

Nottinghamshire County Joint Strategic Needs Assessment Evidence summary 2017

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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 46 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. It is only possible to present a brief overview of this information in this Evidence Summary and so it should be used in conjunction with the full JSNA. All supporting data and information for this evidence summary including references can be found in individual chapters or other reports (hyperlinks included). Where possible, the latest available data has been presented in this evidence summary and therefore this may differ from the data presented in the original JSNA chapter.

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 805,800 (ONS mid-year estimate 2015). 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.

Overall the age structure of Nottinghamshire is slightly older than the national average, with 20% of the population aged 65+ in 2015 compared with 18% in England. Our population is predicted to continue to age and 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.

More 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 in detail 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 activity¹. 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 The people of Nottinghamshire \(2015\) chapter](#).

DEPRIVATION, SOCIO-ECONOMIC STATUS AND WIDER DETERMINANTS OF HEALTH

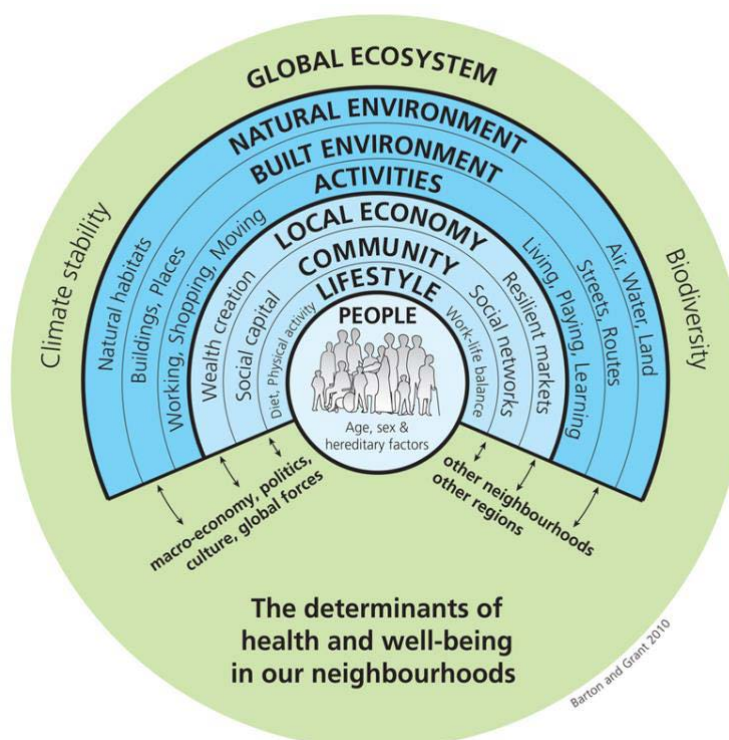
Research shows that many health and wellbeing outcomes are linked to socio-economic factors and the 'wider determinants of health' (figure 3). It is therefore important to understand the socio-economic context of the County when trying to understand and improve health and health inequalities². Health and wellbeing

¹ Activities include: going out of doors and walking down the road; getting up and down stairs; getting around the house on the level; getting to the toilet; getting in and out of bed

² 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.

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.

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



The Index of Multiple of 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 inequalities³ 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)⁴ 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.

³ 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.

⁴ 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.

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%).

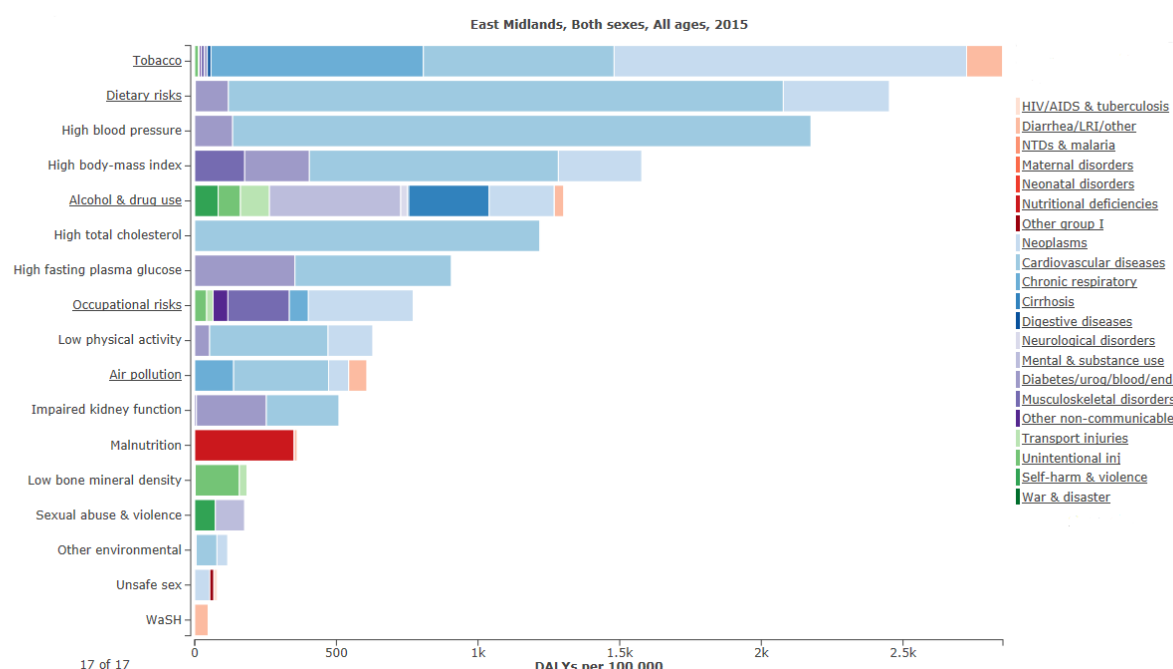
Generally residents felt safer to go out during the day than the night time, particularly in Bassetlaw, Mansfield and Ashfield.

[Click here to access the full JSNA demography and wider determinants report](#)

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 (DALY⁵) by risk factors and causes, East Midlands



Source: Global Burden of Disease, Public Health England

Smoking

Smoking causes 80,000 deaths in England each year, more than any other preventable cause. Smoking is the single biggest cause of inequalities in death rates and life expectancy between the richest and poorest in our communities. On average in Nottinghamshire County this difference in life expectancy is 8.5 years and tobacco contributes to half of this difference.

Smoking prevalence in Nottinghamshire has fallen from 21.7% in 2010 to 15.7% in 2015. This mirrors the change in national smoking prevalence rates. Nottinghamshire has similar rates of deaths due to smoking related illnesses such as cancers, respiratory disease and cardiovascular disease compared to England. There are strong correlations between smoking prevalence and deprivation. Smoking prevalence varies between districts; Bassetlaw (23.5%), Ashfield and Gedling (17.4%), Newark and Sherwood (17.1%), Mansfield (15.6%), Rushcliffe 7.5%. Amongst certain groups, smoking prevalence is also higher. For example, both nationally and locally routine and manual workers have a higher smoking prevalence at 26.5% and 26.2% respectively.

The high smoking rates during pregnancy in the County (14.5%), compared to England (10.6%) in 2015/16, are of particular concern. Smoking in pregnancy increases risk of

⁵ 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.

complications, which affect mothers and babies health, and increase risk of miscarriage and maternal death. Children who grow up in families and communities with a high proportion of smokers are more likely to become smokers themselves.

The Nottinghamshire JSNA chapter highlights a focus on: stopping smoking, particularly for higher risk groups; preventing the uptake of smoking by young people and; reducing harm from tobacco use by tackling illegal tobacco and reducing exposure to second hand smoke.

[Click here to access the Tobacco theme page on Nottinghamshire Insight](#)

Excess weight

Being overweight or obese significantly increases the risks of developing and dying from cardiovascular disease, kidney and liver disease and cancer and the risk increases as BMI increases. It is the fourth largest contributor to Disability-Adjusted Life Years (DALYs) the number of "healthy years" lost due to ill health, disability or early death in England (see figure 1)

9% of Nottinghamshire children aged 4-5 years old and a 17% of 10-11 year olds are obese. Children aged 10-11 years living in the most deprived areas in the country are more than twice as likely to be obese compared with those living in the least deprived areas. Approximately two thirds of the adult population are overweight or obese. Estimates of adult obesity show that it is expected to be significantly higher than England in all districts apart from Broxtowe and Rushcliffe. Four in ten pregnant women are estimated to be overweight or obese with nearly two in ten being obese.

Current trends suggest that 80% of children who are obese at age 10–14 will become obese adults. The number of children who are overweight or obese is expected to increase by 5% between 2015-2019 and in adults by 4% over the same period. Morbid obesity in adults is expected to increase by 16% during this same period.

JSNA recommendations include:

- Work with partners across the system to ensure there is no duplication or gaps in obesity prevention and weight management service provision targeting areas and groups with the highest levels of excess weight to maximise health outcomes, monitoring uptake by protected groups;
- Improving access to local intelligence for higher risk groups;
- Ensure local obesity and weight management services are outcomes based and target those with the greatest need.

[Click here to open the JSNA for Excess Weight](#)

Diet and nutrition and physical activity

An individual's diet and nutrition status has both a direct impact on health status as well as an indirect one through the maintenance of a healthy weight.

Poor diet and nutrition are recognised as major contributory risk factors for ill health and premature death. A poor diet is the biggest contributor to the number of "healthy years" lost due to ill health, disability or early death (see figure 1). Good nutrition has

a key role to play both in the prevention and management of diet-related diseases such as cardiovascular disease (CVD), cancer, diabetes and obesity.

In Nottinghamshire it is estimated that just over a quarter of adults are consuming the recommended 5 or more portions of fruit and vegetables per day, with women eating more than men and the lowest consumption in the 16-24 and over 75 age groups. Residents in Mansfield eat the least fruit and vegetables per day (see figures 2).

Table 2: Estimated number and percentage of adults aged 16 and over in Nottinghamshire County and Districts consuming 5 portions or more of fruit and vegetables per day. Modelled estimate based on national (deprivation, gender) rates 2013.

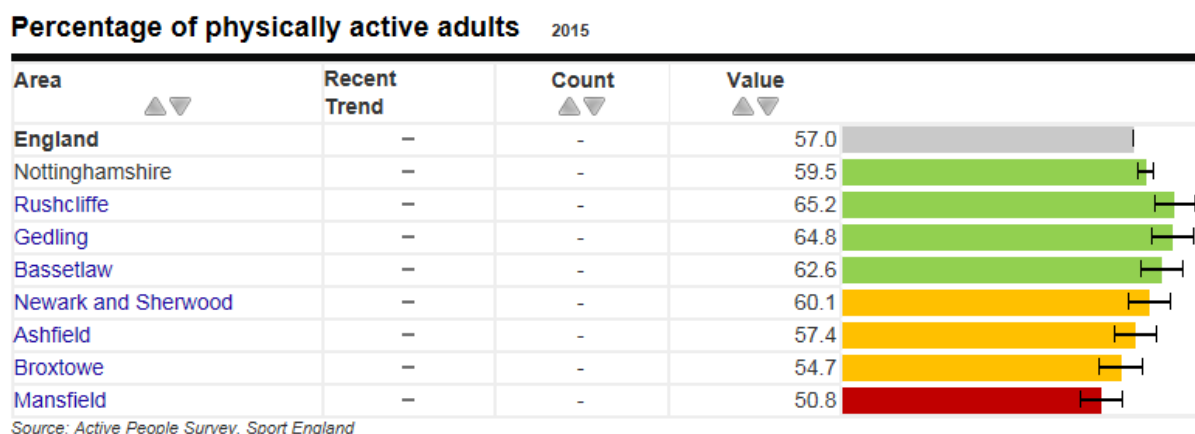
5 portions or more	Aged 16+		
Organisation	Estimated number	Total residents	Estimated percent
Bassetlaw	23,769	93,641	25.4
Mansfield	21,676	86,133	25.2
Ashfield	25,127	98,536	25.5
Newark and Sherwood	25,507	95,796	26.6
Gedling	25,840	94,282	27.4
Broxtowe	25,300	92,276	27.4
Rushcliffe	26,793	92,148	29.1
Nottinghamshire County	174,012	652,812	26.7

Source: HSE2013 national fruit and vegetable consumption (IMD Deprivation, Gender) rates for those aged 16+, ONS Mid-Year population estimates 2013

Physical inactivity directly contributes to one in six deaths in the UK. Physical activity can prevent or help manage over 20 chronic conditions including type 2 diabetes mellitus, heart disease and some cancers. These conditions incur a huge cost to the health and wellbeing of the individual, the NHS and the wider economy.

Around a quarter of adults in Nottinghamshire self-report being inactive, failing to achieve a minimum of 30 minutes of activity a week. Approximately 60% of adults in Nottinghamshire self-report meeting the recommended 150 minutes a week of physical activity. Participation in physical activity decreases with age and is higher in males than females. Residents in Rushcliffe, Gedling and Bassetlaw are most likely to meet the physical activity guidelines and those in Mansfield are least likely to meet them (see figure 3).

Figure 3: Estimated proportion of adults aged 16 and over achieving at least 150 minutes of physical activity per week



Source: PHE Health Profiles

Recommendations include:

- strengthening awareness through social marketing;
- improving local intelligence to understand why healthy eating locally is below expected levels, current levels of physical activity and obesity, maternal obesity, how obesity tracks through childhood;
- addressing prevention by working within communities across the life course;
- improving integrated commissioning to ensure services are joined up;
- developing closer relationships between planners regarding access to affordable healthy food and re-designing environments to encourage active lifestyles;
- auditing services to ensure they meet quality standards and are equitable by targeting those with the greatest needs and;
- building capability of the workforce to ensure benefits of physical activity and a healthy diet are shared with patients and service users.

[Click here to open the JSNA for Diet and Nutrition](#)

[Click here to open the JSNA for physical activity](#)

Substance misuse (alcohol and drugs)

Anyone could be at risk of developing a substance misuse problem during their lives. There are recognised risk and protective factors at different stages of life and these are inextricably linked to the family and community environment. Certain populations are particularly at risk. Substance misuse has wide-ranging and significant adverse effects on individuals, families and communities.

Evidence presented suggests that there could be in the region of at least 172,725 individuals in Nottinghamshire who use substances frequently and could benefit from a substance misuse intervention, with 26,068 dependent on substances. Alcohol represents the greatest need (noting that a significant proportion of the drug using population are also likely to be drinking). These figures are likely to be under-estimates due to the hidden nature of some substance misuse.

Local substance misuse data is not collected comprehensively across agencies who may be in contact with people who misuse substances. Improved substance misuse-related data collection and sharing is required across public sector agencies if substance misuse is to be tackled strategically in a co-ordinated way.

Hospital admissions data is the most reliable source of data: Ashfield has a significantly higher rate of under 18 alcohol-specific hospital admissions; alcohol-related hospital admissions (individuals) are higher than the national average for males in Mansfield and females in Ashfield; Nottinghamshire is significantly worse than England and comparator areas for alcohol-related hospital admissions due to unintentional injuries.

Evidence-based education and prevention programmes aim to reduce the demand for substances within the community. The JSNA recommends that these should continue to be supported across Nottinghamshire.

For those who misuse substances effective support and treatment is vital for recovery. There is strong evidence of the effectiveness of substance misuse treatment and emerging evidence around recovery-orientated interventions. In Nottinghamshire, services which support young people have high success rates for the completion of treatment. However, those presenting to services demonstrate wider vulnerabilities such as domestic abuse, mental health problems and self-harm. In particular, Nottinghamshire has a large proportion of young people in treatment who are not in education, employment or training (NEET). Services which support adults also show high completion rates and low re-presentations. However, a focus is needed on supporting those who have been in drug treatment for 6 years or more to exit treatment successfully to free up resources to engage with more people 'upstream'.

The chapter recommends to strategically tackle substance misuse, co-ordinated partnership action is required to reduce demand and supply and to provide effective support and treatment services for those who require them.

[Click here to open the JSNA for Substance Misuse](#)

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 4: 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>

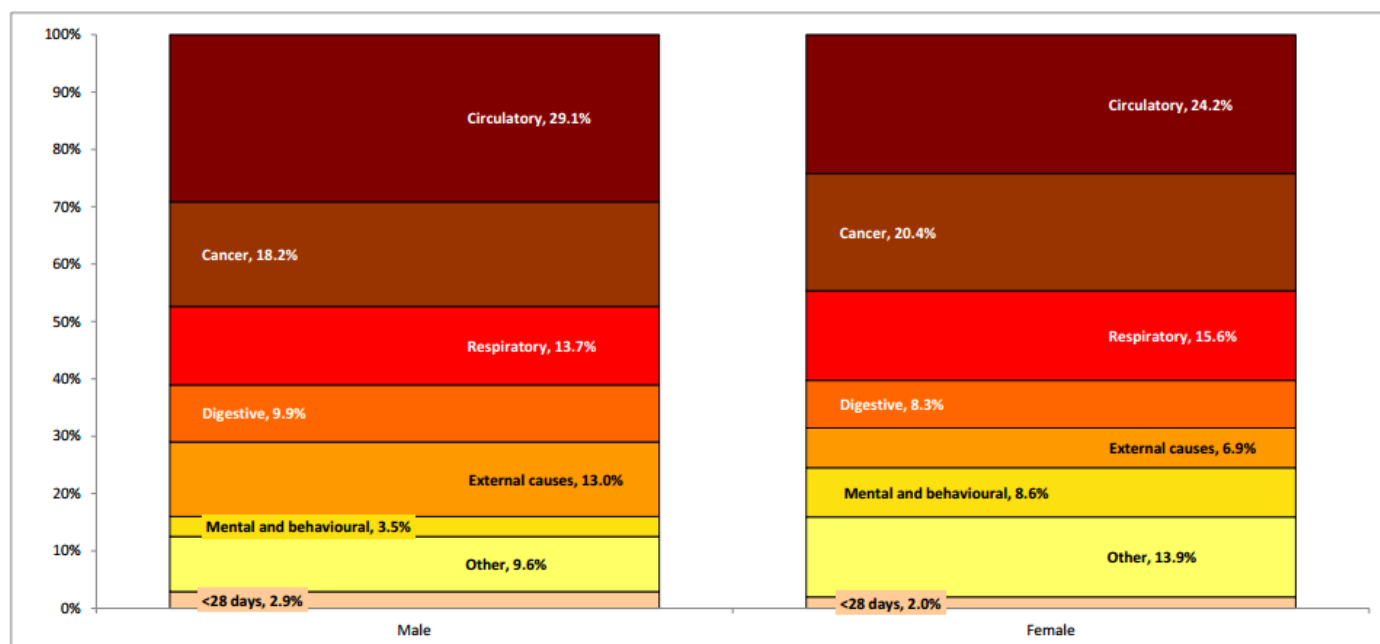
Source: PHE local Health Profiles 2016

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 5: 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.

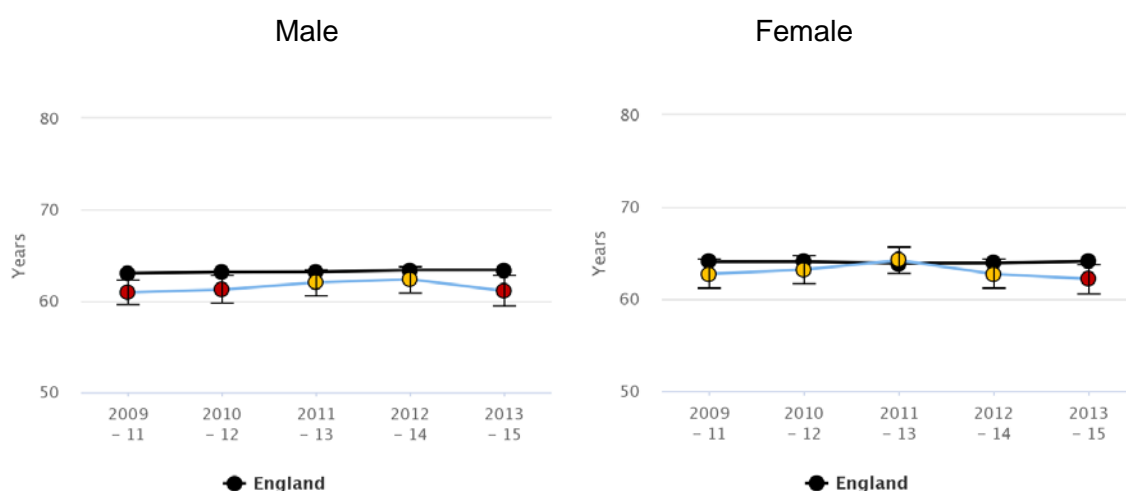
Source: The Segmentation Tool, Segmenting life expectancy gaps by cause of death, Public Health England (Jan 2015)

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 6).

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 6 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 care associated infections in community settings

Healthcare associated infections (HCAs) are caused by a wide range of different infectious micro-organisms. HCAs are those associated with healthcare delivery in any setting, including hospital settings, long-term care facilities such as nursing homes or a person's own home. Despite recent successes in reducing incidence rates, HCAs remain a cause of significant illness and early mortality.

Risk of infection increases with increased contact with health and social care interventions. The very old and very young are most at risk due to a poorer immune response. Effective infection control requires a whole health economy approach and infection control services need to be viewed in the context of the wider health and social care system.

Antimicrobial medicines such as antibiotics are the mainstay of treating infections. Anti-microbial prescribing practices have played a role in development of antibiotic resistance in organisms causing HCAs. Maintaining good infection control practice in all care settings, to prevent infection and the need for use of antibiotics, remains critical.

Rates of MRSA (Meticillin-Resistant *Staphylococcus Aureus*) bacteraemia nationally have decreased by nearly 60% between 2009/10 and 2015/16, similar reductions are seen in Nottinghamshire County. In contrast, infection rates for MSSA (Methicillin-Susceptible *Staphylococcus Aureus*) and *E.coli* bacteraemia increased significantly between 2013/14 and 2014/15. In addition, whilst overall significant improvements have been made in lowering the rates of *Clostridium Difficile* (CDI) infection locally and nationally, this reduction has slowed over recent years.

Key recommendations include: widening of infection prevention and control beyond MRSA and CDI; review the implementation of prescribing guidelines on antibiotic prescribing; embed risk assessment for infection control within the standard care

processes of healthcare professionals in community settings; and consider a comprehensive infection prevention and control support package for all care providers, including care in the home, learning disabilities residential units and residential care homes.

[Click here to open the JSNA for Community Healthcare Infection Prevention and Control](#)

Health impacts of air quality

Despite great improvements in air quality in the UK since the Clean Air Act of 1956, current background levels of air pollution still pose a significant risk to health, particularly for those living in more deprived neighbourhoods. Long term exposure to air pollution at the levels experienced in many urban centres in the UK is now known to cause respiratory and cardiovascular disease and lung cancer. Short term exposure to episodes of elevated air pollution also leads to a worsening of symptoms for those with existing asthma, respiratory or cardiovascular disease, and can trigger acute events such as heart attacks in vulnerable individuals.

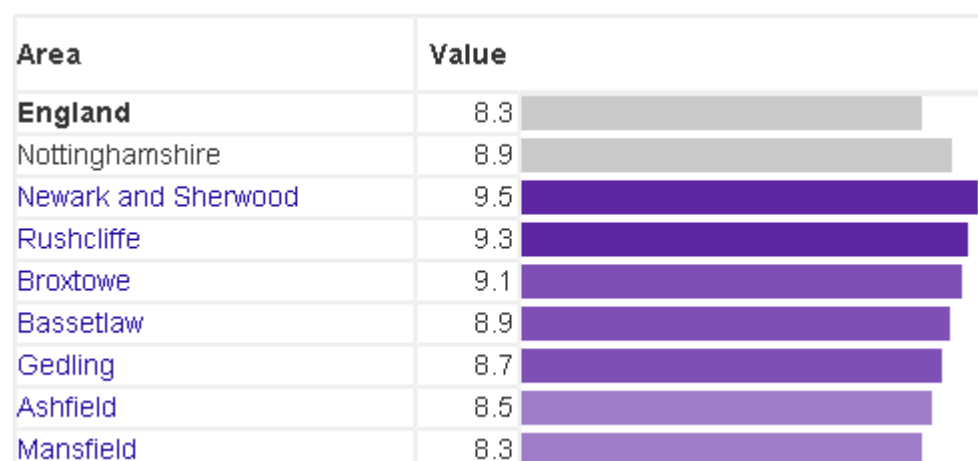
Human-made air pollution comes from a number of different sources, but the leading contributor in urban centres is road traffic emissions.

In Nottinghamshire County 5.7% of all adult mortality (430 deaths) was attributable to long term exposure to human-made particulate air pollution in 2010⁶.

Key recommendations include: considering evidence of effectiveness and cost effectiveness of various interventions such as active travel, public transport, low emission vehicles; continuing to strengthen joint working across planning, transport and environmental health to identify shared opportunities to improve air quality; and providing key messages on air quality to the public.

⁶ Estimating Local Mortality Burdens associated with Particulate Air Pollution, Public Health England, 2014

Figure 7: Air pollution: fine particulate matter (PM2.5 with a metric of micrograms per cubic metre (µg/m3), 2015.



Source: Public Health England, Wider Determinants of Health Profile.

[Click here to open the JSNA for Air Quality](#)

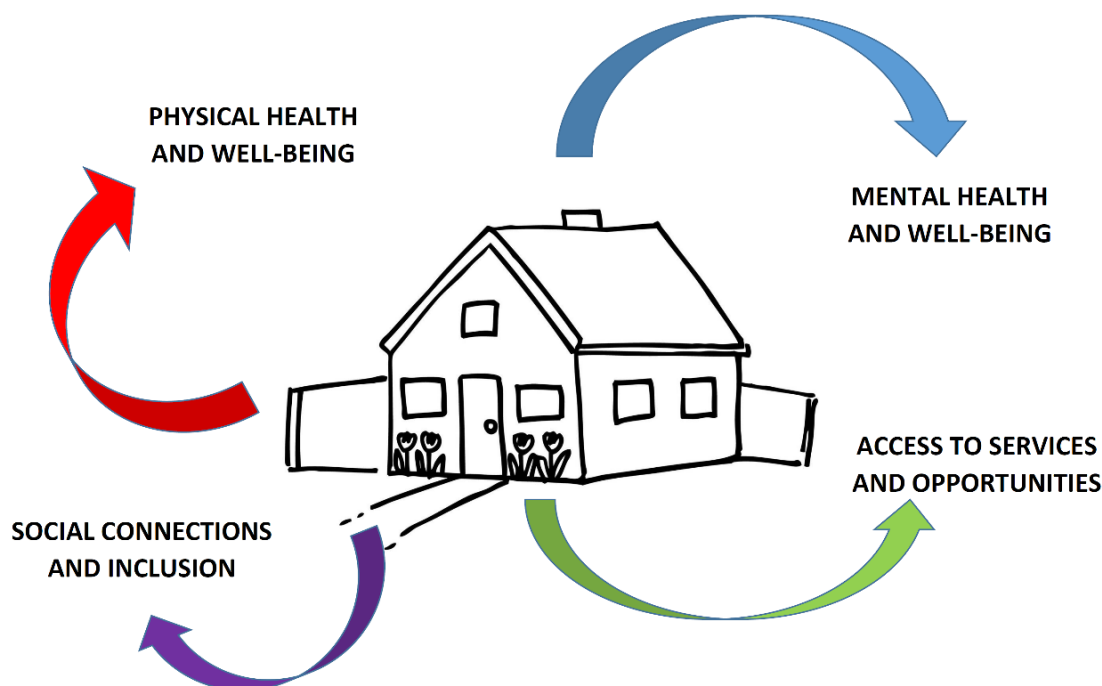
Housing and homelessness

Understanding the inter-relationship between housing, poor health and wellbeing is essential in tackling both poor housing conditions and health inequalities. Affordable and suitable, warm, safe and secure homes are essential to a good quality of life. This has a negative impact on health and wellbeing, drives health inequalities and places an unnecessary burden on public resources.

Outcomes of poor housing conditions such as overcrowding, damp, indoor pollutants and cold have all been shown to be associated with physical illnesses including eczema, hypothermia and heart disease. Respiratory health has been shown to be particularly affected in both adults and children.

The evidence for the mental health and wellbeing impacts of housing is less developed, however there is some evidence, for example, living in poor housing conditions has been shown to increase stress and reduce control. These factors have clear links with mental health outcomes. Homelessness and lack of security of tenure contribute to an individual's mental health and wellbeing.

The location of our home can influence access to healthcare, education, employment, transport, social care and more. Housing offers a wide role in the opportunity to enable people to achieve good health and wellbeing for example through supporting older people, those with long-term conditions or disability, mental health problems or experiencing social isolation.



Source: Housing and Health Resource, Chartered Institute of Environmental Health
<http://www.cieh-housing-and-health-resource.co.uk/>

The Nottinghamshire Health and Housing Commissioning Group has identified key actions based around a number of themes:

- Poor housing conditions – particularly in the private rented sector; the impact of falls in the home, cold and damp homes and fuel poverty, fire in the home and inadequate home security.
- Insufficient suitable housing – including the impact of overcrowding and lack of housing that enables people e.g. older or disabled people, to live independently.
- Homelessness and housing support – including the impact of homelessness on families, those with mental health problems and other crises, that may result in the loss of a home and an individual's ability to live independently.
- Children and young people – ensuring they have the best home in which to start and develop well.

Households in Nottinghamshire are disproportionately affected by one or more of these factors, particularly:

- Children, particularly if they are disabled; are part of the Gypsy and Traveller community; live in poverty; live in the private rented sector; live in a deprived area.
- Older people, particularly if they are disabled; have a limiting long term condition; have a mental health issue and live in the private rented sector; live in poverty; live in a rural area or a deprived neighbourhood.
- Disabled people and people with a limiting long term condition, particularly if they live in poverty; live in the private rented sector; live in a rural area or a deprived neighbourhood.

[click here to read the JSNA summary on housing](#)

[Click here to read the JSNA Housing Plan](#)

[Click here to read summary of excess winter mortality within this report](#)

Accidental Injury

To be included when the chapter is updated in 2018.

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.

Lifestyle issues across the life course are discussed earlier in this report.

[Click here to open the JSNA for Children and Young People](#)

Child Poverty

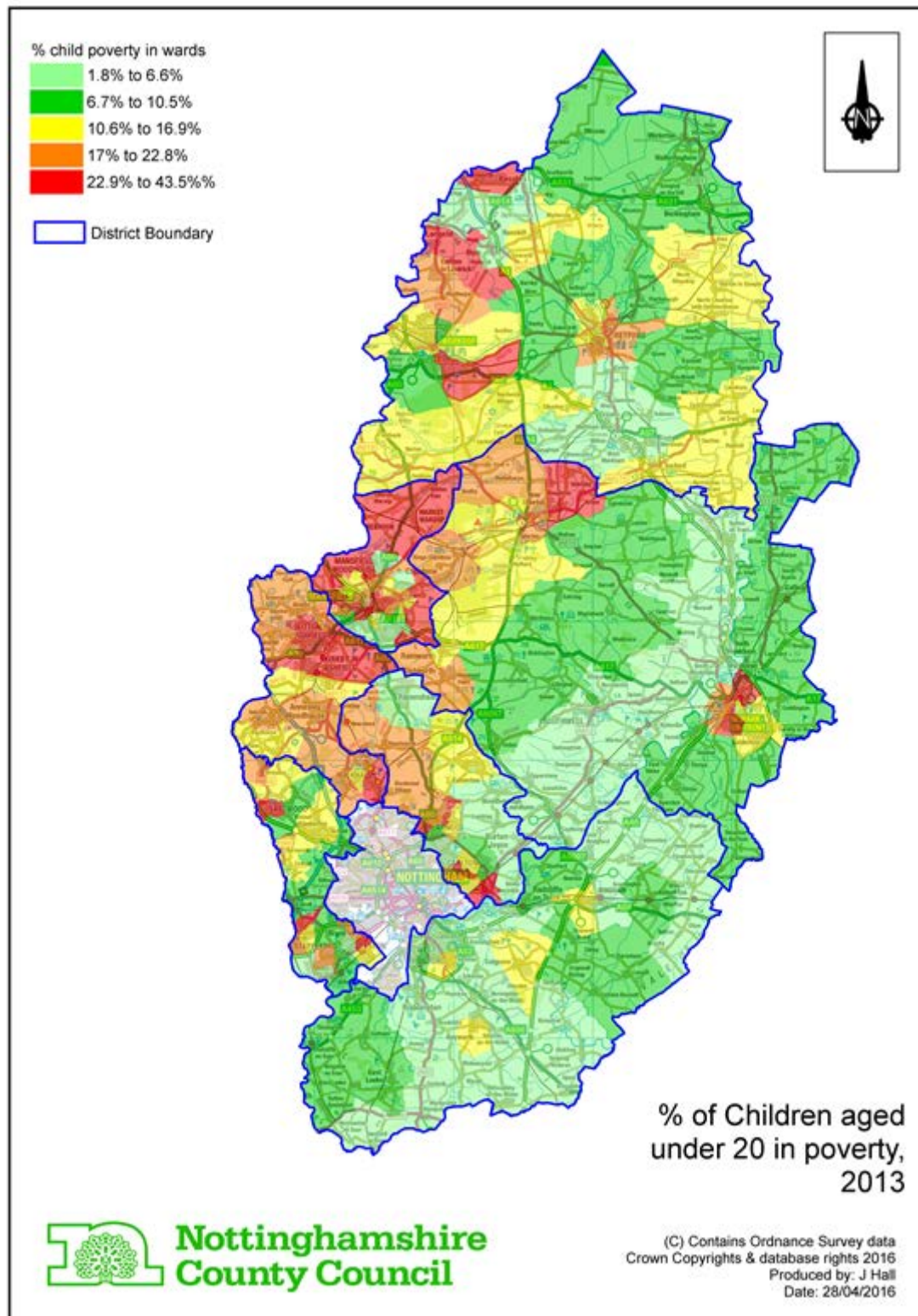
Growing up in poverty can affect every area of a child's development and future life chances. We know that the most disadvantaged children are less likely to achieve their academic potential, secure employment and gain a sense of future financial security. They are more likely to suffer from poor health, live in poor quality housing and unsafe environments. Breaking the cycle of poverty is therefore a priority for Nottinghamshire; and work to reduce child poverty levels and reduce the impact of poverty is critical to achieve a wide range of positive outcomes for children, their families and future generations.

In 2014 across Nottinghamshire 24,565 children and young people aged 0-15 were identified as living in poverty, which equates to 17.7% of the 0-15 population. There are fewer children in poverty in Nottinghamshire compared to England (19.1%) and the East Midlands (20.1%).

The spread of child poverty across Nottinghamshire is not equal with greater levels of child poverty located in central and northern districts. There are 12 'hot spot' wards in

Nottinghamshire where child poverty exceeds 30%. Nine of these are located in Mansfield.

Figure 8: 2013 % of children living in poverty across Nottinghamshire wards.



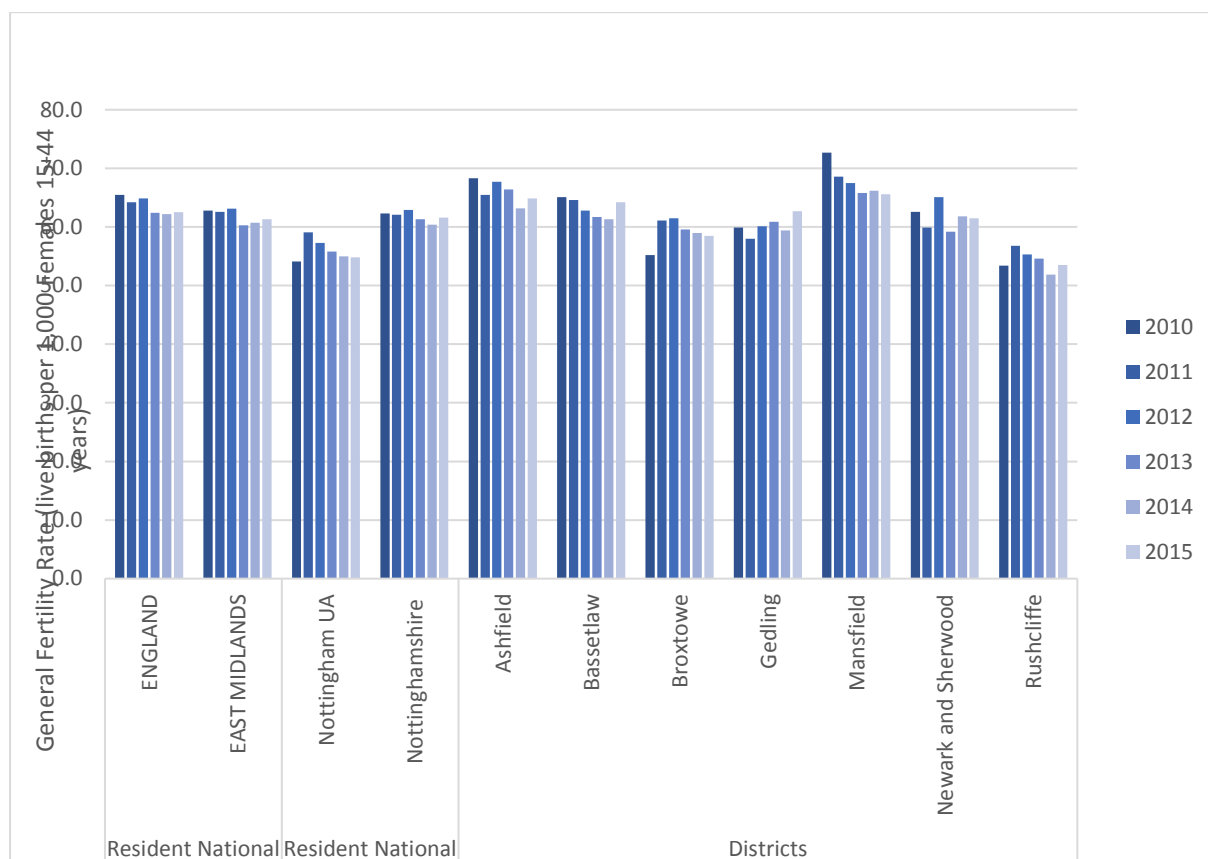
[Click here to open the JSNA for Children and Young People – Child Poverty](#)

Pregnancy and early years

How we treat young children shapes their lives – and ultimately our society⁷. The World Health Organisation describes early child development as a ‘cornerstone of human development’ and goes on to say that it should be central to how we judge the success of a society⁸. If we get the early years right, we pave the way for a lifetime of achievement. If we get them wrong, we miss a unique opportunity to shape a child’s future.

In Nottinghamshire the birth rate, as measured by the General Fertility Rate (GFR), has remained stable at 62 births per 1,000 women between 2010 and 2015. The General Fertility Rate is slightly below the national average at 63 per 1,000 population. The highest birth rates across Nottinghamshire in 2015 are in Mansfield of 66 per 1,000 population followed by Ashfield 65 per 1,000 and Bassetlaw 64 per 1,000 population. However it is clear from 2010 that in Mansfield and Ashfield birth rates have decreased, see figure below:

Figure 9 Live Births per 1,000 Females 15-44 years



Low birth weight⁹ is associated with poorer long term health and educational outcomes. Low birth weight in Nottinghamshire has remained stable for the past 6 years at 7% and is similar to the national average.

⁷ Insert ref from JSNA to the wave foundation – ref isn’t in draft at moment

⁸ See 7 above

⁹ Low birth weight is the % of live births born below 2500g

Both locally and nationally infant mortality rates have been falling over the past 30 years. In Nottinghamshire Infant Mortality rates were 4 per 1,000 live births aged under 1 year in 2012-14, similar to the national average.

Breastfeeding is a crucial in decreasing inequalities in children's health, including: lowering infant mortality rates, reducing preventable infections and unnecessary hospital admissions in infancy, halting the rise in obesity and promoting cognitive development, increased academic attainment and maternal/child bonding.

Breastfeeding initiation at birth (69%) and at 6-8 weeks after birth (40%) in Nottinghamshire were significantly below the national average in 2014/15 and have been below the national average for the past 5 years. There is also considerable local variation in uptake between different groups and geographic areas in Nottinghamshire and breastfeeding rates locally are strongly linked to the age of the mother. Breastfeeding at 6-8 weeks after birth were lowest in Mansfield and Ashfield CCG (30%) and Newark and Sherwood CCG (36%). In addition rates for mothers aged under 20 years was notably lower (10% at 6-8 weeks¹⁰) than the overall breastfeeding rates.

Figure 10: Breast feeding rates at 6-8 weeks across Nottinghamshire County presented at Clinical Commissioning Group level

Area	2012/13	2013/14	2014/15	2015/16
Mansfield and Ashfield	27%	30%	30%	30%
Newark and Sherwood	35%	34%	35%	36%
Nottingham North East	37%	39%	39%	42%
Nottingham West	44%	48%	48%	48%
Rushcliffe	61%	61%	62%	60%
Bassetlaw	34%	36%	37%	36%

Source: NHS England data from 2012 to 2015, 2015/16 data is collected by Nottinghamshire Healthcare NHS Trust (no longer published nationally by CCG).

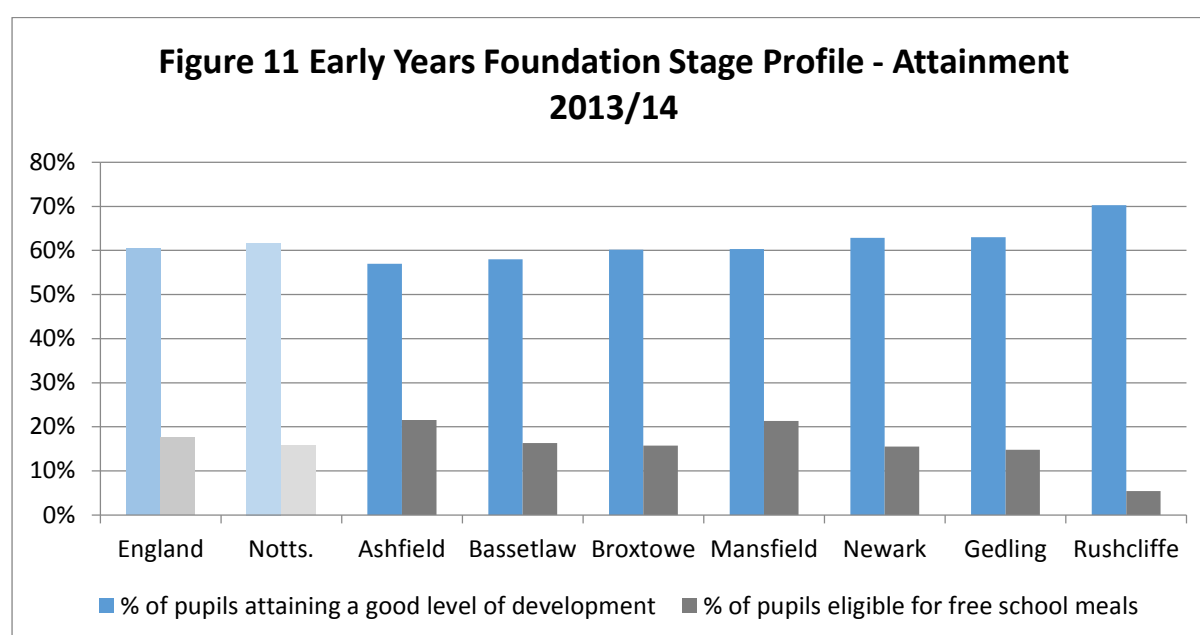
The first five years of a child's life are critical to their future development and opportunities. A child's physical, social and cognitive development strongly influences how ready they are to start school and their educational attainment, as well as their health and employment prospects as an adult.

The high smoking rates during pregnancy in the County (14.5%), compared to England (10.6%) in 2015/16, are of particular concern. Smoking in pregnancy increases risk of complications, which affect mothers and babies health, and increase risk of miscarriage and maternal death. Children who grow up in families and communities with a high proportion of smokers are more likely to become smokers themselves. Whether a woman chooses to smoking in pregnancy is associated with the mother's age, level of education or whether her partner also smokes.

¹⁰ Sample period April-Dec 2013

Immunisation is one of the most effective public health interventions, and high rates of immunisation are necessary to protect individuals and the community from the diseases against which vaccinations have been developed, which can have serious complications. It is important to achieve levels of 'herd immunity' whereby the majority of children are protected and national targets are set accordingly. This ensures levels of disease in the population remain low and also provides a level of protection to those that aren't vaccinated. Locally children's immunisation targets are being met.

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. Research has inextricably linked attachment to school readiness and school success. During 2015/16, 67% of children in Nottinghamshire reached a good level of development by age 5, this is significantly lower than the England average (69%). Figure 11 demonstrates that children tend to do better if the school they attend is in a more affluent and less deprived area. It is recognised nationally that children from lower socio-economic groups tend to do worse than their peers from higher-earning families, and these data demonstrate that this inequality is evident in Nottinghamshire.



[Click to child health profile for Nottinghamshire – PHE fingertips](#)

This JSNA chapter is being refreshed, key recommendations and a link to the chapter will be included when it is published.

Emotional Health & Wellbeing

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](#).

This JSNA chapter is being refreshed, key recommendations and a link to the chapter will be included when it is published.

Oral health

Oral health is essential to general health and quality of life. As well as pain or infection, poor oral health is associated with low weight and failure to thrive in infancy. Poor dental hygiene may continue into adulthood when periodontal disease is associated with heart disease, improved oral health is capable of reversing this effect.

Surveys of the teeth of children in Nottinghamshire County, demonstrate a wide variation in the level of oral health. The dental health survey of 5 year olds showed that in 2014 the proportion of children affected by dental decay¹¹ in Nottinghamshire was lower than the national average. However there were differences between districts relating to level of social deprivation and water fluoridation. For example in Mansfield, where the water is fluoridated but experiences high levels of social deprivation, decay experience has increased since 2008 and was at similar levels to the national average in 2014.

¹¹ proportion of children with decayed, missing or filled teeth

Figure 12: Percentage of 5 year-old children with dental decay

Area	% of 5 year-olds with signs of dental decay		
	2008	2012	2014
Bassetlaw	23	20	20
Ashfield	22	22	23
Broxtowe	26	25	23
Gedling	40	27	23
Mansfield	17	21	25
Newark & Sherwood	26	23	23
Rushcliffe	28	25	13
Notts County	26	23	21
England	31	28	25

Source: Public Health England, Dental Public Health Intelligence Programme

	largely or completely fluoridated
	largely or completely unfluoridated

Recommendations include: develop and implement strategies and approaches that can lead to improved oral health outcomes for children and young people, particularly in the Early Years; increase and improve access to dental health services; influence modifiable risk factors, including the use of fluoride supplements, oral hygiene, practices and frequency of dental visits.

[Click here to open the JSNA for Children and Young People's Oral Health](#)

Disabled children and those with complex needs

This JSNA chapter is being refreshed, a summary, key recommendations and a link to the chapter will be included when it is published.

Looked after Children and care leavers

This JSNA chapter is being refreshed, a summary, key recommendations and a link to the chapter will be included when it is published.

Community safety for CYP

This JSNA chapter is being refreshed, a summary, key recommendations and a link to the chapter will be included when it is published.

Children not accessing full educational entitlement

This JSNA chapter is being refreshed, a summary, key recommendations and a link to the chapter will be included when it is published.

Safeguarding (CSE, missing children, bullying, e-safety)

This JSNA chapter is being refreshed, a summary, key recommendations and a link to the chapter will be included when it is published.

Teenage pregnancy

This JSNA chapter is being refreshed, a summary, key recommendations and a link to the chapter will be included when it is published.

Young offenders

This JSNA chapter is being refreshed, a summary, key recommendations and a link to the chapter will be included when it is published.

Carers

See Carers section in Adults – [click here Nottinghamshire insight - Carers](#)

ADULTS AND VULNERABLE ADULTS

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.

Mental health and wellbeing

This JSNA chapter is being refreshed, a summary, key recommendations and a link to the chapter will be included when it is published.

[Click here to access the Nottinghamshire Insight mental health theme page](#)

Suicide prevention

The impact of every suicide can be devastating – economically, psychologically and spiritually – for all affected. The cost of a completed suicide for someone of working age in the UK exceeds £1.6 million. Suicidal thoughts at some point in a person's life are relatively common: in 2007 16.7% had thought about suicide, 5.6% reported attempting suicide and 4.9% had harmed themselves without suicidal intent.

Death rates from suicide and undetermined injury fell both nationally and locally between 2004-06 and 2009-11 but have since increased. In 2013-2015 there were 200 suicides across Nottinghamshire.

National research has identified that the following groups are at high risk of suicide:

- Men aged 35-59 years
- People in the care of mental health services, including inpatients
- People with a history of self-harm, untreated depression, misuse of alcohol, facing economic difficulties, going through divorce or separation, have a history of sexual or domestic violence or have long-term physical illnesses
- People in contact with the criminal justice system (police, probation, the courts and prisons)

- Specific occupational groups, such as doctors, nurses, veterinary workers, farmers and agricultural workers as well as men aged 24 years and younger who have left the Armed Forces
- Children and Young People who have experience abuse and/or neglect
- Lesbian, Gay, Bisexual or Transgender people
- Older people aged 65+ experiencing social isolation and loneliness

Groups with a higher risk of suicide in Nottinghamshire reflect the national picture, for example men aged 35-64 and people aged 65+ are at higher risk locally. The rate of emergency admissions for intentional self-harm was lower in Nottinghamshire (175 per 100,000) compared with England (193 per 100,000) in 2014-2015. Local data is not available on the all higher risk suicide groups for Nottinghamshire.

Key recommendations include: improving information around suicide in order to identify local risk factors, rapidly identify suicide hotspots and enable suicide investigations; Improve information and communication regarding suicide prevention; suicide prevention training programme; commission mental health services aimed at early identification, intervention and crisis support.

[Click here to access the Nottinghamshire Insight mental health theme page](#)

[Click here to open the JSNA chapter on suicide prevention](#)

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.

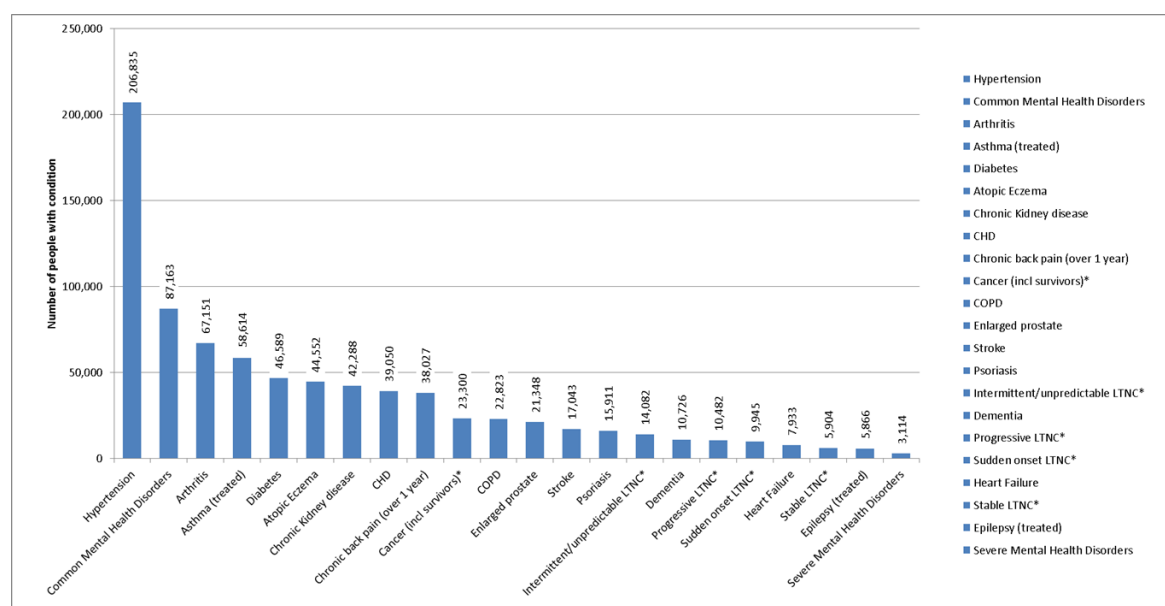
A long term condition is one that cannot be cured but can be managed through medication and/or therapy. There is no definitive list of long term conditions – diabetes, asthma and coronary heart disease can all be included.

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 13 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 13: 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

Cancer is the highest cause of premature death in Nottinghamshire, accounting for 47% of premature deaths (aged under 75years) and 31% of all deaths in the county. More than 1 in 3 people are expected to develop some form of cancer in their lifetime. Both nationally and locally, whilst more people are being diagnosed with cancer, the majority of people will experience successful treatment and a period of subsequent 'survivorship'. Because of this, cancer is increasingly being recognised as a long-term condition.

A number of factors influence the likelihood of developing cancer including: age, gender, socio-economic status, occupation, family history, infection, hormones, and lifestyle. 4 in 10 cancers can be prevented by lifestyle changes; the main risk factors being smoking, which is responsible for 19% of new cases, diet (9% of new cases), obesity (5.5% of new cases), sun and radiation exposure (5% of new cases), alcohol consumption (4%) and physical activity (1% of new cases).

In 2013 there were 5,867 new cancers diagnosed in Nottinghamshire and 2,299 deaths from cancers. The most common cancers were breast, lung, bowel and prostate cancers; lung cancer accounting for the most deaths. Mansfield and Ashfield showed a higher rate of incidence and mortality from lung cancer which is likely to be related to higher rates of smoking in the population.

Early detection is vital in optimising health and survivorship outcomes. In Nottinghamshire uptake of screening programmes for breast, cervical, bowel cancers has been higher than the national average for the past 5 years, however, a significantly

higher proportion of breast and prostate cancers are diagnosed via emergency admissions to hospital in Mansfield and Ashfield.

[This JSNA chapter is being refreshed, key recommendations and a link to the chapter will be included when it is published.](#)

Stroke

Stroke is the largest cause of disability and the fourth largest cause of death in the UK after cancer, heart disease and respiratory disease. The term 'stroke' refers to a sudden change to the blood supply to the brain, often as a result of a blocked artery, depriving it of oxygen and potentially leading to brain damage or death. Of those who survive a stroke, half have a degree of disability such as weakness on one side of the body, communication problems or visual problems.

Non-modifiable risk factors for stroke include age over 65 years, male gender and African or African-Caribbean origin all of which increase the likelihood of experiencing a stroke. Modifiable risk factors from stroke include atrial fibrillation (AF) (erratic heart rhythm), hypertension (high blood pressure), diabetes, deprivation, smoking, obesity, diet, physical activity, and alcohol consumption.

16,179 people were diagnosed with stroke or transient ischaemic attack (mini stroke) in Nottinghamshire in 2015/16. Premature mortality rates (under 75 years of age) for stroke were significantly higher in Gedling, Mansfield, Newark and Sherwood when compared with the England average in 2013-2015.

Although mortality rates following a stroke have been falling over the past 5 years, the number of people living with a longstanding health condition caused by stroke is projected to increase by 27% in Nottinghamshire between 2015 and 2030. This is due to an increasingly ageing population and improving rates of survival following a stroke.

Recommendations include: commissioners planning for an expected increase in the number of people having strokes in the future; understanding equity issues in relation to access to services; improving detection and management in primary care of conditions which increase the risk of strokes; addressing variability across the county in terms of both access to intra-arterial (thrombectomy) treatment and the use of intermittent pneumatic compression devices; ensuring there is specialist stroke support and rehabilitation including psychological support and support to return to work; and support for carers of stroke survivors.

[Click here to open the JSNA chapter on stroke](#)

Long-term conditions

[This is a new JSNA chapter, a summary, key recommendations and a link to the chapter will be included when it is published.](#)

Sexual health

Good sexual health is an important aspect of health and wellbeing, and it is vital that people have the information, the confidence and the means to make choices that are right for them, regardless of their age, gender, ethnicity, sexual orientation, religion or belief or disability. This helps people to develop positive relationships and enables

them to protect themselves and their partners from infections and unintended pregnancy.

Sexually transmitted infections (STIs), including HIV, remain one of the most important causes of illness due to infectious disease among young people (aged between 16 and 24 years old). 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 socio-economically deprived groups.

Diagnosis of sexually transmitted infections (STIs) is rising nationally. These infections have a significant impact on the health of individuals and communities. STIs which remain undiagnosed or are not effectively treated can cause long term serious health consequences which include pelvic inflammatory disease (PID) and infertility. The use of effective methods to prevent transmission, access to fast diagnosis and treatment, and good partner notification processes are all important in reducing STI prevalence and improving sexual health outcomes. Nationally, a large proportion of those with Human Immunodeficiency Virus (HIV) infection are diagnosed late, with serious consequences for individuals' health and survival rates.

In Nottinghamshire rates of diagnosis for all of the common STIs are similar to, or lower than, national averages, however, there has been an increase in new diagnoses of STIs, similar to the rise seen nationally. STI diagnosis rates are higher in more deprived areas of Nottinghamshire. Preventing reinfection is a priority in Nottinghamshire County; Mansfield had the highest reinfection rates in men (9.6%), and Ashfield had the highest reinfection rate in women (9.3%).

The recorded prevalence of HIV in Nottinghamshire County was 0.64 per 1,000 population aged 15 to 59 years, the third lowest in the East Midlands, after Lincolnshire and Derbyshire. Between 2011 and 2013, just over half (50.8%) of those diagnosed with HIV in Nottinghamshire County had a late diagnosis. Although this is not significantly different from the national rates, late diagnosis is the most important predictor of morbidity and one-year mortality among people with HIV infection.

A quality contraceptive service is vital in giving women and men of all ages' choice and control over their reproduction, and is key to avoiding unplanned pregnancies and planning families. The termination of pregnancy rate for Nottinghamshire County in 2013 was 12.7 per 1,000 female residents aged 15 to 44 years which was significantly lower than the England average of 16.6. In women aged under 25 attending for termination of pregnancy, just over 1 in 5 (22.3%) reported having a previous termination at any age.

Recommendations include: alignment of sexual health commissioning plans; maximise outcomes for vulnerable groups via sexual health service contacts; provide up-to-date service information; promotion of healthy behaviours and improvements in access to services for young people and higher risk groups; improve coverage of STI testing and LARC provision; staff training and implementation of best practice to improve early diagnosis and outcomes for people with HIV.

[Click here to access the Nottinghamshire Insight sexual health theme page](#)

Communicable diseases: Hep B & C

Hepatitis B and hepatitis C (HBV and HCV) are blood borne viral infections that can lead to chronic infection. Without treatment these infections can lead to cirrhosis of the liver and liver cancer therefore causing significant costs to the health of the individual and the services providing treatment and care.

In Nottinghamshire it is estimated that approximately 9,000 people are living with Hepatitis B & C. Given the clinical and social manifestation of HBV and HCV (complex sometimes asymptomatic diseases often associated with vulnerable groups such as injecting drug users) infected individuals can often go undiagnosed. In turn this increases the risk of liver disease and death.

Prevention, early diagnosis, treatment and aftercare provide the framework for a comprehensive and robust strategic approach.

Physical disability & sensory impairments

This JSNA chapter is being refreshed, key recommendations and a link to the chapter will be included when it is published.

Autism

This JSNA chapter is being refreshed, key recommendations and a link to the chapter will be included when it is published.

Learning disability

This JSNA chapter is being refreshed, key recommendations and a link to the chapter will be included when it is published.

Carers

Carers look after family, partners or friends in need of help because they are ill, frail or have a disability. The care they provide is unpaid. Most people have caring responsibilities at some stage in their lives: 1 in 8 adults provide care nationally¹². Both the predicted demographic change as a result of people living longer and with long term health conditions and the move towards providing care and support at home and in the community are anticipated to have an impact on carers.

People with caring responsibilities experience a range of health and wellbeing issues including mental and physical health problems, social isolation and lowered social functioning, and increased mortality as a result of mental or emotional distress, especially in more elderly carers.

The National Carers Strategy 2010 provides a vision for carers with an expectation that carers will have access to support services they need; have a life of their own alongside their caring role; stay mentally and physically well; and children and young people will be protected from inappropriate caring. The Care Act 2014 provides an ideal opportunity to capitalise on the new focus of working more closely with carers and the responsibility placed on Local Authorities to undertake a Carer's Assessment which will identify whether the carer has support needs.

¹² Carers UK. www.carersuk.org accessed 11/08/2016

In Nottinghamshire there has been a significant shift in the way carers are identified and supported. There has been a move away from all carers being assessed by Social Care staff at home, towards a more proactive and cost effective approach, which includes more choice for the carer: telephone and on-line carer assessments; community based carer clinics. Carers can also contact the Nottinghamshire Carers Hub for free information, advice and support.

The 2011 Census identified an increase in the number of carers in the last decade by 7,517 across Nottinghamshire County. There are now an estimated 57,426 carers providing between 1-19 hours of care per week and the number of carers providing over 50 hours of care per week reached 21,680 in 2011.

In 2015/16 there were 4735 carers assessed in Nottinghamshire, 319 of which were aged under 18 years. 74% of those assessed were given a Carers Personal Budget. The number of carer assessments carried out has not increased notably in the past 3 years. The Nottinghamshire Carers Hub have been in contact with 1,245 carers from August 2015-March 2016 with most referrals to the service coming from the voluntary sector. It is likely, however, that there are existing carers in Nottinghamshire with unmet needs.

Click here for access to [Carer JSNA link](#)

Gypsies and travellers

This JSNA chapter is being refreshed, key recommendations and a link to the chapter will be included when it is published.

Adult abuse

This JSNA chapter is scheduled to be refreshed, key recommendations and a link to the chapter will be included when it is published.

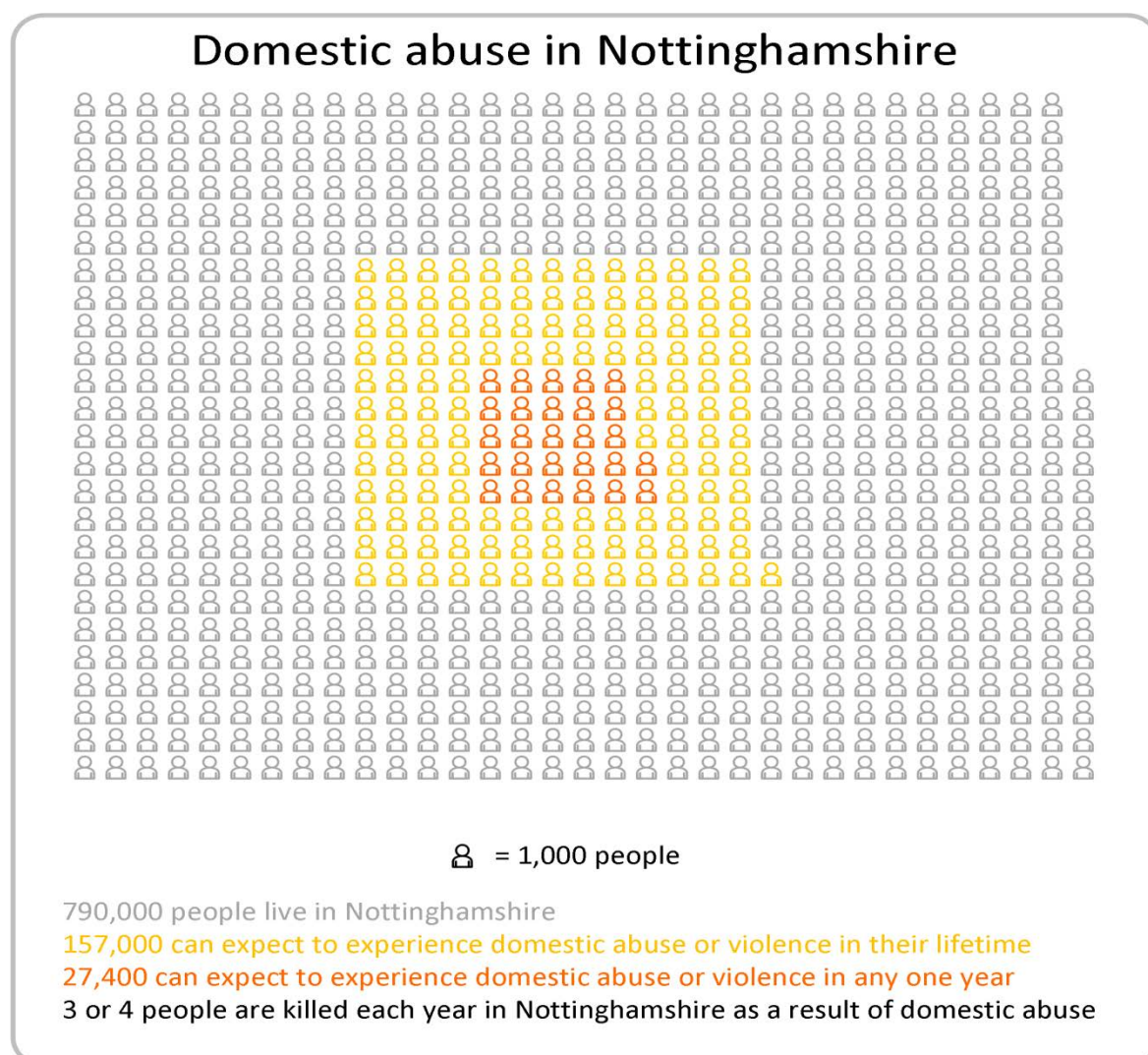
[Click here to open the latest Nottinghamshire Adult Safeguarding Board Annual Report](#)

Domestic abuse and sexual violence

Domestic violence and 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”.

Around 35,000 people in Nottinghamshire experience domestic abuse in an average year and more than 163,000 people do so across their lifetime (16-59 years). 69% of victims were female and 31% were male. There were 15 domestic homicides in Nottinghamshire between Apr 2012 and Mar 2015, 7 victims were female, 8 were male. 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. Reporting of domestic abuse incidents to Nottinghamshire Police has increased from approximately 6,000 in 09/10 to 14,000 in 15/16. 75% of domestic abuse prosecutions resulted in a conviction between Apr 15-Mar 16.

Figure 14 Info-graphic showing estimated numbers of people experiencing domestic abuse in Nottinghamshire



Key recommendations include: improving risk assessment and identification by key agencies; workforce training; national recommended levels of domestic abuse support services; and improving data collection by domestic abuse services.

Nationally, sexual abuse is experienced by 19% of women and 4% of men over the course of their lives. Sexual abuse is often a feature of domestic or intimate partner abuse and has the same common feature: that of perpetrators achieving power and control over their victims. Most of the time, victims know the person perpetrating the abuse and despite this fact, sexual offences are crimes with low levels of reporting and low levels of conviction through the courts.

In Nottinghamshire it is estimated that around 11% of sexual offending in Nottinghamshire in 2013-14 was reported to the Police. The proportion of serious offences reported is much higher 38% than that for other sexual offences 3%. Reporting of serious sexual offences has increased in Nottinghamshire but it is not clear whether this is due to an increase in the prevalence of sexual offences or an

increase in the reporting of such offences. Young people aged 10-25 years were most likely to report a sexual offence to the police in Nottinghamshire.

Recommendations include: reduce levels of sexual abuse in the population through education and awareness raising; improved awareness and identification of sexual abuse by mainstream services; support and access to services for survivors of recent or current sexual abuse and for survivors of historical sexual abuse; and improvements to criminal justice procedures to ensure effective investigation and prosecution of sexual assault and rape.

[Click here to open the JSNA chapter for sexual abuse](#)

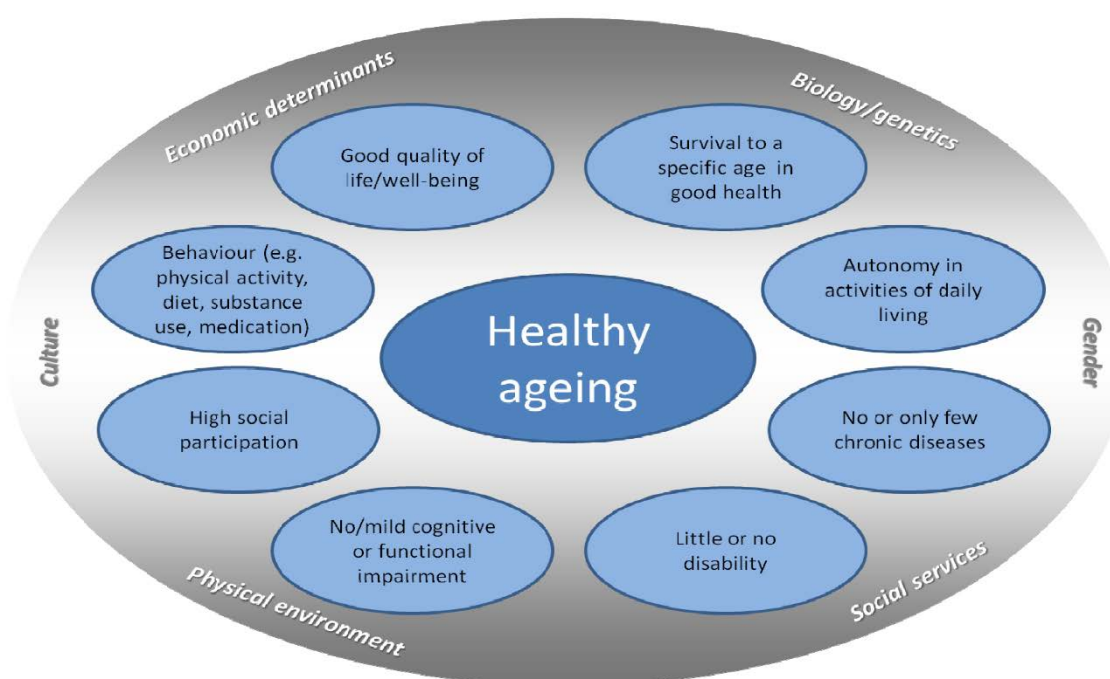
[Click here to access the JSNA report on domestic abuse](#)

[Click here to open the Nottinghamshire Domestic and Sexual Abuse Framework for Action](#)

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 in the quality of life. 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 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.



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 latest population figures on Nottinghamshire Insight [click here](#).

Dementia

Dementia is a term used to describe a range of brain disorders that have in common a loss of brain function that is usually progressive and eventually severe. Dementia is one of the main causes of disability in later life and the number of people with dementia is rising yearly as the population ages.

Dementia can affect people of any age but is most common in older people, particularly those aged over 65 years – overall 5% of people over 65 may have dementia. The most common type of dementia is Alzheimer's disease (62%) followed by Vascular dementia (17%). A further 10% of people have a combination of Alzheimer's and vascular dementia and the remaining 11% have more rare forms of the disease.

Over time dementia significantly affects people's ability to live independently, as a result of:

- Decline in memory, reasoning and communication skills
- Inability to carry out activities of daily living
- Behavioural problems such as aggression, wandering and restlessness
- Continence problems
- Problems with eating and swallowing

Dementia places a particular burden on carers and family members. Timely diagnosis and intervention is helpful, as it enables the person with dementia and their carer/s to come to terms with the disease and make plans for the future.

Many of the carers of older people with dementia are elderly and experience physical and mental health problems themselves. However carer support and education can enable more people to live at home for longer and prevent carer breakdown, which is a major cause of people needing to move into long-term care.

The number of people aged over 65 living with dementia in Nottinghamshire is predicted to rise from 10,900 in 2015 to 15,000 in 2025 primarily due to an increase in the number of people living in Nottinghamshire aged 65 and over.

Figure 15: Over 65 dementia prevalence by district 2015 and 2035

People aged 65 and Over	2017	2020	2025	2030	2035
Ashfield	1,527	1,665	2,023	2,436	2,788
Bassetlaw	1,652	1,819	2,130	2,507	2,919
Broxtowe	1,604	1,718	1,997	2,318	2,590
Gedling	1,620	1,762	2,046	2,386	2,701
Mansfield	1,389	1,492	1,734	2,016	2,328
Newark and Sherwood	1,754	1,889	2,231	2,696	3,142
Rushcliffe	1,770	1,942	2,272	2,695	3,134

Source: POPPI (2017)

Timely diagnosis is important to ensure patients and carers have access to the support they need. In Nottinghamshire, diagnosis rates have risen steadily since and all 6 Nottinghamshire CCGs exceeded the national average in 2015/16 (0.96 and 0.76 respectively).

The Health and Wellbeing Board approved the [Nottinghamshire County Dementia Framework for Action 2016–2020](#) in May 2016 which aims provide services which work together better to support individuals with dementia and their carers.

[Click here to open the JSNA chapter for Dementia](#)

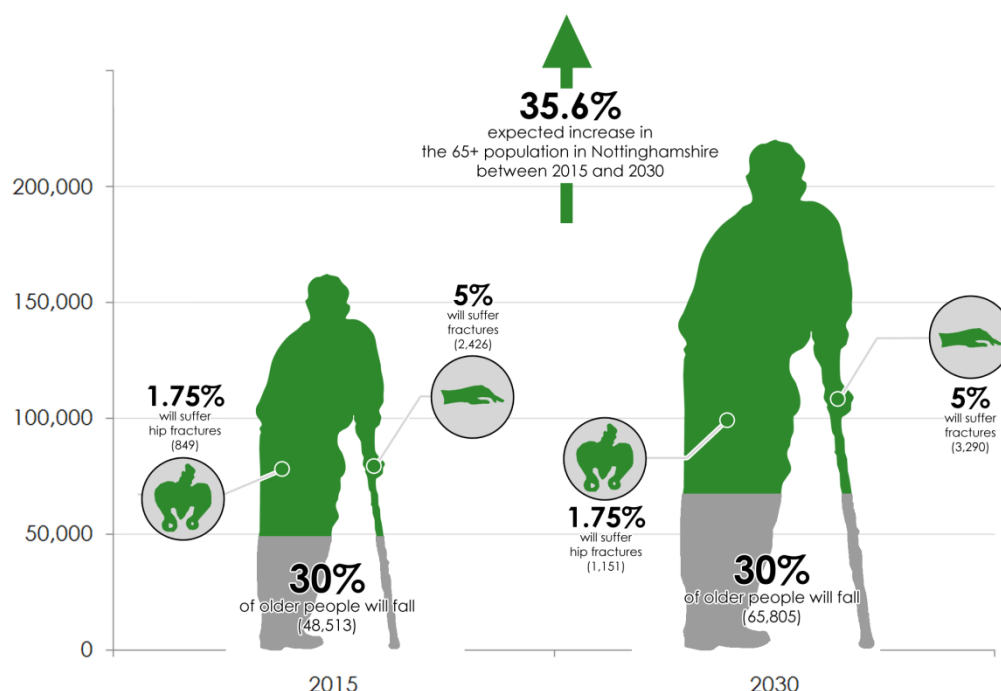
Falls and bone health

Falls and fall-related injuries are a common and serious problem for older people. People aged 65 and older have the highest risk of falling, with 30% of people older than 65 and 50% of people older than 80 falling at least once a year. It is also important to consider bone health alongside falls because osteoporosis increases bone fragility and susceptibility to fracture, particularly as a result of a fall. In addition to age, gender (post-menopausal increase in osteoporosis), existing medical conditions, medication, unsafe environment, impaired mobility and sensory impairment are all factors which increase the risk of a fall and associated injury.

The human cost of falling includes distress, pain, injury, loss of confidence, loss of independence and mortality. Falling also affects the family members and carers of people who fall. Falling has an impact on quality of life, health and healthcare costs.

In Nottinghamshire approximately 30% of older people will fall each year (48,513), some more than once, of these, approx. 5% suffer fractures and 1.75% suffer hip fractures. The expected increase in falls and associated injuries between 2015 and 2030 is shown in figure 16 and is primarily a result of an ageing population.

Figure 16: Infographic showing numbers of people experiencing a fall in Nottinghamshire in 2015 and 2030



Hospital admissions for falls in Nottinghamshire have increased over the past few years, particularly for women aged 80 and over.

Recommendations include: the implementation of a comprehensive falls prevention programme; reduction of home hazards; staff training in falls risk identification; osteoporosis assessment; local falls and bone health co-ordinators, integration of pathway across primary and secondary care; and integrated community crisis response services.

In April 2016 the Health and Wellbeing Board supported the adoption of the partnership-based Falls Pathway and approved the Falls Framework for Action.

[Click here to open the JSNA chapter for Falls and bone health](#)

Excess winter mortality

There were an estimated 43,900 excess winter deaths (EWDs) in England and Wales in 2014/15, representing 28% more deaths compared with the non-winter period and the highest since 1999/00. It is too soon to say if the sharp increase in EWDs in 2014/15 is the beginning of an upward trend. Excess winter deaths in England are historically at a level that surpasses that experienced by other colder, Northern European countries, suggesting that many of these deaths could be prevented.

The majority of excess winter deaths occur in people aged 75 years or older, with women more affected than men. Reasons for this are multifactorial; including the increased amount of time spent indoors, a higher prevalence of fuel poverty, a reduction in fat to retain body heat and an increased likelihood of having underlying health conditions.

The majority of excess winter deaths are due to cardiovascular disease, respiratory illnesses including flu. For every 1 degree Celsius decrease in average winter temperature there is a resultant 8,000 additional deaths in England.

The latest figures for 2014/15 show that In Nottinghamshire there were 806 excess winter deaths recorded, the highest since 1999/00, mirroring national trends.

Recommendations include: the development of a local winter warmth strategy and action plan to address the needs of higher risk groups; development of a communication plan to increase public awareness; training staff from public sector, voluntary and private organisations to support people who have cold homes; ensuring homes meet building standards; and single point of contact for health and housing referral service.

[Click here to open the JSNA chapter on Excess winter deaths](#)

Link to recent HWB update on EWD to be included

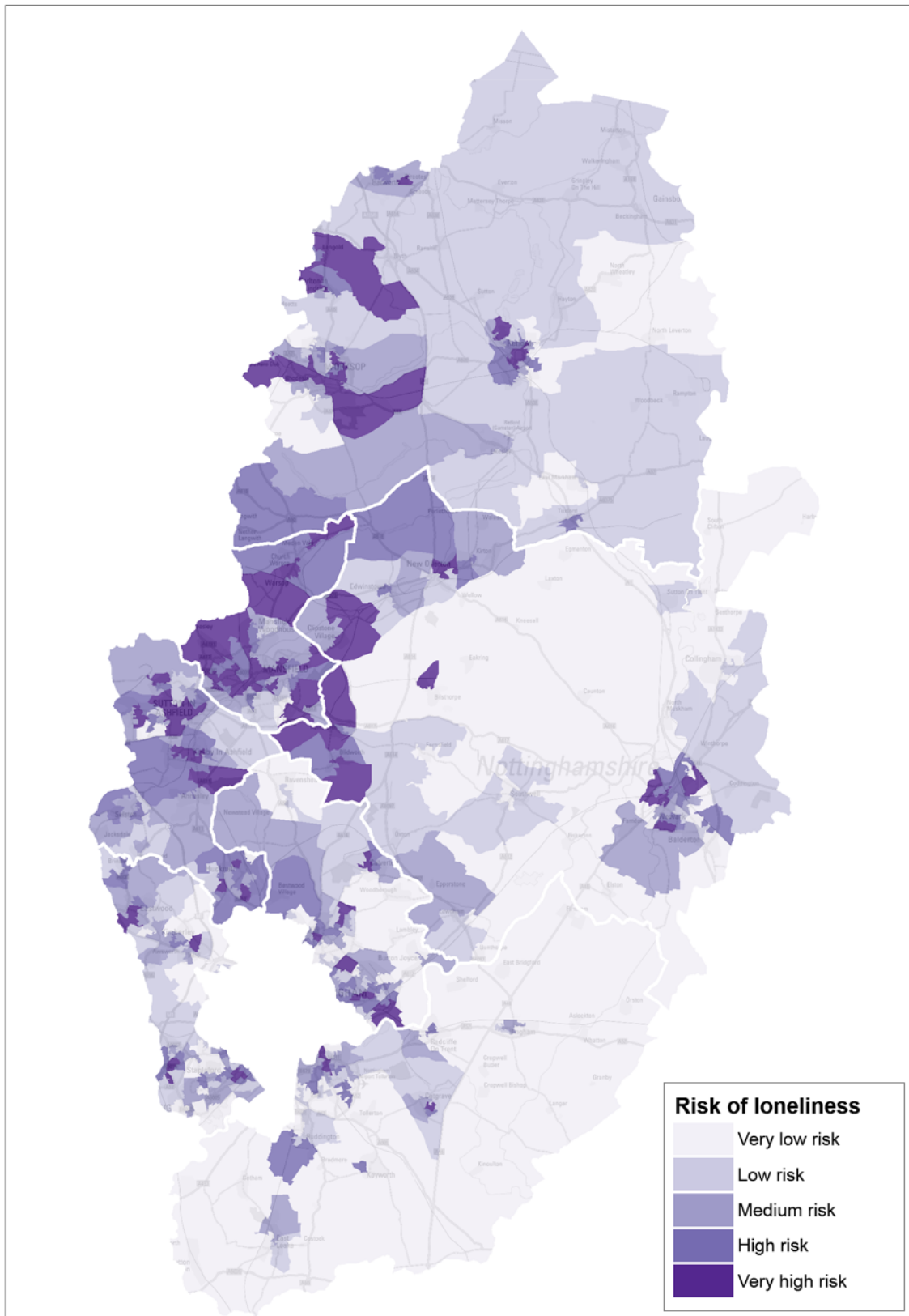
Loneliness

Loneliness is an individual's sense that they lack the depth and quality of relationships with others that they feel they want or need. People can be alone and not feel lonely, or they may be with others and feel very lonely, as many people do who live in care homes.

The causes of loneliness are multi-factorial and complex and therefore difficult to address. Factors that contribute to loneliness include life events, personal circumstances, social group membership, personality, psychological response, environment factors and long-term conditions, particularly dementia.

Older people are particularly at risk, affecting 10-20,000 older people in Nottinghamshire. Whilst there are people living in loneliness across the County, loneliness index mapping for small areas across Nottinghamshire shows that there are expected to be higher levels of need in the north and west of the County.

Figure 17: Risk of loneliness



Data and terminology derived from 'Predicting the prevalence of loneliness at older ages.'
<http://www.ageuk.org.uk/professional-resources-home/research/reports/health-wellbeing/predicting-the-prevalence-of-loneliness-at-older-ages/> Accessed 15/04/2016

Loneliness is bad for your physical and mental health. People who are lonely exercise less, are at higher risk of dementia and depression and heart disease, have a reduced immune response and are more likely to be admitted to hospital or a nursing home. “Being isolated and living alone shortens life and increases disability – it’s equivalent to smoking 15 cigarettes a day.” Duncan Selbie, Chief Executive, Public Health England, March 2013

Poorer physical and mental health and increased use of health and social care services, mean that commissioners have a significant interest in loneliness and social isolation. Key recommendations are listed below.

Key recommendations include: incorporate actions to address loneliness into plans and strategies; ensure co-ordinated response across the County targeted in areas of need; effective communication with older people; consider Age-friendly Communities; consider impact of planning; and improve data around loneliness.

[Click here to open the JSNA chapter on Loneliness and Social Isolation in Older People](#)

End of Life Care

This JSNA chapter is being refreshed, a summary, key recommendations and a link to the chapter will be included when it is published.