diagnoses of STIs, similar to the rise seen nationally. The chlamydia detection remains low compared to the rest of the country although the most up to date data indicates that Nottinghamshire is beginning to improve. Nottinghamshire is performing well in relation to the rate of Longer Action Reversible Contraception (LARC) prescribed but there are local differences in demand and provision. Prevalence of HIV amongst Nottinghamshire residents aged 15-59 years is lower than the national rate, although across the county HIV testing coverage has dropped significantly.

In Nottinghamshire in 2017, 5% of abortions were to women under the age of 18. This figure is similar to the England average of 4.1%. Other age bands are broadly similar to the England averages. Generally, although lower than the national rate across the board, abortions rates were highest in the 20-24 year age group in all CCGs. In 2017, across the county 36.2% of abortions of all ages were repeat abortions compared to 38.8% across England. There were higher levels of repeat abortions in the Nottingham West CCG.

Key JSNA recommendations include:

- **Enhancing sexual health promotion** through understanding needs of vulnerable groups and those who don't access services and supporting stakeholders to prepare Nottinghamshire schools for the implementation of statutory RSE.
- **Preventing poor sexual health outcomes** through greater understanding of Nottinghamshire's varying outcomes, demand and unmet need, and collaborative working to address the pressures in the sexual health system.
- **Ensuring good sexual health treatment outcomes** through considering evaluating the online chlamydia testing service, planning for issues on the sexual health horizon and ensuring that Men who have Sex with Men (MSM) are tested regularly.

Click here to access the JSNA chapter for sexual health and HIV

Click here to access the Nottinghamshire Insight sexual health theme page

Oral Health (2020)

The World Health Organisation (WHO) defines oral health as “a state of being free from chronic mouth and facial pain, oral and throat cancer, oral infection and sores, periodontal (gum) disease, tooth decay, tooth loss, and other diseases and disorders that limit an individual’s capacity in biting, chewing, smiling, speaking, and psychosocial wellbeing.” Oral health problems include tooth decay, gum disease, oral cancers, injuries and trauma, and tooth loss. Tooth decay (dental caries) is the most common dental disease, affecting most of the population, but is highly preventable. It results from the destruction of the hard tissues of the tooth by acids produced in the mouth when bacteria in dental plaque metabolises dietary sugars.

The population as a whole is at risk of developing poor oral health. The table below sets out the main risk factors for specific oral health problems.

Table 1: Risk factors for oral diseases

Oral Diseases	Risk factors
Tooth decay (dental caries)	• Diet – especially where high in sugars • Poor oral hygiene • Lack of fluoride exposure e.g. not using fluoride toothpaste • Socio-economic status
Gum (periodontal) disease	• Poor oral hygiene • Smoking / tobacco use • Other medical conditions e.g. diabetes • Stress responses
Oral cancers - cancers of the tongue, lips, inside lining of the mouth and cheeks and the oropharynx	• Smoking / tobacco use • Alcohol use ○ When both smoking and alcohol use occur together, the risk is increased. Heavy drinkers and smokers have 38 times increased risk of developing oral cancer compared with those who abstain from both products. • Human papillomavirus (HPV) infection • Sun exposure (for cancers of the lips)
Oral injuries / trauma	• Accident and injury (e.g. in playgrounds, or when undertaking activities which carry a risk of injury such as. contact sports) • Violence
Tooth loss	• Untreated tooth decay or gum disease • Access to dental services • Trauma to teeth • Severe tooth wear

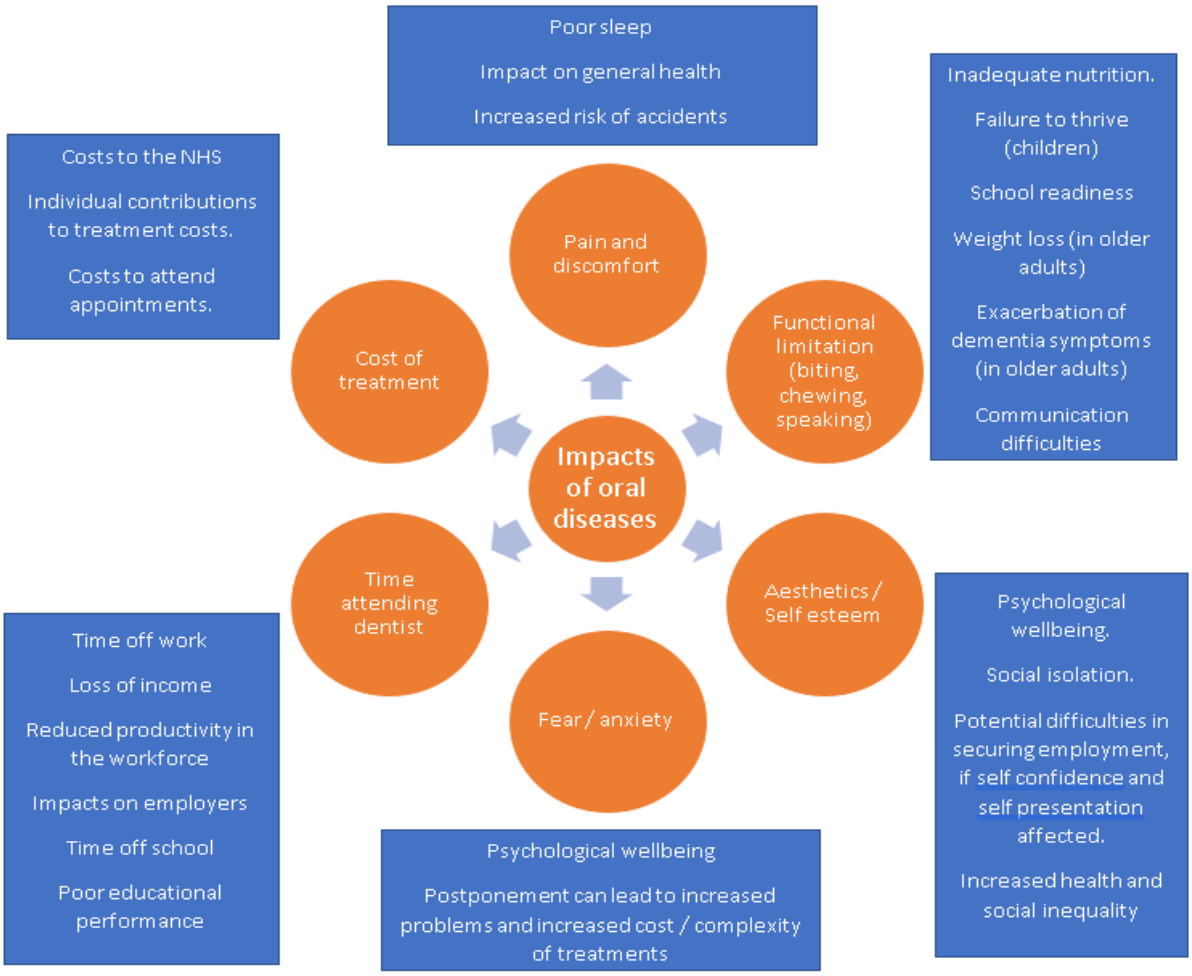
Some vulnerable groups have increased risk of poor oral health, specifically:

- people with a learning disability or with serious mental illness. These groups tend to have fewer teeth, more untreated decay and more periodontal disease
- people who are homeless or who frequently relocate, such as gypsy, Roma and traveller communities

- people who misuse drugs or who drink alcohol at levels posing a risk to health
- prisoners
- frail older people who may have difficulties maintaining good oral hygiene or who have difficulties accessing oral health services

A healthy mouth enables not only nutrition of the physical body, but also enhances social interaction and promotes self-esteem and feelings of well-being. Poor oral health impacts on not just the individual's health but also on their wellbeing and that of their family. It also has wider social and economic consequences, as summarised in Figure 1 below.

Figure 1: Summary of impacts of oral diseases, modified from Daly et al, 2013



National surveys of both adults' and children's oral health indicate improvements in dental health over time, shown by reductions in decayed, missing and filled teeth in children, and by adults keeping teeth longer as they age. However, inequalities persist associated with socio-economic background.

Overall Nottinghamshire County is generally similar or better than the rest of the country when considering oral health outcomes; however, there are variations at a sub-county level. For example, five-year-old children in Broxtowe and Rushcliffe had better oral health than the England average. Five-year-old children in Mansfield and Ashfield showed greater prevalence of tooth decay compared with other districts in Nottinghamshire (National Dental Epidemiology Programme, 2017). There were larger numbers of child admissions for

hospital dental extractions for districts in the north of the County than for the districts in the south (PHE, 2018).

There is a lack of local data related to adult oral health. Based on national surveys, some vulnerable adults have worse than average oral health. Some local information was available from the 2016 PHE oral health survey of mildly dependent older people – those who living in the community but have chosen supported housing. Results for the Nottinghamshire respondents in the survey were lower than the England average for presence of visible plaque and calculus. 51.3% of Nottinghamshire respondents had visible plaque (England average 69.9%). 39.1% of Nottinghamshire respondents had visible calculus (England average 61.3%).

Oral health diseases continue to be widespread despite being highly preventable. Simple measures such as improved oral hygiene practices, improved diet, use of and access to fluoride, along with attending the dentist for regular check-ups to identify problems early, can all help to prevent, or at least reduce, the burden of oral diseases. A common risk factor approach also supports oral health improvement, because the most common oral diseases – tooth decay and gum disease – as well as oral cancers, share many of the same common risk factors (e.g. smoking, alcohol misuse, obesity and poor diet) as other common diseases, such as cardiovascular disease and other cancers – so addressing these risk factors can benefit more than one aspect of health.

Key JSNA recommendations include:

- Integrating oral health within all health policies across adults and children's services and various care pathways.
- Oral health promotion interventions must consider reducing inequalities in our most vulnerable groups by taking a proportionate universalism approach.
- The need to plan for anticipated changes in demography e.g. an increasing number of older people and operating context.
- Improve the oral health care of older people living in care homes through working with care homes to promote the use of NICE and CQC guidance and to improve access.
- Scope how systematic processes for following up children who experience hospital admission because of tooth decay could be established.
- Examining the effectiveness of oral health questions in evaluation of Learning Disability Health Checks.

Click here to access the Oral Health JSNA (2020)

LIFE EXPECTANCY AND HEALTHY LIFE EXPECTANCY

Life expectancy is a measure of the estimated length of life for a particular population based upon current mortality rates. In Nottinghamshire, life expectancy at birth is 79 years for males and 83 years for females (2013-15). Life expectancy is increasing both nationally and locally in both men and women; in Nottinghamshire for men it has increased by 2.3 years in the last 10 years and by 1.8 years for women.

Locally within the districts of Nottinghamshire life expectancy varies considerably with more deprived districts having a shorter life expectancy than less deprived districts, for example in 2013-2015, life expectancy in Bassetlaw, Ashfield and Mansfield was significantly lower than for the England where a both males and female would be expected to live 1.5 years less. In contrast life expectancy in Rushcliffe was significantly higher than for England, where both males and females in Broxtowe could expect to live an additional 2 years longer. In Broxtowe males could expect to live 1 year longer than the national average.

Figure 1: Life expectancy for males and females across Nottinghamshire's districts, 2013-2015

Life expectancy at birth (Male) 2013 - 15

Area	Recent Trend	Count	Value
England	–	-	79.5
Nottinghamshire	–	-	79.4
Rushcliffe	–	-	81.4
Gedling	–	-	79.4
Broxtowe	–	-	80.4
Newark and Sherwood	–	-	79.8
Bassetlaw	–	-	78.6
Ashfield	–	-	78.1
Mansfield	–	-	78.0

Source:
https://www.ons.gov.uk/releases/healthstatelifeexpectanciesuk2013to2015

Life expectancy at birth (Female) 2013 - 15

Area	Recent Trend	Count	Value
England	–	-	83.1
Nottinghamshire	–	-	82.8
Rushcliffe	–	-	85.1
Gedling	–	-	83.6
Broxtowe	–	-	83.2
Newark and Sherwood	–	-	82.9
Bassetlaw	–	-	81.8
Ashfield	–	-	81.7
Mansfield	–	-	81.6

Source:
https://www.ons.gov.uk/releases/healthstatelifeexpectanciesuk2013to2015

Source: PHE local Health Profiles 2016

Although overall life expectancy in the County has improved, this masks substantial inequalities within the County. In 2011-2013 life expectancy varied across Nottinghamshire by nine years in males and seven years in females.

The broad causes of premature death (deaths under 75 years) which contribute the greatest proportion to this 'gap' in life expectancy are explored in figure 4 and show that for males

and females the top four causes are the same: circulatory, cancer, respiratory, digestive and external causes, however the proportion that each of these contributes to the gap in life expectancy varies between genders. Understanding which factors contribute to the gap in life expectancy across Nottinghamshire's population can help to target evidence-based interventions which aim to prevent illness and death in the short and longer term.

If approximately 340 male deaths and 350 female deaths were prevented from the causes in figure 5 below, the gap in life expectancy across Nottinghamshire would be eliminated.

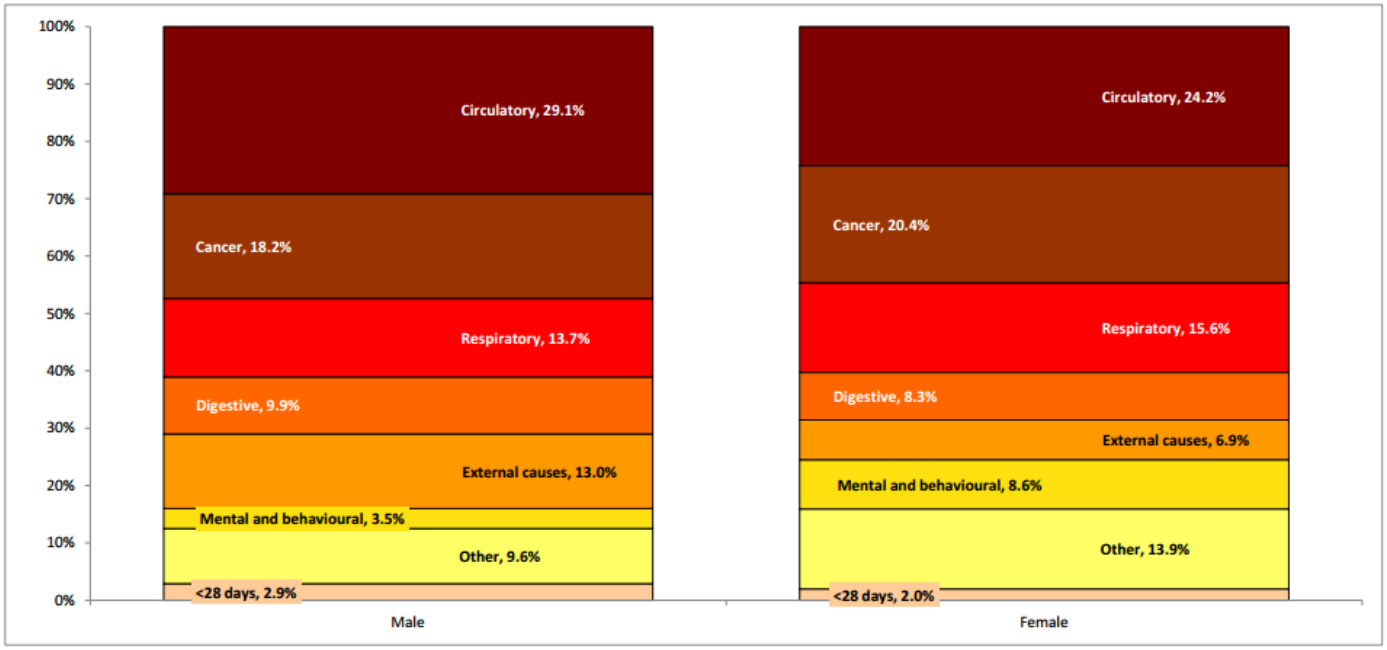


Figure 2: Contribution to the life expectancy gaps between the most and least deprived areas in Nottinghamshire, by cause of death, 2012-14.

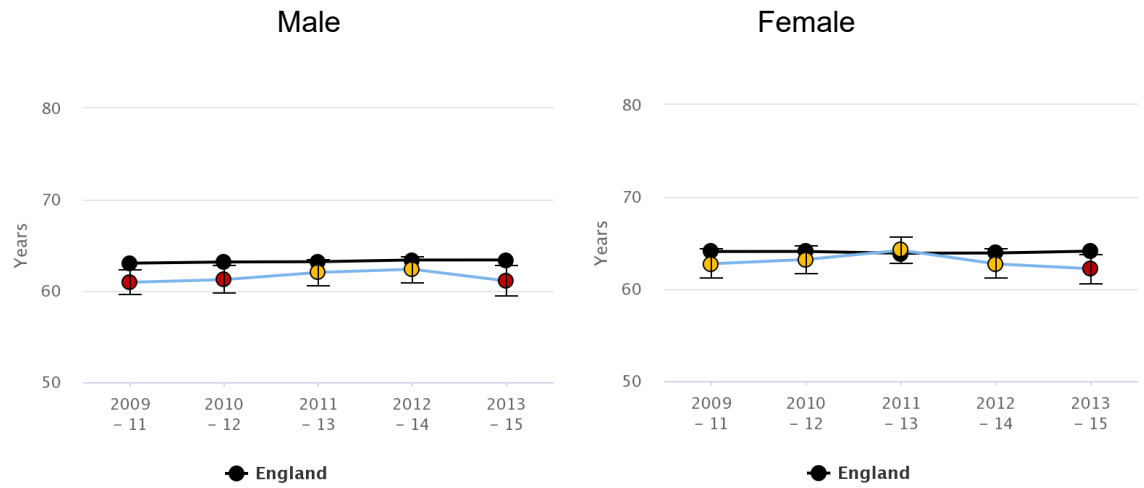
Footnote: Circulatory diseases includes coronary heart disease and stroke. Digestive diseases includes alcohol-related conditions such as chronic liver disease and cirrhosis.
Source: The Segmentation Tool, Segmenting life expectancy gaps by cause of death, Public Health England (Jan 2015)

With the steady rise of life expectancy in the UK and the rising number of older, and very old people, there is a need to capture quality as well as quantity of remaining years lived. Healthy life expectancy describes how long a person might be expected to live in 'good health'. Both life expectancy and healthy life expectancy have increased nationally over recent years; however, life expectancy is increasing at a faster rate meaning that the population is spending a greater proportion of its total life in poor health. This has implications for both individuals – due an increased proportion of life spent with illness and disability – and society due to associated health and social care costs.

Locally in Nottinghamshire healthy life expectancy was 62.2 years for females and 61.1 years for males in 2013-2015. Both males and females had similar healthy life expectancy compared with the England (Figure 3).

When life expectancy and healthy life expectancy are compared it shows that in Nottinghamshire men spend around 18 years of their life in poor health and women 21 years in poor health. This emphasises a need for a focus on the prevention of diseases to maximise time individuals can live in good health.

Figure 3: Healthy Life expectancy at birth in Nottinghamshire (2013-15)



Source: Public Health England, Public Health Profiles.

HEALTH AND WELLBEING IN OUR COMMUNITIES (WIDER DETERMINANTS)

Health and Homelessness (2019)

Shelter defines homelessness as not having a home. You are homeless if you have nowhere to stay and are living on the streets, but you can be homeless even if you have a roof over your head. You count as homeless if you are:

- staying with friends or family
- staying in a hostel, night shelter or B&B
- squatting (because you have no legal right to stay)
- at risk of violence or abuse in your home
- living in poor conditions that affect your health
- living apart from your family because you don't have a place to live together

Homelessness is a far wider a problem than the aspect that is most visible to the public – rough sleeping which is considered the tip of the iceberg.

The causes of homelessness and who is most at risk of homelessness and rough sleeping is complex and warrants action to both address those that are at risk of and who are currently homeless as well as attention to how we can prevent homelessness in the future. This can only be done by agencies from across the public sector working together in a more systematic and joined up way over an extended period.

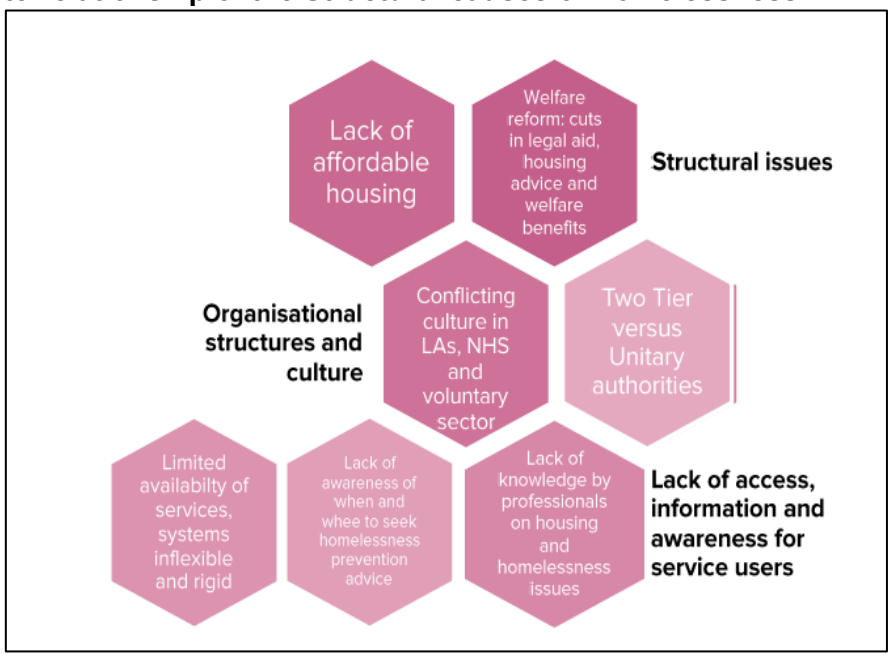
Several multi-faceted factors are driving the recent rise in homelessness in England, which include:

- **Individual circumstances - health, social and behavioural risk factors** including complex and overlapping needs, substance misuse, mental ill health, certain groups such as veterans, care leavers and or those being released from prison and offenders. Socioeconomic factors, such as; relationship breakdown, unemployment, rising relative poverty and problematic debt.

- **Wider forces -** the **supply** of affordable housing and changes to the **welfare system.**

- **Complex interplay** -Structural and individual factors are often interrelated; individual issues can arise from structural disadvantages such as poverty or lack of education and/or poor-quality housing that can lead to worsening of health conditions, such as; respiratory conditions. While personal factors, such as family and social relationships, can also be put under pressure by structural forces such as poverty.

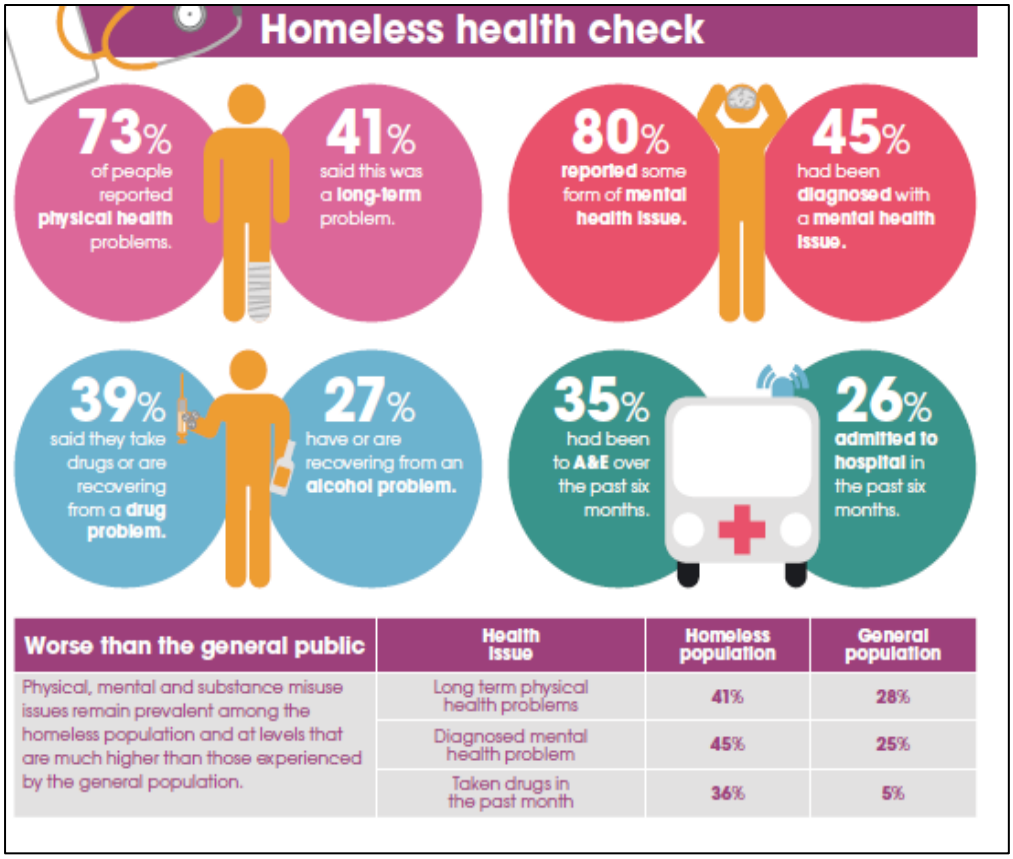
Figure 1: Interrelationship of the Structural causes of Homelessness



Source: Homeless Link (2015) Preventing homelessness to improve health and wellbeing

People who are homeless experience worse health outcomes than the general population. Homeless people aged 16-24 years are at least twice as likely to die as their housed contemporaries; for 25-34-year olds the ratio increases to four to five times, and at ages 35-44, to five to six times.

Figure 2: Comparison of key health issues between homeless and general population



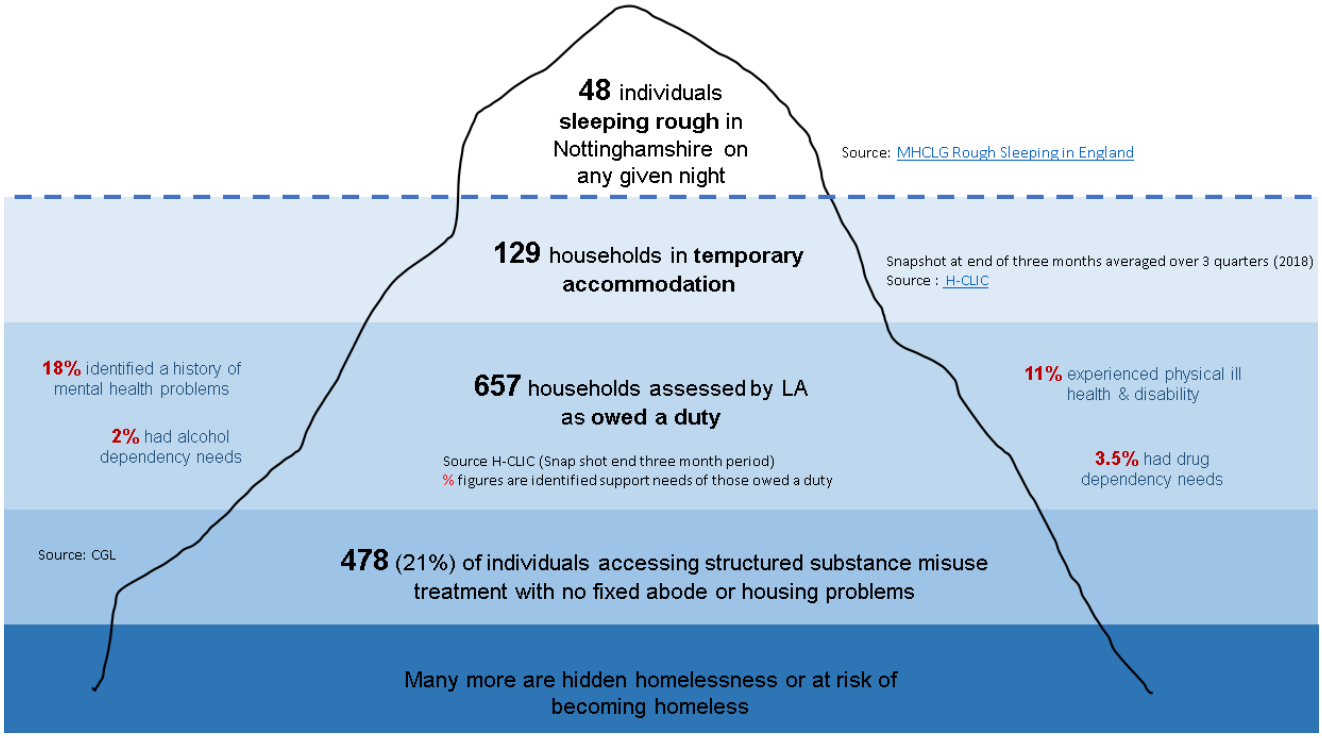
Worse than the general public	Health issue	Homeless population	General population
Physical, mental and substance misuse issues remain prevalent among the homeless population and at levels that are much higher than those experienced by the general population.	Long term physical health problems	41%	28%
	Diagnosed mental health problem	45%	25%
	Taken drugs in the past month	36%	5%

Source: Homeless Link (2014)

Homelessness and poor mental health often go hand in hand. Having a mental health problem can create the circumstances which can cause a person to become homeless in the first place. Yet poor housing or homelessness can also increase the chances of developing a mental health problem or exacerbate an existing condition. In turn, this can make it even harder for that person to recover – to develop good mental health, to secure stable housing, to find and maintain a job, to stay physically healthy and to maintain relationships.
The prevalence of serious mental illness (including major depression, schizophrenia and bipolar disorder) is reported as 25–30% in the street homeless population and those living in direct-access hostels. Homelessness is also associated with higher rates of personality disorder, self-harm and attempted suicide.

The estimated number of homeless people in Nottinghamshire at any one point is outlined below in the iceberg diagram.

Figure 3: Estimate of homeless population in Nottinghamshire at any one point in time



Adapted from Shelter https://twitter.com/shelter/status/1092147212069556225

Key JSNA recommendations include:

- The need and for strong governance and leadership at a strategic level to develop the local system to enable better health outcomes for those at risk of homeless and to prevent homelessness, including setting up a Homelessness Reduction Board
- Developing a care pathway for critical time intervention with specific high-risk groups, the overall healthcare offer and identifying and implementing strategies for opportunistic screening and treatment for communicable diseases.
- To align funding to evidence based primary prevention and to strengthen effectiveness of Street Outreach and Rapid Rehousing Pathway initiatives.

- To embed evidence based psychological approaches to managing and recovering from complex trauma into front line delivery of service, including Psychologically Informed Environments and trauma informed services (ReACH)

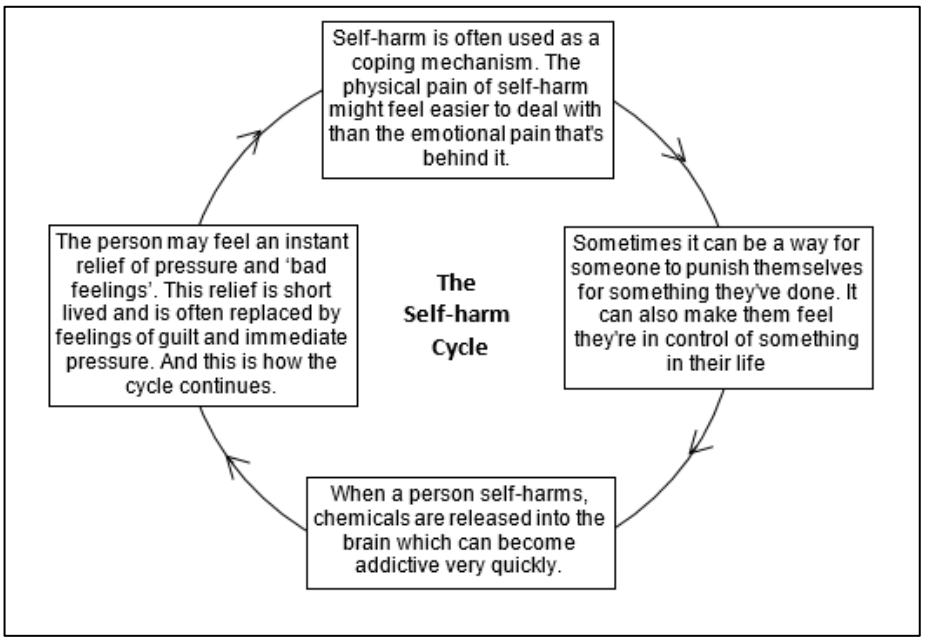
Click here to access the full JSNA chapter for Health and Homelessness

Self-harm (2019)

Self-harm is defined as an intentional act of self-poisoning or self-injury irrespective of the type of motivation or degree of suicidal intent. It covers a wide spectrum of behaviours which include self-cutting, burning, banging and punching, self-poisoning and hair-pulling (trichotillomania). Self-harm is a behaviour rather than a primary or mental health disorder. It is an indicator of underlying emotional/psychological distress. Self-harm is not necessarily a suicide attempt, it may be a coping mechanism for dealing with intolerable situations.

Self-harm is cyclical in nature and usually occurs in the context of multiple life problems. It is likely that there are both psychological and physiological processes and factors preceding and following the behaviour that help to mask the pain associated with physical injury.

Figure 1: The self-harm cycle



Source: Adapted from NSPCC self-harm cycle

It has been reported that the UK has the highest self-harm rate in young people of any country in Europe, with a rate of 400 per 100,000 population. Self-harm is more common in females than males with a girl to boy ratio of as much as 5 or 6 to 1 between ages 12 to 15 years. Not everyone who self-harms will die from suicide and not every suicide is preceded by an act of non-fatal self-harm, however research suggests that self-harm increases the probability of someone dying by suicide within 12 months, by between 50 and 100 times above the rest of the population, with adults over 60 years particularly at risk.

Between 2011 to 2015, there were approximately 220 recorded actual self-harm hospital events in young people between the ages of 12 to 17 years in Nottinghamshire. In addition, we have estimated that there may potentially be over 2,500 12 to 17-year olds in Nottinghamshire who self-harm and are unknown to clinical services. Public Health Outcomes indicators indicate that Nottinghamshire may have higher total rates of hospital admissions relating to self-harm compared to England in 2016/17 for 10 to 14-year olds and similar rates for 15 to 19-year olds and 20 to 24 year olds. These rates should be treated with caution however due to hospital coding issues. Between 2013 and 2016, Nottinghamshire Healthcare Foundation Trust recorded 2,141 self-harm adult referrals.

The true picture of local needs is likely to be underestimated due to the incompleteness and inconsistency of data and the largely unreported nature of self-harm in the community.

Key JSNA recommendations include:

- Focusing on reducing emotional distress/increasing resilience in children and young people and promoting a community assets approach to support improved population emotional health and wellbeing
- Developing trauma/ACE informed practice across the health, care and education system and youth services
- Improving data quality and recording in commissioned services
- Developing system wide multi-agency (all ages) co-ordinated pathway/s recognising self-harm as a primary presenting need

Click here to access the JSNA chapter for Self-harm

CHILDREN AND YOUNG PEOPLE

We know that, on average, children and young people in Nottinghamshire often do as well as those in similar places elsewhere. However, there are large inequalities across the County, and some children and young people face greater disadvantages. National and local data shows that children and young people living in poverty are disadvantaged in many ways.

In Nottinghamshire, the localities where there are higher numbers of families on low incomes are often those localities where children and young people are less healthy, do less well at school and are more likely to need the support of Children's Social Care. Some other children and young people may face particular disadvantages and so need more support. This includes disabled children and children in local authority care.

Priorities in our Children, Young People and Families Plan are based on evidence from our Joint Strategic Needs Assessment and are aimed at reducing inequalities in health and wellbeing across the County.

Children and young people comprised around 22% of the population in 2017 (181,100 aged 0-19 years). This population is expected to show a moderate increase of 7% by 2027 with the greatest increases in Broxtowe (11%) and Gedling (10%). 12.0% of school children are from a minority ethnic group.

Click here to open the JSNA for Children and Young People

1001 days: From conception to age 2 (2019)

The first 1001 days - from conception to the age of 2, are widely recognised as a critical period of development. This is because the earliest experiences, starting in pregnancy, shape a baby's brain development: during the first two years of life the brain develops a remarkable capacity to absorb information, and adapt to its surroundings, and by 2 years of age the brain will be about 80% of its adult size.

A child's physical, social, emotional, and brain development from conception to the age of 2 is shaped by these key factors:

- good maternal mental health
- parent-infant interaction: sensitive and attuned parents
- secure attachment
- healthy pregnancies and the protection and promotion of health in infancy
- quality of the home learning environment

A parent's ability to support their child's health and development can be adversely affected by a range of issues, including:

- domestic abuse
- maternal stress
- level of income
- teenage parenthood
- their own adverse childhood experiences
- having multiple vulnerabilities or complex social needs

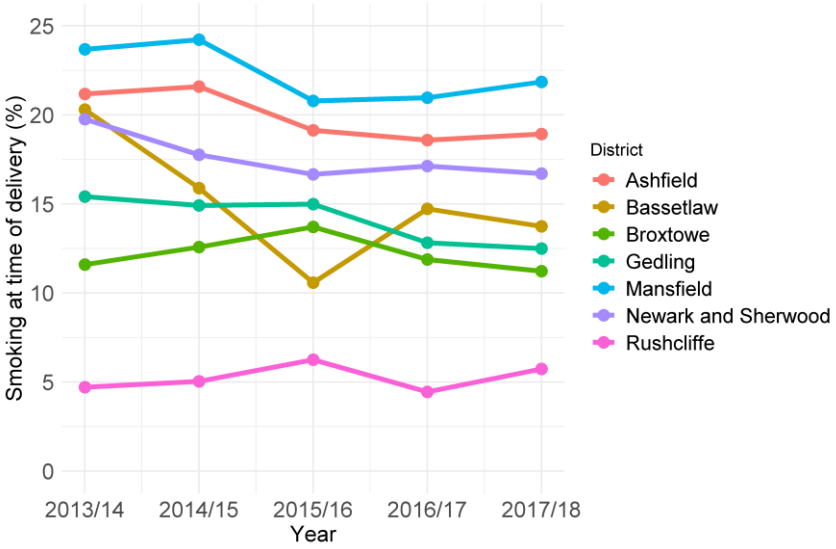
Children and young people make up around 23% of the population in Nottinghamshire and in general, outcomes for children and young people are similar to the national average, however, there are large disparities within the county with some facing greater disadvantage than others.

In Nottinghamshire the birth rate, as measured by the General Fertility Rate (GFR), has fluctuated slightly but overall remained constant, at 61.3 births per 1,000 in both 2013 and 2016. The birth rate is below the national average which in 2016 was 62.5 per 1,000 population. Based on Office of National Statistics data from 2016, the birth rate in Nottinghamshire is projected to increase by 2.3% between 2019 and 2023 from 8,700 to 8,900 births per year. The still birth rate in Nottinghamshire, pooled across 2015-17, was 3.6,

lower than, but not significantly different to the England average of 4.3. In recent years still birth rates in England have fallen, however, they remain the highest in Europe and therefore a key priority to tackle.

Smoking in pregnancy is of particular concern in Nottinghamshire as 14.7% of mothers are smokers when their babies are delivered compared with 10.8% nationally (2017-18), with more pregnant women smoking in areas of greater need such as Mansfield and Ashfield.

Figure 1: Smoking at the time of delivery



Source: Public Health Outcomes Framework

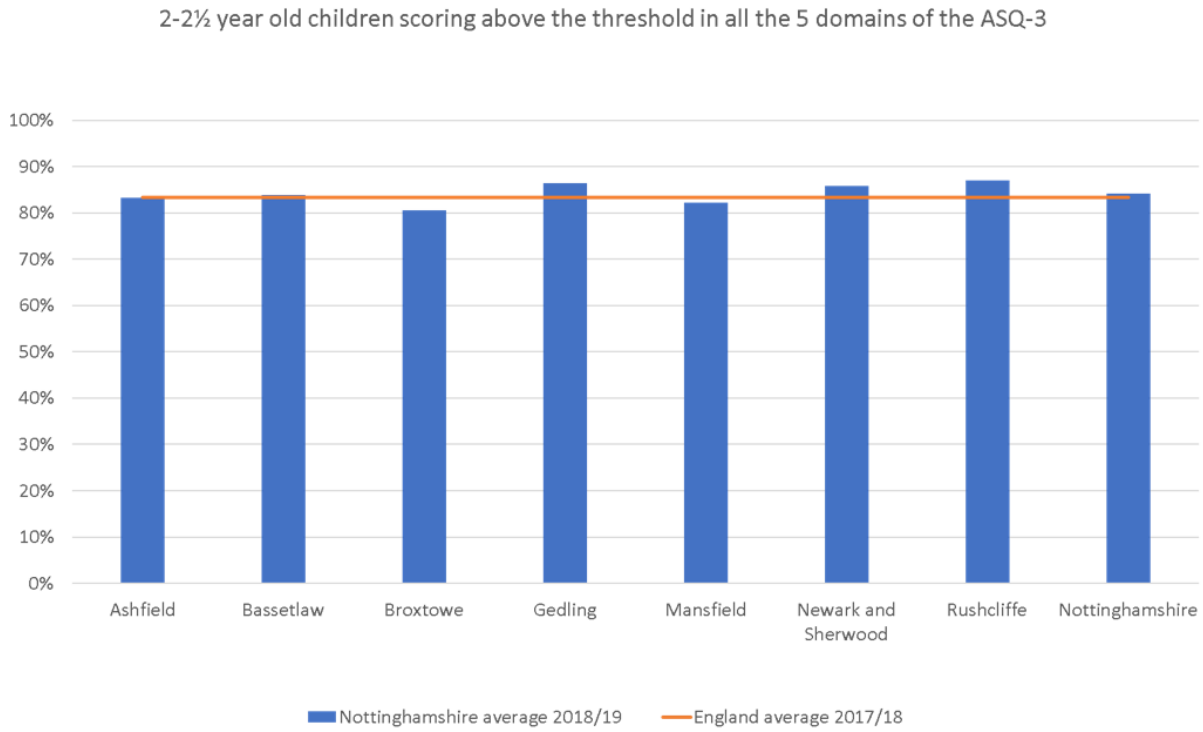
Prevalence of breastfeeding in Nottinghamshire at 6-8 weeks in 2017-18 was slightly lower than the England average at 38.8% compared to 42.7%. Ashfield (32%), Bassetlaw (32%) and Mansfield (34%) have a vastly lower prevalence of breastfeeding at 6-8 weeks than elsewhere in the county, with Newark and Sherwood (40%) also significantly lower.

In Nottinghamshire, vaccine coverage at ages 12 months and 24 months exceeds the England average for all vaccines, though there is variation by CCG.

An important developmental milestone in every child's life is the formation of an attachment bond to the parent. Secure attachment relationships have a long-lasting impact on development, the ability to learn, capacity to regulate emotions and form satisfying relationships.

The evidence-based Ages and Stages Questionnaire is used at age 2 to 2.5 years to determine whether children are meeting the expected levels of development in five key domains: communications, gross motor skills, fine motor skills, problem solving and personal-social skills. In 2018-19 84% of children met the expected level of development in all five areas. Of the 16% of children not meeting the expected level of development in all five areas, some children will not meet the expected level in more than one area. The primary areas of need are communication, with 10% of children not meeting the expected level of development, followed by gross motor at around 7%, and personal-social at around 5%.

Figure 1: Percentage of children meeting a good level of development at age 2-2.5



Source: Nottinghamshire Healthcare NHS Foundation Trust

The JSNA recommendations fall under four key areas:

- The system including establishing a multi-agency, strategic Best Start Group and accompanying strategy to ensure every child in Nottinghamshire has the best possible start in life, beginning in pregnancy and across their early years.
- Health promotion
- Maternal, mental health, attachment and parent-infant interaction
- Child development

Click here to open the 1001 Days: From conception to age two chapter (2019)

Clink to child health profile for Nottinghamshire – PHE fingertips

Early Years and School Readiness (2019)

How we treat young children shapes their lives – and ultimately our society. If we get the early years right, we pave the way for a lifetime of achievement. Despite early education being better than it has ever been, it is still not benefiting our poorest children compared to their peers.

School readiness is measured by the level of development of a child when they reach Foundation Stage at school. A measure called the good level of development (GLD) is used. A child with a GLD at the Early Years Foundation Stage (from birth to five years old) will have reached the expected level in all the prime areas of learning. School readiness is a strong indicator of how prepared a child is to succeed in school cognitively, socially and emotionally.

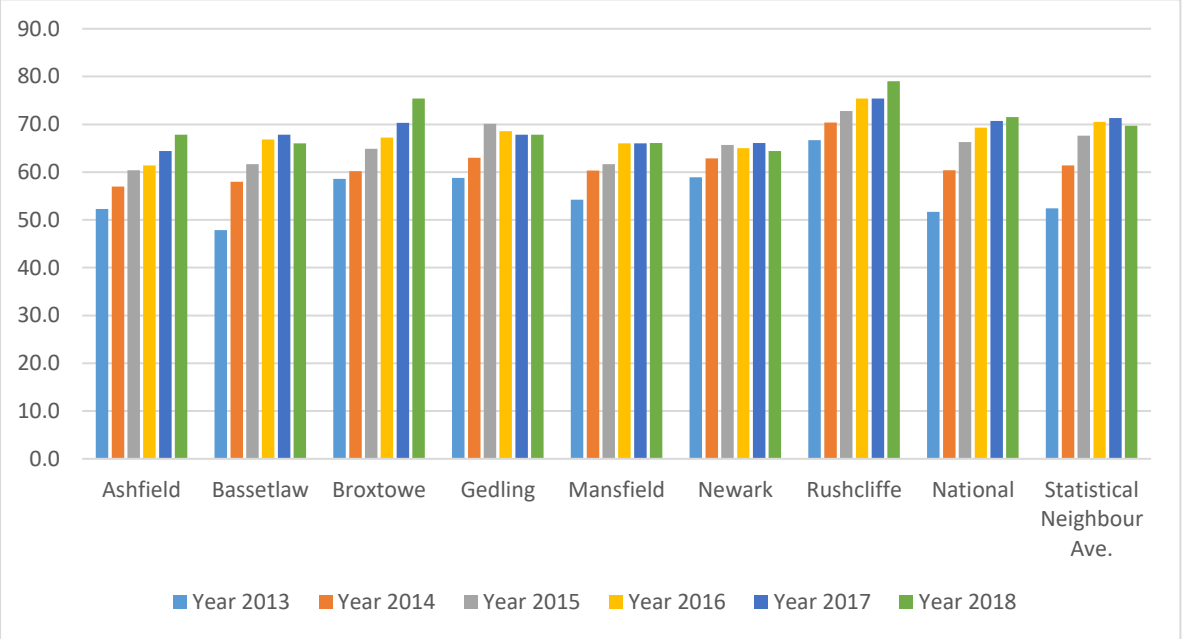
Educational attainment is one of the main markers for wellbeing through the life course making it extremely important that no child is left behind at the beginning of their school life.

Some groups at increased risk of poor educational outcomes are:

- Families living in poverty
- Children and families known to Social Care and those Looked After
- Children with SEND
- Teenage Mothers and their Children
- Children with English as an Additional Language (EAL)
- Some Black and Minority Ethnic Groups
- White British boys
- Children with language delay
- Children and parents affected by Adverse Childhood Experiences (ACEs)
- Gypsy, Roma and Traveller (GRT) Families
- Summer born children
- Children with speech, language and communication needs
- Children affected by Post Natal Depression
- Children affected by Domestic Abuse
- Children with poor sleep routines

In 2018, there was a small increase in the percentage of children who achieved a good level of development both nationally and locally. However, in 2018, 69.7% of Nottinghamshire pupils achieved a good level of development, compared to 71.5% across England. Nottinghamshire also performs poorly in comparison with statistically similar Local Authorities. Progress in Nottinghamshire is slow and despite improvements in many other outcome measures; addressing school readiness remains a challenge and therefore a local priority.

Figure 1: % Children Achieving a Good Level of Development – district progress 2013-2018



Data Source: Nottinghamshire County Council Early Years Foundation Stage results 2018

Children from low income households do less well than their peers. In 2018, only 49.9% of children eligible for free school meals in Nottinghamshire achieved a good level of development. Around 25% are unable to communicate effectively, control their own feelings

and impulses of make sense of the world around them to ensure they are ready to learn. Furthermore, many have reduced opportunities for home learning and parental engagement.

Some key groups susceptible to poorer educational outcomes in Nottinghamshire are:

Boys - In 2018, 76.8% of girls achieved a good level of development compared to 62.8% for boys. Analysis of the Early Years Foundation score by gender identifies a 14%-point gap between boys and girls. This gap has narrowed from 15.6% in 2017.

Summer born – in 2018, 80% of all children across Nottinghamshire born in the autumn term achieved a good level of development compared to 59% of children born in the summer term. The lowest consistently performing group across the early years foundation stage are boys born in the summer term. Summer born boys perform less well with 51.1% achieving a good level of development compared to 71.2% for autumn born boys.

Ethnicity – 65.9% of Children in Nottinghamshire from BME groups achieved a good level of development compared to 70.9% for non BME groups, and the attainment gap is narrowing.

English as an Additional Language – in 2018, 56.2% of children with English as an Additional Language (EAL) achieved a good level of development, compared with 71% of non EAL children.

Early Education and Special Educational Needs and Disability - In 2018 in Nottinghamshire, 16.4% of SEN children achieved a good level of development compared to 72.9% for their peers; this is also reflected nationally.

Key JSNA recommendations include:

- the need to engage families much earlier
- to target resources to children and families most at risk of poor development
- to better engage parents in home learning and to improve parenting skills
- to increase the skills of early years practitioners
- to increase take up of funded high-quality early education by low income groups.

Click here to access the full JSNA chapter for Early Years and School Readiness

Emotional and Mental Health of CYP (2021)

One in ten children aged 5-16 years has a clinically diagnosable mental health problem and, of adults with long-term mental health problems, half will have experienced their first symptoms before the age of 14. Self-harming and substance abuse are known to be much more common in children and young people with mental health disorders – with ten per cent of 15-16-year olds having self-harmed. Failure to treat mental health disorders in children can have a devastating impact on their future, resulting in reduced job and life expectations.

The factors that affect mental and emotional health are complex, ranging from individual biological factors to complex societal issues. Certain groups of children and young people are at higher risk of developing mental health problems e.g. those with learning disability, Special Educational Needs (SEN), physical illness, homeless, lesbian, Gay, Bisexual, and Transgender (LGBT), young offenders, looked after children and children of prisoners.

Information on risk factors for mental and emotional health indicates that in Nottinghamshire most are in line with the national average and are stable or decreasing (click here to access child health profile).

The hospital admission rate for mental health conditions in young people aged under 18 years has increased in Nottinghamshire over the past 5 years. In 2015/16 there were 641 admissions as a result of self-harm for young people aged 10-24 years in Nottinghamshire. These figures are likely to underestimate the true burden of self-harm among children and young people, as the data excludes those individuals seen in primary care or within Child and Adolescent Mental Health Services (CAMHS). Information from local CAMHS service providers indicates an increase in the number and complexity of referrals for self-harm.

Also see the section in this report on suicide prevention.

Nottinghamshire has developed strong, evidence-based strategies to support CYP, particularly through improving access to mental health services. These include the recent introduction of a policy to allow self-referrals, Child and Adolescent Mental Health Services (CAMHS), the Avoidant Restrictive Food Intake Disorder (ARFID) pilot in the CAMHS Eating Disorder Service, and two pilots specific to the youth justice cohort which include the addition of speech and language therapy and clinical psychology. In addition, there has been significant investment in the workforce across a wide range of public sector roles. However, despite the good progress there are still significant unmet needs and gaps in both the understanding of CYP mental health and services provided in Nottinghamshire.

During the COVID-19 lockdown period between March and June 2020, there was a significant reduction in referrals to mental health services, partly due to school closures and restrictions on GP services, but also related to face to face work ceasing for all but the most vulnerable. Referrals have increased since then, but there is further work being undertaken to understand the impact of the reduction of referrals on CYP mental health and the impact of the reduction in face to face services.

Unmet needs and gaps

The **1001 days JSNA** identified the need to better identify and support women with mild to moderate mental health needs and those with parent-infant interaction difficulties. National prevalence data suggests that 5.5% of 2- 4-year olds have mental health needs but there are currently no dedicated infant mental health services commissioned in the County.

The **Self Harm JSNA** (2019) identifies that there is a gap in support for people of all ages who self-harm or who are at risk of self-harm, but do not meet acceptance criteria for clinical/mental health services.

Reductions in funding to early intervention services across the system have resulted in a reduction of universal provision and of parenting support, particularly around the skills they need to help support the positive mental and emotional development of their children.

Additionally, whilst there has been progress made to improve transition from youth to adult services, the question of the quality of transition remains an issue for our young adult service users, and there is potential to tackle this through the development of a comprehensive pathway for those aged 0-25.

More emphasis is needed on targeting inequalities seen in mental health and wellbeing particularly for looked after children, young carers, children with a special educational needs and disabilities and Lesbian Gay Bisexual Transgender, queer (or questioning) and others (LGBTQ+) young people.

The precise prevalence of mental health and wellbeing in CYP in Nottinghamshire is, however, still unknown. Data on the prevalence has been extrapolated based on NHS Digital estimates. Since April 2018 all NHS commissioned providers have been developing their systems to be able to provide service level data to the Mental Health Services Data Set (MHSDS). Therefore, we are now in a better position to understand local need and further develop services to meet this need. Further work is also required to understand the impact of inequalities within Nottinghamshire.

There are also gaps around mental health support for children and young people in schools. Whilst there is additional investment in Mental Health Support Teams for Schools, the national ambition for rollout is coverage of 25% of schools by 2023/24. This means that a significant number of schools in Nottinghamshire will not have access to these teams.

Key JSNA recommendations include:

- Review access to services by minority groups.
- ensure services meet the needs of the 0-25 age group.
- Expand parent education and training programmes to support preventative work around mental health and wellbeing.
- Ensure that mental health and emotional wellbeing are considered in all policies relating to both staff, service users and pupils.
- Embed a whole family approach to tackling children and young people's mental health needs.

Click here to access the full JSNA chapter for Emotional and Mental Health of Children and Young People

Avoidable injuries in children and young people (2019)

Avoidable injuries refer to injury that occurs as a result of 'accidents', whereby the injury is not deliberately caused and could have been avoided. Avoidable injuries tend to occur either in the home, on the roads, or during leisure activities. In children and young people (CYP), avoidable injuries are a serious public health issue and a leading cause of death and hospital admission in the United Kingdom. Avoidable injuries in the home for under 5's are most commonly, choking, suffocation and strangling, falls, poisoning, burns and scalds and drowning.

There is an association between increasing deprivation and likelihood of hospital admission. Children and young people whose parents have never worked or are long-term unemployed have injury death rates 13 times higher than those whose parents are managers/professionals. Other risk factors are children who have a disability or impairment (physical or learning), children from some minority ethnic groups and those who live in accommodation which potentially puts them at increased risk.

The Department of Health calculated the average cost of A&E attendances for under 5's to be £140m per year, with the cost to society being £7.4 billion. There are long-term impacts associated with avoidable injuries, with data suggesting that those who have suffered injury in childhood are at greater risk of physical disability, psychological morbidity, cognitive or social impairment, lower educational achievement and poorer employment prospects.

Nottinghamshire has had significantly lower hospital admissions rates than the England average for the 0-4 and 0-14 age bands since 2010/11. Rates for 15-24 year olds have been statistically similar or lower that the England average rate during this time period. There are some geographical differences, with districts in the North of the County having higher rates of admission to districts in the south.

Since 2009 there has been a decline in killed or seriously injured (KSI) for 0-15 year olds similar to that of the England rate. Ashfield, however has the highest rate of KSI in the County and is significantly higher than regional and national rates. Nottinghamshire KSI rates for pedestrians are significantly higher than for other modes of transport.

Key JSNA recommendations include:

- Strategic leadership and coordination between agencies contributing to preventing avoidable injuries for children in the home, on the roads and in leisure time which includes delivering a range of interventions
- Interventions must consider reducing inequalities
- Consideration for how best to incorporate local views in future strategies
- Addressing unavoidable injuries in the home through:
    - Implementing evidence based, standardised, age appropriate home safety messages across the system
    - Re-establishment of home safety sub group of the Children's Avoidable Injury Strategic Group
- Addressing unavoidable injuries on the road through continuing to support the delivery of a range of local interventions e.g. road safety education programme

- Development of a Leisure Safety Action plan pulling together established working groups

Click here to access the JSNA chapter for avoidable injuries in children and young people

ADULTS AND VULNERABLE GROUPS

There are a significant number of adults in the County who have diverse needs and may require considerable input from health and social care services. This group includes those with mental health conditions, long term conditions, the vulnerably housed, as well as those with physical and/or sensory impairments or learning disabilities.

The number of adults in these groups is increasing. For instance, we know homelessness is increasing, as well as the incidence of learning disability (as well as increased life expectancy of those with learning disabilities). The number of carers has increased by 7,517 between the 2001 and 2011 Census. The health and wellbeing of carers is important as this group provide an essential informal support system to local health and social care services and are also more likely to have increased health needs of their own.

Autism (2019)

Autism is “a lifelong neurodevelopmental condition, the core features of which are persistent difficulties in social interaction and communication and the presence of stereotypical (rigid and repetitive) behaviours, resistance to change or restricted interests”. The way that autism is expressed in individual people differs at different stages of life. There is strong evidence to suggest that autism can be caused by a variety of physical factors, all of which affect brain development. It is not caused by a person's upbringing or their social circumstances and is not the fault of the individual with the condition. Five times as many males as females are diagnosed with autism. Research suggests that autism spectrum disorders are under-diagnosed in females, and therefore the male to female ratio of those who are on the autism spectrum may be closer than the 5:1 ratio.

Everyone with autism experiences difficulties across social communication and interaction and restricted, repetitive patterns of behaviour, interests or activities with varying severity and presentation. Accordingly, some people with autism are able to live relatively ‘unsupported’ lives while others need a lifetime of specialist support. Other effects may be:

- Limited language skills and/or difficulty understanding
- Unusually low or high sensitivity in one or more senses
- Epilepsy, Attention Deficit Hyperactivity Disorder (ADHD), gastro-intestinal problems, mental health issues, motor difficulties, sensory issues and sleep problems in children and young people.

Given these effects having the appropriate support and services in place will have a positive effect upon education, employment, a healthy lifestyle, independence and future relationships. This in turn will have a substantial impact upon overall wellbeing.

Based on the application of national prevalence rates to the local population estimated figures for the number of people with Autism Spectrum Disorders (ASD) across the county are shown in the table below.

Table 2: Estimated prevalence of autistic spectrum disorders in Nottinghamshire

District	Males	Females	Total
Ashfield	862	102	964
Bassetlaw	819	94	913
Broxtowe	813	93	906
Gedling	812	98	910
Mansfield	747	87	834
Newark and Sherwood	844	98	942
Rushcliffe	810	95	905
Total	5715	667	6382

Source: PANSI v.10 and POPPI v. 10

Key JSNA recommendations include:

- Create a multi-agency task and finish group for autism
- At transition stage, build support, resources and employer capacity for people with ASD and their families.
- Build community capacity and responsibility to support people with autism along with building employment opportunities for individuals with autism
- Providing appropriate training for staff and volunteers and attempting to monitor and evaluate training within all agencies
- Address the medical and lifestyle issues which result in poorer health outcomes and increased mortality
- Investigate how diagnostics and the autism pathway could be improved
- Set up and improve data collection across agencies around autism

Click here to access the JSNA chapter for Autism

Learning Disabilities (2019)

A learning disability affects the way a person learns new things, understands information and how they communicate. Valuing People defined learning disability as:

- a significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence), with;
- a reduced ability to cope independently (impaired social functioning) which started before adulthood with a lasting effect on development

Evidence shows that more males are born with learning disabilities, with estimates suggesting the ratio of people with learning disabilities is approximately 60% male and 40% female.

People with learning disabilities are among the most vulnerable in our society, generally having greater and more complex health needs than the general population, and often these needs are not identified or treated. Research shows life expectancy of people with learning disabilities is increasing but is lower than the general population. People with a learning disability are at increased risk of stigma, discrimination, and violent physical contact in the communities they live, making them more prone to lower self-confidence and increased vulnerability.

It is estimated that in 2018 approximately 16,000 adults in Nottinghamshire were predicted to have a learning disability. This is expected to increase from 15,227 in 2017 to 16,600 in 2035. The largest proportionate increase is predicted to be in those aged 65 and over.

Nottinghamshire GP records show that breast cancer screening rates remain low for people with a learning disability, in comparison with adults with no recorded learning disability. For those eligible, 58.5% received a GP health check which exceeds the regional and national averages. There are differences at CCG level, with Bassetlaw and Nottingham West reporting the highest level of checks. Type 2 diabetes rates remain higher for people with a learning disability.

In 2018 there were 2,178 adults with a learning disability receiving a support package from Adult Social Care services. Employment figures in Nottinghamshire for adults with a learning disability (2.7%) are below regional and national comparisons.

Key JSNA recommendations include:

- Ensuring that future strategies across a range of multi-disciplinary areas take into account the current and future needs of people with learning disabilities and that there are accessible health promotion and prevention initiatives
- Ensuring health and care services are joined up to support people with learning disabilities, particularly during transitional periods between services
- Involving a range of stakeholders in the co-design and co-production of provision and replicating where possible best practice identified within the Transforming Care Partnership
- Explore methods to increase the uptake of learning disability health checks and further develop the LeDeR programme
- Working towards maximising employment opportunities in Nottinghamshire.

Click here to access the JSNA chapter for Learning Disabilities

Domestic abuse (2019)

Domestic abuse is defined as any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse: psychological, physical, sexual, financial and emotional abuse. The definition also includes so called 'honour- based' abuse (HBA), which includes female genital mutilation (FGM) and forced marriage (FM).

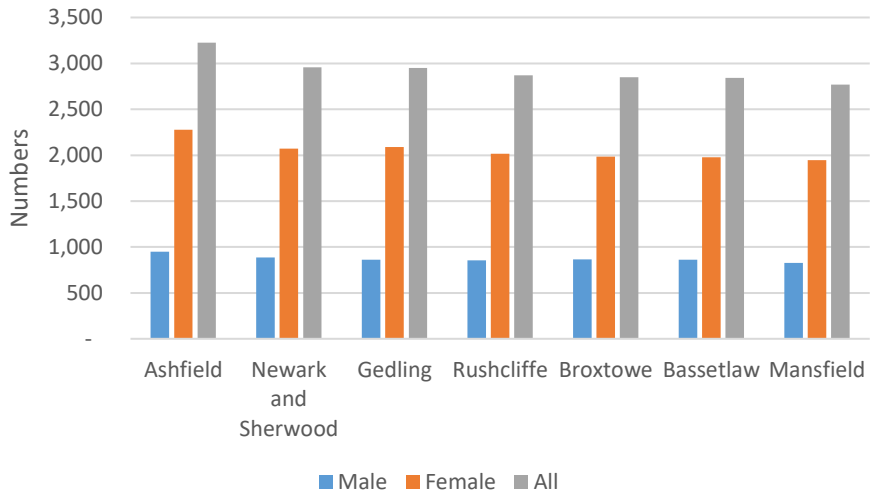
Whilst men do experience domestic abuse, it is a gendered crime, with women much more likely to experience abuse. An estimated 4.6m women (28% of the adult population) have experienced domestic abuse at some point since the age of 16.

Domestic abuse has a significant impact on health and wellbeing including physical injury and in extreme cases homicide, survivors are at increased risk of chronic health problems including gynaecological disorders, chronic pain and gastro-intestinal disorders. Women who have experienced intimate partner violence were almost twice as likely to experience depression and problem drinking and have approximately twice the level of usage of general medical services and between three and eight times the level of usage of mental health services. Domestic abuse is also the single most quoted reason for becoming homeless. It is estimated that the cost of domestic abuse in England and Wales is around £66 billion with the biggest proportion being attributed to the physical and emotional costs of supporting victims.

Approximately 75% of children living in households where domestic abuse occurs are exposed to actual incidents. These children have an increased risk of developing acute and long term physical and emotional health problems.

For the year ending March 2018, in Nottinghamshire 20,464 people will have experienced domestic abuse in the previous 12 months and 79,362 persons over their lifetime, 56,756 women and 22,606 men. This is likely to be an underestimate as it does not include those aged 60 and above.

Figure 1: Estimated numbers (age 16-59) prevalence of domestic abuse by District in previous 12 months



Source CSEW and ONS mid-year population estimates 2018

Domestic abuse recorded crime increased from 5,808 between July 2016 – June 2017 to 6,645 between July 17 and June 18 equating to a 14.4% increase in reporting. Between 2015-2018 there have been 13 Domestic Homicide Reviews (DHRs) in Nottinghamshire.

The recommendations in the JSNA are set out in line with the Nottinghamshire Framework for Tackling Domestic & Sexual Abuse in Nottinghamshire 2016-2020. Given the number of recommendations the Domestic and Sexual Abuse (DSA) Exec will need to prioritise.

Key JSNA recommendations include:

- To maintain strong partnership working and co-ordinated commissioning informed by engagement with survivors.
- For agencies to develop and promote policy and procedures for work with survivors, children and perpetrators and to acknowledge the importance of maintaining provision of refuge and other specialist services.
- Preventative measures which promote healthy relationships, gender equality, and awareness of domestic abuse especially in schools and developing targeted inventions to support at risk victims and young people who harm.
- To improve identification and response across healthcare settings
- Maintaining specialist services e.g community, housing and refuge and developing support for survivors of harassment and stalking and capacity to support children impacted by domestic abuse.

Click here to open the JSNA chapter for Domestic abuse

Long term conditions and cancer

In general, people are living longer but with greater levels of ill health and disability. It is therefore important to understand the chronic illness experienced by people living in Nottinghamshire.

A long-term condition is one that cannot be cured but can be managed through medication and/or therapy. There is no definitive list of long-term conditions – diabetes, asthma and coronary heart disease can all be included.

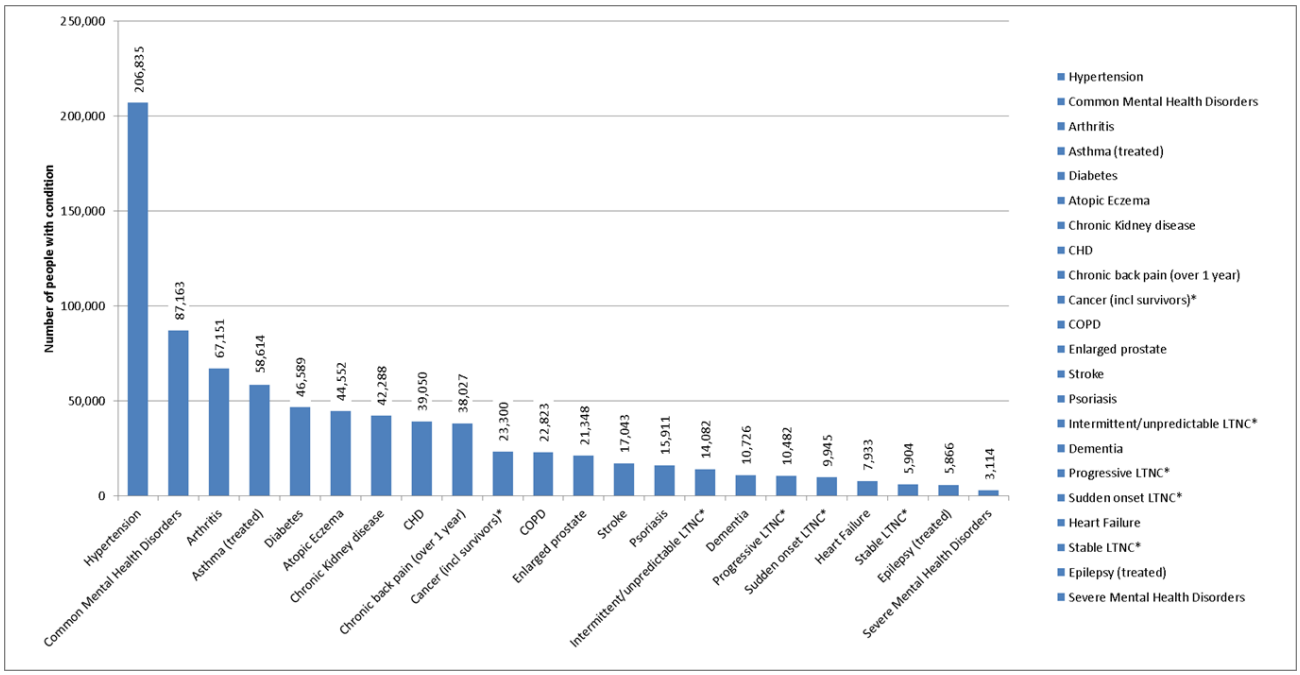
People with long term conditions experience differing needs at different stages of their life and as their condition(s) progress. They may have complex health and social care needs which require integrated support through self-care, clinical care, supporting independence, psychological support and other relevant social factors.

In the Census 2011, those people who reported a long-term health problem or disability (including those related to age) that limited their day-to-day activities. The percentage of people for whom their day-to-day activities were limited a lot was significantly higher in Nottinghamshire (9.7%), Ashfield (11.2%), Bassetlaw (10.8%) and Mansfield (12.2%) compared with the East Midlands (8.7%) or England (8.3%).

Figure 1 below gives an overview of the relative burden of the most common long-term conditions in Nottinghamshire's population. It does not include multi-morbidities, where a person may suffer from more than one condition at the same time. The most common long-term conditions are hypertension, common mental health disorders, asthma, chronic kidney disease, diabetes and coronary heart disease.

Figure 1: Estimates of relative burden of long-term conditions in NHS Nottinghamshire and NHS Bassetlaw: numbers of people suffering from long-term conditions

Note*: these numbers do not include multi-morbidities*



*Sources: different prevalence models, Notts registered population July 2014 *prevalence estimates include children LTNC=long term neurological conditions CHD=coronary heart disease COPD=chronic obstructive pulmonary disease*

Cancer (2019)

Cancer is a disease caused by normal cells changing so that they grow in an uncontrolled way. There are more than 200 different types of cancer. With it being one of the biggest health challenges in the UK, estimates suggest one in three people will develop some form of cancer in their lifetime. Medical developments and an ageing population is resulting in an increasing number of cancer diagnoses.

This is a disease that is largely related to ageing. Nearly two thirds (65%) of cancer diagnoses occur in the over 65s. When a cancer is identified in someone under the age of 75 year it is considered ‘premature’ in the context of the nation’s health overall. Premature death from cancer is an important marker of health inequality within and between communities.

Along with age, an individual’s risk of developing cancer is linked with exposure to a breadth of factors including lifestyle, socio-economic status, occupation and genetic make-up. An estimate is that four in every ten cancers can be prevented by lifestyle change (Cancer Research UK). Other vulnerabilities which people have no or limited abilities to address through lifestyle changes include exposure to certain infections, life course patterns and occupational exposure. Sex, genetics and geographic place of residence also all bring differences in risk exposure. Place differences are related to socio-economic status and experiences of poverty and culture. Ethnicity can impact on an individual’s risk of a diagnosis.

Cancer remains a challenge to diagnose and treat, with treatment and care being complicated, traumatic and expensive. The impact of a diagnosis for an individual and those close to them remains an overwhelming experience. Estimates are that NHS cancer costs, for example, are increasing by 9% a year and are projected to be around £13bn by 2020/21 in England.

Nationally cancer service and cancer health outcome improvement is directed through the strategy, 'Achieving World Class Cancer Outcomes (AWCCO) 2015 – 2020' (Independent Cancer Taskforce (ICT), 2015). In Nottinghamshire strategic direction and coordination of AWCCO delivery is undertaken by the Nottinghamshire STP Cancer Programme Board. This group brings together a range of stakeholders engaging with patients and cancer services. The East Midlands Cancer Alliance, formed in 2017, now provides regional leadership and access to the national transformation funding.

In Nottinghamshire, in 2014, 4,910 people were diagnosed with cancer and 2,299 (2013) people died from the disease. The most common cancers diagnosed in Nottinghamshire are breast (756), prostate (670), lung (645) and bowel (567). The number of new cases of cancer being diagnosed shows an increasing trend. In contrast to rising incidence rates, mortality (death) rates are falling in Nottinghamshire and overall in England. This widening gap between the incidence and mortality rate indicates a growing population who are living with and beyond cancer treatments.

Early detection is vital in optimising health and survivor outcomes. Nationally recognised initiatives for improving early diagnosis include public awareness raising of key signs and symptoms, facilitating access to GP surgeries and encouraging attendance for the NHS national cancer screening services. Screening uptake for breast, cervical and bowel in Nottinghamshire are above average, yet each of the programme have a good proportion of eligible individuals not attending.

The health situation of people living after cancer treatments is an important health need. Treatments themselves can have long-term health impacts, 'late effects', such as chronic pain, crippling fatigue, incontinence and psychological distress.

Key JSNA recommendations are:

- Completion of the ninety-six recommendations in AWCCO (ICT, 2015). Many of these will be implemented at the national and regional level. Successful local implementation, however, will require local engagement including the participation in pilot schemes.
- Addressing the health inequalities and social determinants that increase the risk factors for cancer and full implementation of the Equality Act 2010 throughout cancer prevention and treatment provision.
- To continue to develop the local partnerships and within this establishing a clarity of vision for addressing key service workforce issues across health, social, and the third sector and voluntary provision.
- Ongoing and improving developments in the provision of a supportive environment for the third/voluntary sector to flourish.

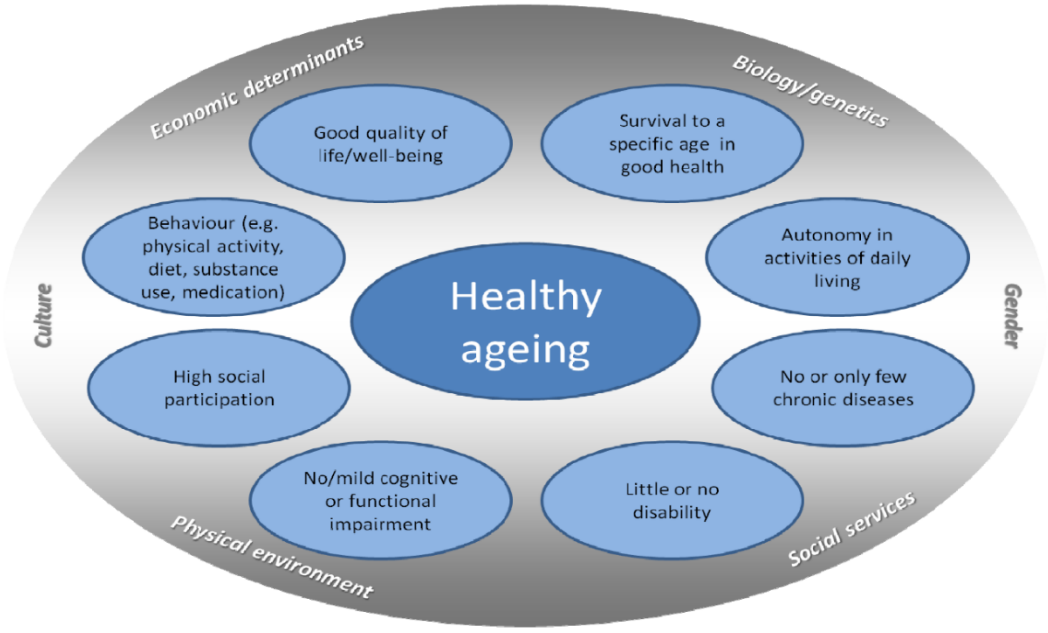
Click here to access the JSNA chapter for cancer

OLDER PEOPLE

In order to age well, older people need to be empowered to live active, healthy lifestyles and limit decline in health and wellbeing and associated reduction is the quality of like. The effects of ageing begin to manifest themselves, particularly after the age of 50 and these effects are influenced in part by people's earlier lifestyles. In order to help people age well, it is important to target prevention or delay of illness, disability and long term conditions; and when such conditions do arise, to try and minimise their impact so that people can remain in their own homes and independent for as long as possible in in order to avoid the need for acute health treatment or social care.

The figure below summarises a number of key themes associated with ageing well. This section brings together evidence from JSNA chapters covering a number of these themes.

Figure 1: Key themes associated with ageing well



Source: J. Fuchs et al, Indicators for Healthy Ageing — A Debate. Int. J. Environ. Res. Public Health 2013, 10(12), 6630-6644

The demography of our ageing population is considered earlier in the report. For the population figures on Nottinghamshire Insight click here.

THE FULL HISTORICAL LIST OF ALL CURRENTLY PUBLISHED JSNA CHAPTERS

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Air quality theme page

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Carers (2014)

sexual abuse (2014)

Nottinghamshire Domestic and Sexual Abuse Framework for Action

Stroke (2017)

Viral Hepatitis (2017)

Dementia (2017)

chapter for Falls and bone health (2017)

Excess winter deaths (2014)

Loneliness and Social Isolation in Older People (2016)

End of Life Care for Adults (2017)

Excess winter deaths (2014)

[i] Health inequalities are preventable and unjust differences in health status experienced by certain population groups. People in lower socio-economic groups are more likely to experience chronic ill-health and die earlier than those who are more advantaged. Health inequalities are not only apparent between people of different socio-economic groups – they exist between different population groups.

[ii] LSOA is a small geographical area. They give an improved basis for comparison across the country because the units are more similar in size of population than, for example, electoral wards. They have an average of roughly 1,500 residents and 650 households.

[iii] The **disability**-**adjusted life year** (DALY) is a measure of overall disease burden. One DALY can be thought of as one lost year of 'healthy' life. The sum of these DALYs across the population, or the burden of disease, can be thought of as a measurement of the gap between current health status and an ideal health situation where the entire population lives to an advanced age, free of disease and disability.