

Joint Strategic Needs Assessment 2012 refresh

Adults and Vulnerable Adults: Key Messages

Smoking prevalence estimates updated Oct 2012

1. Population and demography

- In 2010 the population of Nottinghamshire was approximately 779,900. Of these, around 18% were under 16 and 18% were over 65.
- The 25-44 year old population is greater in western parts of the county, while the 45-65 year old population is more largely concentrated to the east of the county.
- The mean age of the county's population was estimated to be 41 in 2010, compared with England 39.5.
- Projections for the 18 – 64 age group show that by 2025 there is expected to be an increase of 3.4% in Nottinghamshire. The biggest increases in that group will be in Broxtowe (7.5%), Rushcliffe (5.6%) and Ashfield (4.7%) whilst Mansfield will see no change and Bassetlaw will fall by 2.5%.

2. Vulnerable and Seldom heard adults

Ethnicity – black and minority ethnic (BME) population

- The white working age population for the county is 87.8%, above the East Midlands (83.1%), and the UK (82.3%).
- Nottinghamshire's non-white working age population is 2.8%, well below the East Midlands (9.3%) and the UK (11%).
- In only two districts does the percentage of the non-white working age population exceed 6% - Rushcliffe (6.2%) and Broxtowe (7.2%).
- The largest ethnic minority group in the working age population is Black/Black British (2,200 people), followed by Pakistani/Bangladeshi (1,600 people).
- Evidence from National Insurance registrations suggests a significant increase in people from Eastern European countries such as Poland since they joined the EU in 2004.

Migrants

- Inward migration to the UK has been the principal component of population change, overtaking natural change through births and deaths.
- Students are increasingly coming to live and study in Nottinghamshire from across the world (mainly concentrated in Rushcliffe & Broxtowe), so there is the potential for specific local medical conditions to occur and issues arising from cultural differences.

- In Nottinghamshire, the numbers of 'economic migrants' have increased steadily over the past three years from 2,310 in 2008/09 to 3,090 in 2010/11, with almost 60% of these coming from the 'A8' countries of Eastern Europe.
- The majority of 'A8' migrants have settled in the north and east of Nottinghamshire: Ashfield, Bassetlaw, Mansfield and Newark & Sherwood. Broxtowe and Rushcliffe, however, have a broader spread of economic migrants, for example from India and China.
- EU migrant workers are mainly young with general health needs similar to those of the UK population of the same age. However, prevalence rates of smoking are higher in many EU countries, such as Poland where the prevalence is about 32% (national UK rate 22%). Alcohol excess has also been highlighted as an issue amongst some groups, as has demand for UK maternity services.
- There is a need to promote access to health services among students (e.g. sexual health) and economic migrants (e.g. the role of GPs).
- Numbers of asylum seekers, irregular migrants and displaced persons are currently very low in Nottinghamshire, but consideration still needs to be given to their particular needs.

People living in poverty

- Mansfield is the most deprived district locally and is within the fifth most deprived areas nationally. Conversely, Rushcliffe is the least deprived district in the county and is in the least deprived fifth nationally.
- Deprivation is largely concentrated geographically in the north-west of the county, particularly in Mansfield, Ashfield and western Bassetlaw.
- Parts of Nottinghamshire have very low levels of skills and qualifications e.g. one in seven of the working age population in Ashfield and Mansfield have no qualifications, compared with 1 in 9 nationally.
- The employment rate for women is nearly 8% lower than for men, both locally and nationally.
- Nottinghamshire's overall employment rate in 2010/11 was 71.7%, with a range of just over 63% in Mansfield to over 77% in Broxtowe.
- Unemployment in Nottinghamshire is 3.3% (compared to 3.9% nationally) and varies from 4.4% in Mansfield to 2.1% in Rushcliffe. At ward level, rates vary between 1% to over 9%, the highest being Mansfield Ravensdale.
- Unemployment rates among young people are the highest since directly comparable records began in 1992. The overall unemployment rate in Nottinghamshire for people aged 19 and under is 11.8%, which is higher than the regional (10.4%) and national average (9.5%). It is particularly high in Ashfield, Gedling and Newark and Sherwood and

highest amongst young females (13.5%) compared with males (11.0%).

- Benefit claimant rates show concentrations of high rates in the north-west of Nottinghamshire, and of the top ten wards with the highest unemployment rates, four are within Mansfield.
- The largest category of working age benefit claimants is Incapacity Benefit (total ESA and IB claimants in Nottinghamshire at February 2011 was almost 34,000)¹.

Disabled People

Disability is defined as a mental or physical impairment that has a substantial, long-term effect on an individual's ability to carry out normal day-to-day activities.

- Levels of disability in Nottinghamshire (20%) are higher than both the East Midlands (19%) and England (18%).
- Levels of disability are higher in districts with higher deprivation (greatest in Mansfield 24% and lowest in Rushcliffe at 16%).
- It is estimated that in 2011 there were 38,942 people with moderate and 11,726 with severe physical disabilities.
- Projections suggest moderate increases in disabled adults (18-64) of over 4% by 2030 (relative to the 2011 estimates).
- People with disability have more difficulty accessing health services.
- People with disability are at increased risk of other physical health problems. Prevalence of a wide number of diseases (e.g. diabetes, coronary heart, obesity), lifestyle choices (e.g. smoking) and age at death are worse among the disabled population than the general population.
- The proportion of the general working age population in Nottinghamshire that are disabled (23%) is higher than in both the East Midlands (22%) and England (21%).
- The employment rate of the disabled working age population in Nottinghamshire (47%) is similar to Great Britain (48%) but varies between districts (the greatest between Bassetlaw at 55% and lowest in Mansfield at 29%).

¹ The number of people claiming benefits is likely to change due to new assessments introduced from April 2011 as part of government plans to reduce the number of long-term claimants in a rolling programme through to 2014.

People with sensory impairments

- There are around 4,400 people with a visual impairment and 2,500 people with a hearing impairment in contact with services in Nottinghamshire. However it is likely that a number of people with sensory impairments are not registered for services and therefore the needs of these people are unknown.
- A visual impairment can impact on every daily living skills.
- Being hearing impaired can be extremely isolating. There are particular difficulties for deaf people accessing services.
- Acquired deafness with age is increasing and although digital hearing aids are available, being able to adjust to this change mentally is difficult.
- Trained rehabilitation officers can assist people to learn new skills in order to maintain their independence, dignity and wellbeing. Being able to engage in community activities, feel safe and be aware of risks has a huge impact on people's lives.

People with learning disabilities

Learning disability is a life-long condition that occurs as a result of genetic or developmental factors or damage to the brain, often at birth. They affect a person's level of intellectual functioning - usually permanently - and sometimes their physical development too.

- Approximately 2% of the population of England has a Learning Disability, which is about 14,715 people over the age of 18 in Nottinghamshire.
- National figures show an expected increase in people with Learning Disabilities by approximately 14% between 2011 and 2030, which equates to a total of 17,000 people in Nottinghamshire. The increase is expected to be concentrated in the older age range, with 48% growth in people with learning disabilities aged over 65.
- It is estimated that there were 247 people with profound and multiple learning disabilities (PMLD) in Nottinghamshire in 2011. This figure could increase by approximately 32% by 2026 giving a future estimate of 326 people with PMLD throughout the county in the next 15 years.
- People with learning disabilities die younger and have poorer health than the general population (as indicated by higher admissions to secondary healthcare). These differences are, to some extent, avoidable and, as such, represent health inequalities.
- Age profiles of adults known to Adult Social Care and Health confirm a shorter life expectancy than the general population - an analysis of death certificates suggest a median age of death of 56 years.
- Nationally, people with learning disabilities are less likely to live in their own home or be in paid employment than the general population. In

Nottinghamshire a higher proportion than the national average live in their own homes (25%) and the percentage in paid employment (10%) is in line with the national average.

- A Nottinghamshire survey suggests approximately a third of people with learning disabilities would like to move, or would need to move (e.g. due to aging family carers), in the next five years.
- There are concerns locally about levels of hate crime experienced by people with a learning disability.

People with autism

Autism is defined as a lifelong developmental disability that affects how a person communicates with, and relates to, other people. It also affects how they make sense of the world around them.

- According to the diagnostic tools currently used, an estimated 1% of the national population is on the autistic spectrum, with a far higher proportion of men (1.8%) affected than women (0.02%).
- An estimated 4,829 people aged between 18 and 64 have autism in Nottinghamshire. It is believed that this will increase by approximately 3% over the next twenty years.
- Around 50% of people with autism also have a learning disability.
- Evidence suggests that people with autism are much more likely to have mental health problems than the general population, in particular depression and anxiety.
- A number of other conditions occur at a higher rate in people with autism compared to the general population, including epilepsy and attention deficit hyperactivity disorder.

People with mental ill health

Mental ill health is widespread; at least one in four people will experience a mental health problem at some point in their life, and at any one point in time one in six of the adult population in England will be experiencing a mental health problem². Mental health problems have complex causes and effects, involving social and economic circumstances, and having a mental health problem also increases the risk of physical ill health.

- Prevalence estimates indicate there were over 86,500 people in Nottinghamshire experiencing common mental disorders such as depression and anxiety, and over 3,000 suffering from severe mental illness in 2007.
- In terms of common mental disorders, across all age groups prevalence is higher amongst females than males, and the highest prevalence is found among females aged 45-54 years.

² McManus S et al 2009. Adult Psychiatric Morbidity in England 2007: Results of a household survey, The Information Centre

- As at May 2011, 7% of the working age population in Nottinghamshire were claiming unemployment related benefits due to mental or behavioural disorders.
- Over a third of Incapacity Benefit, Severe Disability Allowance and Employment Support Allowance claims in Nottinghamshire in 2011 related to 'mental or behavioural disorders'.
- For men under 35, suicide is the most common cause of death and men are three times more likely than women to take their own lives. Overall, people aged 40-49 have the highest suicide rate.
- Nottinghamshire has a lower overall rate of death by suicide than the England average, but a higher rate of suicides in people over 75.
- There is significant variation in the prevalence of mental illness, rates of suicide, rates of self-harm and proportion of benefits claimants between districts in Nottinghamshire, broadly reflecting the variation in levels of deprivation.

People in touch with adult social care, health and public protection services

- In 2010-11, 6,783 people aged between 18 and 64 years of age were receiving services from adult social care and health.
- Of these, 5,945 were receiving community-based services in their own homes, 707 were in residential care and 131 were in nursing care.
- The largest categories of people receiving care were those with a physical disability, frailty and/or temporary illness (2,395), people with learning disabilities (2,035) and those with mental ill health (1,502).
- The largest components of care services delivered in 2010-11 were those providing professional support, equipment/adaptations and direct payments.

Homeless people

- The levels of homelessness recorded in the annual Nottinghamshire Homeless Watch surveys have been reducing every year since 2005, but have risen again in 2011.
- 264 people presented as homeless to agencies in Nottinghamshire (excluding Nottingham City) during the two week survey period in 2011.
- The highest numbers (72%) were in the 18-40 age groups, although 22% were aged between 41 and 59. The majority of those presenting as homeless were males (62%).
- More homeless people with dependents presented as homeless in 2011 than in 2010 (189 children were homeless in 2011, compared to 135 in 2010).

- Many people presenting as homeless report having other problems, such as domestic violence, having a history of being in care or being an ex-offender, and having drug or alcohol problems.
- The Supporting People budget will reduce over the next three years by almost 50%, so the number of bed spaces and floating support places will reduce accordingly, potentially impacting on the numbers of homeless people.

Carers

A carer is someone, who, without payment, provides help and support to a partner, child, relative, friend or neighbour, who could not manage without their help. This could be due to age, physical or mental illness, addiction or disability.

- 83,000 carers identified themselves in the 2001 census, with approximately 26,000 of those classed as providing 20 hours or more of regular and substantial care.
- Nottinghamshire has a higher proportion of carers in the population than the England average, with most aged between 35 and 59.
- According to Nottinghamshire carers who took part in a 2009/10 survey, there was overall satisfaction with services received from the Local Authority. However, 10% expressed dissatisfaction with support or services and 29% found it difficult to find information and support.
- Around 50% of carers in England experience problems with health because of caring duties, as well as stress, disturbed sleep and irritability and 60% anticipate the amount of time spent caring will increase in the next five years.
- In terms of met need, the older population of carers have the highest levels of support. There may be issues of support for younger carers.
- According to predictions about the ageing population and the increase in morbidity related to old age, it is anticipated that there will be a concurrent increase in the number of carers and also in the number of older carers.

Gypsies and Travellers

- Evidence for the Nottinghamshire community is poor due to lack of monitoring, but nationally there is clear evidence of general worse health for Gypsy and Traveller communities, including significantly higher pregnancy/infantile and young age death due to lack of access to healthcare.
- In 2007 there were 1,479 Gypsies and Travellers living in 448 households. Most of these households, 256, were located in Newark and Sherwood.
- 34% of people lived on authorised sites, 15% on unauthorised sites and 50% in housing.

- In 2007 it was identified that around 120 additional permanent pitches would be needed to meet existing needs. In 2010, 37 additional private pitches had been created but the need for the additional pitches remains.
- A study of the health needs of travellers in Newark and Sherwood showed that Gypsy and Traveller communities were:
 - more likely to suffer from lung cancer, COPD, CHD and Mental Illness.
 - more likely to experience accidents
 - more likely to access health care inappropriately
 - less likely to access preventative health care (e.g. immunisations)

Offenders – health of prisoners

- There are three adult male closed prisons in Nottinghamshire, with a total prisoner population of approximately, 2,820 prisoners. Around 4,000 people will pass through the Nottinghamshire prisons in a year.
- There is a higher proportion of Black and Minority Ethnic groups in prison in Nottinghamshire than in the general county population.
- A 2011 Nottinghamshire prisoner survey reported a high prevalence of mental health problems (up to 21%) in prisoners. (Nationally 10% of men and 30% of women have had a previous psychiatric admission before they come into prison.)
- There are also high levels of alcohol and drug misuse in Nottinghamshire prisoners, 31% and 44% respectively, and nearly half (49%) of prisoners currently smoke.
- There is a predicted high prevalence of learning disabilities, but no data available at present (national data indicates that 20-30% of prisoners have learning disabilities or difficulties).
- Local commissioning priorities for 2012/13 include dental waiting times; improved learning disabilities pathways and access to health services; alcohol interventions; access to dual diagnosis services (for both a mental health problem and substance misuse issues); access to 40+ years health checks and management of long term conditions; and improved uptake of sexual disease screening.

3. Adult lifestyles

Substance misuse

Alcohol

- There are an estimated 123,529 'increasing risk'³ drinkers and 110,248 'binge' drinkers over the age of 16 in Nottinghamshire.
- The rate of alcohol related admissions to hospital in Nottinghamshire has risen by 33% between 2002/3 and 2007/8.
- 63% of the rise is due to male admissions to hospital and 37% due to female admissions.
- There is a clear north/south divide across Nottinghamshire (north higher than south) in terms of alcohol related admissions in both males and females.
- All districts are experiencing a year on year rise in increasing risk drinkers.
- These people are at increased risk of, for example, hypertension, heart disease, irregular heart rate, accidental injuries and mental and behavioural disorders.
- Of over 20,000 estimated dependent drinkers, only a very small number are engaged in specialist treatment.
- There is a group of dependent drinkers who are not currently actively engaged in alcohol treatment, who frequently attend emergency departments with a wide range of physical and mental health issues.
- Around 100 people a year in Nottinghamshire die from alcoholic liver disease.

Drugs

- In Nottinghamshire in 2010/11, there were 3,035 adult drug users in effective treatment – 2,528 of these were opiate and/or crack users.
- The average length of time in treatment is 2.6 years; 19% of clients have been in treatment for more than six years.
- There is a gap in our knowledge about drug users who are not accessing treatment.
- There were 147 drug related deaths (age 20 and above) in the county between 2006 and 2010. The highest number were in the 30-39 age range.
- Access to testing for hepatitis C has improved but more needs to be done to improve access to treatment on diagnosis.

³ i.e. people drinking more than the recommended levels

- Two thirds of those offered a hepatitis B vaccination programme don't take it up. Service providers have agreed to put an action plan in place to address this issue.
- There is a need to:
 - improve access to specialist liver services in the north of the county for both primary alcohol-using clients and clients who have hepatitis C.
 - improve end of life care pathways for end stage liver disease patients.
 - improve hepatitis B vaccination programme uptake.
 - complete a substance misuse health needs assessment to inform future treatment and recovery commissioning arrangements and to ensure equitable service provision across the county.

Smoking

Smoking prevalence estimates updated Oct 2012

- Smoking is the primary cause of preventable illness and premature death in England and the single biggest cause of inequalities in death rates between the richest and poorest in our communities. Tackling tobacco use is central to improving the health of the poorest, fastest.
- It is vital to stop children from smoking in the first place - 90% of people start smoking before the age of 19 and children are three times as likely to start smoking if their parents smoke.
- 22% of people smoke in Nottinghamshire, compared to a national average of 21%. However, this figure masks local differences - 16% of the population of Rushcliffe smoke, whilst 29% of the population of Mansfield are smokers⁴.
- Smoking is responsible for around 1,500 deaths across the county every year.
- Both Nottinghamshire and Bassetlaw NHS are above the national average for women who smoke during pregnancy, Bassetlaw notably so.
- Smokers are four times more likely to succeed in stopping smoking with support and locally, approximately 12,500 Nottinghamshire adults set a quit date last year, of whom 7,000 were successful at four weeks.
- Across the East Midlands, Bassetlaw had the highest percentage of smokers setting a quit date (at 10%) and over the last three years NHS

⁴ Smoking prevalence is currently reported by the Office for National Statistics (ONS) each quarter, but the methods used produce large variations for consecutive measurements at local-authority level. As of July 2012, the ONS is reviewing their methodology. These raw data are not used in this document: instead the medians of quarterly results from the ONS from April 2009-March 2010 to October 2010 to September 2011 are used.

Nottinghamshire County has supported 19,048 smokers to quit at four weeks.

- Services need to be tailored to meet the needs of routine & manual workers, young people and pregnant women, co-designed with them and delivered in locations and at times which make them accessible.

Diet and nutrition

- It is estimated that eating at least five varied portions of fruit and vegetables a day can reduce the risk of death from chronic disease, stroke and cancer by up to 20%.
- Across Nottinghamshire, synthetic estimates of fruit and vegetable consumption show on average one in four people over the age of 16 consume five or more portions of fruit and vegetables a day.
- Over 30% of Rushcliffe residents reported eating five or more portions of fruit and vegetables a day, compared with just over 20% in Ashfield and Mansfield, largely mirroring deprivation in the county.

Obesity

- Obese people are more likely to develop diabetes, colon cancer, hypertension (high blood pressure) and heart attacks, and obesity also has an impact on psychological well-being.
- Almost a quarter of adults in England are obese, with obesity increasing with age (up to around 75) and it is higher in men than in women. It is estimated that by 2030, 41%-48% of men and 35%-43% of women could be obese if trends continue unchecked.
- Adult obesity is high in the areas of Mansfield, Ashfield, parts of Bassetlaw and specific wards of Gedling, Broxtowe and Rushcliffe, largely mirroring levels of deprivation.

Physical activity

- Participation in physical activity across the county shows the lowest rates to be in Gedling, and the highest in Rushcliffe.

Sexual health

- There is considerable geographic variation in the distribution of sexually transmitted infections (STI), with the highest rates seen in urban areas of higher deprivation.
- The impact of poor sexual health is greatest in young heterosexual adults and in men who have sex with men.
- Diagnosed rates for the region broadly reflect those at County level with the highest diagnosed STI rates for chlamydia (350 per 100,000)

and genital warts (125 per 100,000), and the lowest for syphilis and gonorrhoea (below 25 per 100,000).

- The picture varies at district level. For genital warts Mansfield and Bassetlaw are within the top 25% nationally for diagnosis; for diagnosis of Herpes Bassetlaw, Gedling, Ashfield and Mansfield are in the top 25% nationally; for diagnosis of Gonorrhoea Ashfield, Mansfield and Gedling are in the top 25% nationally.
- There has been a year on year rise in the number of new diagnoses of HIV seen for treatment in Nottinghamshire (0.53 per 1,000 people aged 15-59 in 2010).
- The rise in the incidence of chlamydia locally is due to the increased application of more sensitive tests and to the expansion of chlamydia testing.
- Health promotion and education remain the cornerstone of STI and HIV prevention through improving public awareness and encouraging safer sexual behaviour.
- Rates of legal abortions in Nottinghamshire are lower than East Midlands and national averages. However, the proportion which are carried out in under ten weeks is notably lower than the national average (Nottinghamshire NHS - 61%; England - 76%).

4. Adult Health and Social Care

Long-term conditions

- In general, the prevalence of many long-term conditions in Nottinghamshire is similar to the national average.
- The most common long-term conditions are hypertension, common mental health disorders, asthma, chronic kidney disease, diabetes, chronic back pain and coronary heart disease. Most long-term conditions are more prevalent in more deprived communities.
- The estimated number of hypertension sufferers in the county is 210,285, well above the next most common long-term condition (mental health with 86,220 sufferers). It is estimated that just under half of the hypertension cases in Nottinghamshire remain undiagnosed and therefore untreated and at risk.
- Other long-term conditions where there are a relatively high proportion of undiagnosed people include diabetes, COPD (Chronic Obstructive Pulmonary Disease), dementia and chronic kidney disease⁵.

⁵ It has not been possible to assess unmet need for all long-term conditions, e.g. common mental health disorders.

Admissions to hospital

- Planned hospital admissions have increased over the last four years, whereas emergency admission rates have remained relatively stable.
- Rates of admissions to hospital vary across the districts and largely reflect levels of deprivation: more deprived areas have higher rates of general admissions and notably higher emergency admissions.
- Older people are three times more likely to have an emergency admission than any other age group.
- The main reasons for hospital admissions include cancers, respiratory conditions, circulatory diseases and injury/poisoning, which account for 30% of all admissions.
- Emergency readmissions to hospital have increased over the last four years both locally and nationally, though Nottinghamshire rates were significantly lower than the national average.

Health at Work

- Work is generally good for physical and mental health and well-being. Work can be therapeutic and can reverse the adverse health effects of unemployment.
- The longer someone is out of work due to ill-health, the lower their chance of getting back into work.
- In the East Midlands each worker took an average of 1.3 days off for work related injury or ill health.
- Families without a working member are more likely to suffer persistent low income and poverty.
- Nottinghamshire's Fit for Work Service, which supports local people to stay healthy and in work dealt with 278 cases between April-Nov 2011, 75% of whom presented with mental health conditions.
- Bassetlaw has developed a 'Well-being @ Work' workplace award scheme which focuses on smoking, healthy eating, physical activity, alcohol and drugs, mental health and wellbeing, also safe workplaces. 14 local workplaces have signed up to the scheme.

Infectious diseases

In historical terms, there are now relatively few people in the UK who die of communicable diseases. This is due to improvements in a range of environmental factors (e.g. standards of sanitation, nutrition, housing and working environment) as well as prevention and control measures such as vaccination, good hygiene and infection control measures. Nevertheless, communicable disease continues to represent a significant burden of disability and death, much of which is avoidable.

Tuberculosis (TB) is an infectious bacterial disease which can affect a number of organs. Although only 10% of those infected will develop active disease, TB which is left untreated can be fatal.

Hepatitis is inflammation of the liver. In some cases it is associated with long-term damage to the liver. Common causes of hepatitis in the UK include infection with Hepatitis B or Hepatitis C virus which are transmitted through the blood of an infected person. Both viruses may affect the liver but cause distinct diseases.

- Nottinghamshire NHS and Bassetlaw NHS both have relatively low incidences of TB, with rates of 4.0 and 3.6 per 100,000 per year respectively in 2008-2010. This compares to an incidence rate of 15.0 per 100,000 per year in England.
- At the district level, higher rates of TB tend to be seen in Mansfield and Broxtowe districts, with lower rates in other areas, though rates tend to vary from year to year.
- In 2011, there were 94 notifications of Hepatitis B in Nottinghamshire, with the majority of cases in Bassetlaw, Ashfield and Broxtowe districts. The increase in rates in 2011 compared to previous years is due to better reporting.
- There were 228 notifications of Hepatitis C in Nottinghamshire in 2011, with the majority of these from Bassetlaw and Mansfield districts⁶.
- Further work is required to determine the needs of the county's population with respect to communicable diseases within the wider health protection agenda.

All age all cause mortality (AAACM) and life expectancy

- All-age, all-cause mortality and life expectancy at birth are important indicators of health and well-being.
- In Nottinghamshire, AAACM is falling over time, with a corresponding increase in life expectancy.
- The rate of improvement varies by gender and by deprivation. The male AAACM rate improved faster than for females between 1999 and 2009.
- The gap in life expectancy between the most and least deprived communities in Nottinghamshire (9 years for men and 7.6 years for women) increased for women between 2001 and 2010, but not for men.
- In the short-term (2-3 years), case-finding, secondary prevention for cardiovascular disease and stopping smoking will have the largest impact on AAACM / life expectancy and contribute most to closing the inequalities gap.

⁶ The high number of cases from Bassetlaw and Mansfield districts historically tends to reflect a more robust notification system. Notification from other districts has improved in recent years.

End of life Care

- Nearly 7,000 people die in Nottinghamshire each year, of whom more than 80% are over 65. The main causes of death are circulatory disease, cancers and respiratory disease.
- Over half of these people die in hospital, but many of them have no clinical need of hospital care.
- Nationally, older people, people who have a non-cancer diagnosis, people who live in an area of multiple deprivation, people from ethnic minorities, and people who live in rural areas are less likely to die at home.
- It is estimated that around 40% of all deaths could be anticipated, and these people could therefore be offered the opportunity of advance care planning.
- Locally, one in five people in Nottinghamshire NHS and one in four people in Bassetlaw NHS die in their own home.

5. Safety

Crime

- Crime and fear of crime affects particular communities - for example those suffering from deprivation - and groups of people - for example young people, older people and BME communities - disproportionately.
- Although some crime rates have fallen in recent years, Nottinghamshire still has significant crime and anti-social behaviour issues across the county.
- Mansfield, Ashfield and Bassetlaw had the highest crime rates in the county in 2010/11 (83.8, 74.5 and 71.4 per 1,000 respectively).
- Important county issues include violence and domestic violence.
- Theft offences in Nottinghamshire have increased (in line with the national average), domestic burglary has reduced and vehicle crime is stable and below the national level.
- There is a relationship between alcohol and drug use and crime rates and anti-social behaviour, with alcohol in particular being a driver of violent crime and anti-social behaviour.

Domestic violence

- Women are substantially more at risk of being a victim or survivor of domestic violence. Young women, especially teenage mothers, are especially at risk.
- Across Nottinghamshire, approximately 32,000 women will experience domestic violence each year.

- There were over 11,000 domestic incidents and domestic violence crimes in the county reported to the police in 2010/11, the highest number in Mansfield and Ashfield and the lowest in Rushcliffe.
- During 2010/11 in Nottinghamshire, 856 high risk domestic violence cases were taken to a MARAC (Multi Agency Risk Assessment Conferences). 22 of these were male victims.
- Local data indicates that women in the 20-30 year age range make up 36% of all adult domestic violence victims.
- Access to local specialist domestic violence support services (including referral to MARACs) by disabled women, older women, lesbian, gay, bi-sexual and trans-gendered people is low.
- Women from BME groups accessing Nottinghamshire specialist domestic violence services (10.5% of all service users) represent a higher proportion of service users compared with the county's BME population as a whole.
- The implementation of agreed standardised data collection sets across agencies would improve ability to assess need and plan for the future.

Road traffic collisions and avoidable injury

- Road casualty rates in Nottinghamshire are reducing year on year and are currently lower than the national average.
- Comparing 2010 with 2009, the number of people killed in road accidents fell by 17% nationally and by 45% in Nottinghamshire.
- All severities of casualties fell by 6% nationally and 10% in Nottinghamshire.

Adult abuse

- There were 2,357 referrals relating to the abuse of vulnerable adults in Nottinghamshire in 2010/11, up from 1,550 in 2008/09.
- 40% of those referrals led to an assessment, down from 56% in 2009/10. This drop was most prominent in younger adults.
- There has been a significant increase in the proportion of older people being referred, compared to decreasing referrals in other service user groups. More than half of the total referrals in 2010/11 were for people aged 65+.
- The most common type of abuse of vulnerable adults being reported is physical abuse, which is significantly higher than any other form of abuse. However, reports of neglect are increasing.

JOINT STRATEGIC NEEDS ASSESSMENT FOR NOTTINGHAMSHIRE 2012

Adults and Vulnerable Adults

1. Population and Demography

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Adults: Population and Demography

1. Population and Demography

1.1 Population

Key Messages

- In 2010 the population of Nottinghamshire was approximately 779,900. Of these, around 18% were under 16 and 18% were over 65.
- The 25-44 year old population is greater in western parts of the county, while the 45-65 year old population is more largely concentrated to the east of the county.
- The mean age of the county's population was estimated to be 41 in 2010, compared with England 39.5.
- Projections for the 18 – 64 age group show that by 2025 there is expected to be an increase of 3.4% in Nottinghamshire. The biggest increases in that group will be in Broxtowe (7.5%), Rushcliffe (5.6%) and Ashfield (4.7%) whilst Mansfield will see no change and Bassetlaw will fall by 2.5%.

The national Census takes place every ten years when each household is required to complete a questionnaire giving details of all the people in each property. This is used to compile a detailed demographic profile of the whole country. In the intervening years, before the next census is held, the ONS produces estimated population figures for each part of the country taking into account factors such as births, deaths and internal and external migration. The most recent Census was held in March 2011 but the preliminary results will not be published until July 2012 and all the other findings will be rolled out during the rest of 2012 and 2013.

The 2001 Census of Population reported that the population of Nottinghamshire was 748,510, with the gender breakdown being males 366,118 and females 382,392. The county's mean age was 39.6, slightly older than the mean age of the population of the East Midlands region and of England (38.6). According to the ONS mid year estimates by 2010 the total population had risen to 779,900.

Table 1.1.1 below shows the composition of the county's population, broken down into three main cohorts of the adult population. This shows that Ashfield, Broxtowe, and Rushcliffe have larger proportions of the youngest cohort whilst the older age range is better represented in Bassetlaw, Gedling and Newark & Sherwood.

Table 1.1.1: Nottinghamshire Population, by adult cohort, (Aged 18-64) by gender, 2010

Area	18-24	25-44	45-64	Mean Average For All people
Ashfield	9,960	30,840	31,130	40,240
Bassetlaw	8,670	27,220	32,050	41,590
Broxtowe	10,390	31,520	29,850	41,010
Gedling	8,910	29,020	31,440	41,680
Mansfield	8,740	25,240	27,140	40,470
Newark and Sherwood	8,960	27,080	32,170	41,630
Rushcliffe	9,570	29,010	31,120	40,840
Nottinghamshire	9,310	28,560	30,700	41,070

Source: ONS Mid Year Estimates, 2010. Crown copyright 2011

The age profile of the county's population as at 2010 showed that the mean age of the population was 41.1 years, compared with 39.5 for England.

The adult population of the seven districts within Nottinghamshire in mid 2010 ranged from 61,124 to 71,937. (See Table 1.1.2).

Table 1.1.2: Nottinghamshire Population, by adult cohort (Aged 18-64) broken down by gender, 2010

Area	Male	Female	Total
Ashfield	35,502	36,435	71,937
Bassetlaw	34,371	33,564	67,935
Broxtowe	36,244	35,512	71,756
Gedling	34,026	35,337	69,363
Mansfield	30,325	30,799	61,124
Newark and Sherwood	33,822	34,388	68,210
Rushcliffe	35,147	34,548	69,695
Nottinghamshire	239,437	240,583	480,020

Source: ONS Mid Year Estimates 2010. Crown copyright 2011

Figures 1.1.3 and 1.1.4 which follow show the patterns of concentrations of the younger adult and older adult cohorts in the population of the county.

The maps are very different, with the younger cohort being concentrated largely in the western area of the county, whilst the older cohort shown in figure 1.1.4 is largely concentrated in the east of the county, as well as in the northern and southern wards.

Figure 1.1.5 shows the projected changes in population 2010 - 2025 broken down by district, showing marked differences, with Rushcliffe expecting over 13% population growth, whilst Bassetlaw and Mansfield both show growth of just over 7%. The population of the county is projected to grow by almost 11% over the same period.

Looking forward, figure 1.1.6 projects working age population to 2025 and shows an expected increase of 3.4% in total population of 18-64 year olds in Nottinghamshire. Projected changes vary in the districts from a decrease of -2.5% in Bassetlaw to an increase of 7.5% in Broxtowe.

Figure 1.1.3: areas of residence of adult population aged 25-44 across Nottinghamshire

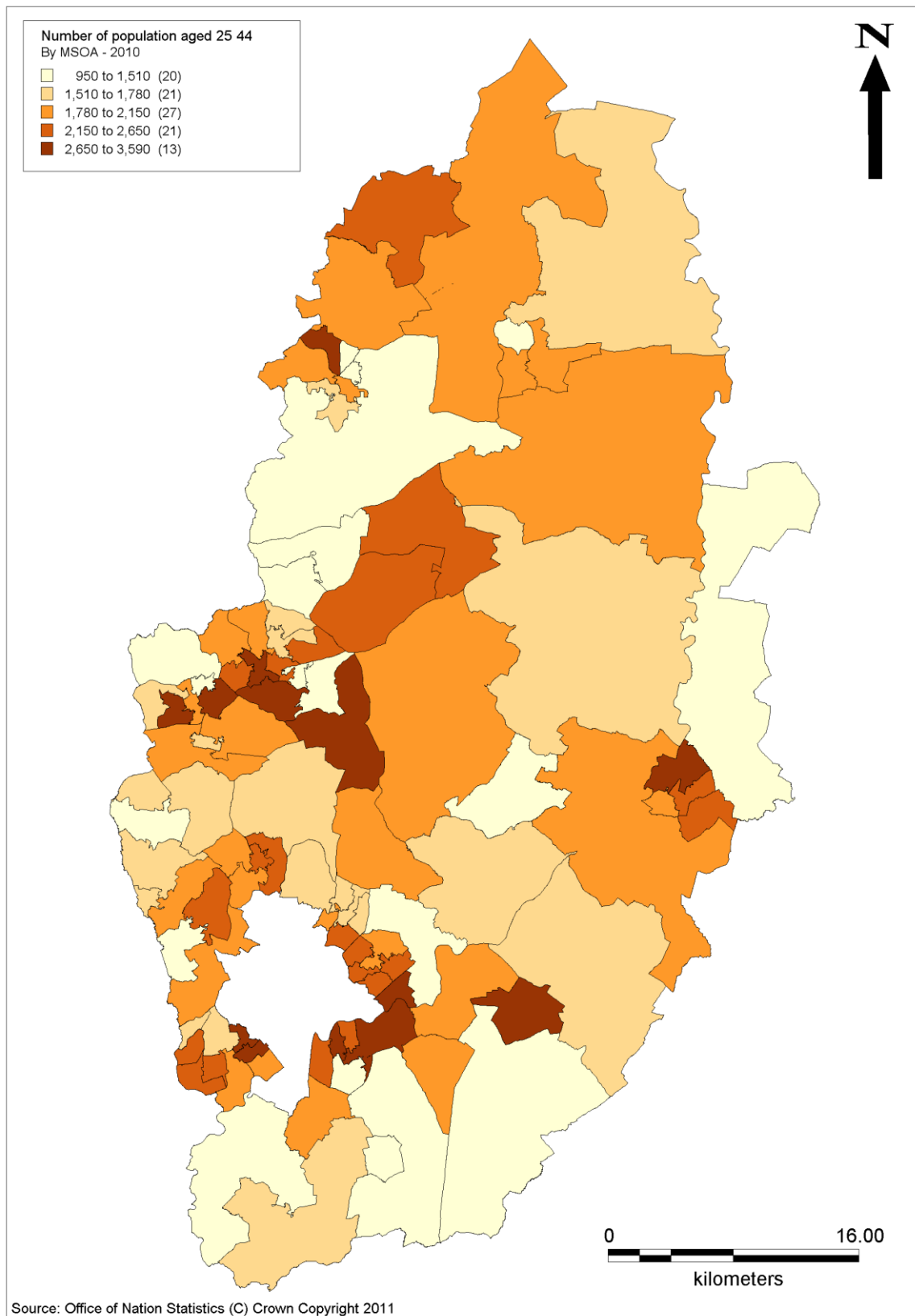


Figure 1.1.4 residence of adult population 45-64 across Nottinghamshire

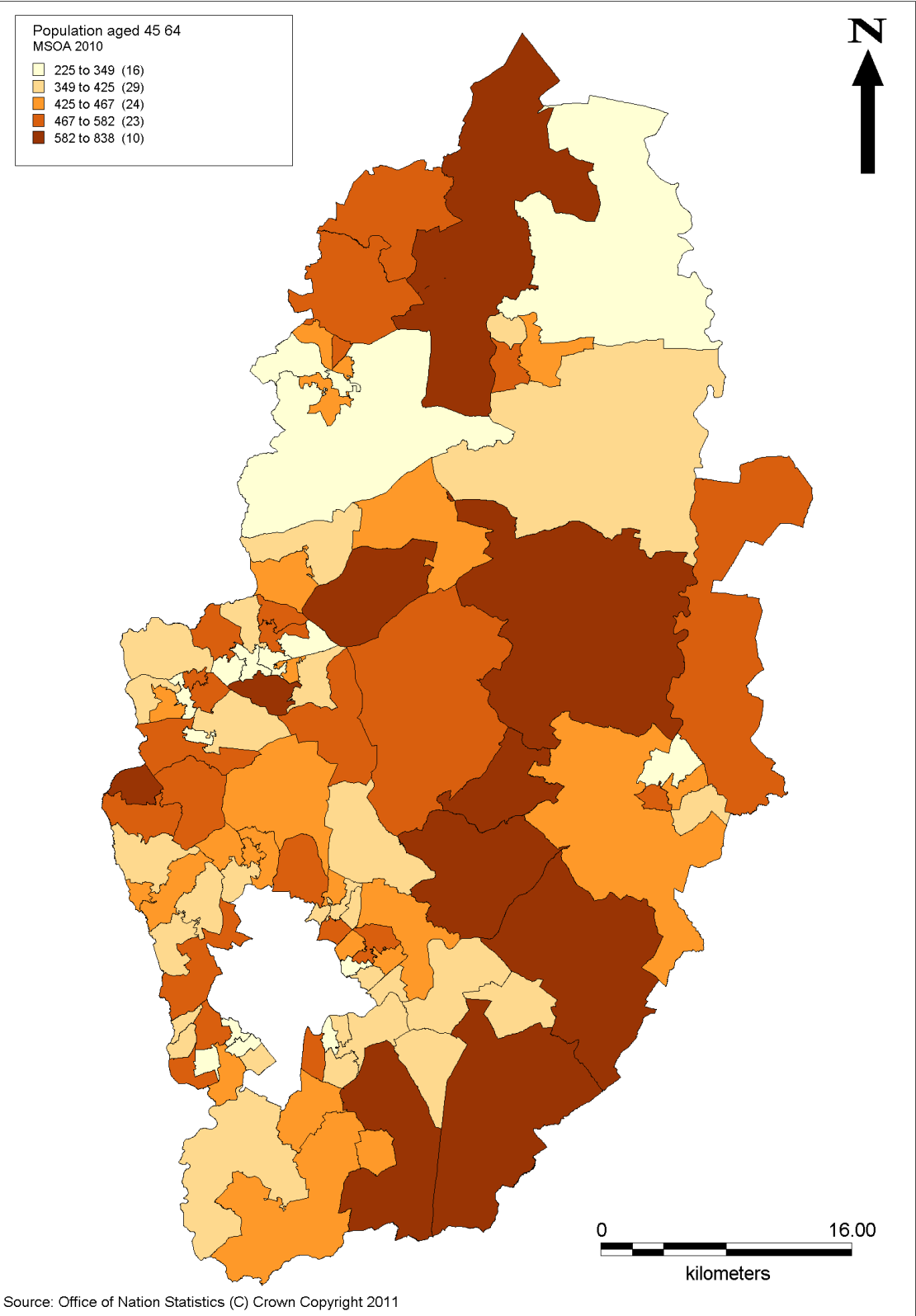


Table 1.1.5: Nottinghamshire District Population change (2010-2025), for the total population.

Rank	Area	Region	% change
1	Rushcliffe	East Midlands	13.24%
2	Broxtowe	East Midlands	12.97%
3	Newark And Sherwood	East Midlands	12.43%
4	Ashfield	East Midlands	11.59%
5	Gedling	East Midlands	11.13%
6	Bassetlaw	East Midlands	7.58%
7	Mansfield	East Midlands	7.37%
8	Nottinghamshire	East Midlands	10.97%

Source: ONS Mid Year Estimates,2010. Crown copyright 2011

Table 1.1.6: Nottinghamshire District Population change (2010-2025), by adult cohort (Aged 18-64).

Rank	Area	Region	% change
1	Broxtowe	East Midlands	7.47%
2	Rushcliffe	East Midlands	5.58%
3	Ashfield	East Midlands	4.70%
4	Newark And Sherwood	East Midlands	3.98%
5	Gedling	East Midlands	3.67%
6	Mansfield	East Midlands	0.00%
7	Bassetlaw	East Midlands	-2.48%
8	Nottinghamshire	East Midlands	3.37%

Source: ONS Mid Year Estimates,2010. Crown copyright 2011

Populations aged 18-64 for Nottinghamshire's Clinical Commissioning Groups.

Table 1.1.7: CCG Population by adult cohort (aged 18-64), 2010.

CCG	20-24	25-44	45-64
Bassetlaw CCG	6,400	27,700	31,200
Mansfield & Ashfield CCG	11,300	49,200	49,200
Newark & Sherwood CCG	7,100	32,000	35,600
Nottingham North & East CCG	8,200	37,900	39,800
Nottingham West CCG	5,400	25,600	24,600
Principia - Rushcliffe CCG	6,400	31,800	34,100
All CCGs	44,800	204,200	214,500

* Adult = 20-64 as age band is the most approximate in band category

Table 1.1.8: CCG Population by adult cohort (aged 18-64) and gender, 2010.

CCG	Female	Male	Total
Bassetlaw CCG	32,400	32,900	65,300
Mansfield & Ashfield CCG	54,200	55,500	109,700
Newark & Sherwood CCG	37,300	37,400	74,700
Nottingham North & East CCG	42,800	43,100	85,900
Nottingham West CCG	27,800	27,800	55,600
Principia - Rushcliffe CCG	36,100	36,200	72,300
All CCGs	230,600	232,900	463,500

* Adult = 20-64 as age band is the most approximate in band category

Table 1.1.9: CCG Population percentage change (2010-2025) total population.

Rank	Clinical Commissioning Group CCG	% Change between 2010 and 2025 (projected)
1	Nottingham West CCG	13.71%
2	Principia - Rushcliffe CCG	13.69%
3	Newark & Sherwood CCG	11.75%
4	Nottingham North & East CCG	11.66%
5	Mansfield & Ashfield CCG	9.26%
6	Bassetlaw CCG	7.91%
	All CCGs	11.14%

Table 1.1.10: CCG Population percentage change (2010-2025) by adult cohort (aged 18-64).

Rank	Clinical Commissioning Group CCG	% Change between 2010 and 2025 (projected)
1	Nottingham West CCG	12.51%
2	Principia - Rushcliffe CCG	11.34%
3	Nottingham North & East CCG	9.69%
4	Newark & Sherwood CCG	9.03%
5	Mansfield & Ashfield CCG	7.22%
6	Bassetlaw CCG	4.59%
	All CCGs	8.87%

** Adult = 20-64 as age band is the most approximate in band category*

1.2. Religion

The 2001 national census included a voluntary question: 'What is your religion?'. The results of this for Nottinghamshire are shown in table 1.1.11. This will be updated when the results of the 2011 Census are released.

Table 1.1.11: Number of people living in Nottinghamshire districts by religious group, Census 2001.

Religious group	Ashfield	Bassetlaw	Broxtowe	Gedling	Mansfield	Newark and Sherwood	Rushcliffe	Nottinghamshire
Buddhist	90	100	340	190	100	120	230	1,170
Other religion	190	230	240	220	150	180	260	1,470
Christian	81,170	87,820	75,910	80,210	74,650	84,080	75,850	559,690
Hindu	110	140	610	370	220	60	650	2,160
Jewish	40	50	130	120	10	60	390	800
Muslim	140	360	930	690	260	190	960	3,530
No religion	19,820	10,760	20,450	20,870	14,950	13,720	19,000	119,570
Sikh	110	80	670	490	170	70	720	2,310

Source: Census 2001

Numbers rounded to nearest 10.

JOINT STRATEGIC NEEDS ASSESSMENT FOR NOTTINGHAMSHIRE 2012

Adults and Vulnerable Adults

2. Vulnerable and Seldom Heard Groups

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Adults: Vulnerable and Seldom Heard Groups

2. Vulnerable and Seldom Heard Groups

2.1. Ethnicity

Key Messages

- The white working age population for the county is 87.8%, above the East Midlands (83.1%), and the UK (82.3%).
- Nottinghamshire's non-white working age population is 2.8%, well below the East Midlands (9.3%) and the UK (11%).
- In only two districts does the percentage of the non-white working age population exceed 6% - Rushcliffe (6.2%) and Broxtowe (7.2%).
- The largest ethnic minority group in the working age population is Black/Black British (2,200 people), followed by Pakistani/Bangladeshi (1,600 people).
- Evidence from National Insurance registrations suggests a significant increase in people from Eastern European countries such as Poland since they joined the EU in 2004.

The black and minority ethnic part of the county's population is relatively small; according to the 2001 census, at that date 97.4% of the county's population was white and 2.6% non-white. The census breakdown showed the relative Nottingham City rates to be 84.9% white and 15.1% non-white. The census also showed that the non-white rate for England was 9.1% and for the region 6.5%.

Population / Demography

Table 2.1.1 shows the region of birth for all persons in Nottinghamshire, as reported in the 2001 census, and shows that 98% of the population are European born. However, those born in Asia, Africa and North America made up a greater percentage than those reporting their birthplace as in Eastern Europe. The recent surge in Eastern European migrants is likely to have changed this picture.

More recent information regarding ethnicity can be found in the Annual Population Survey. The white working age population for the county is 87.8%, for the East Midlands 83.1%, and the UK 82.3%. Within the county the breakdown shows marked disparities and these can be seen in Table 2.1.2. The highest percentages of the white working age population are found in Ashfield, Bassetlaw and Broxtowe, - all with over 90% - and in three other districts the percentages are 86% and above.

Table 2.1.1: Region of Birth of Nottinghamshire residents 2001

Region of birth for all persons in Nottinghamshire (2001 census)	%
Europe	98.1
Asia	1.02
Africa	0.40
North America	0.32
Europe - Eastern Europe	0.29
Oceania	0.11
South America	0.04
Other	0.02

Source: ONS Country of Birth, Census 2001.

Table 2.1.2: Working Age Population, April 2010-March 2011

Area	% of white aged 16-64		% of non-white aged 16-64	
	number	percent	number	percent
Ashfield	68,100	92.0	!	!
Bassetlaw	63,900	91.2	1,400	2.0
Broxtowe	67,600	92.8	5,200	7.2
Gedling	65,000	89.1	!	!
Mansfield	56,100	86.9	1,300	2.1
Newark and Sherwood	60,400	87.6	!	!
Rushcliffe	54,600	75.1	4,500	6.2
Nottinghamshire	435,700	87.8	14,100	2.8
Nottingham City	157,100	72.1	51,300	23.5
East Midlands	2,383,900	83.1	266,000	9.3
United Kingdom	32,956,300	82.3	4,406,800	11.0

!Estimate & confidence interval not available as sample size is zero or disclosive (0-2).

Source: Annual Population Survey via NOMIS

In terms of the working age population (this is a useful proxy for the adult population), Nottinghamshire's non-white population is 2.8%, as compared to 9.3% for the region and 11% for the UK.

Looking at the percentages of the non-white working age population, the numbers are so small in Ashfield, Gedling and Newark & Sherwood that the Annual Population Survey does not permit disclosure of numbers or percentages. In only two districts does the percentage of the non-white working age population exceed 6%, Rushcliffe at 6.2% and Broxtowe at 7.2%.

Table 2.1.3: Working Age Population by Ethnic Group, Apr 2010-Mar 2011

Area	% mixed ethnic group		% Indian		% Pakistani/Bangladeshi		% Black or Black British		% 16-64 of other ethnic group	
	number	%	number	%	number	%	number	%	number	%
Nottingham City	2,100	1	8,900	4.1	11,300	5.2	12,600	5.8	16,400	7.5
Nottinghamshire	!	!	900	0.2	1,600	0.3	2,200	0.4	8,500	1.7
East Midlands	22,100	0.8	99,800	3.5	36,600	1.3	44,000	1.5	63,500	2.2
United Kingdom	339,300	0.8	923,900	2.3	871,400	2.2	1,031,700	2.6	1,240,500	3.1

! Estimate and confidence interval not available since the group sample size is zero or disclosive(0-2)

Source: Annual Population Survey via NOMIS

As the percentages of the non-white population are very small, examining the breakdown of the component parts of the population is unreliable. However, the Annual Population Survey (APS) does break the BME population down into component parts, e.g. Indian, Pakistani etc., but once again the numbers are so small that the Annual Population Survey does not permit disclosure. Not even at county level are there sufficient numbers to allow full classification into the component parts of the BME population.

At the county level, the Indian sub-group of the working age population accounts for 0.2% (900), the Pakistani/Bangladeshi sub-group accounts for 0.3% (1,600), and the Black/Black British percentage is 0.4% (2,200). There are 8,500 people in the 'other ethnic origin' group accounting for 1.7% of the population.

Below county level, only Nottingham City has large enough numbers of minority ethnic working age populations to be disclosed. Within Nottingham, the largest sub-groups are 'other', with 16,400 (7.5%), 'Black and Black British' with 12,600 (5.8%) and 'Pakistani/Bangladeshi' with 11,300 (5.2%).

2.2. Migrants

Key Messages

- Inward migration to the UK has been the principal component of population change, overtaking natural change through births and deaths.
- Students are increasingly coming to live and study in Nottinghamshire from across the world (mainly concentrated in Rushcliffe & Broxtowe), so there is the potential for specific local medical conditions to occur and issues arising from cultural differences.
- In Nottinghamshire, the numbers of 'economic migrants' have increased steadily over the past three years from 2,310 in 2008/09 to 3,090 in 2010/11, with almost 60% of these coming from the 'A8' countries of Eastern Europe.
- The majority of 'A8' migrants have settled in the north and east of Nottinghamshire: Ashfield, Bassetlaw, Mansfield and Newark & Sherwood. Broxtowe and Rushcliffe, however, have a broader spread of economic migrants, for example from India and China.
- EU migrant workers are mainly young with general health needs similar to those of the UK population of the same age. However, prevalence rates of smoking are higher in many EU countries, such as Poland where the prevalence is about 32% (national UK rate 22%). Alcohol excess has also been highlighted as an issue amongst some groups, as has demand for UK maternity services.
- There is a need to promote access to health services among students (e.g. sexual health) and economic migrants (e.g. the role of GPs).
- Numbers of asylum seekers, irregular migrants and displaced persons are currently very low in Nottinghamshire, but consideration still needs to be given to their particular needs.

Background

A study into the health needs of migrants in the EU, suggests there are five major categories:

The Five Types of Migrant¹

- Students
- Economic Migrants
- Asylum seekers
- Irregular or undocumented migrants
- Displaced persons

Traditionally there has been internal migration of students within the country with some Nottinghamshire residents attending university and colleges elsewhere and people from other parts of the country coming to Nottinghamshire to live and study. With globalisation, both of Nottinghamshire's universities have built extensive academic links with foreign countries, such as China and Eastern Europe for example, and this has resulted in an influx of students from those countries. The potential for students from anywhere in the world to come to Nottinghamshire to study means the local health and wellbeing community need to be aware of them being able to access local health services, the potential for conditions more prevalent in their home countries to occur and the possibility of issues arising with some young people being away from home for the first time, around sexual health for example. There is a need to promote how to access health services at colleges and universities to all students, but in particular those from abroad.

Economic migrants refers to people who come to the county for work and employment opportunities. Some might come for a short time to do low paid, seasonal work for example, others might be looking for a career and move with the potential for staying permanently.

The term 'Irregular migrants' describes people who are not complying with some aspect of immigration law and rules. Although often referred to as 'Illegal migrants', many people prefer to use the terms 'irregular', or 'undocumented', migrants. This is because many irregular migrants commit administrative, rather than criminal, offences and so it is misleading to use the term 'illegal' which has associations with criminality.

Asylum seekers refers to people who have left their own country for reasons such as political persecution and torture and are applying to be allowed to live in the new country.

Displaced persons can cover many issues but basically refers to people who are unable to live in their own country for reasons such as war, civil unrest, and natural disasters such as floods or earthquakes.

Of these categories, the first two – students and economic migrants - are the most important for Nottinghamshire. With regard to students, the 2001 census revealed that in the county there were almost 29,400 full time students, of which 15,600 were aged 18 and over. Whilst the numbers of those aged 16-17 were fairly evenly spread across all

¹ Mladovsky P. Migrant health in the EU. *Eurohealth*. Vol 13, No.1. 2007.

the districts in the county, those aged 18 and over were concentrated in Broxtowe and Rushcliffe and this is likely to be due to the proximity of these two districts to the higher education institutions located in the City of Nottingham. By way of comparison, also in 2001, Nottingham City recorded over 31,000 full time students living in its area.

New data on student numbers will be available later in 2012 once findings from the 2011 census are revealed.

A study undertaken by the Institute of Community Cohesion (ICOCO) and published in December 2007 by the Local Government Association, 'Estimating the scale and impacts of migration at the local level', observes that international migration is a growing phenomenon and notes the numbers of migrants coming into and leaving the UK in recent years. The study observes that there is a recognition that data sources on migration are inadequate and partial with researchers having to rely on Census figures, the International Passenger Survey, the Labour Force Survey and other sources. In spite of these difficulties the report is able to state that since 1998, inward-migration to the UK has been the principal component of population change, overtaking natural change through births and deaths.

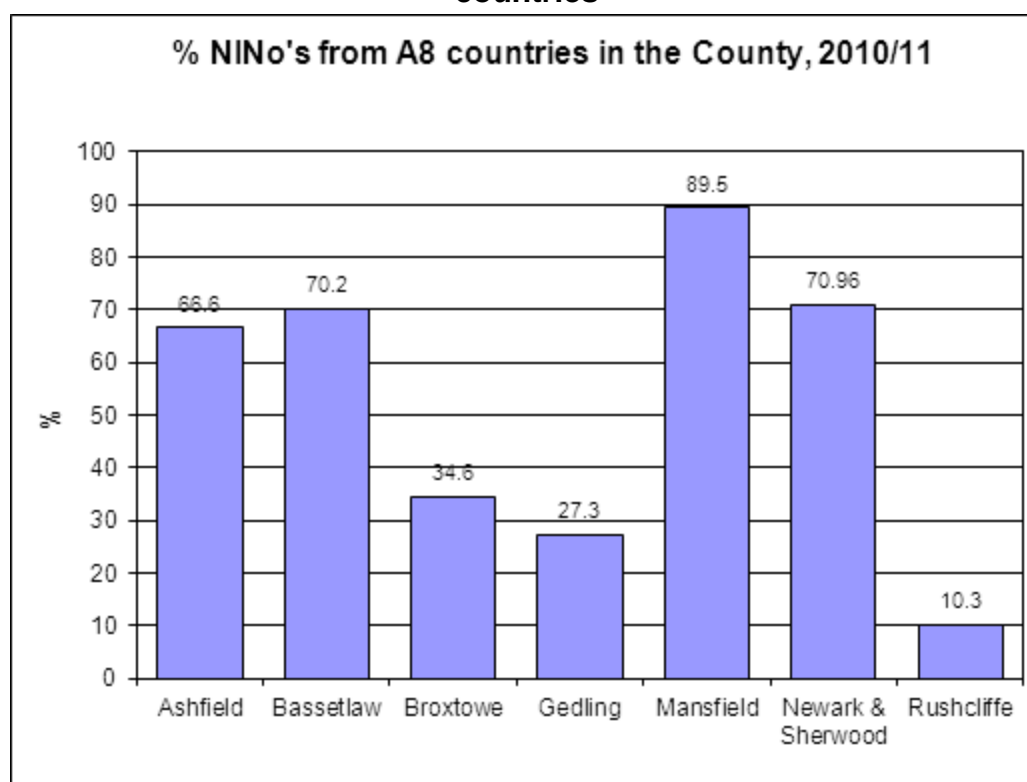
Actual numbers of asylum seekers are difficult to identify as official figures are disputed given issues such as people being able to enter via other EU countries, but it is estimated they only accounted for 2% of all non-British migration in 2007. The principal countries of origin of asylum seekers to the UK in 2010 were Iran, Afghanistan, and Zimbabwe according to UNHCR, Asylum Levels and Trends in Industrialised Countries 2010.

Economic Migrants

Migrants continue to play an important role in national, regional, and local based economies of the UK. In Nottinghamshire, the numbers of 'economic migrants', have increased steadily over the past three years from 2,310 in 2008/09 to 3,090 in 2010/11, with almost 60% of these coming from Eastern Europe, particularly Poland. In line with these sharp increases, it is therefore important for local stakeholders to adapt and tailor services accordingly to assess, understand, and most importantly tackle the health and social care needs of this diverse and often difficult to reach group.

The following figures look at the National Insurance Number allocations to overseas nationals (NINo's) entering the UK in 2010/11. It should be noted that NINo figures, although authoritative, only give part of the picture regarding migrant workers as there are other categories of workers captured by other counts.

Figure 2.2.1: % National Insurance Number allocations from eastern European countries

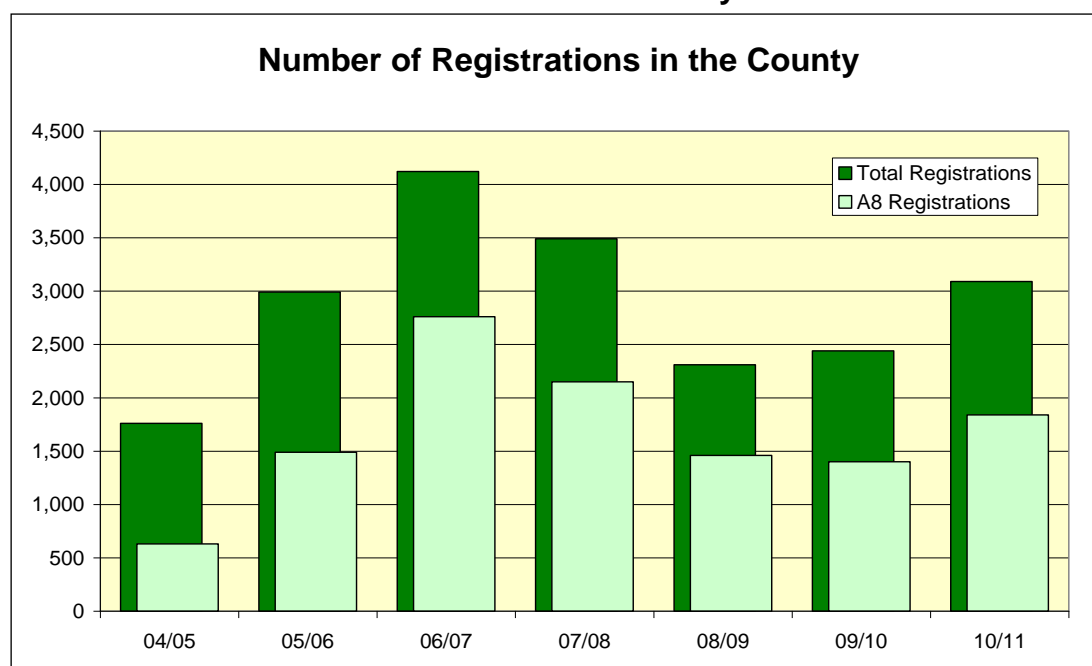


Source: Department for Work and Pensions: National Insurance allocations to overseas nationals entering the UK. 2010-2011.

The number of National Insurance Number (NINo) allocations to non-UK nationals living in the county has risen by 650 over the year. Of the total 3,090 NINo's, 1,840 or 59.5% were from the "Accession 8" or "A8" countries which joined the European Union (EU) on 1 May 2004. The 'A8' countries are: Czech Republic, Lithuania, Estonia, Poland, Hungary, Slovakia, Latvia and Slovenia. Figure 2.2.1 shows the number of NINo's from people originating in the A8 countries as a proportion of registrations from people from all countries. Four districts have proportions above the East Midlands figure of 48.1% with the figure for Mansfield approaching 90%. In contrast, only 10% of registrations in Rushcliffe are made by people originating from the eastern European countries.

These 'A8' migrants in Nottinghamshire are significant as these workers mainly have taken up low skilled jobs in elementary occupations or as process, plant or machine operatives. EU migrant workers are mainly young with general health needs similar to those of the UK population of the same age. However, prevalence rates of smoking are higher amongst many EU countries, such as Poland where the prevalence is about 32% (national UK rate 22%). Alcohol excess has also been highlighted as an issue amongst some groups, giving concerns about issues such as health and safety (e.g. the handling of machinery) and driving over legal limits.

Figure 2.2.2: National Insurance Number allocations for overseas nationals in the County



Source: Department for Work and Pensions: National Insurance allocations to overseas nationals entering the UK. 2010-2011.

The main issue common to all 'A8' migrants is one of accessing services. A number of factors leading to low uptake of services by migrants include:

- limited understanding of the UK health system, and in particular the role of the GP
- differing health seeking behaviours and expectations of healthcare services
- returning home for medical care amongst some groups of migrants
- language and cultural differences
- changing entitlements to healthcare services
- poverty acting as a barrier to access.

Figure 2.2.2 illustrates the trend in NINo's for both total registrations and those for people coming from the A8 countries since 2004/05. It can be seen that whilst both groups are down from the peak in 2006/07 they have been steadily increasing over the last three years. In 2004/05 registrations from A8 countries represented 35.8% of the total registrations, by 2006/07 that proportion had risen to 67% and in 2010/11 it stands at 59.5%.

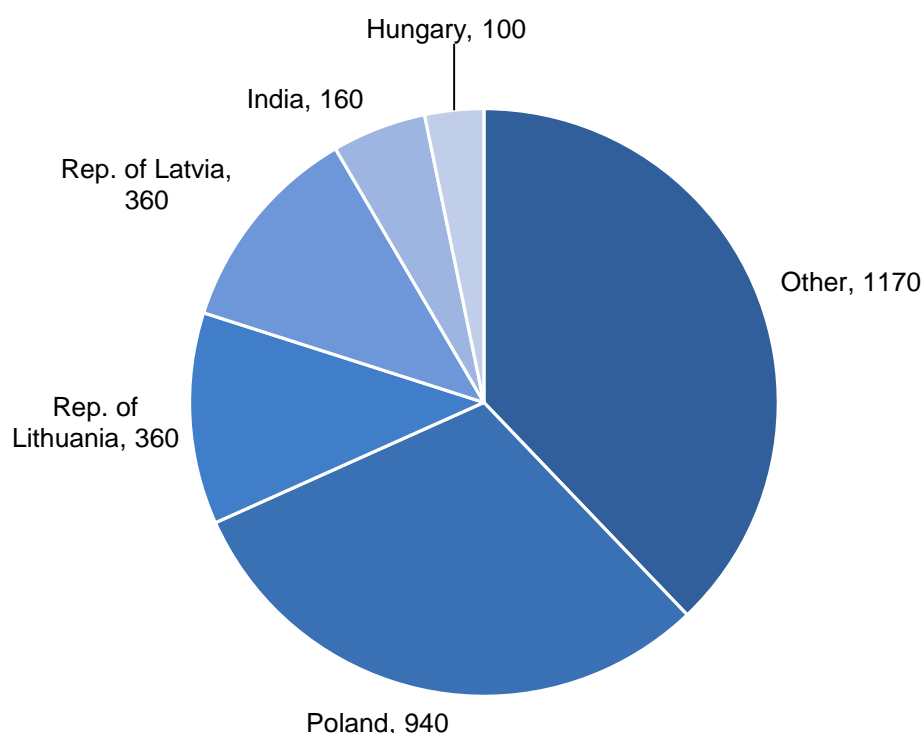
The NINo data contains details of the district in which people were living when they registered and this is shown in Table 2.2.3 of the total 3,090 NINo registrations in the county in 2010/11 the largest proportion (21.7%) were living in Mansfield. This is followed by Newark & Sherwood with 20.1% and Broxtowe with 16.8%.

Table 2.2.3: National Insurance Registrations of non-UK Nationals 2010/11

Ashfield	Bassetlaw	Broxtowe	Gedling	Mansfield	Newark & Sherwood	Rushcliffe	Notts County
300	470	520	220	670	520	290	3,090
9.7%	15.2%	16.8%	7.1%	21.7%	20.1%	9.4%	100.00%

Source: Department for Work and Pensions: National Insurance allocations to overseas nationals entering the UK. 2010-2011.

Figure 2.2.4 NINo registrations by country of origin: 2010/11



Source: Department for Work and Pensions: National Insurance allocations to overseas nationals entering the UK. 2010-2011.

Figure 2.2.4 Shows NINo registrations by country of origin. As can be seen, by far the largest numbers (940) from any one country originate from Poland. This is up from 630 in the previous year and represents just over 30% of all registrations in the county. The Republics of Latvia and Lithuania are joint second with 360 registrations (11.6% of the total) each, followed by India with 160 (5.2%) and Hungary with 100 (3.2%). The remaining 37.9% is made up from registrations from all other countries.

A similar pattern is evident at the district level. In Bassetlaw for example, 57% of all NINo registrations were from people originating in Poland. For the other districts in the County the comparable figures are: Ashfield 30%, Broxtowe 6%, Gedling 23%, Mansfield 48%, Newark & Sherwood 26% and Rushcliffe 7%.

Almost 90% of NINo registrations in Mansfield and over two thirds of registrations in Ashfield, Bassetlaw and Newark & Sherwood were from people originating in the A8 countries.

Broxtowe and to a lesser extent Rushcliffe show a different pattern by having registrations from people who originate from a broader spread of countries. In Broxtowe, only 6% of registrations were from people originating in Poland whilst 8% were from Lithuania, 8% from China, 10% from India and 10% from Hungary. In Rushcliffe, the largest proportion of people from any one country originated in India, which accounted for 14% of the total.

In total for the County there were 210 registrations from people from Lithuania. Of these, 200 or over 95% were in Newark & Sherwood.

Overall, Broxtowe had registrations from people originating in 22 different countries, followed by Rushcliffe 16, Newark & Sherwood 15, Ashfield 11, Gedling 11, Bassetlaw 8 and Mansfield 7.

Migrant Healthcare Needs

Data on the healthcare needs of migrants is sparse at both national and local levels. Even so, a literature review on the subject identified the following as healthcare issues for migrants:

- Infectious Diseases – Including Sexually Transmitted Infections
- Accidents and Injuries
- Musculoskeletal disorders
- Violence and drug abuse

In terms of age, the Health Protection Agency (HPA) estimate that 85% of migrants are aged between 15 and 44 years and will have general health needs similar to individuals of equivalent age and sex in the indigenous UK population.

The commentary in the ICOCO report referred to earlier in this section discussing the effects of in-migration suggests that the key areas being impacted are schools, children's services, health and housing; however, anecdotal evidence of impacts reported by a selection of local authorities in the report suggests few health impacts with some areas suggesting that there were increases in people reporting to accident and emergency departments (Ealing, Hull and Southampton), some impact upon maternity services and some increased calls upon mental health services from asylum seekers and refugees who may have experienced trauma. Conversely, other quotes contained in the report comment upon the youth and general fitness of the main cohorts of economic migrants and the fact that they tend not to make major demands on UK health services. Although some localities, say they have experienced some inappropriate use of A & E services due to a lack of awareness of the UK system of separation of primary and acute care services, other localities said that some economic migrants prefer to return

home to use services rather than trying to access an unfamiliar system and its accompanying bureaucracy.

The Migrant Health Guide (<http://www.hpa.org.uk/MigrantHealthGuide/>) is a free online resource for GPs and nurses working in primary care. The guide has been developed in consultation with GPs and health professionals from around the country, and is endorsed by the RCGP and RCN. It is intended to be a 'one stop shop' for information to support GPs and nurses in assessing and treating migrant patients, in recognition of the fact that these patients sometimes have health needs which are more complex than those of UK born patients.

2.3. People Living in Poverty

Key Messages

- Mansfield is the most deprived district locally and is within the fifth most deprived areas nationally. Conversely, Rushcliffe is the least deprived district in the county and is in the least deprived fifth nationally.
- Deprivation is largely concentrated geographically in the north-west of the county, particularly in Mansfield, Ashfield and western Bassetlaw.
- Parts of Nottinghamshire have very low levels of skills and qualifications e.g. one in seven of the working age population in Ashfield and Mansfield have no qualifications, compared with 1 in 9 nationally.
- The employment rate for women is nearly 8% lower than for men, both locally and nationally.
- Nottinghamshire's overall employment rate in 2010/11 was 71.7%, with a range of just over 63% in Mansfield to over 77% in Broxtowe.
- Unemployment in Nottinghamshire is 3.3% (compared to 3.9% nationally) and varies from 4.4% in Mansfield to 2.1% in Rushcliffe. At ward level, rates vary between 1% to over 9%, the highest being Mansfield Ravensdale.
- Unemployment rates among young people are the highest since directly comparable records began in 1992. The overall unemployment rate in Nottinghamshire for people aged 19 and under is 11.8%, which is higher than the regional (10.4%) and national average (9.5%). It is particularly high in Ashfield, Gedling and Newark and Sherwood and highest amongst young females (13.5%) compared with males (11.0%).
- Benefit claimant rates show concentrations of high rates in the north-west of Nottinghamshire, and of the top ten wards with the highest unemployment rates, four are within Mansfield.
- The largest category of working age benefit claimants is Incapacity Benefit (total ESA and IB claimants in Nottinghamshire at February 2011 was almost 34,000)².

This section discusses poverty, economic activity, employment and labour market issues and their inter-relationships.

For many years the Government, arms length agencies and academics have expended much effort on defining and measuring poverty. Organisations such as the Joseph

² The number of people claiming benefits is likely to change due to new assessments introduced from April 2011 as part of government plans to reduce the number of long-term claimants in a rolling programme through to 2014.

Rowntree Foundation, the Child Poverty Action Group and the Centre for Economic and Social Exclusion have done significant work to define and measure poverty and various government schemes have tried to alleviate poverty and social deprivation. Sure Start centres have been built across the country to help children get a good start in life and Neighbourhood Renewal Funding has run schemes in Ashfield and Mansfield. In 2002 the government introduced tax credits to top up the wages of people in low-paid work to offer an incentive to take jobs.

In terms of long term social change, more women have gone to work and so the number of two-earner households has increased. However, the number of households where no one works has also increased. The proportion of households with one person working and another staying at home has halved from almost 40% in the 1970s to under 20% now. Put another way, work has become more unevenly distributed. The dual-earners are big winners but there are more big losers among the fifth of working-age households that are workless. Tax changes undertaken by successive governments to move from a couple-based income tax system to an individually based system has strengthened the trend to avoid having anyone workless in a family.

The Secretary of State for Work and Pensions, Iain Duncan Smith, has announced the introduction of a Universal Credit designed to simplify the benefit system and improve work incentives, which may change the emphasis to get at least one person in a household working.

Think Tank, The Resolution Foundation has identified that there are 11 million adults in low to middle income households (LMIs), living on below median income but broadly independent of state support. The LMI group is defined by focusing on those members of the working-age population in income deciles 2-5 who receive less than one-fifth of their gross household income from means-tested benefits. It is adjusted for households with children. As such, couples with no children fall into deciles 2-5 if their gross household income (from all sources) is between £12,000-£30,000 a year, while couples with two children qualify if their income is in the range £17,000-£42,500 and those living alone need an income between £8,000 and £20,000.

By these definitions, there are six million LMI households in the UK and 11 million LMI adults. They are not the poorest in society, but they are struggling to get by. Low to middle income households have become more exposed as a result of the recession and the contraction of the consumer credit and mortgage markets, alongside recent rises in the cost of living and a flatlining in wage increases. Research from the Resolution Foundation shows that wages increased by almost 2% above inflation between 1977 and 2003 but have since flat lined with men's wages falling back slightly.

The picture of the economy highlights the significant health challenges that now exist as a result of worklessness, falling incomes and the inability of large numbers to afford housing.

Activity such as above is built upon a foundation of regular and authoritative measurement of poverty and deprivation. The 2004, 2007 and 2010 Indices of Deprivation measure multiple deprivation at a lower geographical level than was possible previously and enable more accurate targeting of activities by partners.

All of the sub sections below draw upon extant statistics for the adult population and show where there are particular deprivation and labour market hotspots in the county.

2.3.1 Indices of Deprivation and Benefit Claimants

The Indices of Deprivation 2010 were published by the Department for Communities and Local Government in 2011. As in previous years, the ID 2010 attempts to measure a broad concept of multiple deprivation by using 38 separate indicators, organised across seven distinct domains. These domains can then be combined, using appropriate weights, to calculate the Index of Multiple Deprivation 2010. This is an overall measure of multiple deprivation experienced by people living in an area and is calculated for every Lower layer Super Output Area (LSOA) in England. The IMD 2010 can therefore be used to rank every LSOA in England according to their relative level of deprivation.

The domains used in the Index of Multiple Deprivation 2010 are income, employment, health, education, crime, access to services, and living environment.

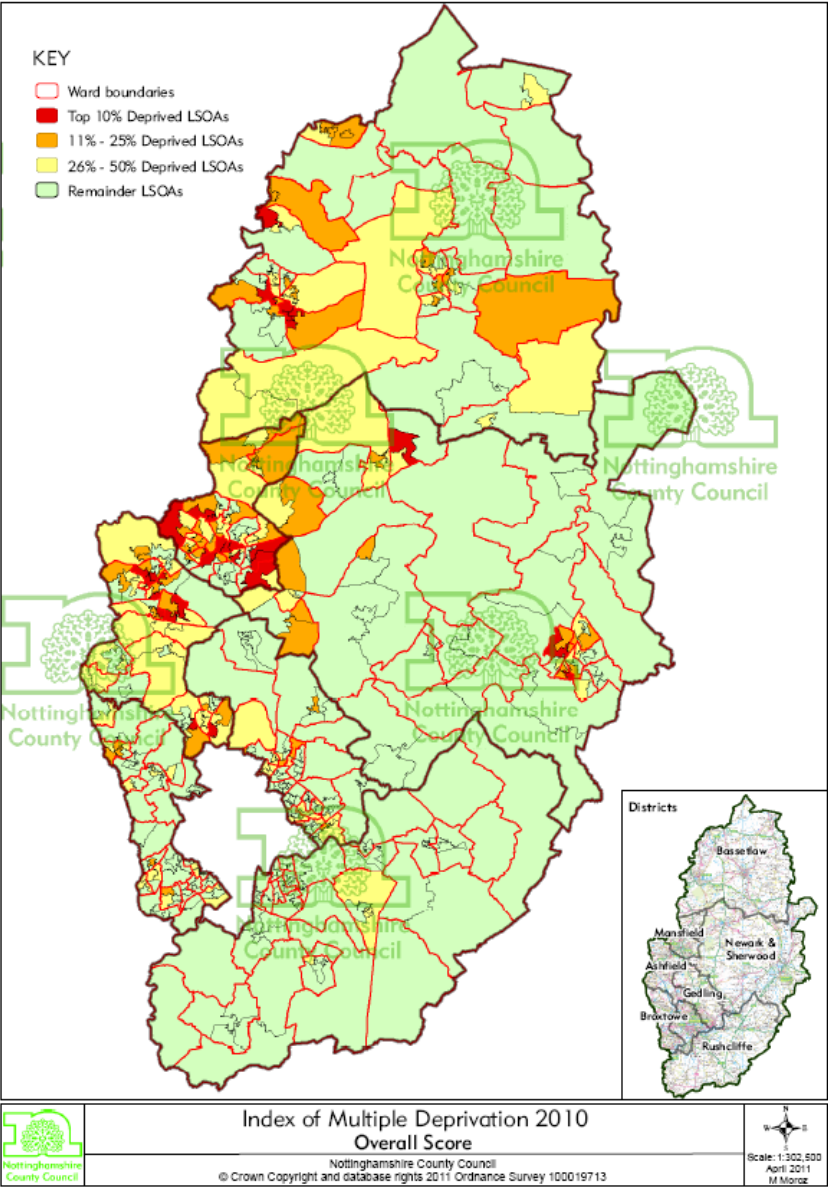
Deprivation covers a broad range of issues and refers to unmet needs caused by a lack of resources of all kinds, not just financial. The Indices of Deprivation 2010 is based on the concept that deprivation consists of more than just poverty. Put simply, poverty is not having enough money to get by on whereas deprivation refers to a general lack of resources and opportunities.

Deprivation is also considered in the Child Poverty Needs Assessment for Nottinghamshire which can be found at www.nottinghamshire.gov.uk/childpoverty

Each of the indices of deprivation is produced using different methodology and is therefore not directly comparable year on year. It can, however, be compared at population level within the year. The ranking is therefore a more useful comparable indicator than the actual score.

The map reproduced as Figure 2.3.1 shows the pattern of deprivation across the county under the overall ID 2007, showing those Nottinghamshire Super Output Areas which fall into the 10% and 25% most deprived SOAs in England. Thirty one Nottinghamshire SOAs fall within the most deprived 10% of English SOAs and 104 are within the most deprived 25% of English SOAs.

Figure 2.3.1: Overall ID 2010 results for Nottinghamshire mapped onto Census Output Areas



Source:DCLG 2010

2.3.2. Employment, unemployment and skills

Definitions

Economic activity (employment and unemployment)

Employment rates are calculated using the working age population and therefore exclude those who are working but are over retirement age. Employment figures include the self-employed; those carrying out unpaid work in a family business, and people on Government-support training and employment programmes. Annual Population Survey (APS) data provides an annual average employment figure, providing a longer term picture than the quarterly, and monthly, employment data which is also published.

The ILO definition of unemployment is as follows: The widely quoted unemployment rate is the number of ILO defined unemployed individuals expressed as a percentage of the relevant economically active population.

Whilst unemployment tends to be talked about as an economic negative, an element of unemployment is necessary to the efficient functioning of a healthy labour market providing the flexibility required for people to leave and re-enter the labour market. This is known as the 'natural rate of unemployment'. During times of recession however, unemployment reaches much higher rates than the 'natural rate', causing hardship for those who are unemployed; and risk aversion and reduced consumption for those who feel their jobs are at risk. This can also lead to increased ill health across the entire population.

Economic inactivity

Economic inactivity measures those that are not engaged with the labour market, i.e. not in employment or classed as unemployed using the International Labour Organisation (ILO) definition. Under this definition, a person must either be economically active or inactive. The economically inactive, as measured by the Labour Force Survey (LFS), can be split into three broad groups:

- Those seeking work but not available to start;
- Those who want work but are not actively seeking it;
- Those who do not want to work.

The majority of students and those in retirement are classified as economically inactive.

Employment in Nottinghamshire

Nottinghamshire's overall employment rate amongst the 16 to 64 age population in the period April 2010 to March 2011 was 71.7%; this is slightly above the employment rate for the East Midlands region – 71.0% and above that for the UK – 70.2%.

Table 2.3.2: Employment rate – aged 16 to 64, April 2010-March 2011

Area	Total		Male		Female	
	number	%	number	%	number	%
Ashfield	49,500	66.9	25,300	68.9	24,200	65.0
Bassetlaw	49,900	71.2	26,200	75.8	23,700	66.7
Broxtowe	56,200	77.2	31,400	83.8	24,800	70.2
Gedling	54,300	74.4	25,800	73.0	28,500	75.9
Mansfield	40,800	63.2	21,400	67.9	19,500	58.8
Newark and Sherwood	50,100	72.7	26,700	77.2	23,400	68.1
Rushcliffe	54,600	75.0	29,400	81.4	25,200	68.8
Nottinghamshire	355,400	71.7	186,100	75.6	169,300	67.8
Nottingham City	117,200	53.8	62,400	56.4	54,800	51.1
East Midlands	2,037,700	71.0	1,085,900	76.0	951,700	66.1
United Kingdom	28,097,500	70.2	15,023,300	75.4	13,074,100	65.0

Source: Annual Population Survey via NOMIS

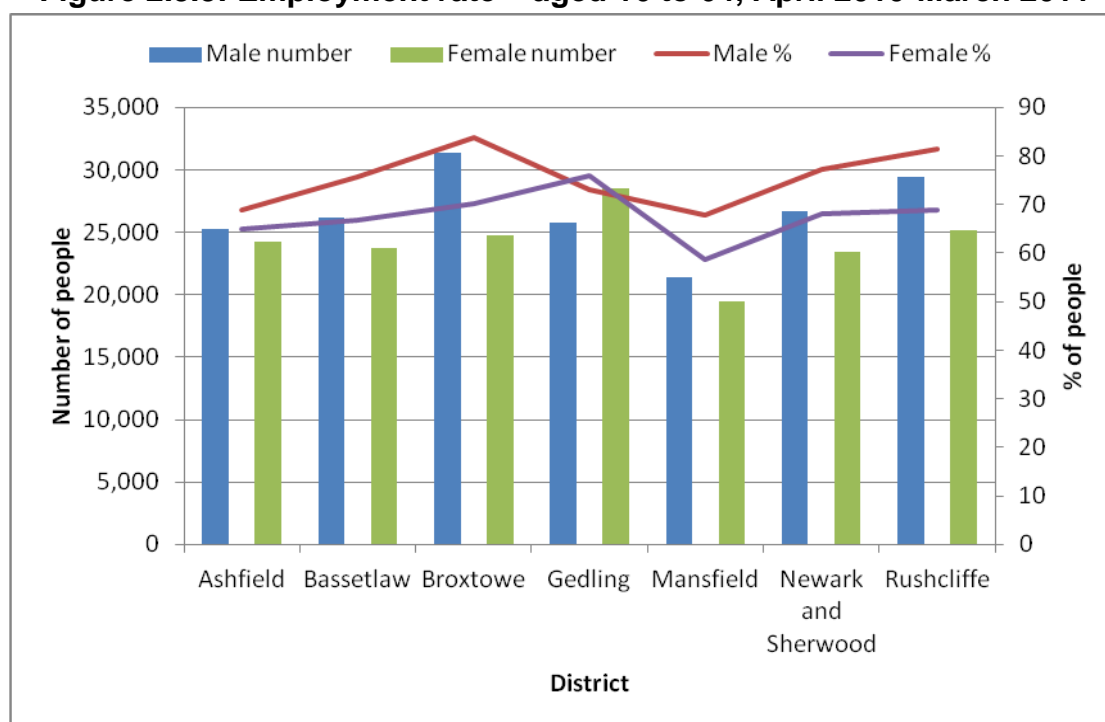
Within the county, employment rates vary considerably, ranging from almost 80% in Broxtowe to less than 60% in both Ashfield and Mansfield. Nottingham has an employment rate of just 53.8%. Table 2.3.2 shows the huge disparity across the county in terms of employment rates, with a difference of 14% between Broxtowe and Mansfield and 23.4% between Broxtowe and Nottingham City.

The gender breakdown of employment is equally interesting and as shown in Figure 2.3.3. Amongst working age men, the county rate of 75.6% is below that of the region but slightly above the UK. The highest rate is found in Broxtowe – 83.8%, with Rushcliffe also having a rate above 80%. Conversely Ashfield, Mansfield and Nottingham have male employment rates over 10% below this.

The countywide employment rate for working age women is approximately 8% lower than the rate for men. In some districts the differences are more marked; in both Broxtowe and Rushcliffe for example, the difference between the rate for men and women is 13.6% and 12.6% respectively whereas in other districts there is a much smaller difference between the rates for the sexes.

For working age women, the county rate is above both regional and UK rate. The highest rate is recorded in Gedling with 75.9% but most districts have rates below 70% and Nottingham City records a rate of 51.1%, almost 25% below that of Gedling.

Figure 2.3.3: Employment rate – aged 16 to 64, April 2010-March 2011



Source: Annual Population Survey via NOMIS

When employment rates for older people are considered – (see Table 2.3.4), Nottinghamshire's rates are close to those of the region and the UK, standing at 38.3% against 39.2% and 38.3% respectively. Disparities within the county however are stark; Gedling records a rate of 44.6%, Rushcliffe and Ashfield both have rates of around 41%, whilst Bassetlaw has a rate of 32% and Nottingham a rate of 31%.

When the gender breakdown for over 50s employment is examined, these disparities become even more marked. For males the county rate is almost 2% below the regional figure and 1% below that of the UK.

The highest male employment rate amongst over 50s is that recorded by Rushcliffe with 51%, the next highest rate being Gedling at 47.3%. The lowest employment rates for older men are recorded in Newark & Sherwood (36.5%) and Nottingham (32.8%).

For older women the county rate mirrors that of the region and is just over one percent higher than the UK rate. It is however worth noting that the difference between the rates for older men and older women is just under 10%.

The district breakdown shows the highest rates of female employment amongst over 50s to be in Gedling – 42.3%, followed by Newark & Sherwood on 38.1% and the lowest rates of less than 30% in Bassetlaw, Broxtowe, Nottingham and Mansfield.

Table 2.3.4: Employment Rate – aged 50+, Apr 2010-Mar 2011

Area	Total		Male		Female	
	number	%	number	%	number	%
Ashfield	17,200	40.8	9,000	44.7	8,200	37.2
Bassetlaw	11,400	32.1	6,700	38.7	4,700	25.8
Broxtowe	12,700	37.1	8,000	45.8	4,700	28.1
Gedling	20,600	44.6	10,200	47.3	10,400	42.3
Mansfield	13,900	33.0	6,700	37.9	7,300	29.5
Newark and Sherwood	15,000	37.2	7,600	36.5	7,400	38.1
Nottingham	23,600	30.7	11,900	32.8	11,700	28.9
Rushcliffe	17,700	41.1	10,500	51.0	7,200	32.1
Nottinghamshire	108,400	38.3	58,600	43.3	49,900	33.7
East Midlands	617,600	39.2	340,600	45.2	277,000	33.7
United Kingdom	8,085,200	38.3	4,404,100	44.3	3,681,100	32.9

Source: Annual Population Survey via NOMIS

Unemployment in Nottinghamshire

The latest unemployment figures for the county show that as at September 2011, over 16,000 people were claiming Job Seekers Allowance (JSA) – a rate of 3.3%. At the same date Nottingham City recorded a rate of 6.2%. The district breakdown for the same date shows the highest rates to be in Mansfield (4.4%) and Ashfield (4.2%) and the lowest rate to be in Rushcliffe – (2.1%) see Table 2.3.5 and Figure 2.3.6. For the geographic county including the city the rate rises to 4.2%.

At the local level, the highest ward rates in the county exceed 9.0%, with one ward – Mansfield Ravensdale – having a rate of 9.2%. Sixty wards in the county have claimant count unemployment rates above the county average and only three wards have rates below 1.0%.

The gender breakdown of unemployment, as measured by the JSA claimant count, is also shown in Table 2.3.5. It is apparent from this that unemployment rates for men are around double those for women; for the county, the male rate is 4.4% contrasted with the female rate of 2.3% and in Mansfield, the local authority area having the worst labour market performance, 3.3% against 1.8%.

The age breakdown of unemployment is also important. Table 2.3.7 shows the numbers and percentages of unemployed young people under the age of 19, together with the duration of unemployment. This table shows that Ashfield, Gedling and Newark & Sherwood have the highest rates of youth unemployment, with rates of 13.1%, 12.5% and 12.5% respectively. The county rate of 11.8% is substantially higher than both the regional rate of 10.4% and the national rate of 9.5%.

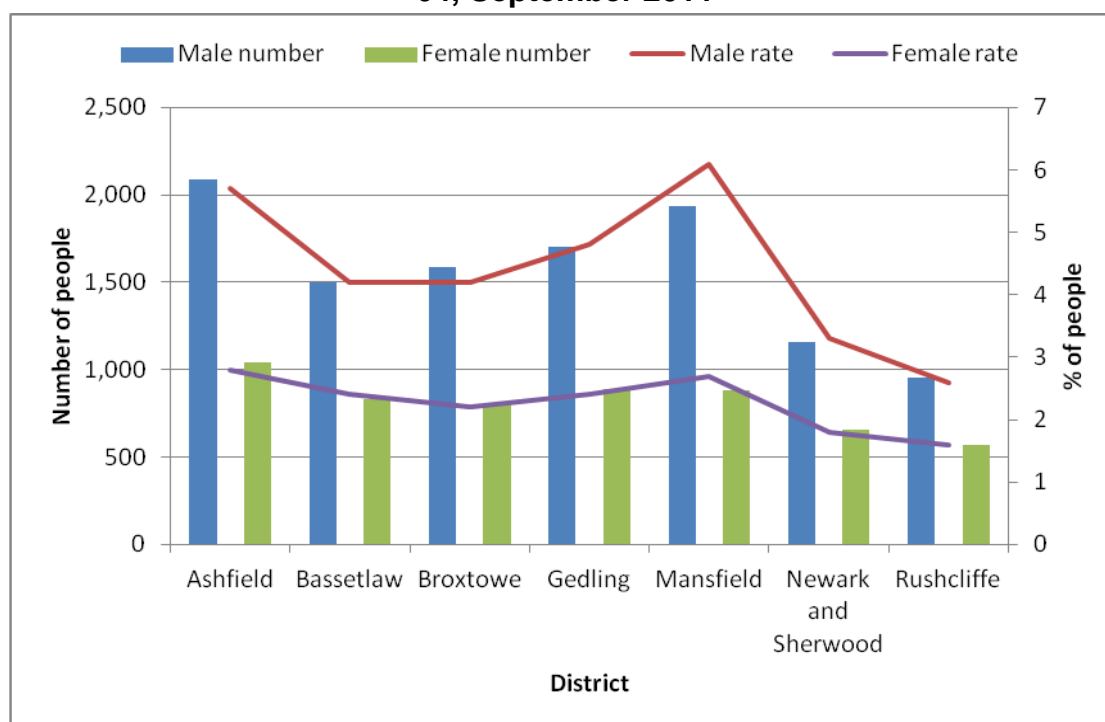
Conversely, long term unemployment – 12 months and over – shows lower rates for the county than for the region and the UK. The highest rates in the county are found in Gedling, Ashfield and Mansfield.

Table 2.3.5: Unemployment – Claimants as % of resident population aged 16 to 64, September 2011

Area	Male		Female		Total	
	number	rate	number	rate	number	rate
Ashfield	2,091	5.7	1,043	2.8	3,134	4.2
Bassetlaw	1,496	4.2	830	2.4	2,326	3.3
Broxtowe	1,584	4.2	808	2.2	2,392	3.2
Gedling	1,700	4.8	886	2.4	2,586	3.6
Mansfield	1,932	6.1	880	2.7	2,812	4.4
Newark and Sherwood	1,161	3.3	653	1.8	1,814	2.6
Nottingham	9,275	8.2	4,393	4.0	13,668	6.2
Rushcliffe	953	2.6	570	1.6	1,523	2.1
Nottinghamshire	10,917	4.4	5,670	2.3	16,587	3.3
East Midlands	69,859	4.8	36,383	2.5	106,242	3.7
United Kingdom	1,041,555	5.2	537,054	2.7	1,578,609	3.9

Source: NOMIS

Figure 2.3.6: Unemployment – Claimants as % of resident population aged 16 to 64, September 2011



Source: NOMIS

Table 2.3.7: Age and duration of unemployment, September 2011

Area	Aged 19 and under		Claiming for over 12 months		Claiming for over 6 months	
	number	percent	number	percent	number	percent
Ashfield	410	13.1	465	14.8	1,275	40.7
Bassetlaw	270	11.7	255	10.9	840	36.1
Broxtowe	270	11.3	320	13.4	905	38.0
Gedling	320	12.5	385	15.0	1,010	39.2
Mansfield	335	11.8	385	13.8	1,125	40.0
Newark & Sherwood	225	12.5	205	11.3	625	34.6
Nottingham	1,275	9.3	2,575	18.9	6,110	44.8
Rushcliffe	130	8.6	205	13.6	525	34.5
Nottinghamshire	1,960	11.8	2,225	13.4	6,300	38.1
East Midlands	11,080	10.4	15,290	14.4	40,295	38.0
United Kingdom	148,990	9.5	249,835	15.9	608,120	38.6

Source: NOMIS

Data rounded to nearest 5.

Percentage given is that of particular age/duration as a proportion of all age/durations within that particular gender.

Tables 2.3.8 and 2.3.9 show the gender breakdown of current unemployment. Table 2.3.8 containing male rates, shows the county as having higher rates of youth unemployment than both the region and the UK. It also shows that Ashfield and Mansfield have the highest percentage rates.

Long term unemployment (over 12 months) amongst men shows similar disparities; at county level the rate is lower than at the regional and UK level and within the county Gedling has the highest rate. Nottingham has a rate of almost 21%.

Table 2.3.9 showing female age and duration figures indicates that at the county level over 13% of unemployed women are aged 19 and under and in Ashfield this rate rises to almost 16%.

In terms of long term unemployment amongst women (over 12 months), the county rate is below that of the region and UK and the only district having a significantly higher rate is Ashfield at 13.1%. Nottingham has a rate of 14.9%. At the district level many of the rates relate to very small numbers in terms of individual women affected.

Table 2.3.8: Age and duration of male unemployment, September 2011

Area	Aged 19 and under		Claiming for over 12 months		Claiming for over 6 months	
	number	percent	number	percent	number	percent
Ashfield	245	11.8	330	15.7	880	42.2
Bassetlaw	155	10.2	170	11.5	570	38.0
Broxtowe	160	10.1	230	14.7	630	39.9
Gedling	195	11.5	295	17.4	720	42.7
Mansfield	225	11.7	295	15.3	830	43.0
Newark and Sherwood	130	11.4	140	12.1	425	36.8
Nottingham	755	8.1	1,920	20.8	4,405	47.6
Rushcliffe	85	8.7	145	15.2	365	38.2
Nottinghamshire	1,195	11.0	1,605	14.8	4,420	40.6
East Midlands	6,645	9.5	11,215	16.1	28,065	40.3
United Kingdom	89,345	8.6	181,140	17.4	420,585	40.5

Source: NOMIS

Data rounded to nearest 5.

Percentage given is that of particular age/duration as a proportion of all age/durations within that particular gender.

Table 2.3.9: Age and duration of female unemployment, September 2011

Area	Aged 19 and under		Claiming for over 12 months		Claiming for over 6 months	
	number	percent	number	percent	number	percent
Ashfield	165	15.8	135	13.1	395	37.9
Bassetlaw	120	14.4	80	9.9	270	32.7
Broxtowe	110	13.5	90	10.9	275	34.2
Gedling	125	14.2	90	10.4	285	32.4
Mansfield	105	12.2	90	10.4	290	33.2
Newark and Sherwood	95	14.3	65	10.0	200	30.7
Nottingham	520	11.9	655	14.9	1,705	38.8
Rushcliffe	45	8.3	60	10.9	160	28.5
Nottinghamshire	765	13.5	615	10.9	1,880	33.2
East Midlands	4,435	12.2	4,070	11.2	12,230	33.7
United Kingdom	59,645	11.1	68,700	12.8	187,535	35.0

Source: NOMIS

Data rounded to nearest 5.

Percentage given is that of particular age/duration as a proportion of all age/durations within that particular gender.

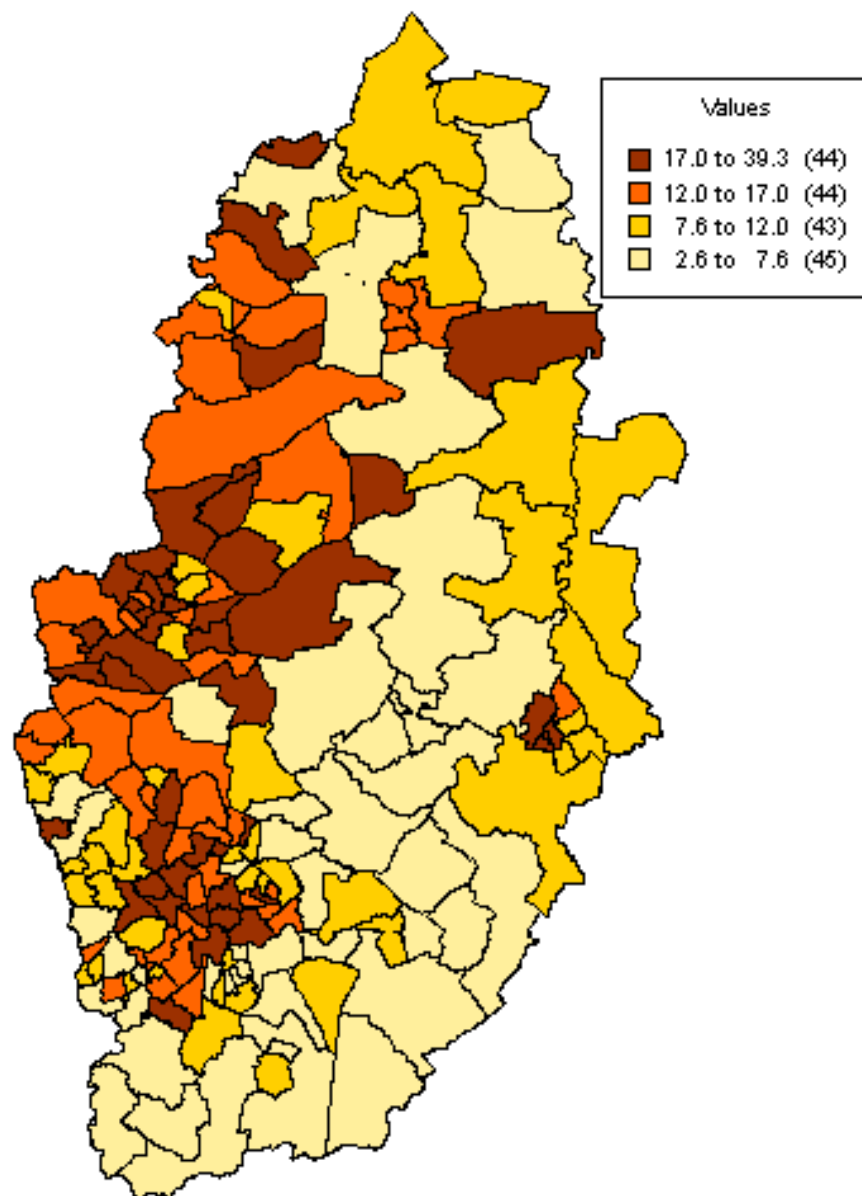
Benefits claimants in Nottinghamshire

The maps which follow (Figures 2.3.10 and 2.3.11) show the countywide breakdown of benefit claimants, for two cohorts of the adult population. Each map shows a similar pattern, with concentrations of higher rates of benefit claimants in the western part of the county, particularly around Mansfield, and in central Newark.

The largest category of working age benefit claimants is Incapacity Benefit (total ESA and IB claimants in Nottinghamshire at February 2011 was almost 34,000). To bring this down and drive the employment rate up are two of the central issues being addressed by partners and each have clear implications for health equality.

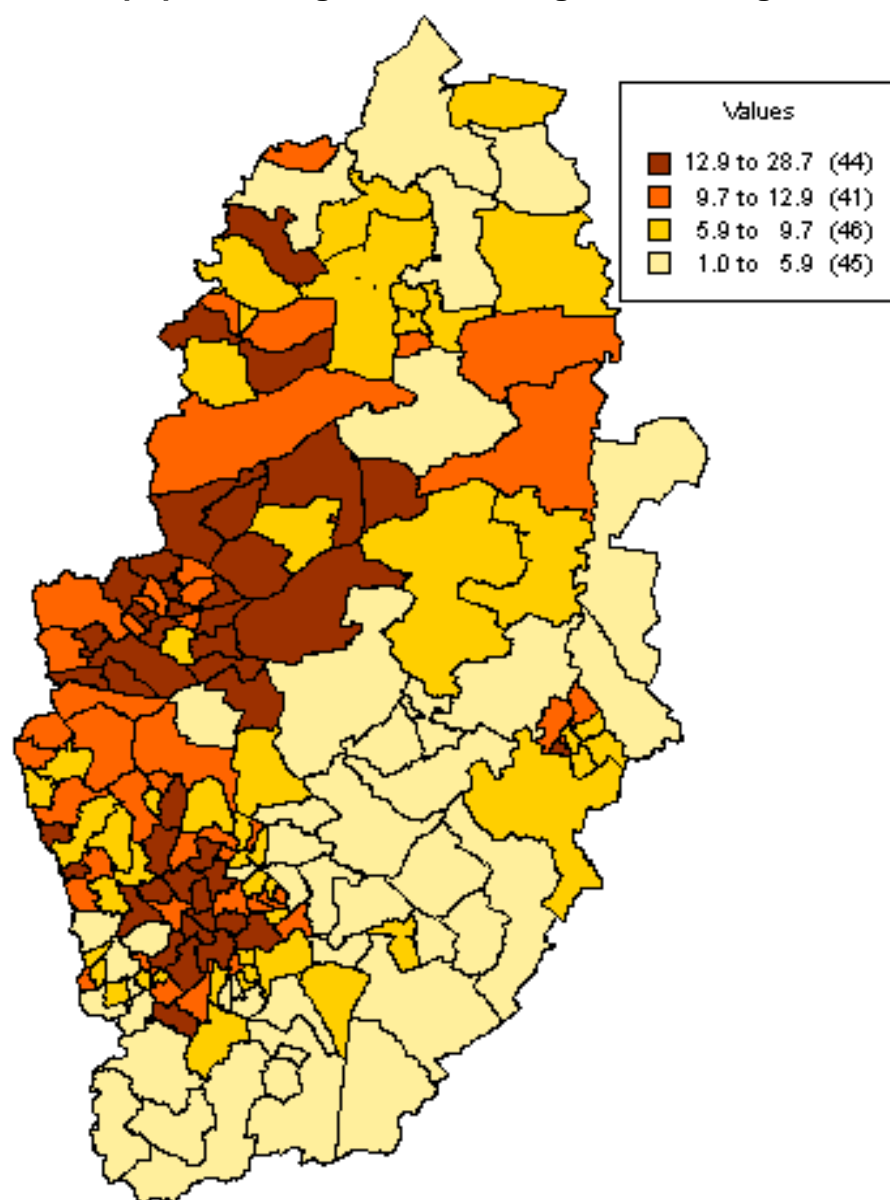
The number of people claiming benefits is likely to change due to new assessments introduced from April 2011 as part of government plans to reduce the number of long-term claimants in a rolling programme through to 2014. Almost 30% of those who took the new test during pilot schemes in Burnley and Aberdeen were declared fit to work, and a further 39% were assessed as able to work but needing the right support to do so.

Figure 2.3.10: % of population aged 25-49 claiming benefits August 2009



Source; Work and Pensions Longitudinal Study via Nottinghamshire Knowledge

Figure 2.3.11: % of population aged 50+ claiming benefits August 2009



Source: Work and Pensions Longitudinal Study via Nottinghamshire Knowledge

Skills in Nottinghamshire

Education and skills are the focus of much Government activity and have clear links with employment, and affect people's ability to access work, contribute to their sense of involvement and well-being and feel a full member of the community and society. As the recent Leitch report into skills observed; 'Our natural resource is our people and their potential is both untapped and vast. Skills are the key to unlocking that potential.'

Employers in Nottinghamshire identified only 8% of vacancies as 'skills shortage vacancies' compared to 16% in England. These are vacancies which are hard-to-fill because of a lack of candidates with the right skills, qualifications or experience and are a useful indicator of whether the labour market matches employer demands. These figures suggest that skills available in the local labour market match employer requirements fairly closely³.

The Employment and Skills Board has highlighted that there are differences in terms of skills and occupations when looking at it through a residency or workplace perspective. In terms of workplace assessment Nottinghamshire does have a higher than average level of higher skilled occupations; however by residency Nottinghamshire has around 440,000 residents below NVQ2 level. Nottinghamshire also has below national average weekly earnings, with a quarter of all its job creation being those of an elementary level. The conclusion from this is that people travel into the county from outside to occupy the higher skilled and higher paid jobs, as a trend. This then impacts on Gross Value Added (GVA), income levels and statistics covering the proportion of families earning below median levels⁴.

Skill levels are best measured through the proxy of qualifications and NVQ levels are commonly used to identify a range of generic qualifications at various levels ranging from NVQ1 to NVQ4 and above. Table 2.3.12 shows the number and percentage of working age people in Nottinghamshire having qualifications up to NVQ1 and also gives the same figures for those aged 16-24 and over 50. The table shows that at the county level, Nottinghamshire has higher percentages having only NVQ1 than the average for the UK – 14.2% against 12.9%. Within the county, the districts having the highest percentages are Ashfield at 19.4%, Bassetlaw at 17.4% and Mansfield at 15.8%, contrasting with the very low rate of 9.5% found in Rushcliffe.

³ Nottinghamshire Child Poverty Needs Assessment 2010

<http://www.nottinghamshire.gov.uk/nottschildpovertyneedsassessmentfinal240211.pdf>

⁴ Nottinghamshire Child Poverty Needs Assessment 2010

<http://www.nottinghamshire.gov.uk/nottschildpovertyneedsassessmentfinal240211.pdf>

Table 2.3.12: Qualifications – NVQ1 only, Jan 2010-Dec 2010

Area	% with NVQ1 only - aged 16-64		% with NVQ1 only - aged 50-64		% with NVQ1 only - aged 16-24	
	number	percent	number	percent	number	percent
Ashfield	14,400	19.4	4,000	19.2	4,100	29.5
Bassetlaw	12,300	17.4	2,700	13.0	1,500	11.7
Broxtowe	10,000	13.7	1,600	9.3	2,800	16.7
Gedling	7,400	10.3	1,000	4.4	1,400	11.4
Mansfield	10,200	15.8	3,100	14.3	3,000	24.1
Newark & Sherwood	9,500	13.8	1,700	7.1	3,800	37.0
Nottingham	25,200	11.7	3,900	10.7	6,900	11.6
Rushcliffe	6,900	9.5	3,400	12.5	!	!
Nottinghamshire	70,700	14.2	17,600	11.4	17,600	19.2
East Midlands	377,600	13.2	92,600	11.1	88,100	16.2
United Kingdom	5,153,000	12.9	1,319,100	11.7	1,133,200	15.5

Source: Annual Population Survey via NOMIS

! Estimate and confidence interval not available since the group sample size is zero or disclosive (0-2)

Qualifications data are only available for Jan-Dec periods.

When the age breakdown is examined, it is apparent that several parts of the county have very low rates amongst the older working age cohort. Newark & Sherwood, where 37% of the cohort of 16-24 year olds has only level 1 NVQ qualifications, is particularly disadvantaged.

Table 2.3.13 shows the breakdown of the working age population of the county having no qualifications. The county has 10.5% of its working age population with no qualifications, a lower and therefore better rate than is found in both the UK and region. However, once again, some districts can be seen to have significant problems; this is particularly the case in Ashfield with 15% of its working age population with no qualifications. This is closely followed by Mansfield (14.7%) and Bassetlaw (11.4%). Nottingham with a rate of 15.7% also has a large proportion of working age people with no qualifications. Figure 2.3.14 shows the figures for 2010 graphically.

Table 2.3.13: Qualifications – No Qualifications, Jan 2010-Dec 2010

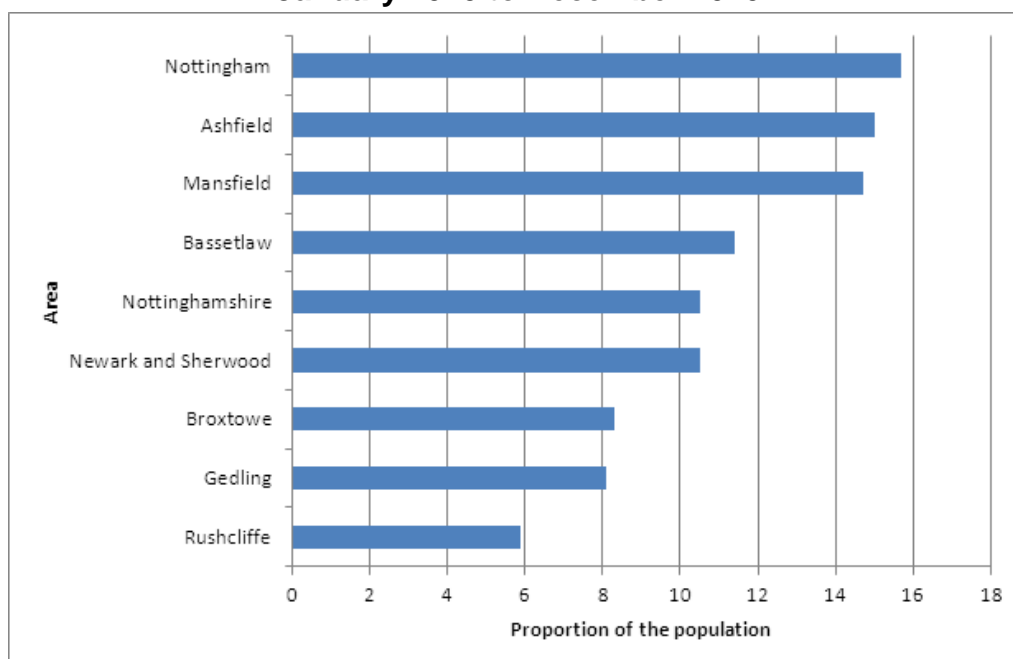
Area	% with no qualifications - aged 16-64		% with no qualifications - aged 50-64		% with no qualifications - aged 16-24	
	number	percent	number	percent	number	percent
Ashfield	11,100	15.0	5,900	28.2	2,000	14.0
Bassetlaw	8,100	11.4	4,500	21.6	1,000	7.6
Broxtowe	6,000	8.3	2,600	15.0	!	!
Gedling	5,800	8.1	3,700	17.0	!	!
Mansfield	9,400	14.7	5,200	23.5	!	!
Newark & Sherwood	7,300	10.5	4,500	19.1	!	!
Nottingham	34,000	15.7	10,300	28.2	4,700	7.9
Rushcliffe	4,300	5.9	3,400	12.3	!	!
Nottinghamshire	52,100	10.5	29,900	19.3	5,200	5.7
Midlands	369,600	12.9	167,000	19.9	54,700	10.1
United Kingdom	4,625,900	11.6	2,101,800	18.7	717,700	9.8

Source: Annual Population Survey via NOMIS

! Estimate and confidence interval not available since the group sample size is zero or disclosive (0-2)

Qualifications data are only available for Jan-Dec periods.

Figure 2.3.14: Proportion of the population aged 16-64 with no qualifications, January 2010 to December 2010



Source: Annual Population Survey via Nottinghamshire Knowledge

2.4. Disability

2.4.1. Disabled people

Key Messages

Disability is defined as a mental or physical impairment that has a substantial, long-term effect on an individual's ability to carry out normal day-to-day activities. Disability impacts on the length and quality of an individual's life, and can inversely affect access to services. Disabled people generally fare less well than non-disabled people across a wide range of indicators and opportunities

- Levels of disability in Nottinghamshire (20%) are higher than both the East Midlands (19%) and England (18%).
- Levels of disability are higher in districts with higher deprivation (greatest in Mansfield 24% and lowest in Rushcliffe at 16%).
- It is estimated that in 2011 there were 38,942 people with moderate and 11,726 with severe physical disabilities.
- Projections suggest moderate increases in disabled adults (18-64) of over 4% by 2030 (relative to the 2011 estimates).
- People with disability have more difficulty accessing health services.
- People with disability are at increased risk of other physical health problems. Prevalence of a wide number of diseases (e.g. diabetes, coronary heart, obesity), lifestyle choices (e.g. smoking) and age at death are worse among the disabled population than the general population.
- The proportion of the general working age population in Nottinghamshire that are disabled (23%) is higher than in both the East Midlands (22%) and England (21%).
- The employment rate of the disabled working age population in Nottinghamshire (47%) is similar to Great Britain (48%) but varies between districts (the greatest between Bassetlaw at 55% and lowest in Mansfield at 29%).

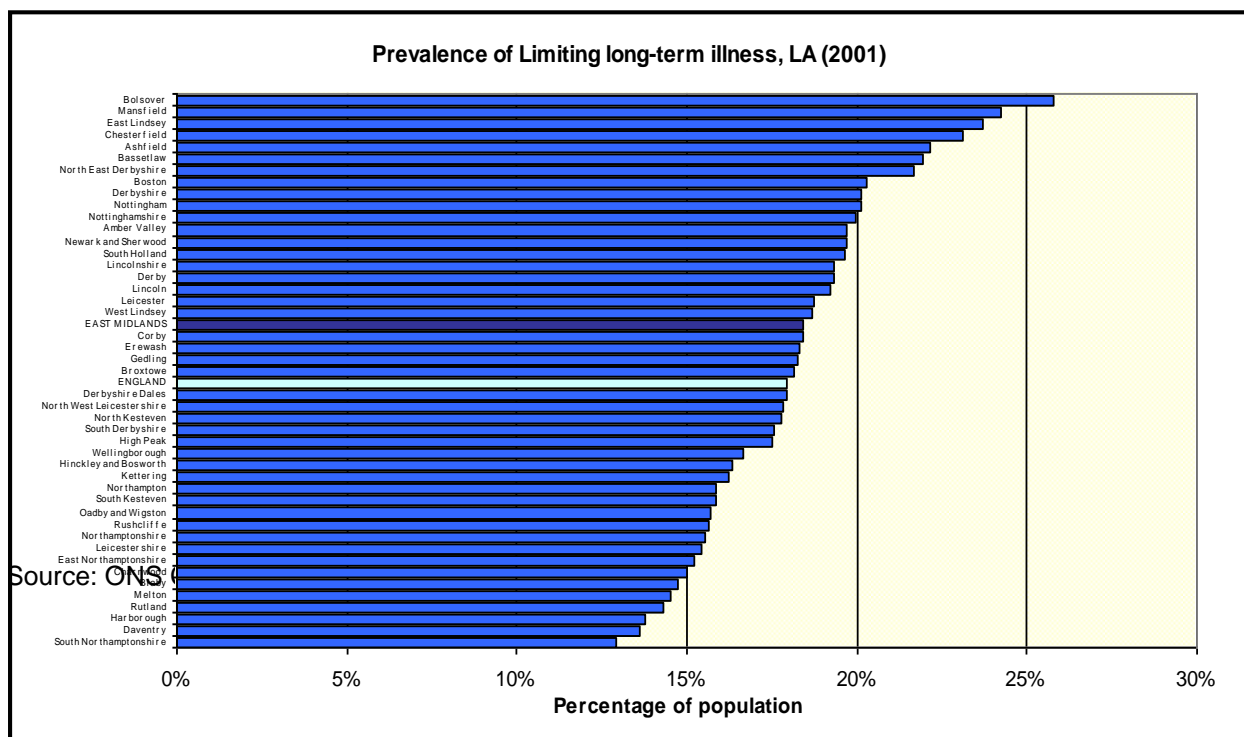
Disability impacts on the length and quality of an individual's life, and can inversely affect access to services. Disabled people generally fare less well than non-disabled people across a wide range of indicators and opportunities. However, the lack of inclusion of disability in routine data recording makes it difficult to measure equity of access and treatment for disabled people.

The Disability Discrimination Act (DDA) 1995 defines disability as:

- A mental or physical impairment;
- which has an adverse effect on an individual's ability to carry out normal day-to-day activities;
- where the adverse effect is substantial;
- and, the adverse effect is long-term (meaning it has lasted for 12 months, or is likely to last more than 12 months or the rest of an individual's life).

Accurate numbers for disabled people are scarce, but many studies have shown that 'long-standing limiting illness' is a good proxy indicator of disability. The 2001 census recorded numbers who reported having a long-term condition which limits their daily activities in any way. Similar data from the 2011 census will be available after November 2012.

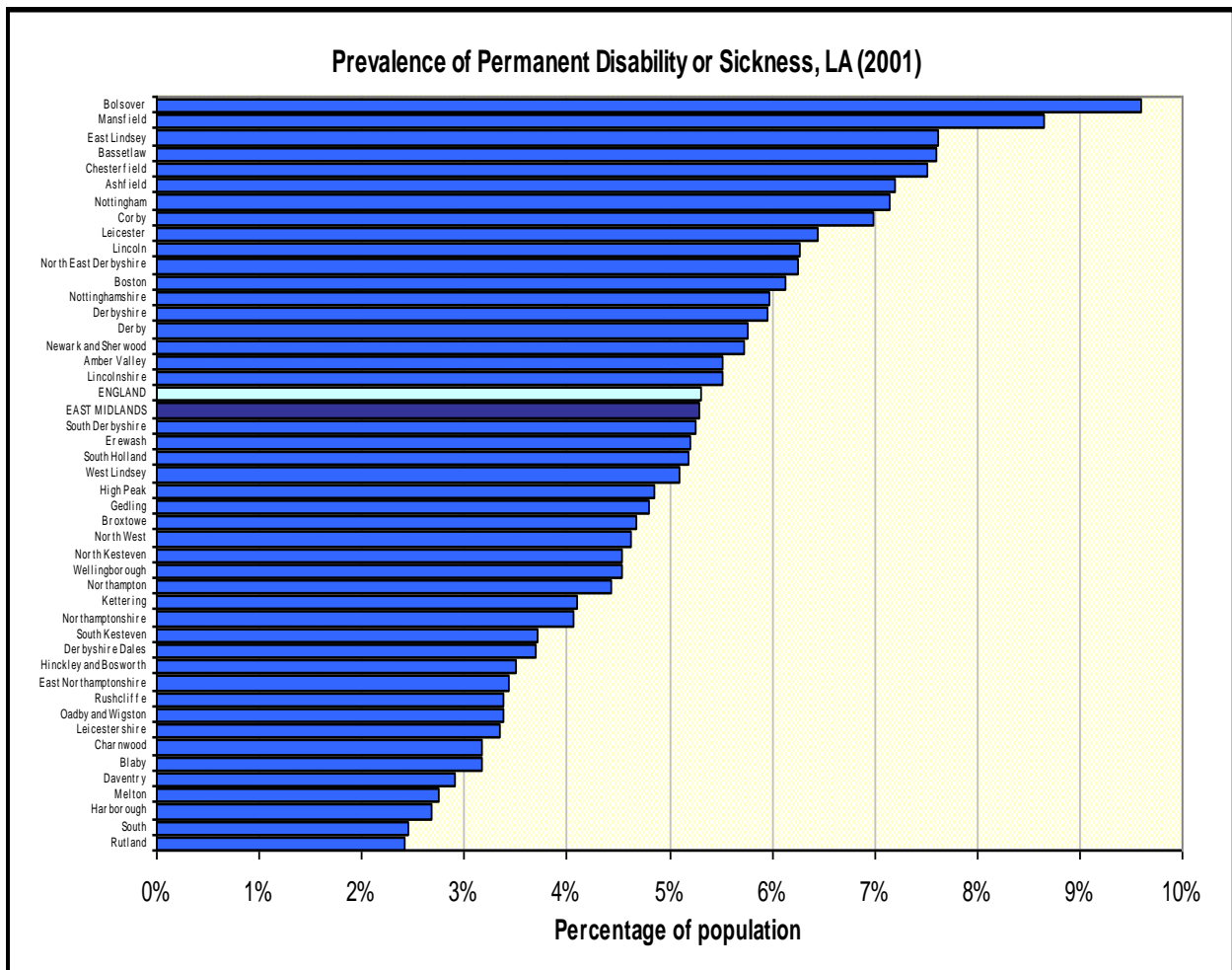
Figure 2.4.1 - Percentage of people who reported having a long-term condition which limits their daily activities in any way by local authority – 2001



Source: ONS Census 2001.

Figure 2.4.1 shows that of the local authorities within Nottinghamshire county Mansfield, Ashfield, Bassetlaw, Newark and Sherwood, Gedling and Broxtowe all had higher than average percentages of people reporting long-term limiting illnesses. Only Rushcliffe had a lower than average percentage. The 2001 census also recorded numbers who reported they were economically inactive due to permanent disability or sickness (See Figure 2.4.2).

Figure 2.4.2 – Percentage of people who reported they were economically inactive due to permanent disability or sickness - 2001



Source: ONS Census 2001.

Figure 2.4.2 shows that of the local authorities within Nottinghamshire county Mansfield, Bassetlaw, Ashfield and Newark and Sherwood had higher than average percentages of people reporting long-term limiting illnesses. Rushcliffe, Broxtowe and Gedling had lower than average percentages.

Prevalence and severity of disability

Oxford Brookes University produces a national database called Projecting Adult Needs and Service Information (PANSI) for adults aged under 65 for the Department of Health. Tables 2.4.3 and 2.4.4 show the numbers of people with moderate and severe disability in Nottinghamshire up to 2030. The tables show a significant increase in the number of people affected by age, with more than five times as many people aged 55-64 having a moderate disability compared to those aged 18-24. This increase is even more marked for those with severe disability, which is more than 10 more common in the oldest age group compared to the youngest.

Table 2.4.3 – Numbers of people with Moderate disability projected from 2011 to 2030 by age for Nottinghamshire

Moderate Disability	2011	2015	2020	2025	2030
People aged 18-24 predicted to have a moderate physical disability	2,644	2,546	2,312	2,316	2,542
People aged 25-34 predicted to have a moderate physical disability	3,906	4,343	4,557	4,381	4,154
People aged 35-44 predicted to have a moderate physical disability	6,115	5,589	5,774	6,563	6,866
People aged 45-54 predicted to have a moderate physical disability	11,242	11,795	11,068	9,923	10,330
People aged 55-64 predicted to have a moderate physical disability	15,034	14,751	16,464	17,701	16,688
Total population aged 18-64 predicted to have a moderate physical disability	38,942	39,024	40,175	40,885	40,580

Source: PANSI, 2012

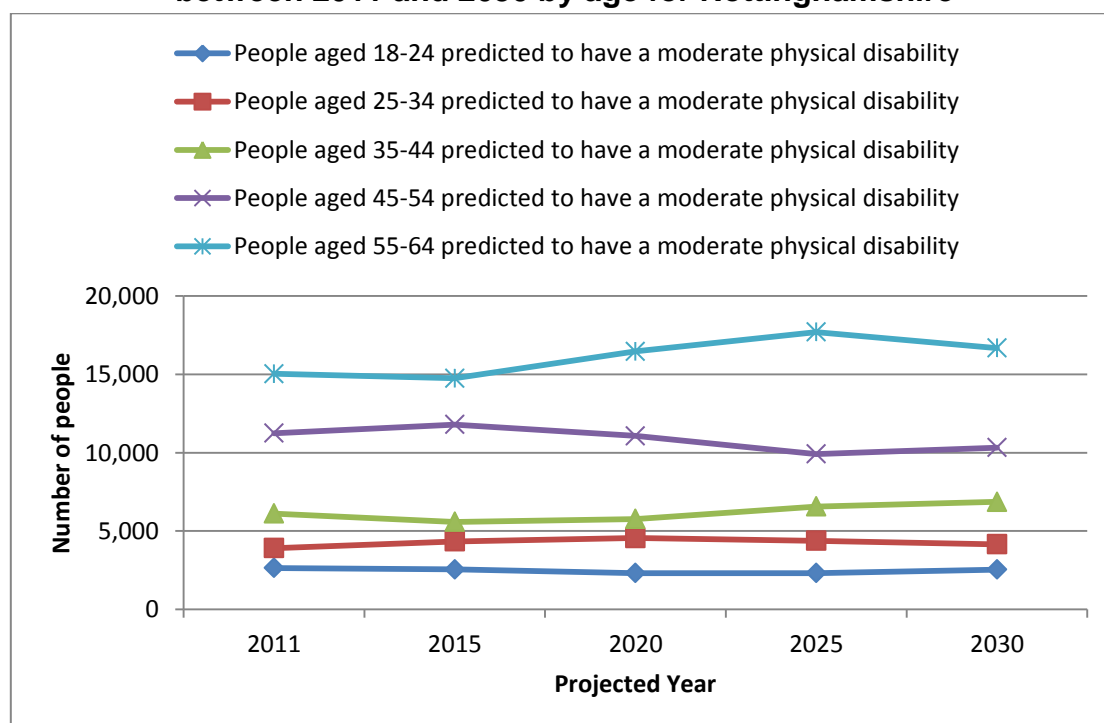
There is a small increase in the number of people predicted to have a disability in Nottinghamshire between 2011 and 2030. For moderate disability, the increase will be 4% and for severe disability the increase will be 5%. The numbers in each age band vary in line with the total population of that age in the county.

Table 2.4.4 – Numbers of People with Serious disability projected from 2011 to 2030 by age for Nottinghamshire

Severe Disability	2011	2015	2020	2025	2030
People aged 18-24 predicted to have a serious physical disability	516	497	451	452	496
People aged 25-34 predicted to have a serious physical disability	372	414	434	417	396
People aged 35-44 predicted to have a serious physical disability	1,856	1,697	1,753	1,992	2,084
People aged 45-54 predicted to have a serious physical disability	3,129	3,283	3,081	2,762	2,876
People aged 55-64 predicted to have a serious physical disability	5,852	5,742	6,409	6,890	6,496
Total population aged 18-64 predicted to have a serious physical disability	11,726	11,632	12,128	12,514	12,347

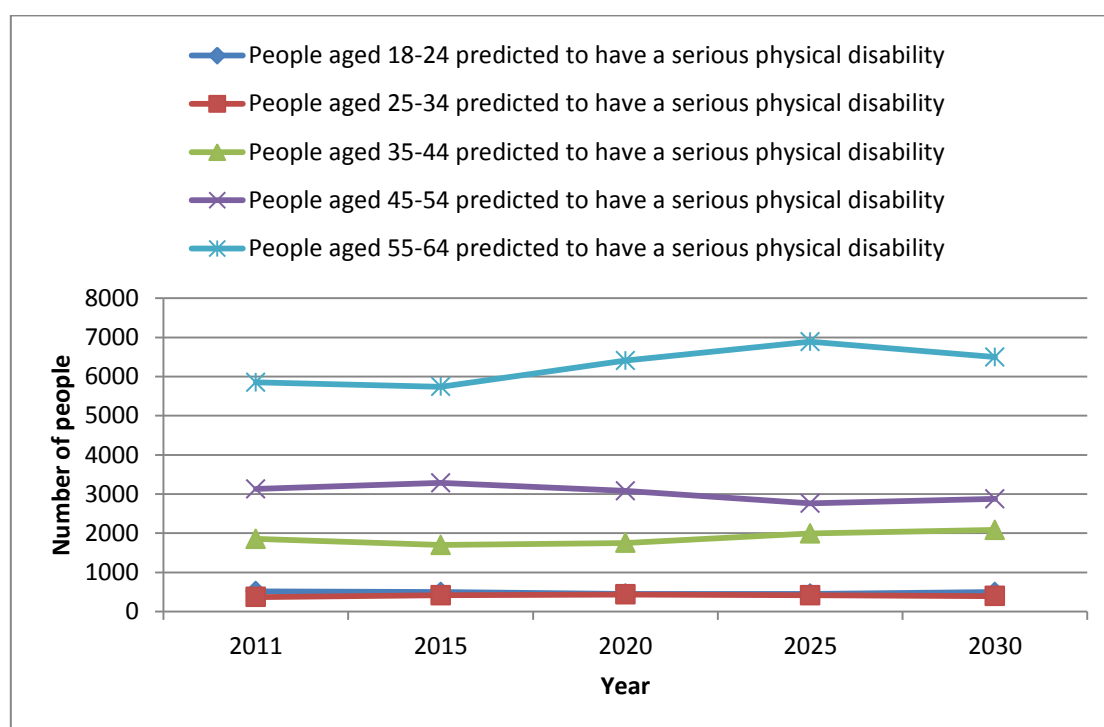
Source: PANSI, 2012

Figure 2.4.5 – Chart showing number of people with moderate disability projected between 2011 and 2030 by age for Nottinghamshire



Source: PANSI, 2012

Figure 2.4.6 – Chart showing number of people with serious disability projected between 2011 and 2030 by age for Nottinghamshire



Source: PANSI, 2012

Geographical variations

The geographical pattern of disability varies considerably across regions and localities. Where areas have a high proportion of men with disabilities this can often be related to the area's industrial heritage; within Nottinghamshire, for example, high incidences of respiratory and musculoskeletal diseases are likely to be the legacy of coal mining and other industries⁵.

Disability and deprivation

Disability rates are also associated with the relative deprivation of a local area. For example:

- disabled people have lower household incomes on average and are more likely to be in the lowest income groups
- they are more likely to have no educational qualifications and less likely to be employed
- many people with disabilities live in deprived communities where employment and economic activity rates are lower than the regional average
- the more affluent areas have lower proportions of residents describing themselves as disabled

⁵ EMDA (2007), Disability Equality Scheme 2006-2009

Disability and access to health services

Disability can have an adverse effect on people's access to and experience of health services, for example:

- Breast screening uptake is 76% for all women in the UK within the appropriate age range but between just 17% (family care) and 52% (formal care) for women with learning disabilities⁶.
- Uptake for cervical screening is 85% for women aged 20-64 but between just 3% (family care) to 17% (formal care) for women aged 18 and over with learning disabilities⁷.
- Disabled people are four times more likely than the general population to find dentists' offices inaccessible or inadequate, and twice as many find their doctor's surgery inaccessible⁸.
- 40% of visually impaired people consider that their GP is not fully aware of their needs. This rises to 60% when considering other surgery staff. 95-97% never receive health advice, letters or prescriptions in preferred formats such as Braille or large print⁹.
- 21% of disabled people and 64% of profoundly deaf people find A&E units inaccessible or inadequate¹⁰

In addition, for those with sensory impairment¹¹:

- 40% of visually impaired people believe that their GPs are not fully aware of their needs
- 24% of deaf or hearing-impaired people miss appointments and 19% miss more than five appointments because of poor communication

In line with other forms of disability, more than two fifths of those who report poor vision or that are registered blind are in the bottom income quintile for their age group and much more likely than those without impairments to be renting their homes¹².

Disability and health

Disability and poor-health often go hand-in-hand, for example, for people with mental health problems:

- there are higher rates of ischaemic heart disease, stroke, high blood pressure and diabetes among people with schizophrenia or bipolar disorder compared to the rest of the population.
- People with schizophrenia are 90% more likely to get bowel cancer and women are 42% more likely to get breast cancer

⁶ Disability Rights Commission (2004), Discriminating Treatment? Disabled people and the health service

⁷ Disability Rights Commission (2004), Discriminating Treatment? Disabled people and the health service

⁸ Leonard Cheshire (2002) Inclusive citizenship : the Leonard Cheshire Social Exclusion Report

⁹ Nzegwu F (2004), The experience of visually impaired users of the NHS : a survey, The Guide Dogs for the Blind Association

¹⁰ Disability Rights Commission (2004), Discriminating Treatment? Disabled people and the health service

¹¹ RNID (2004), A simple cure, 2004

¹² Nick Bosanquet and Pritti Mehta (2009) Evidence base to support the UK Vision Strategy

- 31% of people with schizophrenia and chronic heart disease (CHD) are diagnosed under 55, compared to 18% of others with CHD; these figures are 41% and 30% respectively for diabetes.
- After five years, 28% of people who have had a stroke and have schizophrenia have died, as have 19% of people with bipolar disorder, compared with 12% of people with no serious mental health problems.
- over 60% of people with serious mental health conditions smoke

People with learning difficulties:

- have higher rates of respiratory disease at 19.8% than the remaining population (15.5%).
- are more likely to be obese. The rate of obesity in all those with their body mass index (BMI) recorded was 28.3% in people with a learning disability, as compared to 20.4% for the remaining population.
- one study estimated that people with learning disabilities or long-term mental health problems are 58% more likely to have significant health problems and die before the age of 50

Disability free life expectancy at age 16 years

Estimated disability-free life expectancy figures suggest that both males and females in Rushcliffe have the highest disability-free life expectancy in the Nottinghamshire county council area. Males and females in Mansfield have the lowest disability free life expectancy in Nottinghamshire (figure 2.4.7). Figure 2.4.7 also shows that although females live longer than males, the proportion of life spent free of disability is usually slightly lower in females than males and is lower in more deprived areas of Nottinghamshire.

Figure 2.4.7 - Disability-free life expectancy (DFLE) for Males and Females at age 16: by local authority district, 2006–2008 (experimental statistics)

Males					
	Life expectancy	Disability-free life expectancy	Lower 95 per cent confidence interval	Upper 95 per cent confidence interval	% of life spent disability free
Ashfield	61.2	46.2	43.42	49.06	76%
Bassetlaw	61.7	48.8	45.80	51.78	79%
Broxtowe	63.1	49.1	46.42	51.81	78%
Gedling	62.9	50.1	47.14	53.02	80%
Mansfield	60.7	44.3	41.26	47.38	73%
Newark and Sherwood	61.9	47.9	44.92	50.97	77%
Rushcliffe	64.8	52.3	48.73	55.93	81%
East Midlands	62.4	48.1	47.67	48.57	77%
England	62.3	48.8	48.68	48.94	78%

Source: Disability-free life expectancy: comparison of sources and small area estimates in England, 2006–08 Health Statistics Quarterly 50, Summer 2011, Office for National Statistics.

Females					
	Life expectancy	Disability-free life expectancy	Lower 95 per cent confidence interval	Upper 95 per cent confidence interval	% of life spent disability free
Ashfield	65.4	48.1	45.20	50.91	73%
Bassetlaw	65.6	50.5	47.46	53.48	77%
Broxtow e	66.7	49.1	46.06	52.11	74%
Gedling	66.7	51.5	48.54	54.45	77%
Mansfield	65.3	46.4	43.29	49.59	71%
New ark and Sherw ood	66.2	52.7	49.72	55.75	80%
Rushcliffe	68.2	52.5	49.54	55.50	77%
East Midlands	66.3	49.4	48.89	49.84	74%
England	66.4	49.8	49.65	49.92	75%

Disability in the working age population

Information from the latest Annual Population Survey shows that 23% of the working age population of Nottinghamshire are disabled. This is higher than the figure for the East Midlands of 22% and also higher than the national figure of 21%. At a district level, Bassetlaw has the highest proportion of disabled people, 29% of the working age population. This is followed by Mansfield with 28%, and Ashfield with 25%. (see Table 2.4.8).

Similar proportions of men and women are disabled, 51.7% of disabled people in Nottinghamshire are women and 48.3% are men. The difference between the sexes is most marked in Broxtowe where 57% of working age people with a disability are women. In Ashfield, on the other hand, 53.3% of those with a disability are men.

Table 2.4.8: Disabled working age population, July 2010 – June 2011

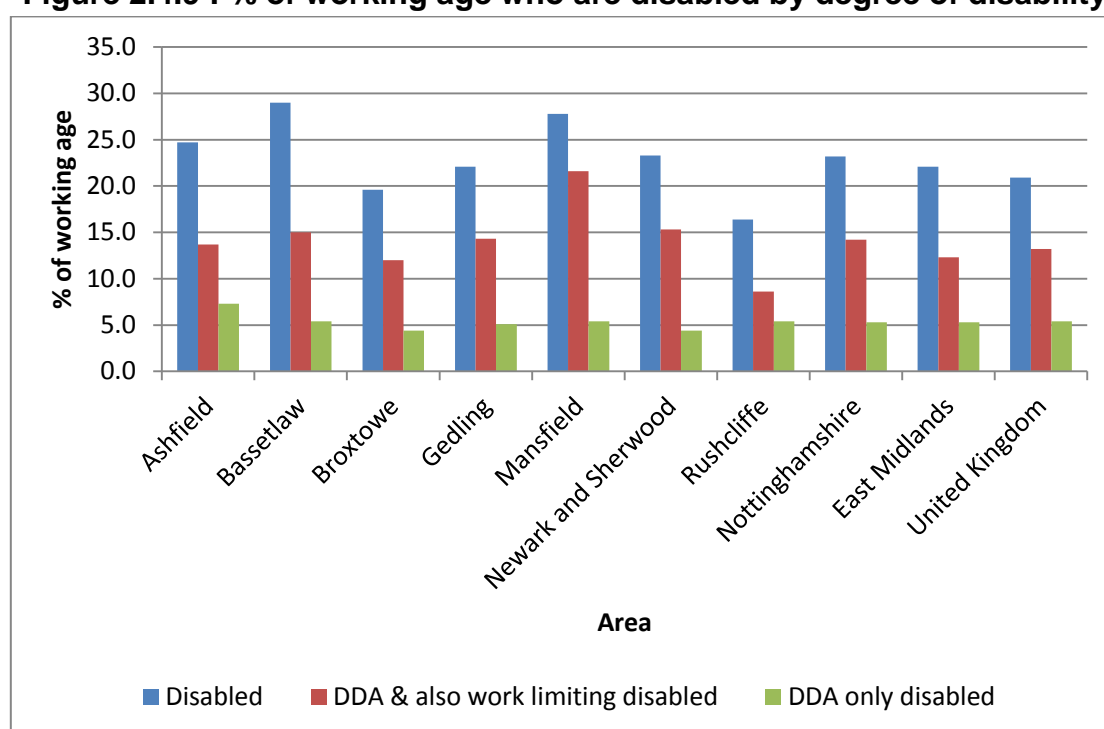
Area	% of working age who are disabled		% of working age males who are disabled		% of working age females who are disabled	
	number	percent	number	percent	number	percent
Ashfield	18,200	24.7	9,700	26.5	8,500	22.9
Bassetlaw	20,300	29.0	10,700	30.8	9,700	27.2
Broxtowe	14,200	19.6	6,100	16.3	8,100	23.3
Gedling	16,100	22.1	8,200	23.3	7,800	21.0
Mansfield	17,900	27.8	8,000	25.5	9,900	30.0
Newark & Sherwood	16,200	23.3	7,100	20.6	9,100	26.0
Rushcliffe	12,000	16.4	5,600	15.5	6,400	17.3
Nottinghamshire	114,900	23.2	55,500	22.5	59,400	23.8
East Midlands	634,700	22.1	295,700	20.7	339,000	23.5
United Kingdom	8,365,700	20.9	3,932,900	19.7	4,432,800	22.0

Source: Annual Population Survey via NOMIS, 2012

Figure 2.4.9 shows the percentage of working age who are disabled and gives an indication of the level of disability by looking at the three classifications; 'DDA only disabled', 'DDA & also work limiting disabled' and 'All disabled'.

It can be seen quite clearly that Bassetlaw has the highest proportion of "disabled" people with a rate of 29%. This is followed by Mansfield (27.8%), and Ashfield (24.7%) These three districts all have rates well above that of the East Midlands (22.1%) and the United Kingdom (20.5%). The patterns for the other two classifications of disability are rather different. For 'DDA and also work limiting disabled', Mansfield has much the highest percentage 21.6% and Rushcliffe (8.6%) has a proportion much below the regional average (13.2%). For 'DDA only disabled', only Ashfield (7.3%) is much above the regional figure of 5.4%.

Figure 2.4.9 : % of working age who are disabled by degree of disability



Source: Annual Population Survey via NOMIS, 2012

Figure 2.4.10 shows the employment rate of disabled working age residents in the county broken down by district. The Nottinghamshire rate of 46.5% is very similar to the Great Britain rate; however the district breakdown shows marked disparities with 26% difference between the best performing district - Bassetlaw at 55.1% - and that showing the worst performance - Mansfield at 29%. Two other districts - Newark and Sherwood and Broxtowe, have rates exceeding 50%.

Figure 2.4.10: Employment rate of disabled working age residents (July 2010 – June 2011)

District	%	Notts Rank
Bassetlaw	55.1	1
Broxtowe	53.6	2
Newark and Sherwood	50.4	3
Gedling	47.4	4
Rushcliffe	47.0	5
Ashfield	44.4	6
Nottingham	34.9	7
Mansfield	29.0	8
Nottinghamshire : 46.5		
Great Britain : 48.2		

Source: NOMIS, 2011

2.4.2. People with Sensory Impairments

Key messages

- There are around 4,400 people with a visual impairment and 2,500 people with a hearing impairment in contact with services in Nottinghamshire. However it is likely that a number of people with sensory impairments are not registered for services and therefore the needs of these people are unknown.
- A visual impairment can impact on every daily living skills.
- Being hearing impaired can be extremely isolating. There are particular difficulties for deaf people accessing services.
- Acquired deafness with age is increasing and although digital hearing aids are available, being able to adjust to this change mentally is difficult.
- Engagement in communities is usually supported via local voluntary organisation.
- Trained rehabilitation officers can assist people to learn new skills in order to maintain their independence, dignity and wellbeing. Being able to engage in community activities, feel safe and be aware of risks has a huge impact on people's lives.

A visual impairment can impact on every daily living skills, such as: cooking and eating, using household appliances, reading, personal hygiene, dressing, colour identification, lighting, communication aids, social activities, depth perception, mobility and much more.

Many visually impaired members of the community can still work with support from agencies such as Royal National Institute for the Blind (RNIB), access to work via job centre plus and there are lots of unique IT packages to assist people to remain in employment. Some people do have to give up work or do not receive the appropriate support to do so. This can be challenged because the Disability Discrimination Act (DDA) calls for 'reasonable adjustments' in order to support people with a disability.

Being hearing impaired can be extremely isolating as we live in a hearing world where adjustments to those who communicate in a different language, such as British Sign Language (BSL), is often not taken into account. Acquired deafness with age is increasing and although digital hearing aids are available, being able to adjust to this change mentally is difficult.

Difficulty in hearing everyday things such as the door bell, the telephone, the television can often lead to isolation, missing contact with family and friends. When people who

are profoundly Deaf access to services such as hospitals, GPs, Dentists, or any other professional, they can find the experience challenging when people do not use BSL. Often services are unaware of their responsibilities of providing adequate communication support under the DDA Act.

Engagement in local communities can be limited although most Counties in the country have pockets of Deaf people where they congregate for social interaction and support. These are usually within Local Charitable or voluntary organisations.

Living with a sensory impairment can be very isolating, lonely, frightening yet frustrating. Trained rehabilitation officers can assist people to learn new skills in order to maintain their independence, dignity and wellbeing. Being able to engage in community activities, feel safe and be aware of risks has a huge impact on people's lives.

Local Authorities are legally obliged to hold and maintain a register of visually impaired people but this is not the case for hearing impairment. The County Council's Adult Deaf and Visual Impairment Service collects data on the numbers of people with visual and hearing impairment registering with the council covering the whole of Nottinghamshire.

These figures represent those with sensory impairments who are in contact with services, however it is likely that a number of people with sensory impairments are not registered and therefore the needs of these people are unknown. It is difficult to quantify the nature of possible unmet needs for this group.

The most recent statistics held by the service show that there are:

- 1,732 registered blind people in the county
- 2,675 registered partially sighted
- 1,073 known to the service who are pre-registered*
- 324 deaf people who have speech
- 190 deaf people without speech
- 427 hearing impaired
- 1,586 people who are hard of hearing

* Pre-registered means there are people who are not registered but for whom support is offered to assist daily living.

Table 2.4.11: The district numbers of registrations

	Visual impairment	Deaf/deafened and hard of hearing
Ashfield	693	307
Bassetlaw	603	292
Broxtowe	614	368
Gedling	692	320
Mansfield	585	408
Newark & Sherwood	574	258
Rushcliffe	559	310
Others	87	97

Source: County Council's Adult Deaf and Visual Impairment Service

The Adult Deaf and Visual Impairment Service provide services as part of the new *Personalisation Agenda*, prioritising need in the context of *Putting People First*. They have developed a 'reablement service' for sensory adults aged 18+ with a focus on maximising people's independence before (or during) a full community care assessment of need for personal budgets, giving people more choice and control of how they meet their needs and outcomes.

The Visual Impairment reablement process focuses on five elements: impact on daily living, communication, mobility, employment/social inclusion and emotional wellbeing. The provision of equipment for visually impaired people is currently issued free where there is clear risk(s) connected with the health and safety of service users. In other instances, advice and information is given on suitable self-purchases.

Specialist Technical Officers for the Deaf also have a reablement function in relation to environmental aids for Deaf/deafened and hard of hearing people across Nottinghamshire. The provision of equipment is based on an eligibility criteria in line with the Chronically Sick and Disabled Persons Act and aims to maximise people's independence where possible to keep people safe within their own homes.

Specialist Social Workers for the Deaf also have an assessment function as part of personalisation: each has adequate British Sign Language skills in order to communicate directly with the Deaf community which is vital to meet their needs. Social Workers for visually impaired adults contribute to the community care assessment process offering a specialist insight into the needs of adults with a visual or dual sensory impairment.

Nottinghamshire County Council is also to embark on a VISION 2020 strategy in 2012 which is to be launched with both the City Council and our voluntary and private sector partner. The strategy has three main aims; to improve the eye health of people of the UK; to eliminate avoidable sight loss and to deliver excellent support for people with sight loss considering inclusion participation and independence for these people. This is a five year aim to map existing services and identify gaps such as better transport for visually impaired people and fair/equitable access to services.

The Deaf community face challenges in everyday life due to communication barriers and accessing the most basic information can be difficult. The development of means of accessing services in Nottinghamshire is high on the council's agenda. This year an inclusive SMS text service to directly refer people is being developed. The Deaf Team currently holds an SMS service but this is to be extended into front line customer services in 2012.

2.4.3. People with Learning Disabilities

Key messages

Learning disability is a life-long condition that occurs as a result of genetic or developmental factors or damage to the brain, often at birth. They affect a person's level of intellectual functioning - usually permanently - and sometimes their physical development too.

- Approximately 2% of the population of England has a Learning Disability, which is about 14,715 people over the age of 18 in Nottinghamshire.
- National figures show an expected increase in people with Learning Disabilities by approximately 14% between 2011 and 2030, which equates to a total of 17,000 people in Nottinghamshire. The increase is expected to be concentrated in the older age range, with 48% growth in people with learning disabilities aged over 65.
- It is estimated that there were 247 people with profound and multiple learning disabilities (PMLD) in Nottinghamshire in 2011. This figure could increase by approximately 32% by 2026 giving a future estimate of 326 people with PMLD throughout the county in the next 15 years.
- People with learning disabilities die younger and have poorer health than the general population (as indicated by higher admissions to secondary healthcare). These differences are, to some extent, avoidable and, as such, represent health inequalities.
- Age profiles of adults known to Adult Social Care and Health confirm a shorter life expectancy than the general population - an analysis of death certificates suggest a median age of death of 56 years.
- Nationally, people with learning disabilities are less likely to live in their own home or be in paid employment than the general population. In Nottinghamshire a higher proportion than the national average live in their own homes (25%) and the percentage in paid employment (10%) is in line with the national average.
- A Nottinghamshire survey suggests approximately a third of people with learning disabilities would like to move, or would need to move (e.g. due to aging family carers), in the next five years.
- There are concerns locally about levels of hate crime experienced by people with a learning disability.

Introduction

Learning disability is a life-long condition that occurs as a result of genetic or developmental factors or damage to the brain, often at birth. They affect a person's level of intellectual functioning - usually permanently - and sometimes their physical development too. The Department of Health White Paper, Valuing People (2001), was

designed to improve support for people with learning disabilities and their families. Valuing People Now (2009) gave a progress update and concluded that while there have been improvements in access to housing, health, employment and personal budgets there remains much to be done regarding equal access to services.

- Only 15% of people have a home of their own;
- more than 30% of people with learning disabilities live in residential care homes, a significant proportion of which are miles away from their place of origin and their families;
- many people with learning disabilities are living with older family carers who have their own needs;
- only one in ten of those known to social services has any form of paid employment, and of those only very few work more than 16 hours a week
- There are significant and on-going inequalities in access to healthcare services and in the quality of services.

In Nottinghamshire of those with a learning disability known to Adult Social Care in 2011:

25% live in their own home (above national averages). There are 16 approved Supported Living providers who will support people living in their own home according to their needs. This can range from a few hours a week to 24/7 care and support.

There are a range of accommodation types from an individual living in a single occupancy home, to people sharing a house, living in core and cluster accommodation, or flats with or without a shared entrance.

Tenure will also vary: people live in social housing; private rented; shared ownership or as owner occupiers.

The Shared Lives scheme provides accommodation and support to 20 people with learning disabilities in Nottinghamshire, offering people the opportunity to live with a paid carer in a family setting.

26% live in residential care (below national averages) of whom approximately 15% live out of County (excluding Nottingham City). The reasons people moved out of county were varied but in 32% of cases it was due to no local service being available, mainly relating to complex needs or challenging behaviour. Many of these individuals have lived out of county for many years and services have now developed which could meet their needs. Work is being undertaken to assess current out of county service users with a view to moving them more locally if appropriate.

A survey carried out on 1,110 people with a learning disability in Nottinghamshire (which is about half of those known to Adult Social Care and Health) suggests approximately a third would like to or would need to move (e.g. due to aging family carers) in the next 5 years which equates to 728 people in total.

Of those who would wish to move, 4% currently live in supported living and 4% currently live in residential care. The biggest section of people wanting or needing to move were people living with family carers where approximately 13% wanted or may need to find alternative accommodation and support in the next 5 years.

Approximately 10% of people with a learning disability known to ASCH are in supported employment (the same as national averages). This has been achieved via specialist employment support for people with learning disabilities. Examples include promoting self employment and developing business enterprise and the use of personal budgets. It also includes working with 9 out of 11 special education schools from year 9 to promote employment at reviews, plan work experience; weekend and holiday jobs and assisting in finding employment for those that leave.

Approximately 35% of people with a learning disability known to ASCH had a Personal Budget at the end of November 2011. This is increasing on a monthly basis and it is anticipated that 100% of people will be on a personal budget by 2013.

218 people (approximately 10%) had a direct payment at the end of November 2011. We currently have no statistics to tell us what kinds of services people are buying with their personal budgets.

The Nottinghamshire Learning Disability Partnership Board is a mechanism for service user and carer involvement, drawing in representatives from each district and each Nottinghamshire County council run day service. In 2011/12 the board was particularly concerned about hate crime experienced by people with a learning disability and felt this was a key priority along with ensuring support services operated in a person centred way and health service delivery was more accessible, especially for those with complex needs.

The Prevalence of Learning Disability

Approximately 2% of the population of England has a Learning Disability which is just under 800,000.

National figures show an expected increase in people with Learning Disabilities by approximately 14% between 2011 and 2030.

Table 2.4.12: National prevalence figure applied to Nottinghamshire.

	2011	2015	2020	2025	2030
Total	14,715	15,182	15,694	16,215	16,790
severe	694	698	710	734	755
moderate	2343	2420	2502	2591	2690
mild	11,678	12,064	12,482	12,890	13,345

Source: Analysis of PANSI data

The increase is driven by 3 main factors:

- An increase in the proportion of younger adults from South Asian Communities (studies¹³ suggest prevalence in this ethnic group are higher than average)
- Increased survival rates for young people with severe and complex disabilities
- Older people with learning disabilities living longer.

Information from the Institute of Public Care Projecting Adult Needs and Service Information (PANSI) categorises learning disability as either severe/profound or mild/moderate.

(These figures may be slightly exaggerated as Nottinghamshire has a low South Asian population)

The increase is expected to be concentrated in the older age range with 48% growth in people with learning disabilities aged over 65.

The prevalence of severe learning disability is higher in males than females (1.2 males: 1 female) and this gap increases people with mild learning disabilities 1.6 males to 1 female.

Socio-economic factors have also been noted to affect the prevalence of mild learning disabilities but this is not evidenced for severe learning disability.

People with profound and multiple learning disabilities (PMLD)

- have more than one disability
- have a profound learning disability
- have great difficulty with communication
- need high levels of support with most aspects of daily life
- may have additional sensory or physical disabilities, complex health needs or mental health difficulties
- may have behaviours that challenge

It is estimated that there were 247 people with profound and multiple learning disabilities within Nottinghamshire in 2011 of which 34 were in Bassetlaw. This figure could increase by approximately 32% by 2026 giving a future estimate of 326 people with PMLD throughout the county in the next 15 years¹⁴.

With an aging population there are likely to be increases in age related frailties. Studies have been carried out showing the increased likelihood of people with Down's syndrome to develop dementia. However, using Projecting Older People Population Information System (POPPI) data it suggests that there will not be a significant change in the number of people with Down's syndrome overall within Nottinghamshire (2011 estimates

¹³ Emerson and Hatton (2004)

¹⁴ Source: Estimating Future Numbers of Adults with Profound Multiple Learning Disabilities Eric Emerson 2009

are 307 for Nottinghamshire increasing to only 322 by 2030) and therefore the predicted increase in people with Down's syndrome and dementia is limited.

An audit undertaken by Nottinghamshire Healthcare Trust identified 29 people within Nottinghamshire and Nottingham City with Downs Syndrome and dementia compared to 35 (28 in Nottinghamshire) suggested by POPPI data.

Data sourced from PANSI estimates 14,671 adults aged 18-64 in England with learning disabilities that display challenging behaviour. Applying the national prevalence estimates to local populations suggests that there are 218 individuals with challenging behaviour in Nottinghamshire (of which 31 are in Bassetlaw), predicted to rise by approximately 3.7% over the next 15 years.

For more detailed information relating to people with Challenging behaviour and people with profound and Multiple Learning Disabilities please see "A Review of Services for Adults with Profound and Multiple Learning Disabilities and/or Challenging Behaviour in Nottinghamshire" (note this report will be added to the JSNA website)

Learning disability and health needs

People with learning disabilities die younger and have poorer health than the general population. These differences are, to some extent, avoidable. As such, they represent health *inequalities*. These inequalities are the result of the interaction of several factors including increased rates of exposure to common 'social determinants' of poorer health (e.g., poverty, social exclusion), experience of overt discrimination and barriers people with learning disabilities face in accessing health care¹⁵.

A recent study based on information from death certificates found two causes of death which stood out because they are to an extent preventable, and were connected to large numbers of deaths across most groups of people with learning disabilities¹⁶. They were:

- Lung problems caused by solids or liquids going down the wrong way (14% of deaths where a condition associated with learning disabilities was reported)
- Epilepsy or convulsions (13% of deaths where a condition associated with learning disabilities was reported).

Common health problems among people with learning disabilities include¹⁷:

- Respiratory disease.
- Coronary heart disease

¹⁵ Emerson, E., Baines, S., Allerton, L. and Welch, V. (2011) Health Inequalities and People with Learning Disabilities 2011. Improving Health and Lives Learning Disability Observatory.

¹⁶ Glover G. & Ayub M. (2010) *How People with Learning Disabilities Die*. Improving Health and Lives Learning Disabilities Observatory.

¹⁷ Sir Jonathan Michael (2008). Healthcare for All, Independent Inquiry into Access to Healthcare for People with Learning Disabilities

- Physical impairment with associated risk of postural deformities, hip dislocation, chest infections, eating and swallowing problems, gastro-oesophageal reflux, constipation and incontinence
- Underweight
- Obesity
- Mental health problems (including dementia)
- Epilepsy
- Sensory impairments

People with a learning disability have greater and more complex health needs compared to the general population. Mental ill health, sensory impairment, physical disabilities and chronic health problems are all more common¹⁸.

Life Expectancy of adults with learning disabilities

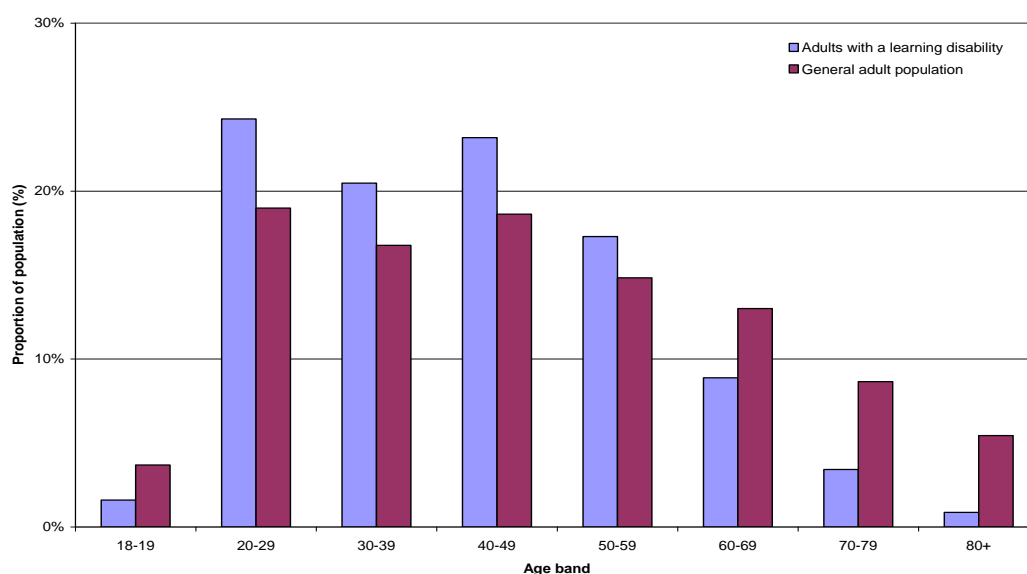
The age profiles of adults with learning disabilities known to Adult Social Care services in Nottinghamshire suggest a shorter life expectancy than the general population.

An analysis of Nottingham City and Nottinghamshire County Council death certificates demonstrated a median age of death of 56 years for adults with learning disabilities recorded on the death certificate, compared to 80 years for individuals with death certificates where learning disabilities was not recorded.

Pneumonia was the most common (43%) cause of death in individuals with learning disabilities recorded on the death certificate, followed by aspiration pneumonia and cardio-respiratory failure.

¹⁸ Dept of Health (2001) Valuing People

Figure 2.4.13: Age profile of general population and adults with learning disabilities known to Adult Social Care services



Source: Adult Social Care services, Nottinghamshire County Council and Nottingham City Council. PCT population from registered population table July 09

The age profiles of the combined adult population of NHS Nottingham City, NHS Nottinghamshire County and NHS Bassetlaw and adults with learning disabilities known to Adult Social Care and Health show a distinct difference (Figure 2.4.13). A higher proportion of the learning disabilities population are aged 20-59 and a lower proportion aged 60 and above, compared to the general population. This would suggest that people with learning disabilities in Nottinghamshire die younger than the general population.

Lifestyle factors and learning disabilities

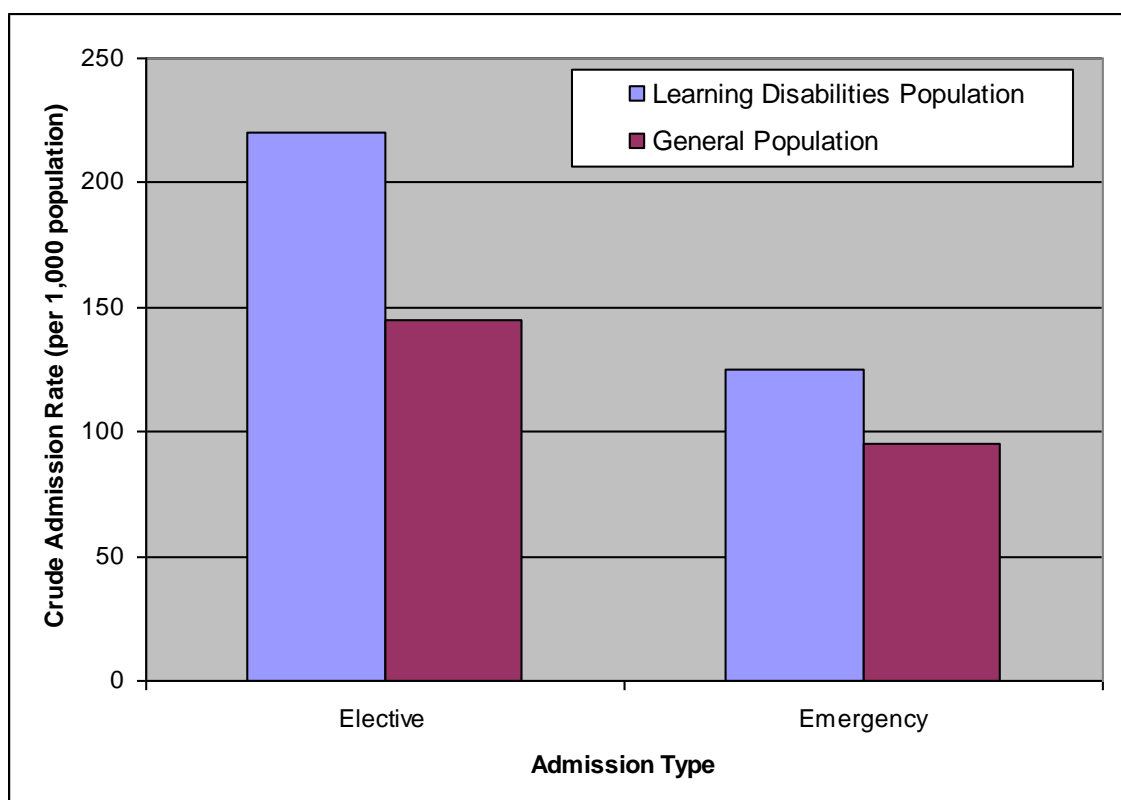
In terms of lifestyle factors national and international reviews have identified that people with learning disabilities tend to have poorer nutrition, lower levels of physical activity, higher rates of obesity¹⁹ and in community dwellings, equivalent rates of smoking to the general population²⁰. However, locally one study found smoking rates amongst people with a learning disability attending 4 days services was as low as 6%²¹. Those with mild learning disabilities were more likely to smoke than those with severe learning disabilities and they also reported smoking more heavily. As life expectancy increases for people with a learning disability then these factors are likely to impact on the risk of age-related illness such as cardiovascular disease and cancer.

¹⁹ Messent PR, Cooke CB, Long J. Physical activity, exercise and health of adults with mild and moderate learning disabilities. *British Journal of Learning Disabilities* 1998;26:17-22

²⁰ Wilkinson JE, Culpepper L, Cerreto M. Screening tests for adults with intellectual disabilities. *Journal of the American Board of Family Medicine*. 2007; 20(4):399-407

²¹ Taylor N et al Smoking prevalence and knowledge of associated risks in adult attendees at day centres for people with learning disabilities. *Journal of Intellectual Disability Research* 2004; 48(3):239-244

Figure 2.4.14: Crude admission rates for the general adult population and adults with learning disabilities, 2004/8 average



Source: *A Health Needs Assessment for Adults with a Learning Disability in Nottingham and Nottinghamshire 2010*

Currently there is no information on the local levels of obesity, physical activity undertaken or alcohol consumed by adults with a learning disability in Nottinghamshire. Systems for recording and reporting this data in primary care are currently being developed.

Hospital admissions for adults with learning disabilities

A review of hospital admissions across the population of NHS Nottinghamshire, NHS Nottingham City and NHS Bassetlaw between 2004 and 2008 indicates that adults with learning disabilities were 1.5 times more likely to be admitted to secondary care as an elective admission than the general adult population and 1.3 times more likely to be admitted as an emergency (Figure 2.4.14)

Table 2.4.15: Conditions for which adults with learning disabilities were significantly more likely to be admitted, based on yearly average 2004 to 2008

Reason for admission	Rate ratio*	Crude admission rate for adults with learning disabilities (per 1,000 population)	Crude admission rate for general adult population (per 1,000 population)
Epilepsy	22.6	24.9 ^{1,2,3}	1.1
Schizophrenia	4.6	2.3 ¹	0.5
Oral Health	3.4	13.4 ¹	3.9
Mental Health	3.1	4.7 ¹	1.5
Diabetes	2.9	3.2 ¹	1.1
Hearing problems	2.5	2.8	1.1
Bladder disorders	1.6	9.7 ¹	6.2

Source: SUS data – Local Data Warehouse System

Rate ratio is calculated as (the admission rate for adults with learning disabilities) / (the admission rate for the general adult population)

1 rate is significantly higher for patients registered with NHS Nottinghamshire County

2 rate is significantly higher for patients registered with NHS Bassetlaw

3 rate is significantly higher for patients registered with NHS Nottingham City

Adults with learning disabilities were significantly more likely to be admitted than the general adult population for epilepsy, an oral health condition, a mental health condition, a hearing problem and diabetes (Table 2.4.15). Adults with a learning disability were significantly less likely to be admitted than the general adult population for cancer, coronary heart disease, respiratory disease and gastro-intestinal disorders (Table 2.4.16). Nationally people with learning disability have an increased uptake of medical and dental hospital services, but a reduced uptake of surgical specialities compared with the general population. This is reflected to a certain degree locally.

For more information on the Health Needs of People with a Learning Disability in Nottinghamshire Please see the Health Needs Assessment for Adults with a Learning Disability in Nottingham and Nottinghamshire.

Table 2.4.16: Conditions for which adults with learning disabilities were significantly less likely to be admitted, based on average across 2004 to 2008 admissions

Reason for admission	Rate ratio*	Crude admission rate for adults with learning disabilities (per 1,000 population)	Crude admission rate for general adult population (per 1,000 population)
Cancer	3.7	5.5 ^{1,2}	20.1
Coronary heart disease	1.8	11.2 ¹	19.6
Respiratory disease	1.5	9.6	14.3
Gastro-intestinal disorders	1.2	30.4	37.7

Source: SUS data – Local Data Warehouse System

Rate ratio is calculated as (the admission rate for the general adult population) / (the admission rate for adults with learning disabilities)

1 rate is significantly lower for patients registered with NHS Nottinghamshire County

2 rate is significantly lower for patients registered with NHS Bassetlaw

2.4.4. People with Autism

Key messages

Autism is defined as a lifelong developmental disability that affects how a person communicates with, and relates to, other people. It also affects how they make sense of the world around them.

- An estimated 1% of the national population is on the autistic spectrum, with a far higher proportion of men (1.8%) affected than women (0.02%).
- An estimated 4,829 people aged between 18 and 64 have autism in Nottinghamshire. It is believed that this will increase by approximately 3% over the next twenty years.
- Around 50% of people with autism also have a learning disability.
- Evidence suggests that people with autism are much more likely to have mental health problems than the general population, in particular depression and anxiety.
- A number of other conditions occur at a higher rate in people with autism compared to the general population, including epilepsy and attention deficit hyperactivity disorder.

Introduction

Autism is defined as a lifelong developmental disability that affects how a person communicates with, and relates to, other people. It also affects how they make sense of the world around them. It is a spectrum which means people will be affected by the condition in different ways. Autism in itself is neither a learning disability nor a mental health issue. There is however a strong correlation between autism and learning disability and autism and mental health issues.

The Government's strategy set out in The National Autism Strategy 2011 is that "All adults with autism are able to live fulfilling and rewarding lives within a society that accepts and understands them. They can get a diagnosis and access support, if they need it and can depend on mainstream public services to treat them fairly as individuals, helping them make the most of their talents."

The National Autistic Society estimate that:

- Nearly two-thirds of adults with autism do not have enough support to meet their needs
- At least one in three people with autism are experiencing mental health difficulties due to lack of support
- Only 15% of adults with autism are in full time paid employment and 61% of those out of work say they want to work.
- 51% of adults with autism have spent time without either paid employment or benefits. For 10% of them this has been the case for at least 10 years.

In Nottinghamshire, of the 208 people with Asperger's known to Health and Social care 18 (9%) are currently in full or part time paid employment. It is likely that the majority of people with Asperger's in paid employment are not known to Adult Social Care.

Learning Disability and Autism

Nationally, estimates of the number of people with autism who also have a learning disability range of around 50%.

Of the 335 people known to Nottinghamshire Adult Social Care in 2011, 127 (38%) also have a learning disability.

It is thought that between 20 and 30% of people with a learning disability also have autism.

Of those people with a learning disability known to Adult Social Care in Nottinghamshire, only 9% have a diagnosis of autism which is recorded.

Asperger's Syndrome

Asperger's is a form of autism but has no accompanying learning disability. People with Asperger's often have average or above average intelligence. People with Asperger's will have difficulties in three main areas:

- Social communication
- Social interaction
- Social imagination.

The Prevalence of Autism

There are a number of different studies which have estimated prevalence rates for autism in England. The best available national prevalence estimates indicate 1% of the population is on the autistic spectrum with a far higher proportion of men (1.8%) affected than women (0.02%)²².

²² Autism Spectrum Disorders in adults living in households throughout England - report from the Adult Psychiatric Morbidity Survey 2007 conducted by Brungha et al, NHS Information Centre 2009.

Table 2.4.17: 2011 estimates of adult population in Nottinghamshire with Autism

	Bass	Ash	Mans	N&S	Rush	Brox	Ged
Males aged 18-64	617	643	554	616	637	668	616
Females aged 18-64	67	73	62	70	69	72	71
Total	684	716	616	686	706	740	687

Source: PANSI www.pansi.org.uk

Table 2.4.18 2030 projections of adult population in Nottinghamshire with Autism

	Bass	Ash	Mans	N&S	Rush	Brox	Ged
Males aged 18-64	603	677	554	641	680	738	646
Females aged 18-64	64	77	61	72	73	78	74
Total	667	754	615	713	753	816	720

Source: PANSI www.pansi.org.uk

There is no evidence to suggest prevalence differs according to age but diagnosis in younger age groups is likely to be significantly higher due to contact with education services and the relatively recent advances in identification of autism.

Applying the 1% figure to Nottinghamshire it is estimated that there are 9,140 people of all ages on the autistic spectrum.

PANSI Data shows an estimated 4,829 people aged between 18 and 64 have autism in Nottinghamshire. It is estimated that this will increase by approximately 3% over the next twenty years (tables 2.4.17 & 2.4.18).

Autism and health needs

Co-occurring conditions

A number of conditions occur at a higher rate in people with autism compared to the general population. These include learning disabilities and difficulties, epilepsy, attention deficit hyperactivity disorder, mental health problems and other less common genetic conditions.

Epilepsy

A number of studies have examined the association between autism and epilepsy, with a lower IQ being associated with a higher risk of having epilepsy^{23 24}. A recent meta-analysis found that 21.5% of people with autism and a learning disability also had epilepsy, whereas 8% of those with autism and no learning disability had epilepsy. In addition females with autism were found to be at higher risk of having epilepsy than

²³ Tuchman R & Rapin I 2002. Epilepsy in autism. *Lancet Neurology*, 1:352-358

²⁴ Cantino R 2007. Epilepsy in autism spectrum disorders. *European Child Adolescent Psychiatry* 16: 61-66

males with autism²⁵. The lowest prevalence rate (4%) of epilepsy is said to be found in those with Asperger Syndrome (AS)²⁶ whereas the highest prevalence (77%) is found in those with childhood disintegrative disorder, a form of pervasive developmental disorder²⁷. It is important this medical condition is managed in this already vulnerable group. In addition there is potential for undiagnosed people with AS to be identified and referred for diagnosis through epilepsy services.

Mental Health Problems

Evidence suggests that persons with autism are much more likely to have mental health problems than the general population, in particular depression and anxiety. Estimates of the prevalence of common mental health problems amongst persons with Autism Spectrum Conditions vary but may be as high as 35%. This is in comparison to the general population prevalence estimate of 17.6%²⁸.

In a large scale survey of parents of adults with Asperger's Syndrome it was reported that 30% of those with Asperger's Syndrome had experienced a mental health problem at some point in time, over half experiencing depression²⁹. The presence of autism may potentially mask the appearance of a mental health problem due to the reduced ability of the person to convey feelings and emotions, therefore rates may in fact be an underestimate.

The expression of autistic traits may be misinterpreted as a mental health problem leading to an individual being misdiagnosed with a mental health problem. This obviously has significant implications including the possibility of incorrect intervention/treatment provision and cost of care packages which may not be entirely necessary had the correct diagnosis and support been given at an earlier stage. The individual and family would also be less likely to experience frustration and distress from an incorrect diagnosis.

Not all of those with autism experiencing a mental health problem will require specialist mental health services. The less severe, more common mental health problems such as depression and anxiety would most often require low intensity support that can be provided through primary care, such as a modified version of Cognitive Behavioural Therapy, which is shown to be effective in this population for the treatment of common

²⁵ Amiet C, Gourfinkel-An I, Tordjman A et al 2008. Epilepsy in autism is associated with intellectual disability and gender: Evidence from a meta-analysis. *Biological Psychiatry* 64 (7); 577-582.

²⁶ Cederlund M & Gillberg C 2004. One hundred males with Asperger syndrome: A clinical study of background and associated factors. *Dev Med Child neurology* 46: 652-660

²⁷ Mourisden SE, Rich B, Isager T 1999. Epilepsy in disintegrative psychosis and infantile autism: a long term validation study. *Dev Med Child Neurology* 41: 110-114

²⁸ Projecting Adult Needs and Service Information (PANSI) 2010. Available at <http://www.pansi.org.uk/index.php?pageNo=402&PHPSESSID=t5lorfii61bcdhqcqambtecg96&sc=1&loc=8640&np=1>. Accessed 26/04/11

²⁹ Barnard J, Harvey V, Prior A et al 2001. Ignored or ineligible: the reality for adults with Autistic Spectrum Disorders. The National Autistic Society, UK

mental health problems^{30 31 32}. The traditional form of Cognitive Behavioural Therapy is not appropriate for those with autism due to their unique cognitive style and inability to use social imagination.

It is thought the majority of less severe mental health problems could be prevented if individuals are provided with timely support to access employment, educational opportunities, social skills training and social groups. Without the appropriate low intensity support, mental health problems could escalate resulting in need for intensive high cost crisis intervention. This comes at a high social and emotional cost to the individual and can cost up to £300 per day³³.

Ensuring those with autism have access to primary care mental health services is important, as is ensuring preventative support such as employment, education, social skills training and social groups are made available.

Attention Deficit Hyperactivity Disorder (ADHD)

Evidence suggests persons with autism can be misdiagnosed with ADHD in childhood due to the similarities in presentation of the two conditions³⁴. In addition, co occurring ADHD and ASC is reported to be very high: up to 43%³⁵. The number of prevalence studies looking at co-occurring ADHD and ASC are minimal therefore this rate should be interpreted with caution. It may in fact confirm the theory of a high rate of misdiagnosis. Again, as above, this is a potential route for identifying undiagnosed or misdiagnosed cases of AS therefore staff in ADHD services should receive specialist training on ASCs.

For more information on the Health Needs of People with Autism please see the “Needs Assessment for Adults and Young People with Autistic Spectrum Conditions in Nottingham, Nottinghamshire and Bassetlaw”. This report will be made available on the JSNA website.

³⁰ Attwood T 2003. Cognitive behavioural therapy (CBT), In: Willey LH, Asperger Syndrome in adolescence: living with the ups, the downs and the things in between. Jessica Kingsley.

³¹ Hare DJ 2004. Developing cognitive behavioural work with people with ASD. Good Autism Practice 5 (1): 18-22

³² Anderson S, Morris J 2006. Cognitive Behavioural Therapy for people with Aspergers Syndrome. Behavioural and Cognitive Psychotherapy 34 (3); 293-303

³³ Curtis L 2008. Unit costs of health and social care. Personal Social Services Research Unit, Canterbury

³⁴ Ghaziuddin M 2005. Mental Health Aspects of Autism and Asperger Syndrome. Jessica Kingsley Publishers, London.

³⁵ Hofvander B, Delorme R et al 2009. Psychiatric and psychological problems in adults with normal-intelligence autism spectrum disorders. BMC Psychiatry 9:35

2.5. People with Mental Ill Health

Key Messages:

Mental ill health is widespread; at least one in four people will experience a mental health problem at some point in their life, and at any one point in time one in six of the adult population in England will be experiencing a mental health problem. Mental health problems have complex causes and effects, involving social and economic circumstances, and having a mental health problem also increases the risk of physical ill health.

- Prevalence estimates indicate there were over 86,500 people in Nottinghamshire experiencing common mental disorders such as depression and anxiety, and over 3,000 suffering from severe mental illness in 2007.
- In terms of common mental disorders, across all age groups prevalence is higher amongst females than males, and the highest prevalence is found among females aged 45-54 years.
- As at May 2011, 7% of the working age population in Nottinghamshire were claiming unemployment related benefits due to mental or behavioural disorders.
- Over a third of Incapacity Benefit, Severe Disability Allowance and Employment Support Allowance claims in Nottinghamshire in 2011 related to 'mental or behavioural disorders'.
- For men under 35, suicide is the most common cause of death and men are three times more likely than women to take their own lives. Overall, people aged 40-49 have the highest suicide rate.
- Nottinghamshire has a lower overall rate of death by suicide than the England average, but a higher rate of suicides in people over 75.
- There is significant variation in the prevalence of mental illness, rates of suicide, rates of self-harm and proportion of benefits claimants between districts in Nottinghamshire, broadly reflecting the variation in levels of deprivation.

2.5.1 Introduction

Mental ill health is widespread; at least one in four people will experience a mental health problem at some point in their life, and at any one time 1 in 6 of the adult population in England will be experiencing a mental health problem³⁶. Mental health problems have complex causes and effects, involving social and economic circumstances. Good mental health is central to an individual's quality of life and economic success. In addition there is a direct relationship between physical and mental health. Having a mental health problem increases the risk of physical ill health.

³⁶ McManus S et al 2009. Adult Psychiatric Morbidity in England 2007: Results of a household survey, The Information Centre

Depression is associated with a four-fold increase in the risk of heart disease³⁷, and people with long term physical health conditions, such as diabetes, are 3 to 4 times more likely to experience mental illness than the rest of the population³⁸.

Increasing focus is being placed on promoting mental wellbeing and preventing mental illness as well as improving the care provided to those with mental health problems. In 2011 the Government published a new mental health strategy for England *No Health Without Mental Health*³⁹. The interconnections between mental health, housing, employment and the criminal justice system are highlighted.

The strategy sets out six key shared objectives for better mental health and improved mental health care. It supports the Government's aim of achieving parity of esteem between physical and mental health, a theme that is further reinforced in the public health White Paper *Healthy Lives, Healthy People*. In addition the NHS Outcomes Framework and the Quality and Outcomes framework for general practice includes a number of new measures in relation to mental health.

The Government has committed £400 million over the next four years to ensure people have a choice of NICE approved psychological therapies by 2015. This investment should secure wider access to IAPT (Improving Access to Psychological Therapies) services, extend the benefits of talking therapies to people with physical long term conditions and those with severe mental illness.

2.5.2. The Prevalence of Mental Health Problems among Adults

The Survey of Psychiatric Morbidity Among Adults Living in Private Households¹ is generally regarded as providing the best available data about the rates of mental health problems in adults in England, their treatment and impact on sufferers. The surveys have been carried out on three occasions, in 1993, 2000 and 2007, and include large samples of the population. The survey used assessment tools to detect the prevalence of a range of mental illnesses including common mental health disorders, psychoses, and suicide and self harm.

Risk factors for mental health

The surveys of adult psychiatric morbidity included assessment and analysis of factors associated with increased risk of developing mental health problems. Factors associated with an increased risk of both common mental health disorders and psychotic disorders were:

³⁷ Osborn D et al 2007. Relative risk of cardiovascular and cancer mortality in people with severe mental illness from the United Kingdom's General Practice Research Database. *Archives of General Psychiatry* 64; 242-9

³⁸ Layard R et al 2007. Cost benefit analysis of psychological therapy. Centre for Economic Performance. CEP Discussion paper No 829, October 2007.

³⁹ HM Government 2011. *No Health without mental health*. A cross government mental health outcomes strategy for people of all ages.

- Being separated or divorced
- Living as a single person family unit or as a lone parent
- Unemployment
- Deprivation

Common mental disorders

Common Mental Disorders (CMD) cause appreciable emotional distress and can interfere with daily functioning, but do not usually affect insight or cognition. The term includes the following diagnoses:

- Depressive episode
- Generalised anxiety disorder
- Mixed anxiety and depressive disorder
- Phobia
- Panic disorder
- Obsessive compulsive disorder.

Unfortunately, the psychiatric morbidity survey sample sizes are not large enough to enable direct reporting at a county or Local Authority (LA) level. However, analysis has been undertaken to apply the prevalence rates of CMD from the 2000 survey for England to the Nottinghamshire population to give an estimate of the number of people with CMD within each LA area. These estimates are shown in Table 2.5.1. This data can then be further modelled to derive estimates of the number of people expected to have such a diagnosis in each Clinical Commissioning Group (CCG). These estimates are shown in Table 2.5.2.

The findings of the 2007 survey were not significantly different to the 2000 survey so we can be assured that estimates based on the 2000 survey remain appropriate. The main exception to this is the calculation of prevalence among people aged 75+, where 2007 data had to be used as this age group were excluded from the 2000 survey. Note that the analysis should be treated as an estimate only. It is based on national rates which have been adjusted to take into account of a range of local demographic characteristics at the level of the lower tier Local Authority. The CCG rate is based on the LA estimates weighted for the proportion of the CCG population resident in each LA area.

The rates vary considerably, with Principia having the lowest estimated prevalence and Mansfield and Ashfield having the highest estimated prevalence.

In addition, prevalence of CMD varies by age and sex. Across all age groups prevalence is higher amongst females than males, and the highest prevalence is found among females aged 45-54 years.

Table 2.5.1: Estimated prevalence of CMD by lower tier Local Authority

Local authority	Prevalence of any CMD (rate/1000 pop)	Estimated number of cases
Nottinghamshire County	135.8	86,550
Ashfield	150.9	14,290
Bassetlaw	121.3	11,250
Broxtowe	143.2	13,460
Gedling	147.3	13,620
Mansfield	155.1	12,710
Newark & Sherwood	117.6	10,850
Rushcliffe	115.6	10,360

Source: East Midlands Public Health Observatory, Nottinghamshire Mental Health Needs Assessment 2011

Table 2.5.2: Estimated prevalence of common mental disorders by CCG

Cluster	Prevalence of any CMD (rate/1000 pop)	Estimated number of cases
Bassetlaw	121.3	10,840
Mansfield & Ashfield	153.2	22,670
Newark & Sherwood	121.3	12,540
Nottingham North & East	148.3	17,460
Nottingham West	147.3	11,290
Principia Rushcliffe	115.6	11,420

Source: East Midlands Public Health Observatory, Nottinghamshire Mental Health Needs Assessment 2011

2.5.3. Severe Mental Health Problems among Adults

Severe and enduring mental illness refers to psychosis and includes disorders such as schizophrenia, bipolar disorder and manic depression.

Despite being relatively uncommon, psychotic illness results in high service and societal costs. The World Health Organisation calculates the burden and human suffering associated with psychosis at the family level is exceeded only by dementia and quadriplegia. People with psychotic disorders living in the community are known to have low rates of employment, and when employed, are often in poorly paid and less secure jobs.

Table 2.5.3: Estimated prevalence of psychotic disorders by CCG

Clinical Commissioning Group	Population Total	Estimated prevalence of psychotic disorder at 0.4%
Bassetlaw	109,774	439
Mansfield & Ashfield	182,857	731
Nottingham North & East	144,258	577
Newark & Sherwood	127,201	509
Nottingham West	93,122	372
Principia Rushcliffe	121,560	486
Total	778,772	3115

Source: East Midlands Public Health Observatory, Nottinghamshire Mental Health Needs Assessment 2011

Psychotic illness has a significant effect on the physical health of the individual affected. Life expectancy for people with schizophrenia is, on average, 10 years shorter than the general population. They also experience high rates of obesity, diabetes, musculo-skeletal complaints and cardiovascular disease.⁴⁰⁴¹

The 2007 Survey of Psychiatric Morbidity Among Adults found the prevalence rate for probable psychotic disorder in the year prior to interview (2006) was 0.4%. This is broadly in line with evidence from other studies of the epidemiology of severe mental illness in Great Britain. In men and women the highest prevalence was observed among those aged 35 to 44 years.

Survey data in respect of the prevalence of psychotic illness has not been modelled in the same way as for CMD. As a result any estimation of the local prevalence can be based only on a crude application of the England rate to the Nottinghamshire population. The results of this analysis are presented in Table 2.5.3. However the analysis should be treated with some caution as it takes no account of factors prevailing in particular populations that affect prevalence and, therefore, assumes that each CCG has the same prevalence as the overall England prevalence. This is unlikely to be the case as demographic factors that are associated with psychotic disorder are unlikely to be equally distributed across CCG populations and, as a result, there are likely to be variations in prevalence between CCGs.

⁴⁰ Robson D & Gray R 2007. Serious mental illness and physical health problems: a discussion paper. International Journal of Nursing Studies 44; 457-466

⁴¹ Mitchell A & Malone D 2006. Physical health and schizophrenia. Current Opinion in Psychiatry 19; 432-7

2.5.4. Suicide

In England one person dies every two hours as a result of suicide⁴². For men under 35, suicide is the most common cause of death. There were 333 adult deaths from suicide and injury undetermined in the East Midlands in 2008.

Several factors are known to increase the risk of suicide. These include:

- Gender – men are three times more likely than women to take their own lives
- Age – people aged 40-49 have the highest suicide rate
- Mental illness
- Physically disabling or painful illnesses
- Alcohol and drug misuse
- Prison
- Experiencing a stressful life event e.g. job loss, debt, bereavement and family breakdown.

In 2002 the Department of Health published the first National Suicide Prevention Strategy for England with the aim of reducing the suicide rate. Since then the rate has declined to record low levels. However, periods of high unemployment or severe economic problems are known to be associated with higher rates of suicide⁴³. Given the current economic climate it is important that efforts are sustained to further reduce suicide rates and support those affected by suicide. To this end the Department of Health are due to publish a new Suicide Prevention Strategy for England early in 2012, and the Nottinghamshire and Nottingham Suicide Action Plan should be reviewed in the light of this new national strategy.

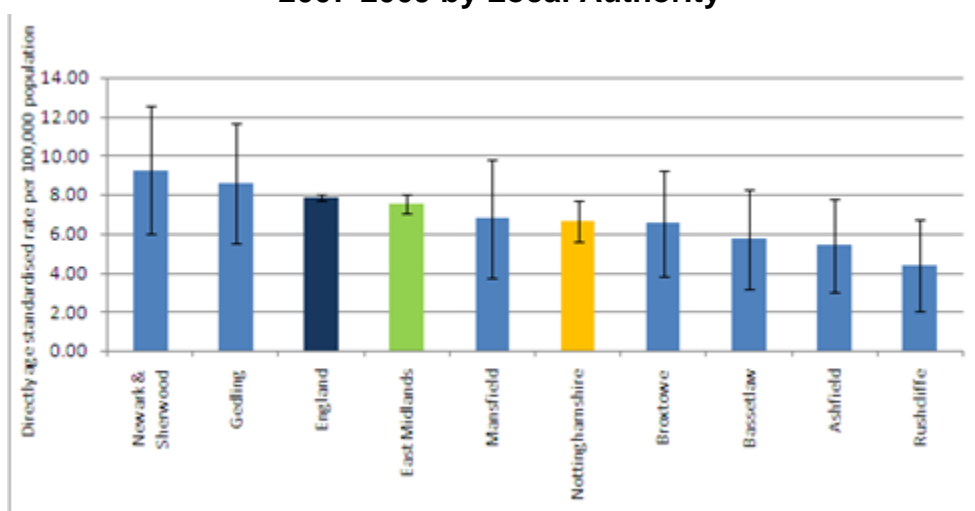
Figure 2.5.4 shows the directly age standardised mortality rate from suicide and injury undetermined for the period 2007–2009 for each of the local authorities in Nottinghamshire, together with the rates for the East Midlands and England. The highest rate was in Newark & Sherwood (9 deaths per 100,000 population), but wide confidence intervals mean that all but one local authorities were not significantly different from the England average. Only Rushcliffe shows any significant difference with a lower rate than both the East Midlands and England.

Figure 2.5.5. shows the mortality rates from suicide and injury of undetermined intent in Nottinghamshire and England for the period 2007-2009 broken down by gender and age group. Of particular note is the difference in the pattern of suicides by age group between Nottinghamshire and England. Nottinghamshire has a higher rate of suicides in those aged 75+ compared to the England average.

⁴² HM Government 2011. Consultation on preventing suicide in England. A Cross-government outcomes strategy to save lives.

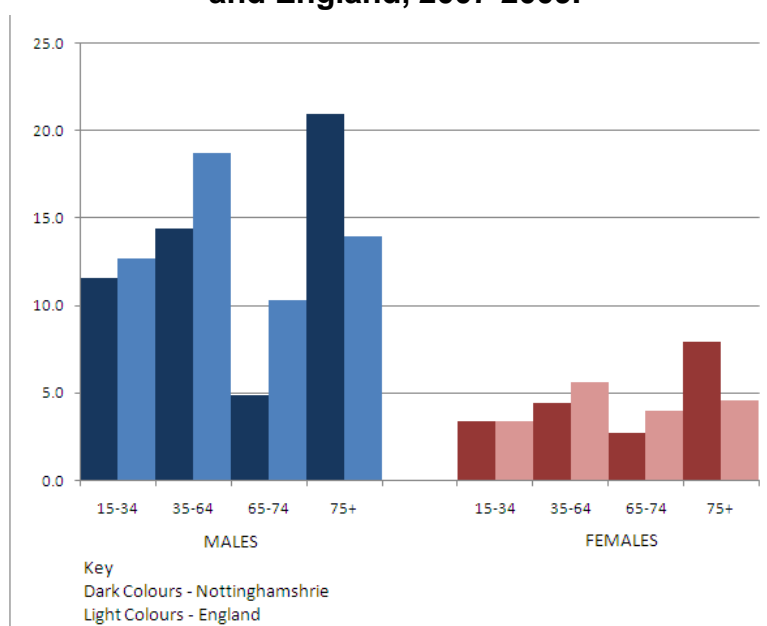
⁴³ Gunnell D, et al 1999. Suicide and unemployment in young people. Analysis of trends in England and Wales, 1921-1995. *British Journal of Psychiatry* 175; 263-270

Figure 2.5.4: Directly standardised mortality rate from suicide in Nottinghamshire, 2007-2009 by Local Authority



Source: Nottinghamshire Mental Health Needs Assessment 2011

Figure 2.5.5: Age and sex specific death rates from suicide in Nottinghamshire and England, 2007-2009.



Source: Nottinghamshire Mental Health Needs Assessment 2011

It is important to remember the absolute numbers of deaths by suicide for older age groups are lower than for younger age groups, but the smaller overall population 75+ results in the lower number of suicides giving a higher rate. This also means that a small reduction in the number of suicides in those aged 75+ will have a greater effect on the rate than the same reduction in numbers of suicides in younger age groups.

2.5.5. Self harm

The term self-harm covers a wide range of behaviours, including habitual self cutting and poisoning. Self-harm is of particular interest because of its power in predicting who

is most likely to go on to commit suicide.⁴⁴ Self harm is also associated with high levels of distress, both for the people engaging in it and for those around them. By its very nature, self harm is a secretive behaviour and so collection of population prevalence data is difficult and is likely to under estimate the scale of the problem.

Self-harm is one of the commonest reasons for A&E attendance in England, but detailed information on the number and pattern of such attendances is very sparse. Hospital Episode Statistics (HES) A&E data (NHS Information Centre) record approximately 100,000 attendances for self-harm annually. However it has been estimated that the actual number could be almost double this with the shortfall being due to case recognition, data completeness and recording.⁴⁵

A recent report scoping the usability of A&E attendance data in the East Midlands⁴⁶ concluded that A&E data are potentially a rich source of information but data quality must improve before robust analyses can be undertaken to inform local work. Overall in the East Midlands in 2008/9 over half of A&E HES attendances did not include a diagnosis code.

Figure 2.5.6 shows the directly standardised rate of hospital admissions for self harm in persons aged 18 and over by District in 2009/10. However it is important to recognise that only a small proportion of people who self-harm are ever admitted to hospital,⁴⁷ and data on admitted patients alone will give a distorted picture of the epidemiology and management of this problem.

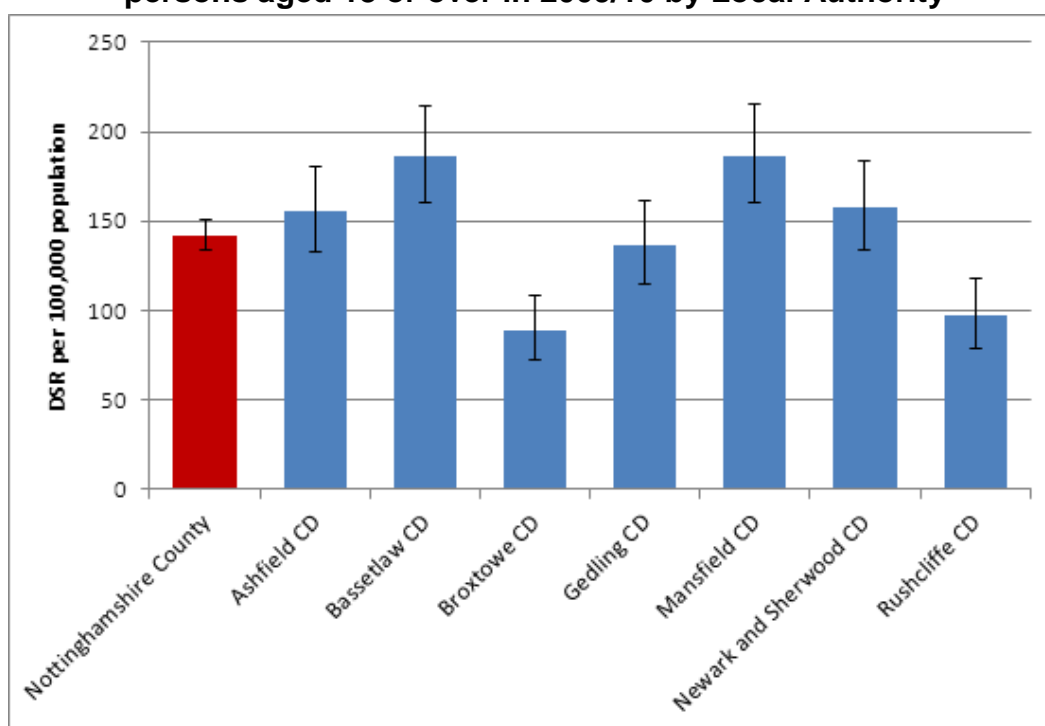
⁴⁴ Owens D, Horrocks J, House A. Fatal and non-fatal repetition of self-harm. Systematic review. *Br J Psychiatry* 2002; 181: 193–199.

⁴⁵ Hawton K, Fagg J, Simkin S, Bale E, Bond A. Trends in deliberate self-harm in Oxford, 1985–1995. Implications for clinical services and the prevention of suicide. *Br J Psychiatry* 1997; **171**: 556–560.

⁴⁶ Alcohol related A&E attendances: A scoping study. EMPHO, 2010, available at: <http://www.empho.org.uk/viewResource.aspx?id=11910>

⁴⁷ Kapur N, House A, Creed F, Feldman E, Friedman T, Guthrie E. Management of deliberate self poisoning in adults in four teaching hospitals: descriptive study. *Br Med J* 1998; **316**: 831–832.

Figure 2.5.6: Directly standardised rate of hospital admissions for self harm in persons aged 18 or over in 2009/10 by Local Authority



Source: Nottinghamshire Mental Health Needs Assessment 2011

2.5.6 Incapacity Benefit, Severe Disability Allowance and Employment Support Allowance Data

Data is available from the Department for Work and Pensions concerning the number of people who claim Incapacity benefit (IBD), Severe Disability Allowance (SDA) and Employment Support Allowance (ESA). All these benefits may be claimed on the basis of “mental or behavioural disorders” and provide an additional, up to date, source of information on Nottinghamshire residents of working age who are unable to work due to mental health problems.

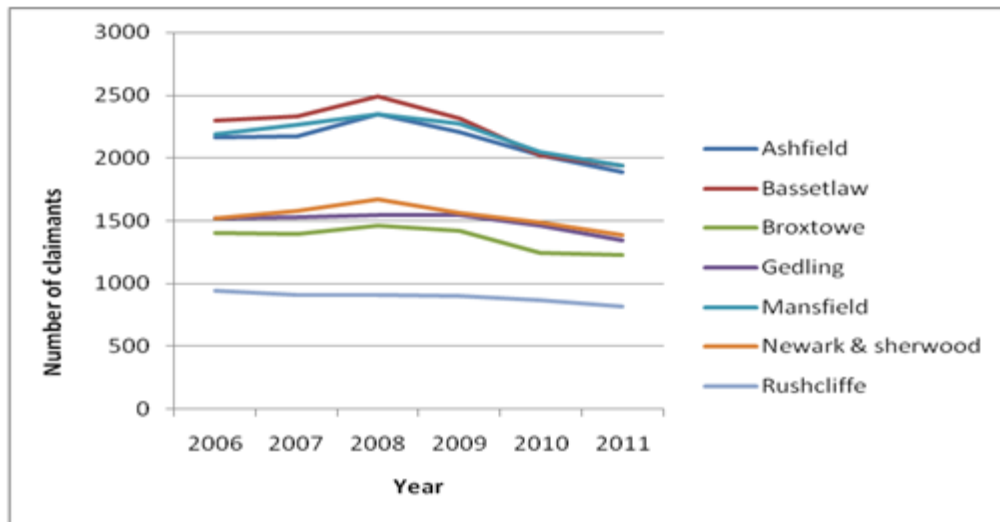
As at May 2011 33,770 people were claiming either IBD, SDA or ESA. This equates to nearly 7% of the working age population⁴⁸. However there is significant variation across the county with Mansfield showing the highest rate at 10.3% and Rushcliffe the lowest at 3.4%. Over 38% of IBD, SDA and ESA claims across Nottinghamshire relate to mental or behavioural disorders.

Data in respect of ESA claimants does not provide the medical reason for the claim prior to 2010. However, such detail is available for IBD/SDA claims and Figure 2.5.7 shows the trend in IBD/SDA claims due to mental or behavioural disorders by district for the period 2006 to 2011.

⁴⁸ NOMIS Official Labour Market Statistics, available at:

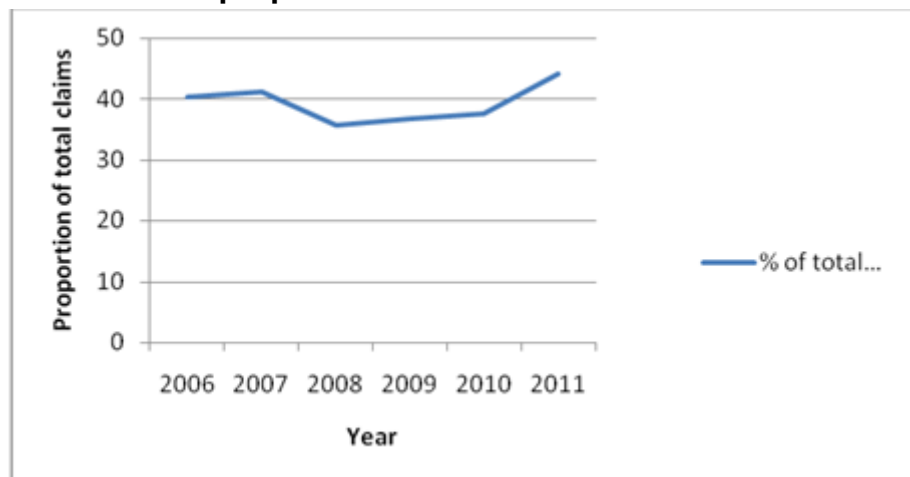
<http://www.nomisweb.co.uk/reports/lmp/la/1967128603/report.aspx#tabwab>

Figure 2.5.7: IBD/SDA claims due to mental or behavioural disorders by Local Authority, 2006 to 2011.



Source: Department for Work and Pensions, Neighbourhood Statistics Data: ward and super output area data zone

Figure 2.5.8 IBD/SDA claims due to mental or behavioural disorders as a proportion of all IBD/SDA claims



Source: Department for Work and Pensions, Neighbourhood Statistics Data: ward and super output area data zone

The data in Figure 2.5.7 show a downward trend in the number of claims for IBD/SDA as a result of mental or behavioural disorders. This reflects an overall reduction in claims for these benefits for all medical causes. However, the number of claims due to a mental or behavioural disorder as a proportion of the total number of IBD/SDA claims is increasing. This is demonstrated in Figure 2.5.8 which shows the number of claims for IBD/SDA due to mental or behavioural disorders as a proportion of all claims for IBD/SDA.

2.6 People in touch with adult social care, health and public protection services

Key Messages

- In 2010-11, 6,783 people aged between 18 and 64 years of age were receiving services from adult social care and health.
- Of these, 5,945 were receiving community-based services in their own homes, 707 were in residential care and 131 were in nursing care.
- The largest categories of people receiving care were those with a physical disability, frailty and/or temporary illness (2,395), people with learning disabilities (2,035) and those with mental ill health (1,502).
- The largest components of care services delivered in 2010-11 were those providing professional support, equipment/adaptations and direct payments.

Introduction

Local authority adult social care departments have a legal duty to assess people's needs for community care services under the NHS and Community Care Act 1990. Eligibility for social care services is determined by the national Fair Access to Care Services (FACS) criteria⁴⁹. In Nottinghamshire since 2011, social care services are offered to people who have a 'substantial' or 'critical' risk of loss of their independence. Prior to April 2011 Nottinghamshire County Council offered services to those people who had a 'moderate' risk of loss of independence, as a result of this change in policy some people may no longer be eligible for social care services. It is therefore difficult to compare data from previous years with the current data and to draw conclusions.

In October 2010 Nottinghamshire County Council also introduced Personal Budgets as part of the Putting People First⁵⁰ programme. "Putting People First concentrating on four main areas: 1) universal services, 2) prevention and early intervention, 3) support close to home, 4) choice and control - self directed support.

Through self directed support, people who have received a community care assessment and have been assessed as eligible for long-term social care services under FACS will be given a personal budget.

Local authorities also provide services that support prevention and early intervention. In Nottinghamshire support can be provided to people prior to a community care assessment for a limited time and to help the individual maximise their independence and regain functioning after a period of illness or a crisis. This is usually through a

⁴⁹ Prioritising need in the context of Putting People First: A whole system approach to eligibility for social care – Guidance on Eligibility Criteria for Adult Social Care, England 2010

⁵⁰ Putting People First: A shared vision and commitment to the transformation of Adult Social Care. HM Government. 2007

reablement type service such as the Short Term Assessment and Reablement Team (START) or intermediate care; Intermediate care is a jointly funded and provided service between health and Nottinghamshire County Council. As reablement services are provided prior to a community care assessment they are not subject to FACS eligibility or fairer charging so are free to the recipient during the period of reablement or rehabilitation.

Adult Social Care, Health & Public Protection - Clients assessed and in receipt of social care services

The figures in the following tables show numbers of adults aged 18-64 identified in care groups for reporting purposes – i.e. physical disability, frailty and sensory impairment, mental health, vulnerable people, learning disability and substance misuse who were assessed and found to be eligible under FACS. The figures show that in 2010-11, a total of 6,783 adults were receiving services from adult social care. Of those, 5,945 adults were receiving 'community based services', a broad category that includes direct payments, professional support (care management), equipment and adaptations, respite care, meals at home, day care and home care. 707 people were living in residential care homes and 131 in residential homes with nursing.

The largest care group amongst the 18-64s is those with a physical disability, frailty or temporary illness (2667) followed by learning disability (2035) and mental health (1502).

Information around assessment of clients give an indication of demand for services but it is likely that there are people living in Nottinghamshire who may be eligible for services but who are not accessing them. This is known as unmet needs. Understanding the level and characteristics of unmet need can help inform targeting of services towards those who need them most. It is difficult to assess unmet need for adult social care and is a current gap in our knowledge.

Table 2.6.1, showing data taken from the CSSR's internal systems used for the RAP (Referrals, Assessments and Packages of Care) returns for 2010-11, gives the total and breakdown of numbers of new and existing clients for Nottinghamshire assessed between April 2010 and March 2011.

Tables 2.6.2, 2.6.3 and 2.6.4 (in a similar manner to Table 2.6.1) show differing cuts of the RAP returns: Primary Client Group cut by service type (Nursing, Residential, Community based) and components of service (Home care, Day care, Meals) and (short term not respite, direct payments, professional support, equipment and adaptations and other).

It should also be pointed out that support is offered in other ways and through other routes; in 2010-11 for example, Nottinghamshire County Council provided funding to 134 voluntary sector organisations which provide services to adults across Nottinghamshire. The total funding was £2,251,287 which was split between organisations that provide services to all adults (47%) and specific service user groups;

physical disability and sensory impairment (24%), vulnerable adults (20%), mental health (5%), learning disabilities (2%) and substance misuse (1%).

Table 2.6.1: Number of new clients (18-64 age group) for whom assessments were completed in 2010-11, by primary client type

Primary client type	Some or all (new) services intended or already started (inc. those started and finished)	No (new) services offered or intended to be provided	(New) service(s) offered but declined
Physical Disability, Frailty and Sensory Impairment (total)	1215	113	2
Of which: Physical disability, frailty and/ or temporary illness	628	55	1
Hearing impairment	11	0	0
Visual impairment	31	3	0
Dual sensory loss	1	0	0
Mental Health (total)	87	16	20
Of which: Dementia	15	5	0
Vulnerable People (total)	96	21	1
Learning Disability (total)	46	5	0
Of which: Autism	5	0	0
Aspergers	28	7	0
Substance Misuse	4	2	1
Total of above	1476	164	24

Source: Nottinghamshire RAP Returns 2010-11

Table 2.6.2: Clients aged 18-64 receiving services during the period, provided or commissioned by the CSSR, by primary client type, service type, April 2010 – March 2011.

Primary client type	Total of clients	Community based services in own home	Residential Care	Nursing Care
Physical Disability, Frailty and Sensory Impairment (total)	2,667	2,523	70	74
Of which: Physical disability, frailty and/ or temporary illness	2,395	2,259	64	72
Hearing impairment	47	46	1	0
Visual impairment	205	198	5	2
Dual sensory loss	20	20	0	0
Mental Health (total)	1,502	1,394	85	23
Of which: Dementia	58	41	13	4
Vulnerable People	330	319	7	4
Learning Disability (total)	2,035	1,472	533	30
Of which: Autism	127	84	43	0
Aspergers	208	196	12	0
Substance Misuse	41	41	0	0
Total of above	6,783	5,945	707	131

Source: Nottinghamshire RAP Returns 2010-11

Table 2.6.3: Number of clients receiving community-based services, provided or commissioned by CSSR, by components of service, primary client type (18-64 year olds), April 2010 – March 2011.

Primary client type	Total of clients	Home Care	Day Care	Meals
Physical Disability, Frailty and Sensory Impairment (total)	2,523	539	507	29
Of which: Physical disability, frailty and/ or temporary illness	2,259	521	453	27
Hearing impairment	46	6	17	1
Visual impairment	198	10	32	1
Dual sensory loss	20	2	5	0
Mental Health (total)	1,394	73	591	15
Of which : Dementia	41	6	4	3
Vulnerable People	319	66	70	9
Learning Disability (total)	1,460	560	923	5
Of which: Autism	127	8	12	0
Aspergers	208	60	23	0
Substance Misuse	41	0	5	0
Total of above	5,945	1,298	2,119	58

Source: Nottinghamshire RAP Returns 2010-11

Table 2.6.4: Number of clients receiving community-based services during period, provided or commissioned by the CSSR, by components of services, primary client type and age group (18-64 year olds), April 2010 – March 2011.

Primary client type	Short term residential not respite	Direct payments	Professional support	Equipment and adaptations	Other
Physical Disability, Frailty and Sensory Impairment (total)	56	745	1,347	1,237	287
Of which: Physical disability, frailty and/ or temporary illness	53	692	1,290	1,139	124
Hearing impairment	0	12	27	28	6
Visual impairment	2	34	27	58	141
Dual sensory loss	1	7	3	12	16
Mental Health (total)	6	58	855	61	33
Of which : Dementia	2	8	37	11	2
Learning Disability (total)	252	307	948	156	357
Of which: Autism	13	18	16	3	17
Aspergers	1	23	86	0	2
Substance Misuse (total)	16	0	25	2	0
Vulnerable People (total)	7	40	219	79	16
Total of above	337	1,150	3,394	1,535	693

Source: Nottinghamshire RAP Returns 2010-11

2.7. Homeless People

Key messages

- The levels of homelessness recorded in the annual Nottinghamshire Homeless Watch surveys have been reducing every year since 2005, but have risen again in 2011.
- 264 people presented as homeless to agencies in Nottinghamshire (excluding Nottingham City) during the two week survey period in 2011.
- The highest numbers (72%) were in the 18-40 age groups, although 22% were aged between 41 and 59. The majority of those presenting as homeless were males (62%).
- More homeless people with dependents presented as homeless in 2011 than in 2010 (189 children were homeless in 2011, compared to 135 in 2010).
- Many people presenting as homeless report having other problems, such as domestic violence, having a history of being in care or being an ex-offender, and having drug or alcohol problems.
- The Supporting People budget will reduce over the next three years by almost 50%, so the number of bed spaces and floating support places will reduce accordingly, potentially impacting on the numbers of homeless people.

The best sources of information regarding homelessness in the county are the regular Homeless Watch surveys commissioned by the local authorities in Nottinghamshire for the previous seven years. The last of these surveys was undertaken between the last week of September and the first week of October 2011 and the results have now been published. 561 individuals presented as homeless in Nottinghamshire County and City overall. District councils also publish homelessness statistics which can be accessed via each district council housing department.

For the purposes of the survey and report, homeless people are defined as those people presenting to agencies that were sleeping rough, sleeping on a friend's floor for a few days or staying temporarily with relatives.

Table 2.7.1: Area in which respondents presented versus area they reported a local connection.

Connection to → ----- Presented in ↓	City and County	County	No reply	Ashfield	Gedling	Nottingham City	Bassetlaw	Mansfield	Rushcliffe	Broxtowe	Newark & Sherwood	Out of Notts
City County and	561	241	53	42	16	248	55	59	14	12	43	45
County	246		23	40	3	26	54	55	10	8	37	17
No reply	10	2	2	0	0	4	0	0	0	0	0	5
Ashfield	38	38	1	35	0	0	0	3	0	0	0	1
Gedling	3	3	0	0	3	0	0	0	0	0	0	0
Nottingham City	297	32	28	3	13	221	1	3	4	4	4	26
Bassetlaw	60	58	0	0	0	0	54	2	0	0	2	2
Mansfield	60	57	3	5	0	3	0	50	1	0	1	2
Rushcliffe	40	10	17	0	0	16	0	0	9	0	1	0
Broxtowe	8	8	0	0	0	1	0	0	0	8	0	0
Newark & Sherwood	37	33	0	0	0	2	0	0	0	0	33	7

Source; Nottinghamshire Homeless Watch Survey 2011

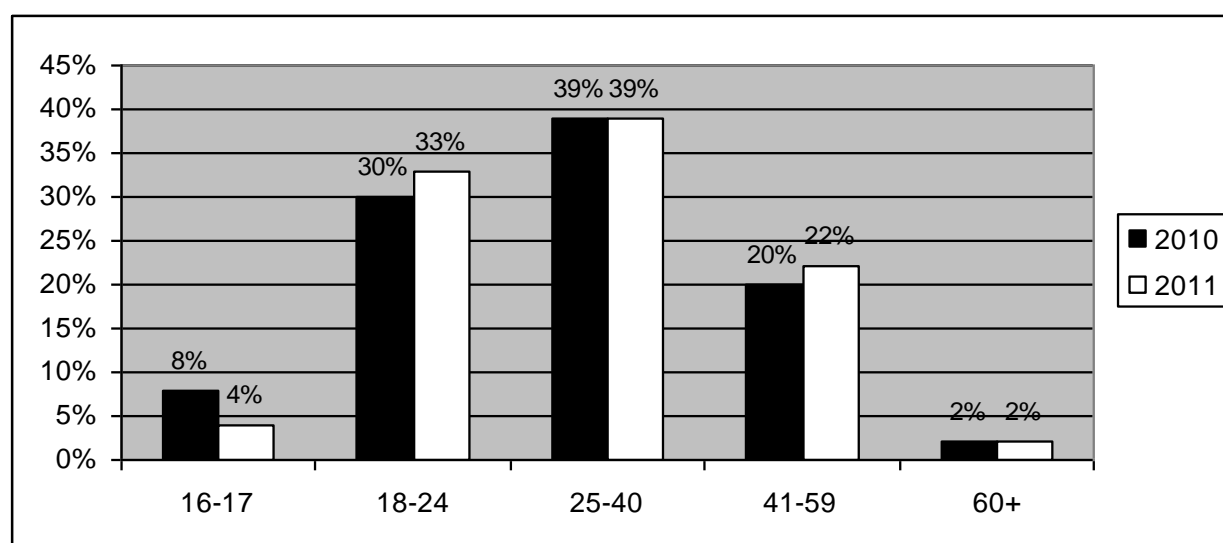
264 people presented as homeless to agencies in Nottinghamshire but only 224 had a local connection to the county whereas 17 had a local connection outside of the county and 23 had a local connection with Nottingham City e.g. of the 40 who presented in Rushcliffe 16 said that they were connected to the City and another 17 did not say where they were connected to (suggesting that a large number were visiting Rushcliffe to use the services at a well-regarded drop-in centre for the homeless, and do not reside there). Conversely 32 people who presented in the City actually had a local connection to Districts and Boroughs in the county e.g. 13 were from Gedling.

Apart from the city the most presentations were in Mansfield and Bassetlaw (60 each). Only 11 people presented in Broxtowe and Gedling together.

The majority of those presenting as homeless were males (62%). In Mansfield and Rushcliffe there were a higher proportion of men whilst in Newark % Sherwood and Broxtowe there was a higher population of women.

The highest numbers (72%) were in the 18-40 age groups although 22% were aged between 41 –59.

Figure 2.7.2: Age profile of respondents: 2010 and 2011.



Source: Nottinghamshire Homeless Watch survey 2011

Table 2.7.3: Support needs 2009, 2010 and 2011

	2009	2010	2011
Alcohol Abuse	21%	20%	22%
Ex-Offender	13%	19%	22%
Drug Abuse	19%	18%	21%
Mental Health	14%	13%	19%
Domestic Violence	11%	11%	11%
Learning Difficulties	4%	5%	8%
Physically Disabled	3%	5%	6%

Source: Nottinghamshire Homeless Watch survey 2011

More homeless people with dependents presented as homeless in 2011 than 2010 ie 189 children were homeless in 2011 whilst in 2010 it was 135 children.

Only 30% of those presenting reported that they had no support needs at all with the remaining 70% reporting a variety of needs the most prevalent of them being related to alcohol abuse, being an ex offender, drug abuse and mental health problems. All of these have increased over the last 2 years. Domestic violence which is almost exclusively reported by women remains an ongoing issue at 11% each year. Men report a much higher prevalence of having support needs than women i.e. 79% of men said they had support needs and 57% of women. Drug abuse and ex offender support needs were reported most widely in Mansfield, mental health needs in Bassetlaw and alcohol abuse in Rushcliffe.

Table 2.7.4 Number of spaces for service users of short term Supporting People services in Nottinghamshire.

Client Type	Accommodation Based Service	Floating Service	Support
-------------	-----------------------------	------------------	---------

Generic	0	232
Offenders or People at risk of Offending	84	85
Older people with support needs	0	45
People with Alcohol Problems	0	40
People with Drug Problems	38	55
People with Learning Disabilities	4	0
People with Mental Health Problems	0	310
Single Homeless with Support Needs	205	272
Teenage Parents	28	0
Traveller	0	24
Women at Risk of Domestic Violence	42	76
Young People at Risk	234	67
Total	635	1206

Source: Nottinghamshire Homeless Watch survey 2011

There has been a reduction in rough sleeping (37) reported throughout the county since 2010 (66) except in Rushcliffe where it has increased from 7 to 17. Rough sleepers have a much higher prevalence of support needs than non rough sleepers particularly around alcohol abuse and being an ex offender. There is a higher incidence of first time rough sleeping this year.

Table 2.7.4 above shows the number of bed spaces that are available in short term (temporary) services and the number of support places available in floating support services.

Floating support services support people to remain living in their own home, which is usually rented but can be owner occupied. They offer advice and guidance on eviction proceedings, debt, tenancy management, independence skills such as managing money, domestic skills, training, employment and other services. Some of the floating support services offer 'drop-in' or surgeries to meet people where they offer advice and support instead of home visits.

The Supporting People budget will reduce over the next 3 years by almost 50% so the numbers of bed spaces and floating support places will reduce accordingly which may impact on the numbers of homeless people.

2.8. Carers

Key Messages

A carer is someone, who, without payment, provides help and support to a partner, child, relative, friend or neighbour, who could not manage without their help. This could be due to age, physical or mental illness, addiction or disability.

- 83,000 carers identified themselves in the 2001 census, with approximately 26,000 of those classed as providing 20 hours or more of regular and substantial care.
- Nottinghamshire has a higher proportion of carers in the population than the England average, with most aged between 35 and 59.
- According to Nottinghamshire carers who took part in a 2009/10 survey, there was overall satisfaction with services received from the Local Authority. However, 10% expressed dissatisfaction with support or services and 29% found it difficult to find information and support.
- Around 50% of carers in England experience problems with health because of caring duties, as well as stress, disturbed sleep and irritability and 60% anticipate the amount of time spent caring will increase in the next five years.
- In terms of met need, the older population of carers have the highest levels of support. There may be issues of support for younger carers.
- According to predictions about the ageing population and the increase in morbidity related to old age, it is anticipated that there will be a concurrent increase in the number of carers and also in the number of older carers.

This chapter defines a 'carer', describes the Government's priorities and identifies the number of carers and amounts of caring at a local level. It also provides details of the carer experience as defined by carers ('Survey of Carers in Household 2009-10'), and also how many Nottinghamshire carers are using Local Authority services.

The next section concentrates on carers evaluating the services they are receiving from County Council services. The final section defines the Outcomes Framework which includes a number of specific measures, which have been agreed to be of value both nationally and locally. The measures are collected via the biannual Carers Survey.

Introduction

Who is a carer?

A carer is someone, who, without payment, provides help and support to a partner, child, relative, friend or neighbour, who could not manage without their help. This could be due to age, physical or mental illness, addiction or disability.

A young carer is a child or young person under the age of 18 carrying out significant caring tasks and assuming a level of responsibility for another person, which would

normally be taken by an adult. More information can be found about young carers in the Children and Young People's Chapter of the JSNA.

Anyone can become a carer; carers come from all walks of life, all cultures and can be of any age. Many carers do not consider themselves to be a carer, they are just looking after their mother, son, or best friend, just getting on with it and doing what anyone else would in the same situation.

What do carers do?

- Give practical, physical and emotional support to vulnerable people
- Support the person they care for with problems caused by short or long term illness or disability
- Keep the people they care for safe
- Their caring responsibilities may change and may be difficult to predict from day to day.

Why do carers need support?^{51 52}

Taking on a caring role can mean facing a life of poverty, isolation, frustration, ill health and depression. Many carers give up an income, future employment prospects and pension rights to become a carer. Many carers also work outside the home and are trying to juggle jobs with their caring responsibilities. The majority of carers struggle alone and do not know that there is help available to them. Carers say that access to information; financial support and breaks in caring are vital in helping them manage the impact of caring on their lives.

National and local strategies and drivers

Key messages from the National Carers' Strategy: 'Carers at the heart of 21st century families and communities' are summarised below.

All carers who provide regular and substantial care have a right to an assessment of need to identify what support they may require to help maintain their physical, mental and emotional well being, their social needs, and to ensure they are able to have fulfilled lives outside of their caring responsibilities. Flexible and responsive services need to be available to carers to enable and support them to continue in their caring role and to be prepared to adjust to a non-caring role if the person they care for dies. Carers who provide regular and substantial care may be eligible to receive carers' services funded via the local authority or by the NHS. Additionally, Carers who provide low levels of support or those who care for people who are self funding will benefit from information and signposting so that they can directly commission their own support including prevention and early intervention services.

⁵¹ The Princess Royal Trust for Carers [online]. 2005-2008 [cited 2008 Mar]. Available at: <http://www.carers.org/>

⁵² Caring Together: Nottinghamshire County Council Strategy for Carers 2007/09 [online]. 2007 July [cited 2008 Mar]. Available at: http://www.nottinghamshire.gov.uk/home/social_care/carers/carersstrategy.htm

Young adult carers aged up to 24, are particularly at risk, and may be adversely affected in terms of their life chances and opportunities because of their caring role (see Children's chapter for further details).

The national strategy seeks to ensure that carers themselves have choice and control over the support they receive in order help them manage the impact of caring and also to improve their quality of life.

The national strategy was refreshed in 2010, entitled, "Recognised, valued and supported: next steps for the Carers' Strategy". Four priority areas were identified:

1. Supporting those with caring responsibilities to identify themselves as carers at an early stage, recognising value of contribution & involving them from the outset both in designing local care provision & in planning individual care packages
2. Enabling those with caring responsibilities to fulfil their educational & employment potential
3. Personalised support for both carers & those they support, enabling them to have a family & community life
4. Supporting carers to remain mentally & physically well

Local authorities' responsibilities under The Carers (Equal Opportunities) Act⁵³.

The Carers (Equal Opportunities) Act came into force in April 2005 and is intended to provide a firm foundation for better practice by councils and the health service. It builds on existing legislation and support for carers by:

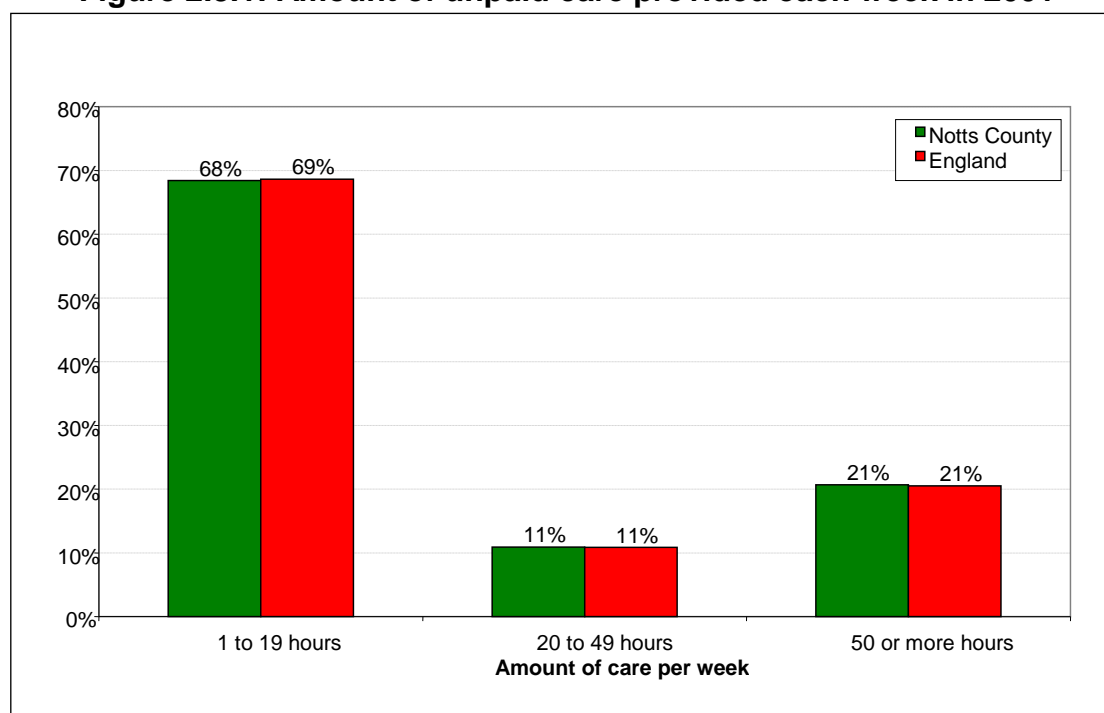
- placing a duty on local authorities to ensure that all carers know that they are entitled to an assessment of their needs
- placing a duty on councils to consider a carer's outside interests (work, study or leisure) when carrying out an assessment
- promoting better joint working between councils and the health service to ensure support for carers is delivered in a coherent manner

Number of carers locally

There are no recent data on the numbers of carers in Nottinghamshire; the following figures are from the 2001 census and will be updated on release of the 2011 Census data.

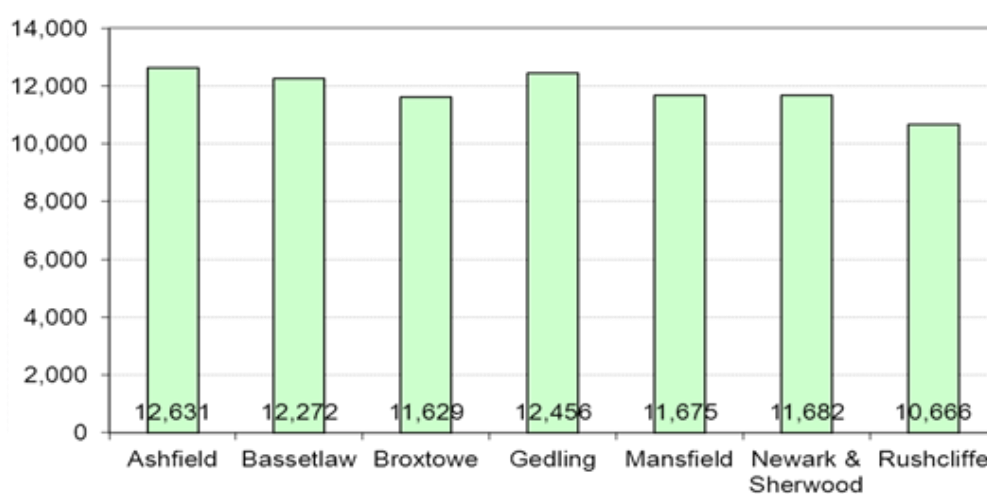
⁵³ 3. Great Britain. Carers (Equal Opportunities) Act 2004. Chapter 15. London: HMSO; 2004. Available from: http://www.opsi.gov.uk/acts/acts2004/ukpga_20040015_en_1

Figure 2.8.1: Amount of unpaid care provided each week in 2001



Source: Census 2001

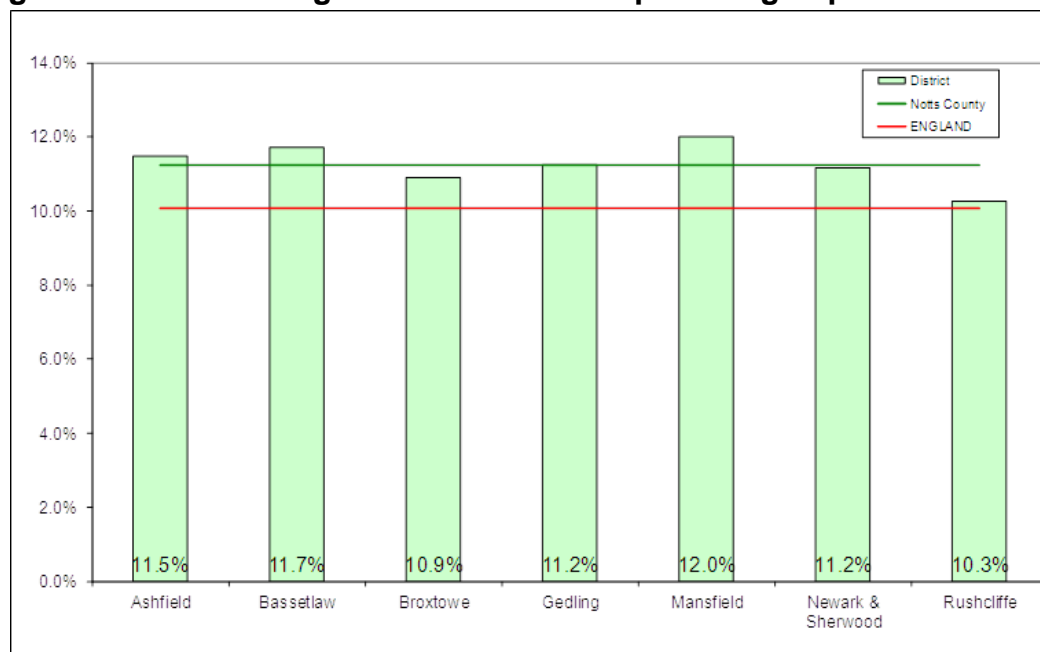
Figure 2.8.2: Number of residents providing unpaid care



Source: Census 2001

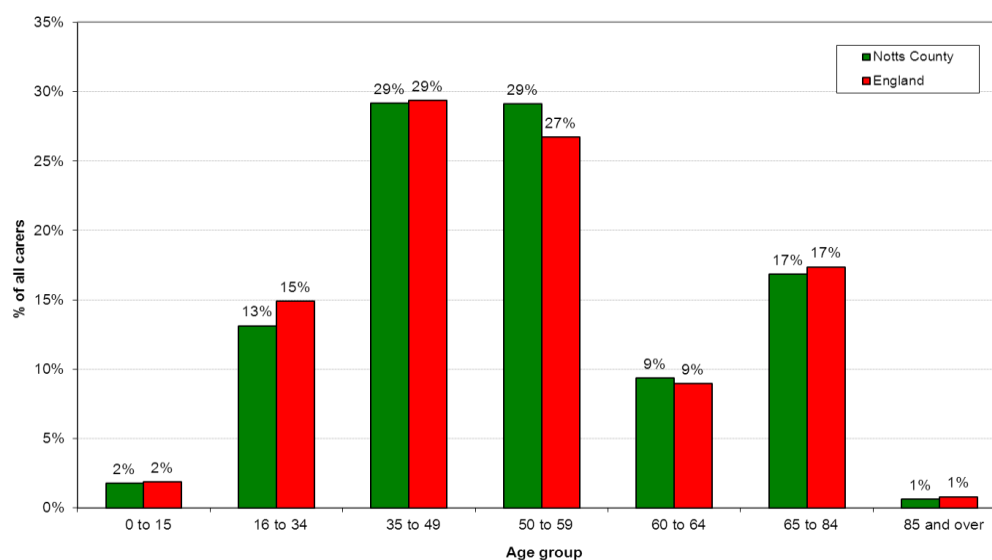
The 2001 Census asked people about the amount of time they spend each week providing unpaid care. There were over 83,000 carers in Nottinghamshire with almost one third providing more than 20 hours of care each week (Figure 2.8.1). Figures 2.8.2 and 2.8.3 show that although Ashfield had the largest number of people providing unpaid care, Mansfield had the highest proportion of carers in the population. Nottinghamshire had a higher proportion of carers than England. Most carers in Nottinghamshire were aged between 35 and 59 (Figure 2.8.4).

Figure 2.8.3: Percentage of adult residents providing unpaid care in 2001



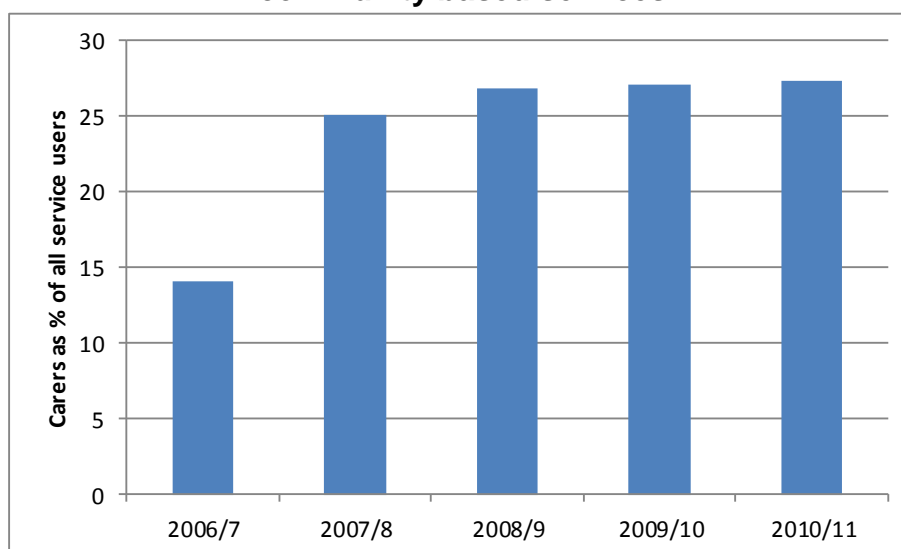
Source: Census 2001

Figure 2.8.4: Percentage of carers in Nottinghamshire by age group in 2001



Source: Census 2001

Figure 2.8.5: Carers receiving services as a % of overall service users receiving community based services



Source: Nottinghamshire RAP Returns 2010-11

The Carer experience of Caring

The national survey 'Survey of Carers in Household 2009-10' was published by the NHS Information Centre in 2010⁵⁴. The key findings were:

- Around 50% of carers in England experience problems with health because of caring duties
- Nearly 33% of estimated 5 million carers in England feel stressed
- 25% have disturbed sleep
- 33% are left tired from caring
- 20% say they are short-tempered or irritable due to their duties
- 60% anticipate the amount of time spent caring will increase in the next 5 years
- 11% of carers receive Carer's Allowance, rising to just under a quarter for those caring for more than 35 hours a week

Carers receiving services

The table below shows the total number of people having received a carers' assessment or review leading to a carers service or advice and information expressed as a percentage of the total number of service users having received a community based service during the report year.

A community based service is one provided to service users living in their own home (non-residential) paid for fully or partly by Adult Social Care and following a community assessment. These include those services arranged by the local authority as well as direct payments made to service users to enable them to arrange their own services.

⁵⁴ The Health and Social Care Information Centre, *Survey of Carers in Household 2009-10*, 2010. Available at: <http://www.ic.nhs.uk/pubs/carersurvey0910>

Table 2.8.6: Number of carers receiving different types of services provided as an outcome of an assessment or review, by age group of carer and comparison of carers in the Nottinghamshire population

Age group of carer (years)	Services including respite for the carer and/ or other carers' specific services	Information and advice only	Number of carers in Notts by age group	% of carers in Notts receiving services/ information and advice by age group
Under 18	3	3	2194	0.3%
18-64	613	2,130	66324	4.1%
65-74	263	1,107	9802	14.0%
75 and over	299	675	4707	20.7%
All ages	1,178	3,915	83027	6.1%

Source: Nottinghamshire RAP Returns 2010-11

Source: Census 2001

Table 2.8.7: Number of carers receiving different types of services provided as an outcome of an assessment or review, by primary client group of person cared for by carer (cared for person being between 18-64 years of age).

Primary client group of person cared for by the carer	Services including respite for the carer and/ or other carers' specific services	Information and advice only
Physical Disability, Frailty and Sensory Impairment	219	464
Mental Health	128	366
Learning Disability	47	452
Aspergers	5	22
Substance Misuse	1	1
Vulnerable People	17	32
Total of above	417	1,337

Source: Nottinghamshire RAP Returns 2010-11

According to predictions about the ageing population and the increase in morbidity related to old age, it is anticipated that there will be a concurrent increase in the number of carers and also in the number of older carers.

The next section concentrates on carers evaluating the services they are receiving from County Council services. This shows an overall satisfaction of services received from the Local Authority, including support, services and information and advice. 10% expressed dissatisfaction with support or services and 29% found it difficult to find information and support. The final section defines the Outcomes Framework which includes a number of specific measures, which have been agreed to be of value both nationally and locally. The measures are collected via the biannual Carers Survey.

National User Experience Survey 2009-10: Caring for Others

This survey was sent in November 2009 to a random selection of Nottinghamshire carers, aged 18+, who had been assessed or reviewed, either separately or jointly with the cared for person, by Adult Social Care and Health during the previous 12 months.

- 90% of respondents were satisfied with the support or services they received from Adult Social Care and Health in the last 12 months with 10% of service users expressing dissatisfaction.
- 73% of respondents said they had the right amount of support or services, in terms of hours or days needed. 26% said they needed more hours or days and 1% said they had too many hours or days.
- When asked to rate the quality of your life as a whole, 82% said it was alright or good. 18% said their quality of life was bad.
- 71% said they found it easy to find information and advice about support, services or benefits. 29% had found it difficult.
- 93% said the information and advice they had received was helpful. 7% had found it unhelpful.

Department of Health Outcomes Framework

The national social care outcomes framework includes a number of specific measures, which have been agreed to be of value both nationally and locally. The following measures are collected via the biannual Carers Survey and show the local data received for Nottinghamshire (shown in the 'Notts Figure' column).

Table 2.8.8: Department of Health Adult Social Care Outcomes aligned with Carers Survey responses for Nottinghamshire

Measure	Definition	Source	Notts figure	Max Score
1D Carer reported quality of life	This is a composite measure which sums responses to 7 questions measuring different aspects of quality of life, with equal weight given to each question. The 7 questions cover: value and enjoyment, time and space to be yourself, control time to look after yourself, worries about personal safety, social contact, encouragement and support.	Carers Survey 2009-10	15.7 (75%)	21 (100%)
3B Overall satisfaction of carers with social services	Those that answered they were extremely or very satisfied in response to the question "How satisfied are you with the care and support services that you receive?"	Carers Survey 2009-10	57.1%	100%
3C The proportion of carers who report that they have been included or consulted in discussion about the person they care for	Those that answer "always" to the question "In the last 12 months, do you feel you have been involved or consulted as much as you want to be, in discussion about the support or services provided to the person you care for?"	Carers Survey 2009-10	45.3%	100%
3D The proportion of people who use services and carers who find it easy to find information about services	This is a combination of answers from the Adult Social Care survey 2010-11 and the Carers survey 2009-10 - those that answered very (or fairly) easy in response to the question "In the past year have you found it easy or difficult to find information or advice about support services and benefits?"	Adult Social Care Survey 2010-11 and Carers Survey 2009-10	73.9%	100%

Sources: DH ASCOF (Adult Social Care Outcomes Framework), Adult Social Care survey 2010-11, Carers Survey 2009-10

2.9. Gypsies and Travellers

Key messages

- Evidence for the Nottinghamshire community is poor due to lack of monitoring, but nationally there is clear evidence of general worse health for Gypsy and Traveller communities, including significantly higher pregnancy/infantile and young age death due to lack of access to healthcare
- In 2007 there were 1,479 Gypsies and Travellers living in 448 households. Most of these households, 256, were located in Newark and Sherwood
- 34% of people lived on authorised sites, 15% on unauthorised sites and 50% in housing
- In 2007 it was identified that around 120 additional permanent pitches would be needed to meet existing needs. In 2010, 37 additional private pitches had been created but the need for the additional pitches remains
- A study of the health needs of travellers in Newark and Sherwood showed that Gypsy and Traveller communities were:
 - o more likely to suffer from lung cancer, COPD, CHD and Mental Illness.
 - o more likely to experience accidents
 - o more likely to access health care inappropriately
 - o less likely to access preventative health care (e.g. immunisations)

Nottinghamshire has substantial numbers of gypsies and travellers living within the county. Two local reports into the needs of travellers have been commissioned and delivered and these give an insight into the numbers of people, families and households as well as the accommodation and health needs of the travelling community.

Section 8 of the 1985 Housing Act required local authorities to consider accommodation needs in their areas and to carry out periodic reviews of these needs. Additionally, Sect 225 of the 2004 Housing Act introduced a specific requirement for local authorities to assess the accommodation needs of gypsies and travellers within their areas.

Nottinghamshire local authorities including Nottingham City (but excluding Bassetlaw) commissioned a study, the Gypsy and Traveller Accommodation Needs Assessment, undertaken by Tribal consultants in 2007; this study revealed that in the seven authorities:

- there was an estimated population of 1479 in 448 households
- that 508 of the above were estimated to be living on authorised sites, 746 in housing, 172 on unauthorised developments and 53 in unauthorised encampments
- Newark and Sherwood had the highest numbers of households – 256, with Nottingham having 94, Ashfield 48, Gedling 26 and Rushcliffe 14; other authorities had numbers in single figures

Based on Government guidance issued by Communities and Local Government, the study established the need for between 109 and 119 new permanent pitches to meet the current backlog and the needs of newly forming households in the study area over the next 5 years. The report also estimated that projecting figures of need forward, there would need to be provision for 490 households by 2010 and 602 by 2017.

April 2010 Update of the Nottinghamshire Gypsy and Traveller Accommodation Assessment compiled by the Countywide Gypsy and Traveller Monitoring Issues Group showed a total of 47 pitches have been created since the 2007 report but a need for 118 pitches still remains of the 165 pitch requirement (this includes all Districts including Bassetlaw). No new public provision has been made with the pitches gained being private family sites.

Communities and Local Government Department compile a bi-annual Traveller Caravan Count which gives a snapshot picture of all Traveller caravans on both authorised and unauthorised sites- most recent published figures for January 2011 give a total of 261 caravans for Nottinghamshire including Nottingham City.

A study on travellers was undertaken on behalf of Newark and Sherwood PCT in July 2004 by Dr Arun Patel, Rosemary George and Fiona Fish. This study, Health Needs Assessment for Travellers in Newark and Sherwood, had the following objectives:

- to compare the mortalities and morbidities of travellers with a settled deprived population (Clipstone)
- to obtain information on utilisation of primary and secondary care health services by travellers
- to obtain service providers' and travellers' views on barriers that travellers face to full utilisation of health services
- to identify lifestyle and cultural factors which threaten or enhance the health of travellers
- to obtain stakeholders' and travellers' views on ways to address the identified needs
- to conduct discussion sessions with stakeholders/service providers in order to plan and develop appropriate services that meet identified health needs of travellers.

The research undertaken involved; obtaining travellers' health information from health services and particularly from Lombard Street Surgery in Newark and Newark Hospital; a survey of traveller families living in Tolney Lane and at New Ollerton; surveys and face-to-face interviews with service providers and focus group discussions with traveller women.

The main findings of the research included identification of the following problems:

- travellers had higher mortality and morbidity rates due to lung cancer and COPD
- high CHD related morbidity
- there were higher rates of mental ill health
- the relatively unsafe environment experienced by travellers led to high accident rates and trauma
- there was inappropriate access to health services and lack of a community of care
- there was poor experience of health services and poor uptake of health promotion services such as screening and immunisation
- high rates of DNAs for hospital appointments
- lack of health data recording for travellers locally
- poor access to water and sanitation
- men in particular had poor awareness of and were unwilling to address health and health problems.

In terms of the standardised mortality rate (all ages) the rate for travellers (1403 per 100,000), was found to be almost double that found in Clipstone (773) which was in turn higher than that in Newark and Sherwood as a whole (707).

The living environment experienced by travellers clearly affected health and well-being; many traveller families lacked basic sanitary facilities such as private toilets (29%) and baths (34%); 32% of families reported that their children had experienced accidents at home or in play areas; 39% of families reported limiting long term illness.

The report said that many respondents said they had difficulties in accessing services and that this was often due to the perceived prejudice of some service providers but was sometimes due to their own lack of knowledge. There was reasonable access to health and education services but it was felt that other services were more difficult to access.

2.10 Health of Prisoners

Key messages

- There are three adult male closed prisons in Nottinghamshire, with a total prisoner population of approximately, 2,820 prisoners. Around 4,000 people will pass through the Nottinghamshire prisons in a year.
- There is a higher proportion of Black and Minority Ethnic groups in prison in Nottinghamshire than in the general county population.
- A 2011 Nottinghamshire prisoner survey reported a high prevalence of mental health problems (up to 21%) in prisoners. (Nationally 10% of men and 30% of women have had a previous psychiatric admission before they come into prison.)
- There are also high levels of alcohol and drug misuse in Nottinghamshire prisoners, 31% and 44% respectively, and nearly half (49%) of prisoners currently smoke.
- There is a predicted high prevalence of learning disabilities, but no data available at present (national data indicates that 20-30% of prisoners have learning disabilities or difficulties).
- Local commissioning priorities for 2012/13 include dental waiting times; improved learning disabilities pathways and access to health services; alcohol interventions; access to dual diagnosis services (for both a mental health problem and substance misuse issues); access to 40+ years health checks and management of long term conditions; and improved uptake of sexual disease screening.

Introduction

The prison population has different health to the general public. They are more likely to have poorer physical, mental and social health than the general public and suffer from conditions associated with offending, such as substance misuse.

This chapter is based on the Nottinghamshire prisons Health Needs Assessments (HNA) and the Substance Misuse Needs Assessments (NA) carried out by NHS Nottinghamshire and NHS Bassetlaw Public Health Directorate in 2010/11 and 2011/12. These reports will be added to the JSNA website.

2.10.1 Who is at risk and why?

There are three adult male closed prisons in Nottinghamshire with a total prisoner population of approximately, 2,820 prisoners⁵⁵, detailed in Table 2.10.1. Around 4,000 people will pass through the Nottinghamshire prisons within a year.

⁵⁵ Ministry of Justice. Prison Finder, available at:

http://www.justice.gov.uk/global/contacts/noms/prison_finder/East%20Midlands.htm

Table 2.10.1: Nottinghamshire County Prisons by Category

Establishment	Prison Category	Operational Capacity	Operational Contract	Healthcare Commissioners
HMP Whatton	C closed adult male training	841	State run prison	NHS Nottinghamshire
HMP Lowdham Grange	B closed male training	920	Privately run prison	Serco Healthcare
HMP Ranby	C closed adult male training	1060	State run prison	NHS Bassetlaw

Source: Ministry of Justice 2011⁵⁶

Table 2.10.2: Demographic Profile of Nottinghamshire County Prisoners

Prison	Age	Ethnicity (Males)
Nationally	N/A	72% (White (British, Irish, Other))
Whatton	Highest 40-49 (30%)	90% White (British, Irish, Other)
Lowdham Grange	Highest 20-29 (37%)	60% White (British, Irish, Other)
Ranby	Highest 20-29 (54%)	67% White (British, Irish, Other)

Source: Nottinghamshire Prisons Health Needs Assessments (HNA) and/or the Substance Misuse Needs Assessments (NA)

Demographic Information

The table below (Table 2.10.2) details the age and ethnicity profiles for the prisons, with national comparison data when available, at the time of the health needs assessments.

2.10.2. Health and wellbeing needs within the prison population

Nationally, prisoners have poorer mental health than the general population. For example:

- Around 70% of sentenced male and female prisoners suffer from two or more mental disorders, compared to 5% of men and 2% of women in the general population.⁵⁷
- 10% of men and 30% of women have had a previous psychiatric admission before they come into prison.⁵⁸
- 7% of male and 14% of female sentenced prisoners have a psychotic disorder; 14 and 23 times the level in the general population respectively.⁵⁹

Lord Bradley's review of people with mental health problems and learning disabilities in the criminal justice system⁶⁰ had 'improving mental health services across the offender pathway' as one of its key themes.

⁵⁶ Ministry of Justice. List of Prisons. 29th of September 2011., available at:

<http://www.justice.gov.uk/downloads/contacts/hmps/prison-finder/prison-list-sept-2011.pdf>

⁵⁷ Prison Reform Trust. (2011). Bromley Briefings Prison Factfile June 2011

⁵⁸ Singleton, N., Meltzer, H., Gatward, R., Coid, J. and Deasy, D. (1998)

⁵⁹ Psychiatric Morbidity among Prisoners in England and Wales, ONS.

⁶⁰ Bradley, Rt Hon Lord. (2009). Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system, available at:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyandGuidance/DH_098694

Table 2.10.3: Nottinghamshire Prisons' Mental Health problems and Mental Health Service Provision

Epidemiological data	Mental Health services
Prisoner surveys (n=627) 21% stated having a current mental health problem Reported current mental health problems from Healthcare records: HMP Whatton – not provided HMP Lowdham (14%) HMP Ranby (4%)	Consultant Psychiatrist (offering 1.5 sessions per week) Registered Nurses/ Mental Health (offering 20 sessions per week)

Source: Nottinghamshire Prisons Health Needs Assessments (HNA) and/or the Substance Misuse Needs Assessments (NA)

The mental health in-reach services across the three Nottinghamshire prison are provided by Nottinghamshire Healthcare NHS Trust. Table 2.10.3 details the information available on mental health problems and details on the service provided at the time of the HNAs.

Learning Disabilities (LD) in the prison population

Very little data is available on the prevalence of LD within the prison population. A study by the Prison Reform Trust –‘No One Knows’⁶¹ estimates that 20-30% of offenders have learning disabilities or learning difficulties that interfere with their ability to cope with the criminal justice system compared to an estimated 8% of the general population.

All three prisons have been rated RED on the PHPQI 1.31 ‘Services for people with LD, up to 2010/11. Improvement on this indicator is expected following the introduction of the LD assessment tool and care pathways led by NHS Nottinghamshire and NHS Bassetlaw Public Health Directorate.

Alcohol misuse among prisoners

For the general adult population for England and Wales approximately (22%) (over 9 million) are misusing alcohol. When compared to the prison population, the prevalence of alcohol misuse is higher with 63% of male prisoners and 39% of females were drinking at levels that could harm their physical and mental health.⁶²

Table 2.10.4 details the information available on alcohol misuse and details the service provided, at the time of the Substance Misuse NA.

Table 2.10.4: Nottinghamshire Prisons' prevalence of alcohol misuse and Service Provision

Information available on alcohol misuse	Alcohol services available

⁶¹ Prison Reform Trust. (2008). Prisoners' Voices: Experiences of the criminal justice system by prisoners with learning disabilities and learning difficulties

⁶² Prison Reform Trust document: Bromley Briefings Prison Factfile (2011) originally produced by the Social Exclusion Unit (2002).

<p>* OASys data on 1,102 prisoners, 31% indicated an alcohol misuse problem</p> <p>Prisoner NA survey (n=592) 36% reported misusing alcohol</p>	<p>HMP Whatton and Lowdham: Nottingham Advice for Alcohol Problems Service (APAS) (offering two sessions per week)</p> <p>HMP Ranby: Phoenix Futures (offering 10 sessions per week)</p>
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**Offender Assessment System (OASys)*

Source: Nottinghamshire Prisons Health Needs Assessments (HNA) and/or the Substance Misuse Needs Assessments (NA)

PHPQI 1.20 'Alcohol Screening, Intervention and Support' recommends that all prisoners are screened for alcohol problems and that a full range of interventions is available. The three Nottinghamshire prisons currently do not offer the full range of alcohol interventions. The 2012/13 commissioning intentions for NHS Nottinghamshire and NHS Bassetlaw Public Health Directorate are developing alcohol services in line best practice and based on prisoner need.

Drug misuse among offenders

When comparing the general adult population illicit drug use 8.6% ⁶³ to that of the prison population of England and Wales, the prevalence of drug use is higher in the prison population with, 15% of men and 24% of women are serving a drug related offence. ⁶⁴

Drug treatment systems are an essential component of healthcare in prisons. The Integrated Drug Treatment System (IDTS), an evidence-based, individual-focused system, and Counselling, Advice, Referral, Assessment, Throughcare (CARAT) offer a low to medium intensity, non-clinical drug treatment including advice and information, assessment of need, care planning, relapse prevention, harm minimisation, crisis intervention and release planning.

Table 2.10.5: Nottinghamshire Prisons prevalence of drug misuse and Service Provision

Information available on drug misuse	Drug services available
<p>* OASys data on 1,102 prisoners, 44% indicated a drug misuse problem Prisoner NA survey (n=593)</p>	<p>All Nottinghamshire prisons have; IDTS & CARAT services HMP Lowdham and Ranby have;</p>

⁶³ NHS Health and Social Care Information Centre (2011) National Statistics. Statistics on Drug Misuse in England 2010. Available online:

http://www.ic.nhs.uk/webfiles/publications/003_Health_Lifestyles/Statistics_on_Drug_Misuse%20_England_2010.pdf

⁶⁴ Department of Health (2010) Health Improvement Analytics, (Feb 2010).

43% used cannabis 12% used heroin	GP with Special Interest in Substance Misuse
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*Offender Assessment System (OASys)

Source: Nottinghamshire Prisons Health Needs Assessments (HNA) and/or the Substance Misuse Needs Assessments (NA)

Table 2.10.6: Nottinghamshire Prisons prevalence of smoking

Estimated percentage of prisoners who smoke	Percentage of prisoners who say they want to stop smoking
Prisoner HNA survey (n=627)	16%
(49%) currently smoke	

Source: Prisoner HNA survey

A major review of the Nottinghamshire prison substance misuse provision is currently under way. The future focus of substance misuse services in prisons will move prisoners from substance misuse treatment into recovery in line with national guidance.

Table 2.10.5 details the information available on substance misuse and the services provided at the time of the substance misuse NAs.

Smoking among prisoners

Smoking is extremely common in the prison population. It is estimated that approximately 80% of the prison population smoke.⁶⁵ This compares with 22% in the general population nationally.

Table 2.10.6 details the information available on smoking prevalence at the time of the HNA.

Long term conditions

A survey by Bridgwood and Malbon (1995) estimated that 60% of male prisoners rated their health as good or very good but 48% said they had a long-standing illness or disability. They were also more likely to have consulted a doctor in the last two weeks and to be taking prescribed medicines.⁶⁶

Figure 2.10.7: Nottinghamshire Prisons prevalence of Long Term Conditions

Prison	Long Term Condition			
	Epilepsy	Asthma	Diabetes	Coronary Heart Disease
Whatton	1.4%	16.3%	8.1%	6.8%
Lowdham Grange	1.08%	6.8%	2.2%	1.5%

⁶⁵ Department of Health. (2004). Choosing Health: Making Healthier Choices Easier.

⁶⁶ Bridgwood A, Malbon G. Survey of the Physical Health of Prisoners 1994. A survey of sentenced male prisoners in England and Wales, carried out by the Social Survey Division of OPCS on behalf of the Prison Service Health Care Directorate. London: HMSO, 1995.

Ranby	3.5%	18%	1%	5%
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Source: Prisoner HNA survey

The HNAs were used to identify the four long term conditions most prevalent in Nottinghamshire prisons (asthma, epilepsy, coronary heart disease and diabetes) and these were then prioritised for the development of agreed long term condition pathways.

Long term condition data was extracted from the prison healthcare SystmOne data source. This source of data had its limitations as HMP Lowdham Grange and HMP Ranby had just converted to using SystmOne, while HMP Whatton had a variety of diagnostic codes applied to the same condition.

Table 2.10.7 details the estimated prevalence of the identified conditions at the time of the health needs assessments.

Comparisons with expected figures for each of the conditions are complex, however from the Nottinghamshire prison HNA indicates that for all Long Term Conditions rates higher than the general population.

Dental waiting times

Several studies have been undertaken in UK prisons which report that the oral health needs of prisoners are higher than the general population. The Scottish Prison's Dental Health Survey⁶⁷ found that prisoners had significantly more decayed teeth, fewer filled teeth and fewer natural teeth than the general population.

PHPQI 1.18 'Prison Dentistry' states that, access standards for dental care must reflect general access guidance. From the HNA, all prisons were exceeding dental waiting times. However, improvement plans are in place to address this.

Communicable diseases and vaccinations

Prisoners have a significantly higher prevalence of communicable diseases. Many prisoners are at particular risk, not only because of injecting drug misuse prior to prison, but also because of the risks of transmission inherent in prison, such as sharing needles and unprotected sex.⁶⁸

The information available on communicable diseases from the HNAs was extremely limited. We would expect offenders to have higher rates of Hepatitis B (11%), Hepatitis C (12%) and HIV (1.2%)⁶⁹ than were found, indicating the need for case finding and testing.

One of the underlying aims of the prison hepatitis B vaccination programme is to improve vaccine coverage among injecting drug users, thereby reducing the number of acute cases of hepatitis B among intravenous drug users in the community.

⁶⁷ The Scottish government. (2004). Scottish Prisoners Dental Health Survey 2002.

⁶⁸ Prison Reform Trust. (2006). HIV and Hepatitis in UK Prisons: Addressing Prisoners' Healthcare Needs.

⁶⁹ Ibid.

The PHPQI state that all consenting prisoners entering prison, who have not already received at least three hepatitis B vaccine doses (HBV), should complete a HBV vaccination course within one month of their arrival.

Currently, HMP Whatton are the only prison with a good uptake rate for HBV vaccination. For HMP Ranby and HMP Lowdham Grange, improvement plans are in place to increase the hepatitis B vaccination uptake rate.

JOINT STRATEGIC NEEDS ASSESSMENT FOR NOTTINGHAMSHIRE 2012

Adults and Vulnerable Adults

3. Lifestyles

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Adults and vulnerable adults: Lifestyles

3. Adult Lifestyles

3.1 Substance misuse

Key messages

Alcohol

- There are an estimated 123,529 'increasing risk'¹ drinkers and 110,248 'binge' drinkers over the age of 16 in Nottinghamshire.
- The rate of alcohol related admissions to hospital in Nottinghamshire has risen by 33% between 2002/3 and 2007/8.
- 63% of the rise is due to male admissions to hospital and 37% due to female admissions.
- There is a clear north/south divide (north higher than south) across Nottinghamshire in terms of alcohol related admissions in both males and females.
- All districts are experiencing a year on year rise in increasing risk drinkers.
- These people are at increased risk of, for example, hypertension, heart disease, irregular heart rate, accidental injuries and mental and behavioural disorders.
- Of over 20,000 estimated dependent drinkers, only a very small number are engaged in specialist treatment.
- There is a group of dependent drinkers who are not currently actively engaged in alcohol treatment, who frequently attend emergency departments with a wide range of physical and mental health issues.
- Around 100 people a year in Nottinghamshire die from alcoholic liver disease.

Drugs

- In Nottinghamshire in 2010/11, there were 3,035 adult drug users in effective treatment – 2,528 of these were opiate and/or crack users.
- The average length of time in treatment is 2.6 years; 19% of clients have been in treatment for more than six years.
- There is a gap in our knowledge about drug users who are not accessing treatment.
- There were 147 drug related deaths (age 20 and above) in the county between 2006 and 2010. The highest numbers were in the 30-39 age range.
- Access to testing for hepatitis C has improved but more needs to be done to improve access to treatment on diagnosis.
- Two thirds of those offered a hepatitis B vaccination programme don't take it up. Service providers have agreed to put an action plan in place to address this issue.
- There is a need to:
 - Improve access to specialist liver services in the north of the county for both primary alcohol-using clients and clients who have hepatitis C.
 - Improve end of life care pathways for end stage liver disease patients.
 - Improve hepatitis B vaccination programme uptake.
 - Complete a substance misuse health needs assessment to inform future treatment and recovery commissioning arrangements and to ensure equitable service provision across the county.

¹ i.e. people drinking more than the recommended levels

Introduction

People who misuse substances can develop a range of health and social problems. These can be physical health problems, e.g. cancer, liver disease, and for those who inject drugs there is a risk of Blood Borne Viruses (BBV) such as hepatitis B and C. Aside from physical health issues there may be mental health problems too e.g. depression, anxiety, paranoia, suicidal thoughts. As a direct result of substance misuse, individuals may also struggle to retain employment. However, the impact of substance misuse often goes beyond the misuser themselves, and is implicated in relationship breakdown, domestic violence and poor parenting, including child neglect and abuse. Wider societal impacts can include criminal justice problems. According to a Home Office Report, offenders who use heroin, cocaine or crack cocaine are estimated to commit between a third and a half of all acquisitive crime. National estimates suggest that 3-5% of absences from work are alcohol related.²

3.1.1 Alcohol

In 2004, 'The Alcohol Harm Reduction Strategy for England'³ was published; this identified the two distinct harms from alcohol: crime and anti-social behaviour, and damage to health from binge drinking. This strategy was updated 3 years later with 'Safe..Sensible..Social. The next steps in the National Alcohol Strategy'⁴. This described the need to understand the burden on the NHS of alcohol-related harm and the need to improve health outcomes through cost effective prevention and treatment. A key part of the actions recommended was to monitor changes in drinking habits over time and to identify what factors are potentially contributing to the rising levels of consumption. At the end of 2009 the Department of Health published the Chief Medical Officer's (CMO) 'Guidance on Consumption of Alcohol by Children and Young People' in response to the recommendations raised in the Youth Alcohol Action Plan (2008) around the problems of increasing levels of young people's alcohol consumption. He recommended that an alcohol-free childhood is the healthiest and best option, with no under 15 year olds drinking alcohol, and 15-17yr olds drinking only under parental guidance.

In recognition of the impact of alcohol on crime and disorder, courts are able to sentence and apply an Alcohol Treatment Requirement (ATR). This provides access to treatment and support programmes for offenders where alcohol use is identified as a significant

² Health & Safety Executive, A guide for employers on alcohol at work.

<http://www.hse.gov.uk/pubns/indg240.htm#nav> Accessed 29th September 2011.

³ Alcohol harm reduction strategy for England (2004)

<http://webarchive.nationalarchives.gov.uk/+/http://www.cabinetoffice.gov.uk/media/cabinetoffice/strategy/assets/caboffice%20alcoholhar.pdf> accessed 29th September 2011

⁴ Safe. Sensible. Social. The next steps in the National Alcohol Strategy (2007)

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_075218 accessed 29th September 2011.

factor in offending. ATR's are also suitable for hazardous and harmful drinkers in certain circumstances; where alcohol is the dominant feature in the offending and the offender would benefit from treatment.

Types of drinkers

In December 2008, the Department of Health issued new guidance on the classification of alcohol misuse based on the associated level of risk. Public consultation identified that the terminology previously used to describe both the classification and intervention was often confusing to the general public. Following the consultation the DOH have made the following changes.

Increasing Risk has now replaced the terminology Hazardous drinking levels and **Higher Risk** has now replaced Harmful.

Increasing risk drinkers is defined as those individuals who are drinking at levels over the recommended drinking limits either through regular excessive drinking or less frequent 'binge' drinking. They have not yet developed alcohol related health problems but are at a greater risk of alcohol morbidity and alcohol related harm. However, these drinkers will display some alcohol related problems which they may not have recognised or associated with their level of alcohol consumption. They may be experiencing difficulty sleeping, mood swings, being over-weight. Cutting back can help improve mood and ability to sleep.

Higher risk drinkers is defined as those individuals who regularly consume alcohol above the recommended drinking limits yet at a higher level than most increasing risk drinkers. . Higher risk drinking is defined by the DOH as regularly consuming over 6 units of alcohol per day for women (over 35 units per week) and over 8 alcohol units per day for men (over 50 units per week). What about their health?

Moderately dependent drinkers are defined as individuals who demonstrate an increased drive to consume alcohol and a difficulty in controlling its use. Moderately dependent drinkers tend to recognise that they may have an issue with drink as a result of pressure or concern from family or acquaintances.

Severely dependent drinkers have serious and long term problems and may once have been termed as 'chronic alcoholics'. They are individuals who will experience alcohol withdrawal symptoms if they attempted to stop drinking alcohol. Severely dependent drinkers may consume alcohol on a daily basis or through heavy periods of drinking.

Numbers and type of drinkers in Nottinghamshire

Figure 3.1.1 Synthetic estimates of drinkers over 16 yrs

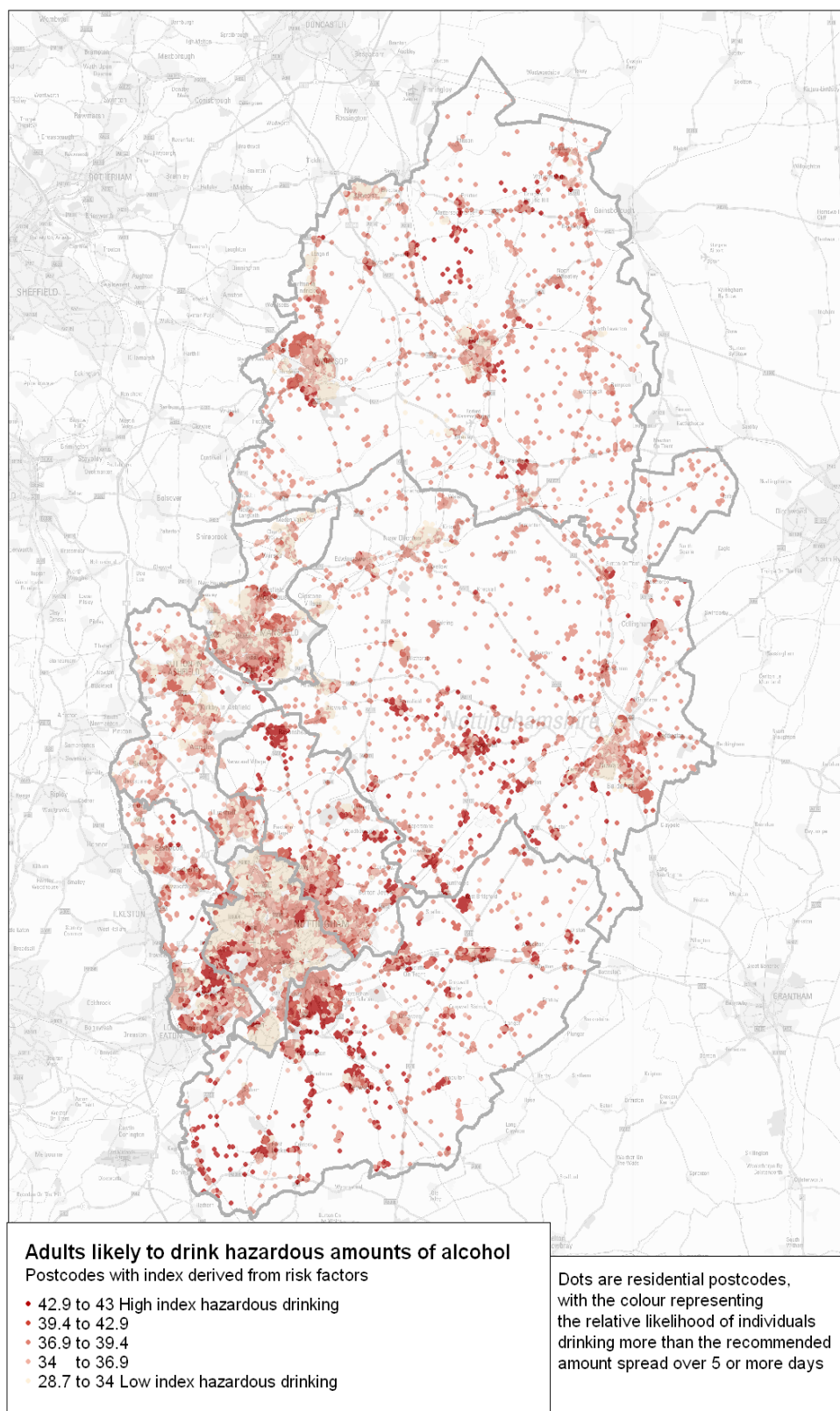
	Increasing Risk	High Risk	Dependent	Binge
NHS Nottinghamshire County	105,604	24,906	17,130	93,903
NHS Bassetlaw	17,925	4519	3108	16,345
total	123,529	29,425	20,238	110,248

Source: NWPHO LAPE

Figure 3.1.1 shows the local population most likely to be at risk of increasing risk (hazardous drinking) based on the following modelling. Both the General Household Survey (GHS) and Health Survey England (HSE) showed that males and both sexes in the 25-54 age groups were more likely to drink more frequently and exceed the recommended limits. The GHS provides a more detailed dataset so was therefore used to identify other 'risk' factors for higher alcohol consumption. From the GHS surveys the following groups were most likely to drink more frequently and exceed daily or weekly recommended limits:

- males
- both sexes aged 25-44 years
- married and over 45 years (both sexes)
- those in managerial and professional households
- households with higher incomes (>£1,000/week)
- higher earners aged 16-64 years in employment (>£800/week)

Figure 3.1.2 Map of hazardous drinkers in Nottinghamshire



Public health effects of alcohol

The North West Public Health Observatory (NWPHO) has produced and published Local Alcohol Profiles for England (LAPE) on an annual basis since 2006. The latest LAPE update was released the August 25th 2011 and is available via www.lape.org.uk.

The alcohol profiles contain 25 alcohol-related indicators for every Local Authority (LA) at district level and 22 for every Primary Care Trust (PCT) in England. The indicators measure the impact of alcohol on local communities and include a national indicator generated by the Department Of Health – *Admission episodes for alcohol-attributable conditions (previously National Indicator 39 or NI39)*.

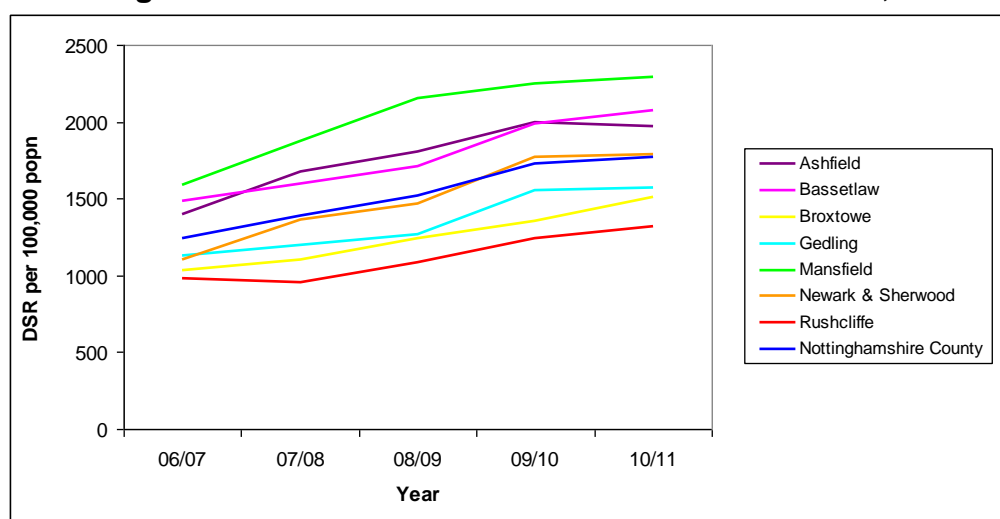
The North West Public Health Observatory (NWPHO) looked at a range of health conditions to identify the links between the amount of alcohol consumed and a disease or injury. 47 conditions were identified as having alcohol contributing to them in a lesser or greater extent, with other factors also contributing to their development, such as age, gender and lifestyle factors, this includes conditions such as hypertension and ischaemic heart disease. 13 of these conditions are caused by excessive alcohol consumption alone, including alcoholic liver disease and alcohol induced pancreatitis

<http://www.lape.org.uk/downloads/AlcoholAttributableFractions.pdf>

The majority (27%) of alcohol related emergency admissions in Nottinghamshire are due to hypertension (high blood pressure), followed by mental and behavioural disorders (20%) and cardiac arrhythmias 20% (irregular heart rate)

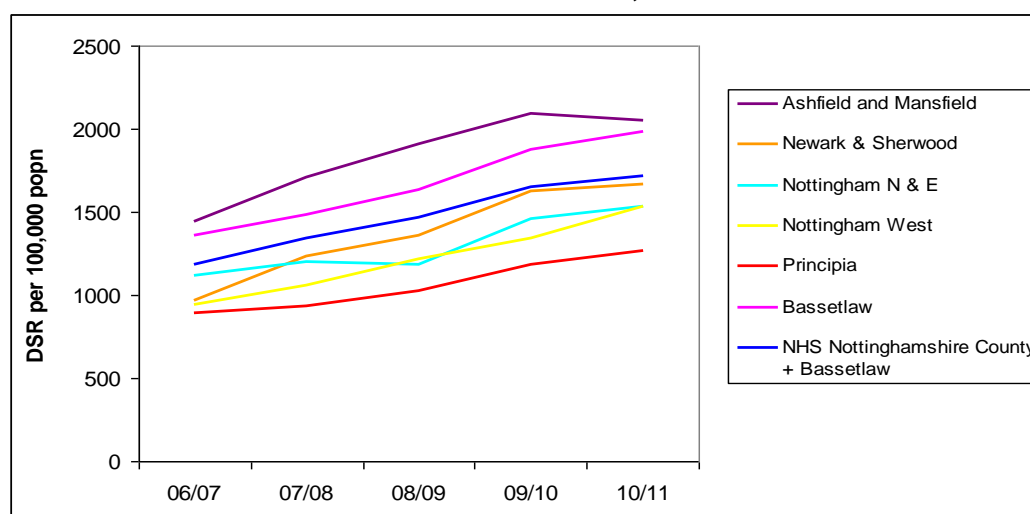
Figures 3.1.3 & 3.1.4 below show the trends in alcohol attributable hospital admissions in Nottinghamshire by district and by Clinical Commissioning Group (CCG's). Alcohol related admission rates are increasing, with the north of the county having more than the south of the county.

Figure 3.1.3: Trend in alcohol attributable hospital admissions for residents in Nottinghamshire districts between 2006/7 and 2010/11, DSRs



Source: HES, date of access November 2011

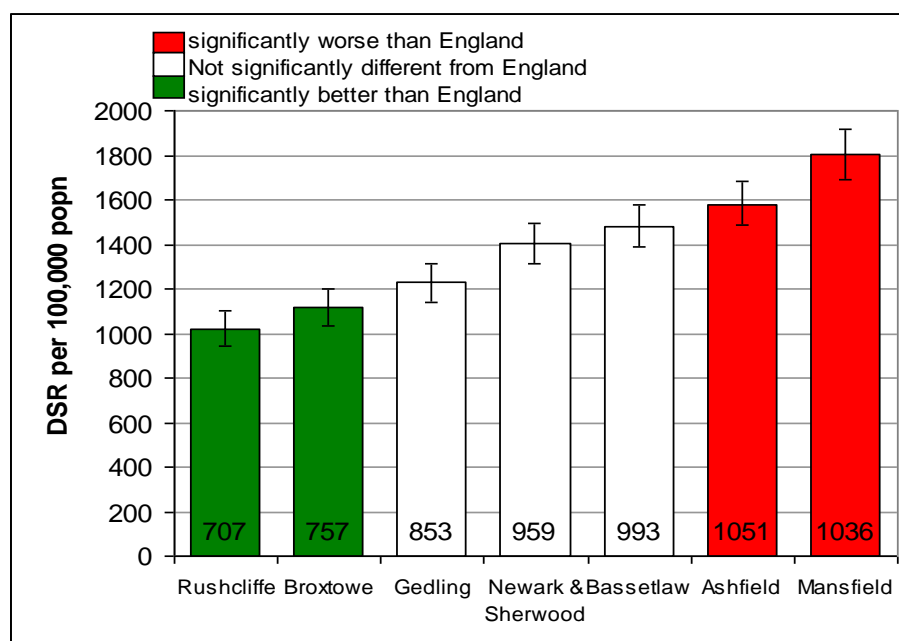
Figure 3.1.4: Trend in alcohol attributable hospital admissions for patients registered with Nottinghamshire Clinical Commissioning Groups (CCGs) between 2006/7 and 2010/11, DSRs



Source: HES date accessed November 2011

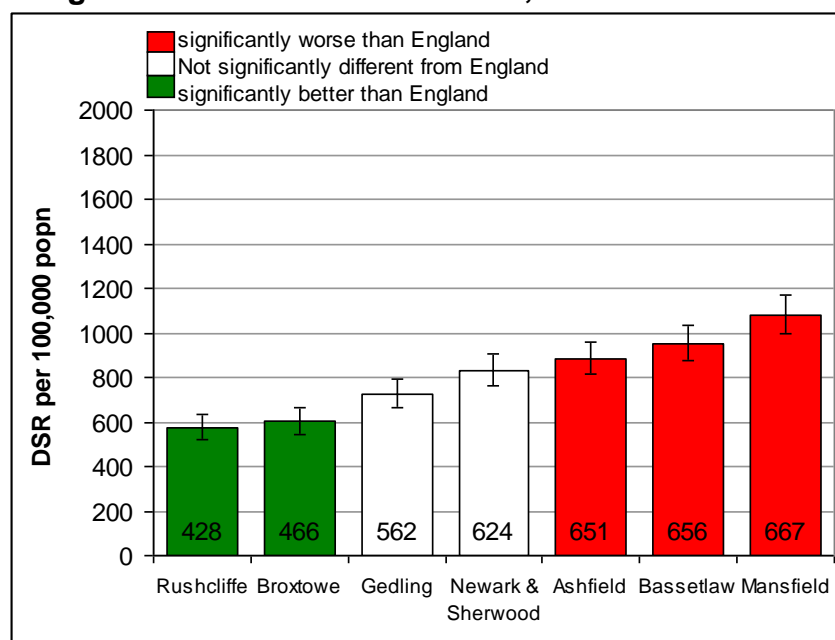
Figures 3.1.5 & 3.1.6 show hospital admission rates for alcohol attributable conditions in males and females respectively. Rates are significantly higher than the national average for both males and females in Ashfield and Mansfield and for females only in Bassetlaw.

Figure 3.1.5: Hospital admissions for alcohol attributable conditions in males resident in Nottinghamshire districts in 2009/10, DSRs & number



Source: NWPFO Local Alcohol Profiles England

Figure 3.1.6: Hospital admissions for alcohol attributable conditions in females resident in Nottinghamshire districts in 2009/10, DSRs & number



Source: NWPFO - Local Alcohol Profiles England

Numbers in alcohol treatment

During 2010/11, 1676 individuals were engaged in specialist alcohol treatment, the majority 94% were seen in 3 weeks or less. In addition to this over 1500 individuals were

seen by specialist alcohol nurses whilst in hospital after receiving referrals from Emergency Departments and hospital wards following brief alcohol assessments.

High Volume Service Users

Work to identify individuals who frequently attend the Emergency Department (ED) and/or have prolonged stays in hospital highlighted that a significant number have substance misuse problems and/or underlying mental health problems. Key reasons why they use ED include:

- Not currently engaging in treatment (they are in the main known to treatment services in the past, but have either chosen to disengage or have been discharged) and may be experiencing signs of withdrawal
- They have an alcohol acquired brain injury and getting an assessment, diagnosis and on-going support is difficult
- They have advanced alcohol liver disease
- They are socially isolated

Their needs often fall between NHS services and social services. A more in depth understanding of the needs of this client group and the impact upon their families and carers is being undertaken as part of a comprehensive health needs assessment.

Alcohol related deaths

Alcohol liver disease (ALD) and liver cirrhosis are the main causes of death in dependant drinkers. 555 individuals died from alcoholic liver disease during 2007 – 2010. There is a strong correlation between deaths from ALD and deprivation, with 24% living in Mansfield and Ashfield and 6% in Rushcliffe at the time of death. 95% of people who died had a previous hospital admission in the 5 years prior to death but only 42% had a previous hospital admission with a diagnosis of ALD

Death from ALD is preceded by a substantial number of medical attendances in secondary care with the opportunity for intervention. Liver disease is unsuspected in a significant number of people in contact with secondary care. Mortality rates over a 4 year period remain high. The majority - 72% die within an acute hospital setting. (Link to end of life chapter)

3.1.2 Drug Misuse

The coalition government published a National Drug Strategy in 2010. The strategy aims to reduce illicit and other harmful drug use, and increase the numbers recovering from their dependence. It is based on three themes: reducing demand, restricting supply and building recovery in communities. Significant emphasis is placed on the recovery theme and this has more recently been subject to further consultation, with the aim of developing a new framework to provide better access to a complete range of services to support people in sustaining their recovery. The strategy sets out an ambition for all individuals to achieve recovery and ultimately the chance to lead a drug-free life.

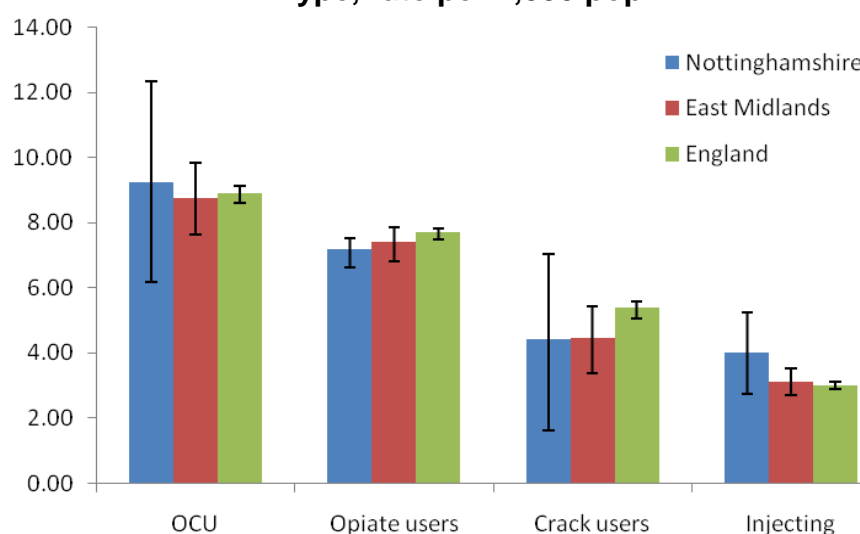
Importantly it places emphasis on providing a more holistic approach, by addressing other issues in addition to treatment to support people dependent on drugs or alcohol, such as offending, employment and housing. The strategy recognises that individuals with these problems can be subject to the criminal justice system, and so the strategy states that services provided in the community and in prison must be more integrated. There is also a clear recognition that severe alcohol dependence raises similar issues to drugs, and therefore where appropriate the strategy includes severe alcohol dependency, particularly with regard to the recovery agenda.

In a similar way to Alcohol Treatment Requirements, courts can use a Drug Rehabilitation Requirement (DRR). This is a community based penalty for people who have committed high levels of crime to support their drug use.

Problematic drug use

Understanding the prevalence of drug users in Nottinghamshire and their characteristics is crucial to build a picture of their needs and to ensure that services are commissioned to meet their needs. Figs 3.1.7& 3.1.8 show the estimated prevalence of users in treatment by type.

Fig 3.1.7: Treated Prevalence Estimates 2009/10 for Nottinghamshire by User Type, rate per 1,000 pop



Source: National Treatment Agency, 2011.
Error bars indicate 95% confidence intervals

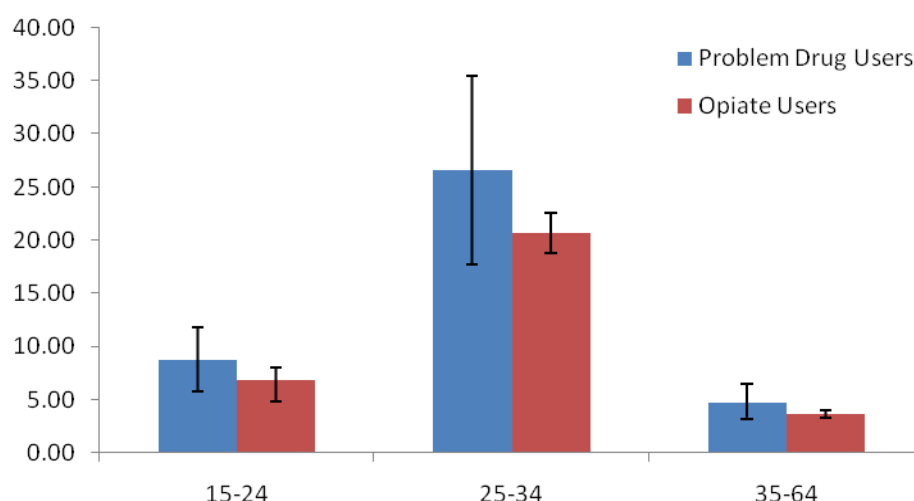
Fig 3.1.8: Treated Prevalence Estimates 2009/10 for Nottinghamshire by User Type, Numbers

	Opiate &/or Crack User	95% Confidence intervals		Opiate users	95% Confidence intervals		Crack users	95% Confidence intervals	
Nottinghamshire	4,710	3,134	6,272	3,655	3,474	3,937	2,257	923	3,683

Source: National Treatment Agency, 2011.

The estimated number of problematic drug users (individuals using heroin and/or crack cocaine problematically) in Nottinghamshire has increased slightly, with estimates in 2006/07 of 3965. It is worth noting however that the 2006/07 data had much wider confidence intervals.

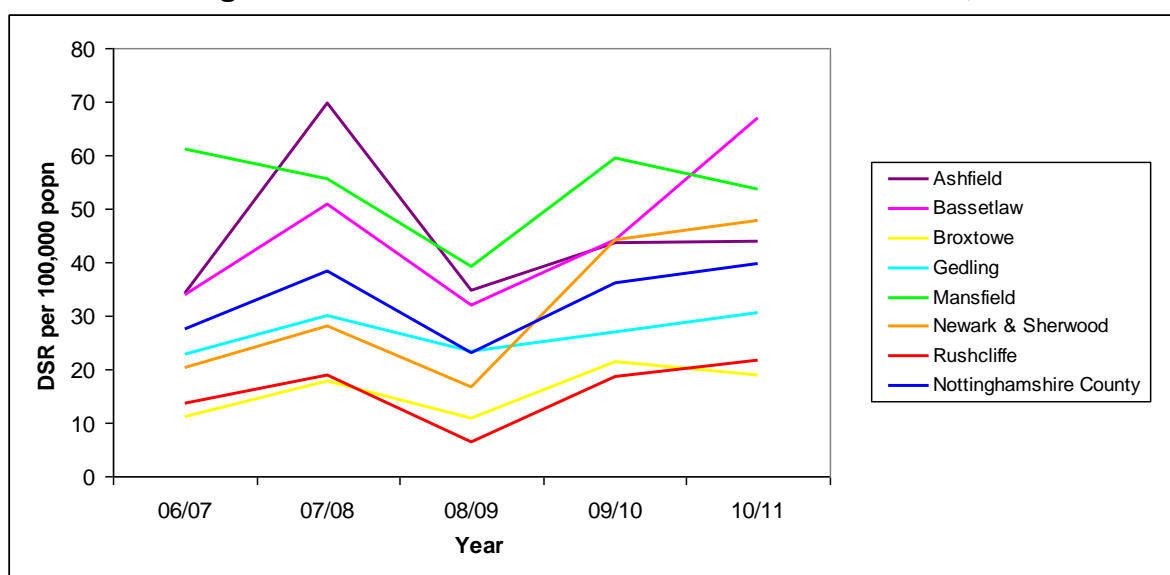
Fig 3.1.9: Treated Prevalence Estimates by Age Group, rate per 1,000 pop



Source: National Treatment Agency, 2011.
Error bars indicate 95% confidence intervals

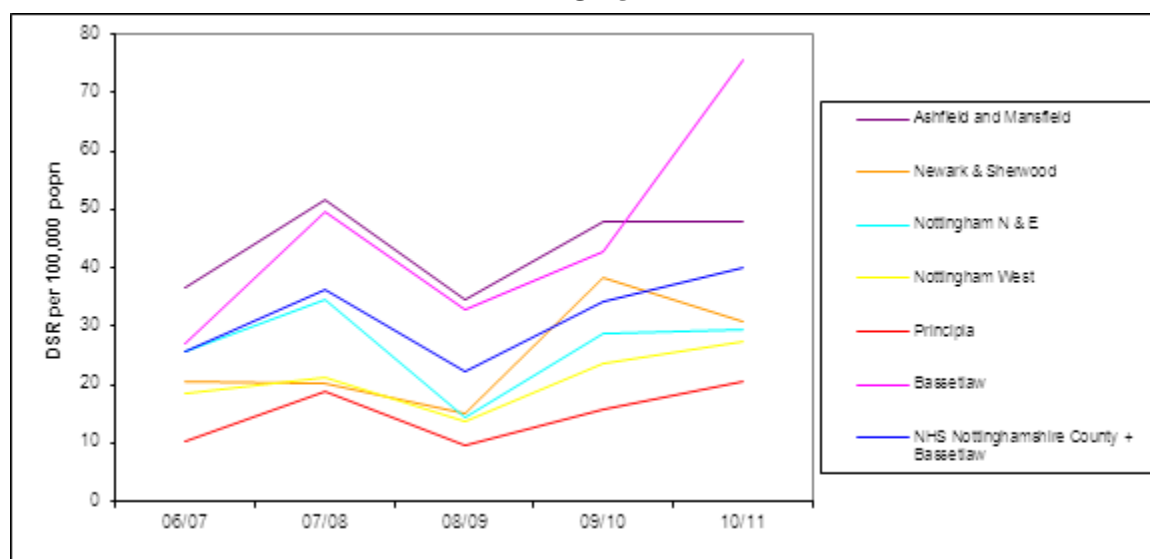
Understanding the trends in drug related hospital admission rates gives us an indication of the complications experienced by users. As Fig 3.1.10 below highlights, the rates of hospital admissions are higher in the north of the county than in the south, which we would expect as the numbers of problematic drug users known to treatment and recovery services in the north of the county is higher than those in the south.

Figure 3.1.10: Trend in drug related hospital admissions for residents in Nottinghamshire districts between 2006/7 and 2010/11, DSRs



Source: HES date accessed November 2011

Figure 3.1.11: Trend in drug related hospital admissions for residents in Nottinghamshire Clinical Commissioning Groups between 2006/7 and 2010/11, DSRs



Source: HES data accessed November 2011

Drug treatment

In Nottinghamshire in 2010/11, there were 3,035 adult drug users in effective treatment, 2528 of these were opiate and/or crack users. Effective treatment is defined by the National Treatment Agency (NTA) as being retained in treatment for 12 weeks or more or completing treatment successfully and achieving identified treatment goals.

During 2010/11, 1,121 individuals began their 'treatment journey'. 766 were identified as opiate and/or crack users. Of these new individuals, 85% were in effective

treatment and for opiate and/or crack users specifically, 87% were in effective treatment

The average length of time in treatment is 2.6 years. For criminal justice individuals (who represent 25% of the treatment population), it is 1.5 years. This is the same as the national average.

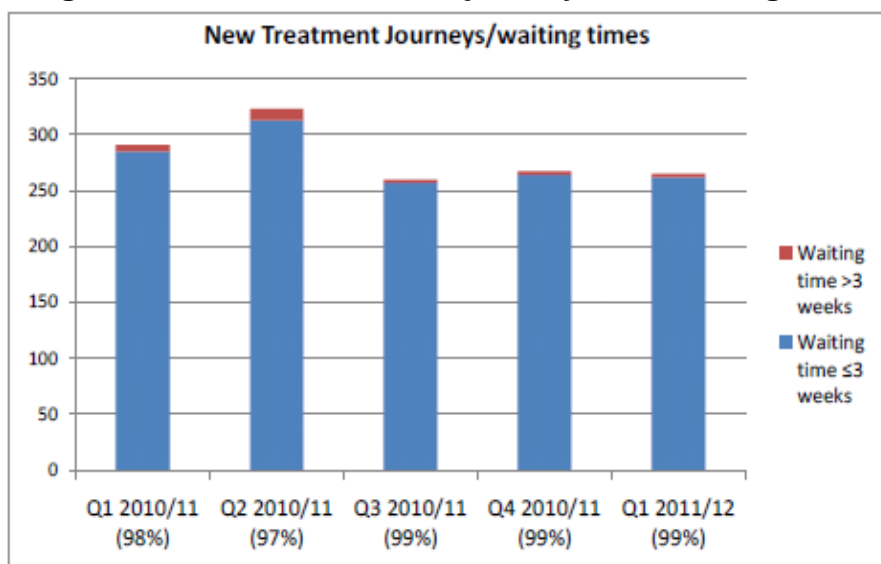
19% of individuals have been in treatment for 6 years or over, 15% for 4 to 6 years, 20% for 2 to 4 years and 16% for 1 to 2 years. Previous drug strategies were concerned with getting people into treatment and keeping them there as the key performance measure. Nottinghamshire was very effective in that regard. However in April 2011, the performance measure changed and services are now monitored on the number of people who come out of treatment, with an emphasis on a lifetime of recovery. Work has been undertaken to commission a new model of delivery to refocus on achieving the new outcomes and providers are looking at the reasons why clients are not moving on.

Access to services

Access to drug treatment remains consistently good, with the majority of clients seen within 3 weeks or less. Those that are waiting longer generally have dual diagnosis

(substance misuse and mental health problems): these issues are addressed in the mental health chapter. The table below illustrates this. Local Access Points (LAPs) are being developed in all districts and will bring together clinical treatment and recovery services. Recovery support, such as support to access housing, education, benefits and longer term self help support are crucial achieving good outcomes for the client, their family and community.

Figure 3.1.12 New treatment journeys and waiting times



Source: NDTMS

Blood borne viruses

Hepatitis C remains a major public health problem with estimates of around 161,320 individuals with a chronic infection in England. The exact number of infected individuals in Nottinghamshire isn't known exactly, as many people infected with hepatitis C will have no symptoms at all. Prevention of hepatitis C focuses on injecting drug use as one of the most important risk factors in the UK. Strategies include reducing injecting and sharing injecting equipment, opiate substitution prescribing, reducing harm from other blood born viruses (for example hepatitis B vaccination, early diagnosis through better testing and referral for treatment). Table 3.1.13 below indicates the prevalence estimates for injecting drug users in Nottinghamshire

Table 3.1.13: Prevalence Estimates 2009/10, Number of Injecting Drug Users

	Numbers	95% Confidence intervals	
Nottinghamshire	2,047	1,425	2,692

Source: National Treatment Agency, 2011.

The Health Protection Agency Collaborative Unlinked Anonymous Survey of Antibodies to HIV, Hepatitis B and C in injecting drug users is linked to specialist treatment

providers and needle and syringe programmes. In Nottinghamshire, the specialist needle and syringe programme participates.

The results of this survey showed that 46% of those tested were positive for hepatitis C anti-bodies.

Of those in treatment in Nottinghamshire, 1,788 were previously or currently injecting, 77% of these have had a hepatitis C test. This performance is good but can be improved. Services have been set a 90% target for 2011/12.

Of those entering treatment, the majority 96% were offered a hepatitis B vaccination programme, however only around 35% commenced the programme. This remains an area of concern.

Access to hepatitis C treatment

Previous JSNAs recommended; *“Increase provision of effective harm reduction, screening, vaccination and treatment programmes for Hepatitis and the provision of specialist liver services”*

As illustrated above, positive progress has been made on improving access to screening and vaccination programmes, with plans in place to improve further. There is however considerable work to be done to address access to hepatitis treatment provision in the north of the county. Clients in the south of the county can access specialist liver services provided by Nottingham University Hospitals (NUH). This provision is not available at Kings Mill Hospital. NUH do provide an outreach session twice a week but waiting times are considerable and the chaotic nature of this client group means that travelling to Nottingham from the north of the county is prohibitive. Clients within Bassetlaw access services in Doncaster.

Drug related deaths

A number of drug related deaths occur each year. These are reviewed by the coroner, and key learning points are fed back to treatment services.

A number of drug related deaths also involved the use of large quantities of alcohol.

Table: 3.1.14 Drug related deaths in Nottinghamshire County 2006 – 2010

Age band	20-29	30-39	40-49	50-59	60+
Males	21	28	18	16	8
Females	7	9	9	15	16
Grand Total	28	37	27	31	24

Source: definition as per ICD10 codes including all deaths, not just those where a controlled drug was mentioned

Conclusion

Substance misuse, whether it is alcohol use or drug use continues to affect a large number of individuals in Nottinghamshire. A legacy of focussed work on targeting drug

using clients suggests that the vast majority are either engaged in treatment or are known to treatment services. Retention rates in treatment are good and areas where more progress needs to take place has been identified. The scale of the problem around alcohol use is of concern, large numbers of Nottinghamshire are consuming alcohol at levels which if not yet are causing harm to their health may well do so in years to come.

3.2 Smoking

Smoking prevalence estimates updated Oct 2012

Key Messages

- Smoking is the primary cause of preventable illness and premature death in England and the single biggest cause of inequalities in death rates between the richest and poorest in our communities. Tackling tobacco use is central to improving the health of the poorest, fastest.
- It is vital to stop children from smoking in the first place - 90% of people start smoking before the age of 19 and children are three times as likely to start smoking if their parents smoke.
- 22% of people smoke in Nottinghamshire, compared to a national average of 21%. However, this figure masks local differences - 16% of the population of Rushcliffe smoke, whilst 29% of the population of Mansfield are smokers⁵.
- Smoking is responsible for around 1,500 deaths across the county every year.
- Both Nottinghamshire and Bassetlaw NHS are above the national average for women who smoke during pregnancy, Bassetlaw notably so.
- Smokers are four times more likely to succeed in stopping smoking with support and locally, approximately 12,500 Nottinghamshire adults set a quit date last year, of whom 7,000 were successful at four weeks.
- Across the East Midlands, Bassetlaw had the highest percentage of smokers setting a quit date (at 10%) and over the last three years NHS Nottinghamshire County has supported 19,048 smokers to quit at four weeks.
- Services need to be tailored to meet the needs of routine & manual workers, young people and pregnant women, co-designed with them and delivered in locations and at times which make them accessible.

Introduction

Tobacco use remains one of the most significant public health challenges. While rates of smoking have continued to decline over the past decades, around 21 per cent of adults in England still smoke. Smoking prevalence has fallen little since 2007.

Smoking is the primary cause of preventable morbidity and premature death, accounting for 81,400 deaths in England in 2009. In England, deaths from smoking are more numerous than the next six most common causes of preventable death combined (i.e. drug use, road accidents, other accidents and falls, preventable diabetes, suicide and alcohol abuse).

⁵ Smoking prevalence is currently reported by the Office for National Statistics (ONS) each quarter, but the methods used produce large variations for consecutive measurements at local-authority level. As of July 2012, the ONS is reviewing their methodology. These raw data are not used in this document: instead the medians of quarterly results from the ONS from April 2009-March 2010 to October 2010 to September 2011 are used.

Smoking rates are much higher in some social groups, including those with the lowest incomes. These groups suffer the highest burden of smoking-related illness and death. Smoking is the single biggest cause of inequalities in death rates between the richest and poorest in our communities. The majority of smokers, 47%, are from Routine and Manual Occupations. Women in low-paid work are 3 times more likely to smoke during pregnancy. Smoking prevalence is higher amongst men in a number of black and minority ethnic groups than in the general population⁶ consequently, tackling tobacco use is central to improving the health of the poorest, fastest.

The Marmot Review⁷ published in 2010 recognises that ‘tobacco control is central to any strategy to tackle health inequalities as smoking accounts for approximately half of the difference in life expectancy between the lowest and highest income groups.’ As well as being the biggest single cause of preventable death and killing half of all long-term users in England, smoking costs the economy billions of pounds every year in NHS costs, reduced productivity, lost revenue and higher welfare payments.

National targets for tobacco control are reflected in *Healthy Lives Healthy People A Tobacco Control Plan for England* where the Government aims to cut adult smoking prevalence to 18.5% by 2015.⁸

The percentage of people who smoke across Nottinghamshire County is 21.6% and 19.4% in Bassetlaw compared to a national average of 20.8%. However, this figure masks the regional differences across the county with 16.4% of the population of Rushcliffe smoking whilst 29.3% of the population of Mansfield are smokers⁹. While in Bassetlaw it is significantly higher in some of the most deprived areas, for example in the local area of Harworth, smoking prevalence is estimated at 35%¹⁰.

Figure 3.2.1 shows the variation of smoking prevalence at a small-area level across Nottinghamshire. Smoking is responsible for 1,300 deaths across Nottinghamshire County every year. The main causes of death are cardiovascular disease, cancers and respiratory disease. All these are underpinned by tobacco. There are approximately 210 smoking related deaths yearly based on 2011 data in Bassetlaw.¹¹

The difference in life expectancy across the county is approximately nine years and half of this difference is due to smoking. Inequalities across Bassetlaw are generally higher

⁶ Reducing Health Inequalities through Tobacco Control A guide for Councils. (2010) Local Government Improvement and Development Group

⁷ Marmot Review (2010) “Fair Society, Healthy Lives” Strategic Review of Health Inequalities in England Post 2010

⁸ Healthy Lives, Healthy People, Department of Health (2011), A Tobacco Control Plan for England.

⁹ Smoking prevalence is currently reported by the Office for National Statistics (ONS) each quarter, but the methods used produce large variations for consecutive measurements at local-authority level. As of July 2012, the ONS is reviewing their methodology. These raw data are not used in this document: instead the medians of quarterly results from the ONS from April 2009-March 2010 to October 2010 to September 2011 are used.

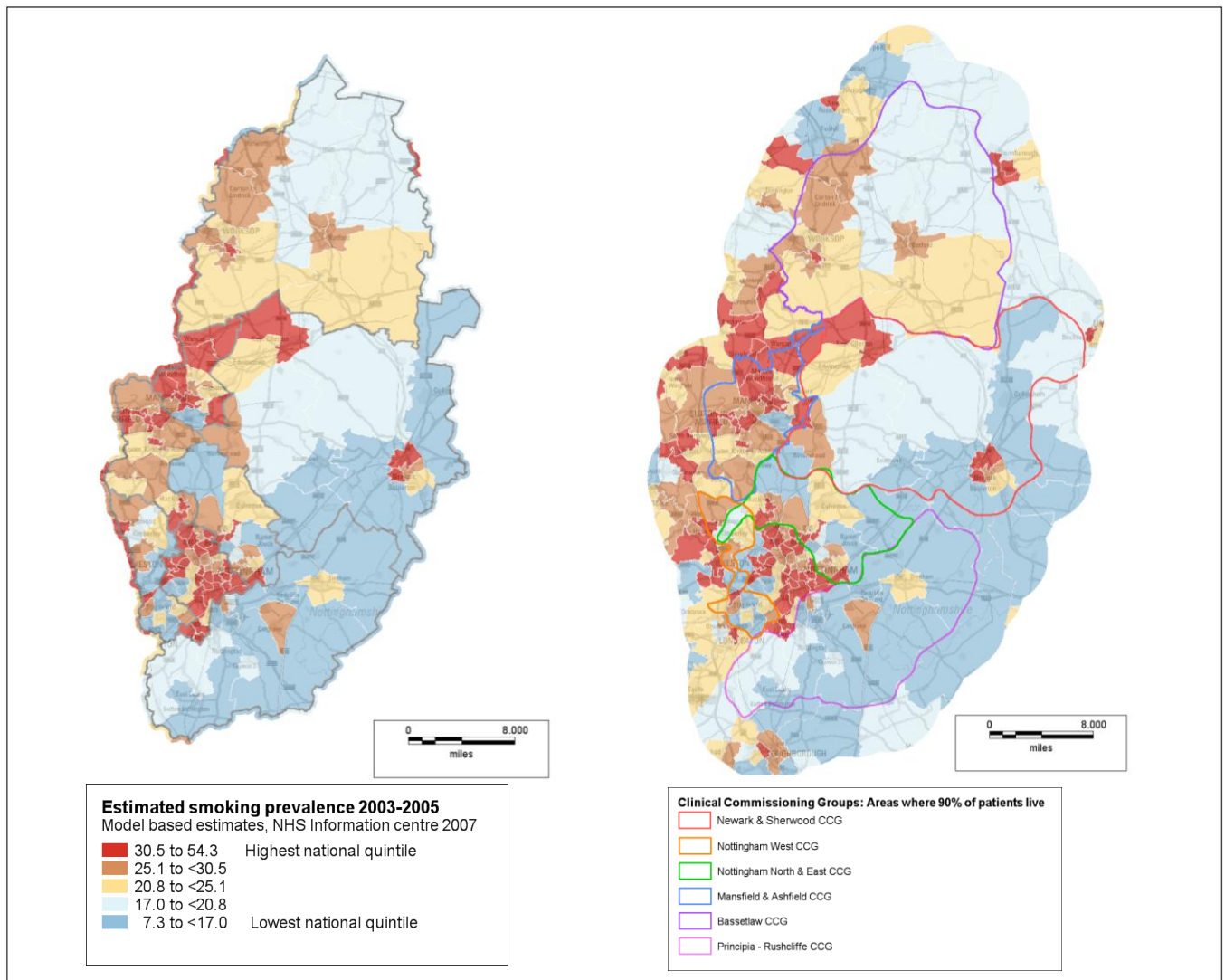
¹⁰ Downs D, et al (2009). NHS Stop smoking services DH 2010/11).

¹¹ Department of Health.(2011): Health Profile for Bassetlaw (APHO)

than the national average. For example; males can expect to live on average for 77.7 years as opposed to the national average of 78.3, with female life expectancy being 81.3 as opposed to the national prevalence of 82.3%.

Both Bassetlaw and Nottinghamshire County use a combination of national and local schemes to tackle this major cause of health inequality. These are outlined in the sections following.

Figure 3.2.1: Estimated smoking prevalence, 2003-2005.
Local Authority boundaries (to left) and CCG populations (to right).



3.2.1 Nottinghamshire

Tobacco control

Tobacco control is an evidence-based approach to tackling the harm caused by tobacco. This approach is multi agency with partners working collaboratively. Locally this is delivered through the Nottinghamshire County Strategic Tobacco Alliance Group (STAG)

The core objectives for the STAG are:

- reducing the number of young people starting to smoke
- motivating and supporting every smoker to quit
- protecting families and communities from tobacco-related harm.

The 'hexagons' model¹² shown in figure 3.2.2 was initially developed in the East Midlands and has been further developed by the Department of Health Tobacco Control National Support Team as an aide memoire of the key tasks for integrated tobacco control planning and delivery at regional and local level. (The seventh, central hexagon illustrates the need for partnership working to successfully deliver against the agenda.)

Figure 3.2.2: Key tasks for tobacco control, Department for Health National Support Team



Reducing the number of young people who start to smoke

It is children who start smoking, not adults. 90% of people start smoking before the age of 19 and children are three times as likely to start smoking if their parents smoke. While the number of children taking up smoking has halved in the last decade, 200,000 of the 250,000 people taking up smoking each year in England are children and young people aged under 18. The earlier someone starts smoking, the more likely they are to smoke for longer and to die earlier from a related condition or disease.

Beyond the direct health impacts of tobacco use, tobacco use in adolescence is associated with many behaviours that can adversely affect health, including the misuse of alcohol or other drugs. Regular smoking is also more prevalent among young people who have truanted or been excluded from school compared with those who have not. In addition to preventing youth uptake, a focus on reducing tobacco use among young

¹² Burnett K (2006) *Tackling Tobacco in the East Midlands - priorities and accountabilities 2006/7* East Midlands Regional Public Health Group / Government Office East Midlands

people is vital, as children can very rapidly develop an addiction to, and dependence on, tobacco.¹³

The Healthy Schools Programme across Nottinghamshire County works with schools to support young people to make positive lifestyle choices.

Brief Advice training for frontline staff in health and social care settings across Nottinghamshire has equipped staff to discuss lifestyle issues and support young people in getting access to support if they have already started to smoke.

The D-vibe Online Surveys which are being piloted in schools in the Ashfield and Mansfield Partnership have been designed to help find out what young people need in Nottinghamshire County to help them be healthy and stay safe across a wide agenda, including tobacco use.

Completed surveys will become part of the way services are planned and will provide an up to the minute picture of what young people know and need to know about tobacco and getting help and support. This will be co-ordinated by the Children and Young People's multi- agency Smoking and Tobacco group that feeds in to the Strategic Tobacco Alliance Group.¹⁴

Social marketing research carried out in Newark and Sherwood which identified effective interventions for young people at key stages needs now to be implemented and then rolled out across the county.

Specialist skills in Stop Smoking Services for Young People need to be commissioned and lobbying support continued to ban smoking in private vehicles in the presence of children.

Brief Advice training needs to be extended across a wider range of frontline staff working with children and families.

Motivating and supporting every smoker to quit

Stopping smoking improves the health and wellbeing of smokers, their families and their communities in the short, medium and long-term. Children are less likely to initiate smoking if they do not live with smokers. Smoking cessation is the single most cost-effective life-saving intervention provided by the NHS. Smokers are four times more likely to succeed in stopping smoking with support, but currently only half of all quit attempts are 'assisted quits' ,where individuals receive support from NHS Stop Smoking Services, Primary Care or by using over-the-counter medication.

¹³ Reducing Health Inequalities through Tobacco Control A guide for Councils. (2010) Local Government Improvement and Development Group

¹⁴ www.d-vibe.com

Last year 10,717 adults set a quit date across Nottinghamshire County. 5,997 of those people were reported as successful quitters at four weeks.

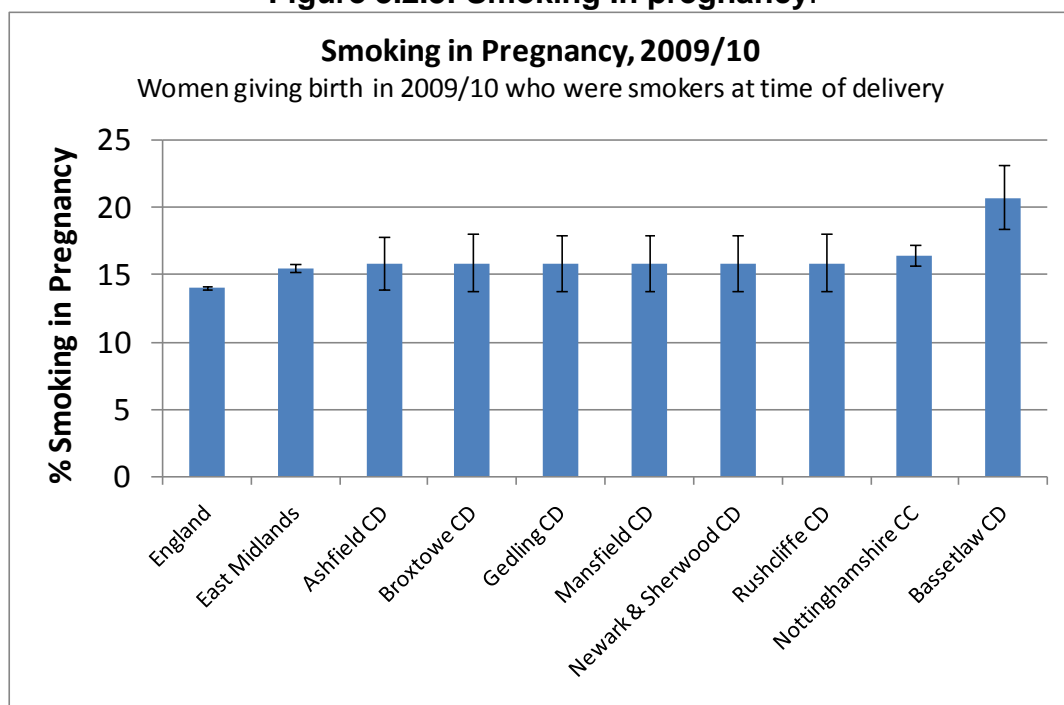
Across the East Midlands, Bassetlaw had the highest percentage of smokers setting a quit date, at 10%, and Derbyshire County and Nottingham City, the lowest with 7% of smokers setting a quit date. Currently smoking quitters are followed up for 4 weeks and we need to extend this time period to see if they remain a quitter in the longer term.

Over the last three years NHS Nottinghamshire County supported 19,048 smokers to quit at four weeks.

Areas with a high smoking prevalence have been targeted to identify smokers and offer appropriate stop smoking services.

Specialist Stop Smoking Services for pregnant women have been developed and all midwives have been trained to give Brief Advice. Figure 3.2.3 shows the 2009/10 data for smoking in pregnancy.

Figure 3.2.3: Smoking In pregnancy.



Brief Advice Training has been delivered to frontline staff across many health and social care settings to support staff to discuss smoking in all their contacts with people across the county and refer them appropriately.

National NHS Quality Improvement schemes such as QIPP and CQUIN have been implemented across Secondary Care settings to identify people who smoke, offer brief advice and a referral to local NHS Stop Smoking Services.

A free or subsidised voucher scheme for NRT products is available to everyone who attends an NHS Stop Smoking Service across Nottinghamshire County.

Future commissioned services to target routine and manual workers, young people and pregnant women, offering services that are tailored to meet the needs of these groups, are co-designed with them and delivered in locations and at times which make them accessible and that overcome barriers to attendance.

Protecting families and communities from tobacco-related harm

The smokefree legislation introduced in 2007 has seen high levels of compliance and public support with nearly all enclosed public and work spaces now smokefree.

The dangers of second hand smoke are now generally accepted, however, awareness of the dangers of second hand smoke in cars and homes is lower, especially among deprived groups within the community.

Second hand smoke is particularly damaging to children, affecting not only physical health but also educational attainment and psychological health. Each year nearly 10,000 children nationally are treated in hospital for exposure to second-hand smoke.

Through the STAG the key agencies are working together to:

- enforce the minimum price of tobacco
- ensure non-price measures such as advertising restrictions, smokefree laws and health warnings are in place locally
- provide information and advocacy
- provide effective stop smoking programmes
- restrict access to minors
- control the illicit trade.

The “Go Smokefree” scheme has been launched across Mansfield and Ashfield offering people advice and support in making their environments smoke free with a “pledge” process for people to sign up for the scheme.

This now needs to be extended across the county, especially in areas where vulnerable children are being exposed to second hand smoke.

The Specialist Stop Smoking Service also offers access to the scheme and works with clients to promote smoke free environments.

Illicit supply makes it possible for many young people and routine and manual workers to smoke more heavily. The STAG needs to build upon current enforcement activity to reduce the supply and demand for illicit tobacco.

3.2.2 Bassetlaw

Local smoking cessation activity

NHS Bassetlaw PCT commission smoking cessation services as part of our provider arm Health Promotion Service contract, delivered by the Bassetlaw Stop Smoking Service and through a Local Enhanced Service (LES) with 6 out of 12 local GP practices.

During 2010 -11 the number setting a quit date in Bassetlaw was 1,888, with 989 quits at 4 weeks achieved, which is an overachievement of 89 on the target of 900.¹⁵

Progress over the last year:

NHS Bassetlaw is committed to reducing the harm caused by smoking across the population, with a specific focus on the most hard to reach smokers, those in the most deprived areas, targeting routine manual workers, pregnant smokers, and preventing young people from starting to smoke.

Over the last year the Bassetlaw Stop smoking service has developed to provide a wider impact on smoking prevalence across our population which include:

- A high performing stop smoking service with regards to four week quit rates that have over-exceeded the targets set.
- Piloted the 'ME2' support programme (utilises alternative therapies as a tool to support pregnant smokers to stop)
- A social marketing research project to gather insight into why people smoke.
- 6 out of 12 GP practices signed up to the LES, with others referring to the stop smoking service.
- Toolkit development and implementation within local schools, aiming to deter young people from starting to smoke.
- Local pharmacists signed up to distribution of the nicotine replacement therapy voucher scheme.
- Successful roll out of the Smoke Free Homes initiative
- Commencement of workplace health smoking cessation programmes, (as part of the wider Bassetlaw Well-being at work workplace award scheme).

Future priorities

Plans are to continue to deliver both universal and targeted interventions to meet the respective needs of the Bassetlaw population include:

- Continue to meet local 4 week quit targets.
- Continue to focus on reducing the prevalence of pregnant smokers from 23% to 15% (at the point of delivery). A specialist advisor has been trained to work specifically with pregnant smokers, which includes working within secondary care to take referrals straight from health visitors. The insight gained from the 2011

¹⁵ The Health & Social Care Information Centre (2010-11) Statistics on NHS Stop smoking Services in England, April 2010 to March 2011.

- pilot programme of the 'ME2' initiative will be used to further shape delivery of smoking cessation programmes for pregnant smokers.
- To increase the proportion of quitters who reside in the most socio-economically deprived areas (linked to the Bassetlaw Neighbourhood Management Programme by targeting services to the areas with the greatest need).
 - To utilise insight gained from recent research to develop targeted interventions aiming to deter young people from starting to smoke.
 - Development and implementation of holistic brief intervention training (linked to the Every Contact Counts national initiative), encouraging people from a range of agencies to be able to deliver a brief intervention and sign post to supportive services.
 - Support the local promotion of smoke free legislation to include smoke free environments.
 - Focused level 1 & 2 training programmes for front line staff from a range of agencies.

This will be achieved through:

The Nottinghamshire Strategic Tobacco Alliance group (Notts-STAG). Members include Local Authority, NHS, Police, Fire Services and Trading Standards.

Work with Community partners. Engaging District Councils and local Voluntary Groups in locally specific plans

Engagement with Public and Patients, Insight work with young people and with Older Adults has already taken place. This needs to now also be extended to discussions with a wider cohort of people including pregnant women.

Collaboration with Local Clinicians, Tobacco Champions in Secondary Care Providers need to be utilised more effectively to ensure that smoking cessation is on every agenda from Board level to ward level.

3.3. Diet and Nutrition

Key Messages

- It is estimated that eating at least five varied portions of fruit and vegetables a day can reduce the risk of death from chronic disease, stroke and cancer by up to 20%.
- Across Nottinghamshire, synthetic estimates of fruit and vegetable consumption show on average one in four people over the age of 16 consume five or more portions of fruit and vegetables a day.
- Over 30% of Rushcliffe residents reported eating five or more portions of fruit and vegetables a day, compared with just over 20% in Ashfield and Mansfield, largely mirroring deprivation in the county.

Good nutrition is vital to good health. Whilst many people in England eat well, a large number do not, particularly among the more disadvantaged and vulnerable in society. In particular, a significant proportion of the population consumes more than the recommended amount of fat, saturated fat, salt and sugar. Such poor nutrition is a major cause of ill health and premature death in England. About one third of cancers can be attributed to poor diet and nutrition.¹⁶

Fruit and Vegetable Consumption

Increasing the consumption of fruit and vegetables can significantly reduce the risk of many chronic diseases. It is estimated that eating at least 5 varied portions of fruit and vegetables a day can reduce the risk of deaths from chronic disease, stroke, and cancer by up to 20%.

The '5-A-DAY' programme is part of a preventative strategy aimed at improving diet and nutrition in the general population. Current guidelines recommend that adults and children should aim to eat five or more portions of fruit and vegetables each day.

The latest Health Survey for England from 2009¹⁷ indicates that more women than men consumed the recommended five or more portions of fruit and vegetables daily (25% of men, 28% of women). These proportions are similar to those reported in 2008, and are slightly lower than in 2006, when 28% of men and 32% of women consumed at least five portions daily.

Consumption varied with age among both sexes; it was lowest among those aged 16-24 (17% of men and 18% of women this age ate five or more portions), and generally increased with age until the oldest age group, where consumption was slightly lower than among those aged 55-74. As in previous years, higher consumption was also associated with higher income, and vice versa: 32% of men and 37% of women in the highest income quintile had consumed five or more portions, but only 18% of men and 19% of women in the lowest quintile had done so.

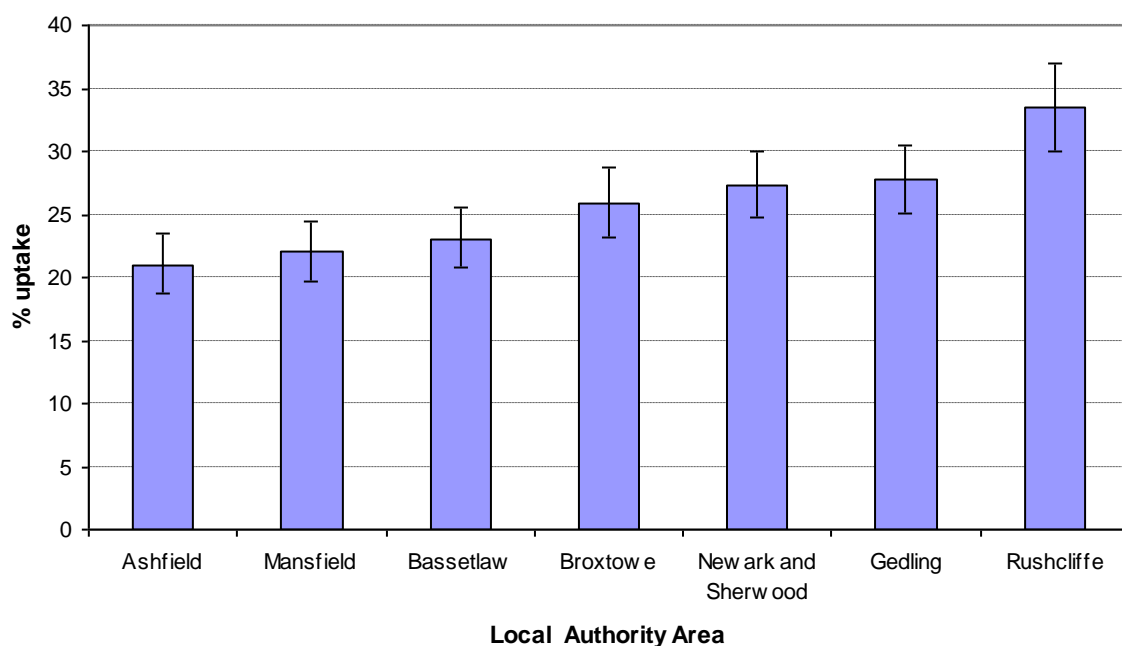
¹⁶ Scientific Advisory Committee on Nutrition. Dietary Recommendations for Energy (2011)

¹⁷ Health Survey For England 2009 Health and Lifestyles, The Information Centre (2010)

In 2003, the Department of Health published model-based synthetic estimates of the uptake of 5-A-DAY in adults (aged 16+ years) at ward level. These synthetic estimates are of a different nature from standard survey results and estimate the expected prevalence of obesity for ward/Local Authority/Primary Care Organisation level given the social and demographic characteristics (such as deprivation and mortality) of its population. The estimates resulting from this model must be used with caution. Although robust, they will almost certainly not mirror precisely any available measures from local studies or surveys. Estimates cannot be used to monitor performance or change over time.

Across Nottinghamshire synthetic estimates of fruit and vegetables consumption show on average 1 in 4 people over the age of 16 consume 5 or more portions of fruit and vegetables. Figure 3.3.1.1 shows the estimated difference in consumption of 5-A-Day across the Nottinghamshire Districts.

Figure 3.3.1: Synthetic estimates of fruit and vegetable consumption (adults) for local authority areas in Nottinghamshire, 2003-2005



Source: Health Survey for England 2003 to 2005

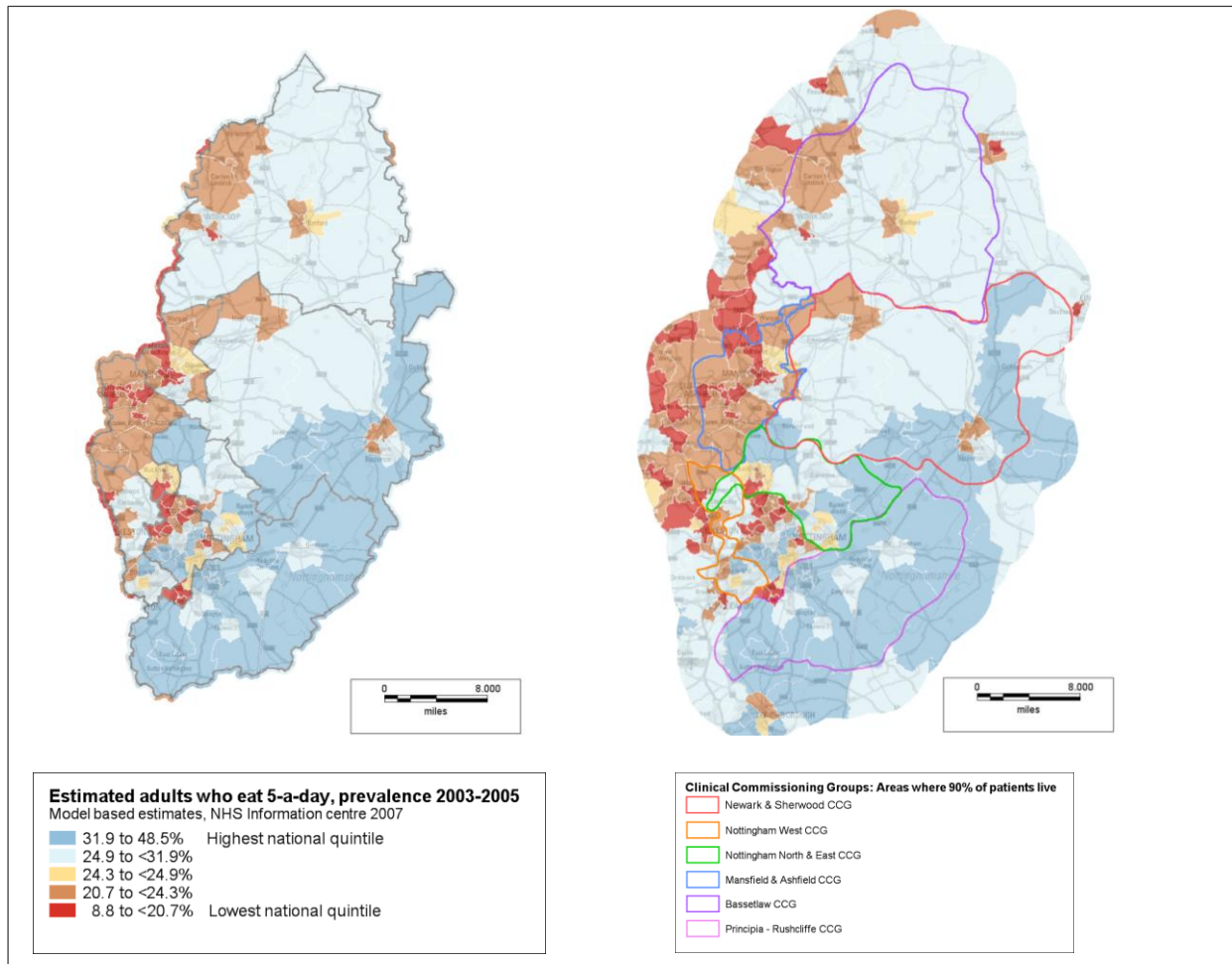
Figure 3.3.1 shows that over 30% of adults in Rushcliffe are estimated to consume at least 5 portions of fruit and vegetables a day compared with 21% in Ashfield and 22% in Mansfield.

Figure 3.3.2 illustrates fruit and vegetable consumption synthetic estimates which were calculated for Nottinghamshire wards using Health Survey for England data. The darker the colour, the more residents eat 5 or more fruit and vegetable portions per day. This

clearly shows that the majority of wards in Rushcliffe and some in Gedling and Newark and Sherwood have the highest proportion of fruit and vegetables being consumed.

Figure 3.3.2- Proportion of adult residents who eat 5 or more fruit and vegetable portions per day (2003 to 2005).

Local Authority boundaries (to left) and CCG populations (to right).



Source; Health Survey for England; Synthetic Health Indicators for Healthy Lifestyle Behaviours.

3.4. Obesity

Key Messages

- Obese people are more likely to develop diabetes, colon cancer, hypertension (high blood pressure) and heart attacks, and obesity also has an impact on psychological well-being.
- Almost a quarter of adults in England are obese, with obesity increasing with age (up to around 75) and it is higher in men than in women. It is estimated that by 2030, 41%-48% of men and 35%-43% of women could be obese if trends continue unchecked.
- Adult obesity is high in the areas of Mansfield, Ashfield, parts of Bassetlaw and specific wards of Gedling, Broxtowe and Rushcliffe, largely mirroring levels of deprivation.

Introduction

The huge rise in the number of obese people worldwide is proving to be a major challenge to our health. The World Health Organisation (WHO, 1998) has described the rapid rise of obesity as a 'global epidemic'. It is the fastest growing non-communicable disease worldwide, a huge threat to public health.

This rapid rise has occurred too quickly for genetic changes to be the cause (Swanton and Frost, 2006). Society has experienced many behavioural and environmental changes for example in work patterns, transport, food production, leisure activities, levels of alcohol consumption and food sales, contributing to a variety of health problems (Foresight, 2007). Added to this, overweight and obesity are health inequality issues, with people from the lower socioeconomic groups most at risk.

Obesity and overweight are conditions in adults in which weight gain in the form of fat has reached a point of affecting health and the difference between obesity and overweight is the increasing degree of fatness. Excess weight is caused by an imbalance between 'energy in' and 'energy expenditure'. If there is more energy in than required for appropriate growth the excess energy will become excess fat.

Obesity has become stigmatised but at the same time overweight has become normalised, and is known to lead to both chronic and severe medical problems. The health risks for adults are stark. Obesity is responsible for an estimated 9,000 premature deaths per year in England (National Audit Office, 2001) and has major consequences for morbidity, disability and quality of life.

Compared with a healthy weight man, an obese man is:

- Five times more likely to develop type 2 diabetes
- Three times more likely to develop colon cancer
- More than two and a half times more likely to develop high blood pressure - a major risk factor for heart disease and stroke.

Compared with a healthy weight woman, an obese woman is:

- Almost thirteen times more likely to develop type 2 diabetes
- More than four times more likely to develop high blood pressure
- More than three times more likely to have a heart attack.

Psychological damage caused by being overweight and obese is also a huge health burden. In adults this has led to clinical depression, with rates of anxiety and depression being three to four times higher among obese individuals.

Alcohol Concern states that there is a lack of public awareness about the calorific content of alcohol drinks, and about how alcohol intake needs to be managed in order to maintain a healthy weight¹⁸.

Apart from the personal and social costs there are significant health and social care costs associated with the treatment of obesity¹⁹. The current total annual cost to the National Health Service (NHS) of treating adults that are overweight and obese has been estimated at £1 billion. Foresight has estimated that the NHS costs attributable to obesity are projected to be £6.5 billion per year by 2050 and the wider costs to society and business are estimated to reach £49.5 billion per year. The average healthcare cost (2006/7) of physical inactivity has been estimated for NHS Nottinghamshire County as £9,793,010 and for NHS Bassetlaw as £1,793,790.

The Department of Health has published care pathways for NHS primary care professionals and a self-help guide for their patients to help with weight loss. The National Institute for Health and Clinical Excellence (NICE) published “Guidance on the prevention, identification, assessment and management of overweight and obesity in adults and children” in December 2006.

Measurement of Obesity

It is important to establish the ranges of weight at which health risks increase. In adults there are two main methods of assessing whether someone is overweight or obese; Body Mass Index (BMI) and waist circumference. A patient’s BMI is calculated by comparing their weight to their height by dividing their weight measurement (kilograms) by the square of their height (metres). According to the WHO, in adults a BMI of 25-29.9kg/m² is defined as overweight; and a BMI of 30kg/m² is defined as obese.

The measurement of waist circumference provides information about the distribution of body fat and is a measure of risk for conditions such as coronary heart disease (CHD).

Prevalence of Obesity

The Health Survey for England is a series of annual surveys covering the health of population. The information collected is used to inform national policy and local decision

¹⁸ Alcohol Concern (2010) Alcohol and Calories Briefing. www.alcoholconcern.org.uk

¹⁹ Government Office for Science (2007) FORESIGHT: Tackling Obesities: Future Choices

makers in terms of health trends across the country. The 2009 Health Survey for England focused on lifestyle issues which impact on health and estimates of the prevalence of health related behaviours (such as body weight) across the population. Although differences in measurement methods make comparison with other countries difficult, the rate of obesity in England is at least as high, if not higher, than other EU countries.

Overall, men and women had the same mean BMI (27.0kg/m²), and mean BMI generally increased with age in both sexes up to the age of 74, but dropped back slightly among those aged 75 and over. Almost a quarter of adults (22% of men and 24% of women) were obese. 66% of men and 57% of women were overweight or obese. Among both men and women, prevalence of overweight and obesity was lowest in the 16-24 age group, and generally increased in the older groups up to the age of 74.

In recent years the upward trend of obesity appears to have flattened out for adults, however the pattern differs greatly by age group. The prevalence of obesity in middle age and older adults continues to rise.

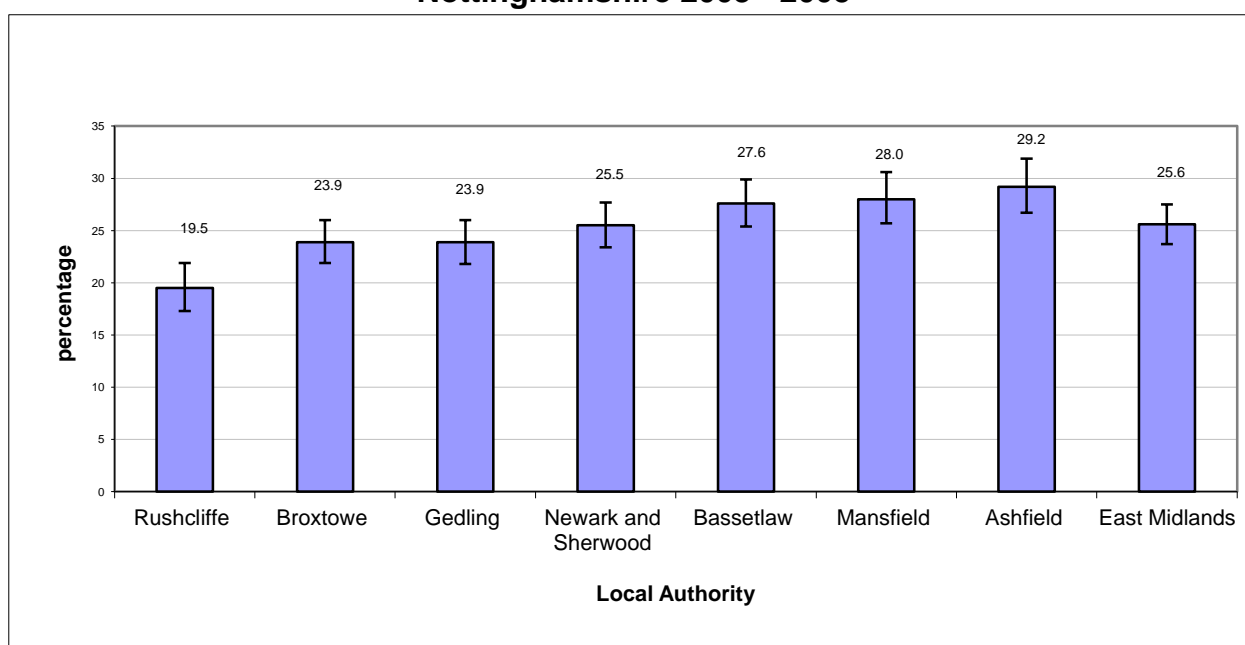
There are health inequalities in relation to obesity. The Marmot Review (2010) showed income, social deprivation and ethnicity have an important impact on the likelihood of becoming obese. The obesity risk is higher among lower socio-economic groups and evidence suggests that the difference between socio-economic groups is widening.

Whilst the number of people sampled does not allow us to look at prevalence below county level, synthetic estimates which have been produced allow areas to estimate the percentage of the adult population within each geographical area who are obese, given the characteristics of the local population. The synthetic estimates are based on a model and represent the expected prevalence for wards, given the demographic and social characteristics of the area.

In 2003, the Department of Health published model-based synthetic estimates of the prevalence of obesity in adults (aged 16+ years) at ward level. These synthetic estimates are of a different nature from standard survey estimates and estimate the expected prevalence of obesity for ward/Local Authority/Primary Care Organisation level given the social and demographic characteristics (such as deprivation and mortality) of its population. The estimates resulting from this model must be used with caution. Although robust, they will almost certainly not mirror precisely any available measures from local studies or surveys. Estimates cannot be used to monitor performance or change over time.

Adult obesity synthetic estimates have been calculated for Nottinghamshire districts and wards using Health Survey for England data.

Figure 3.4.1: Model-based estimates for adult obesity in Local Authorities in Nottinghamshire 2003 - 2005



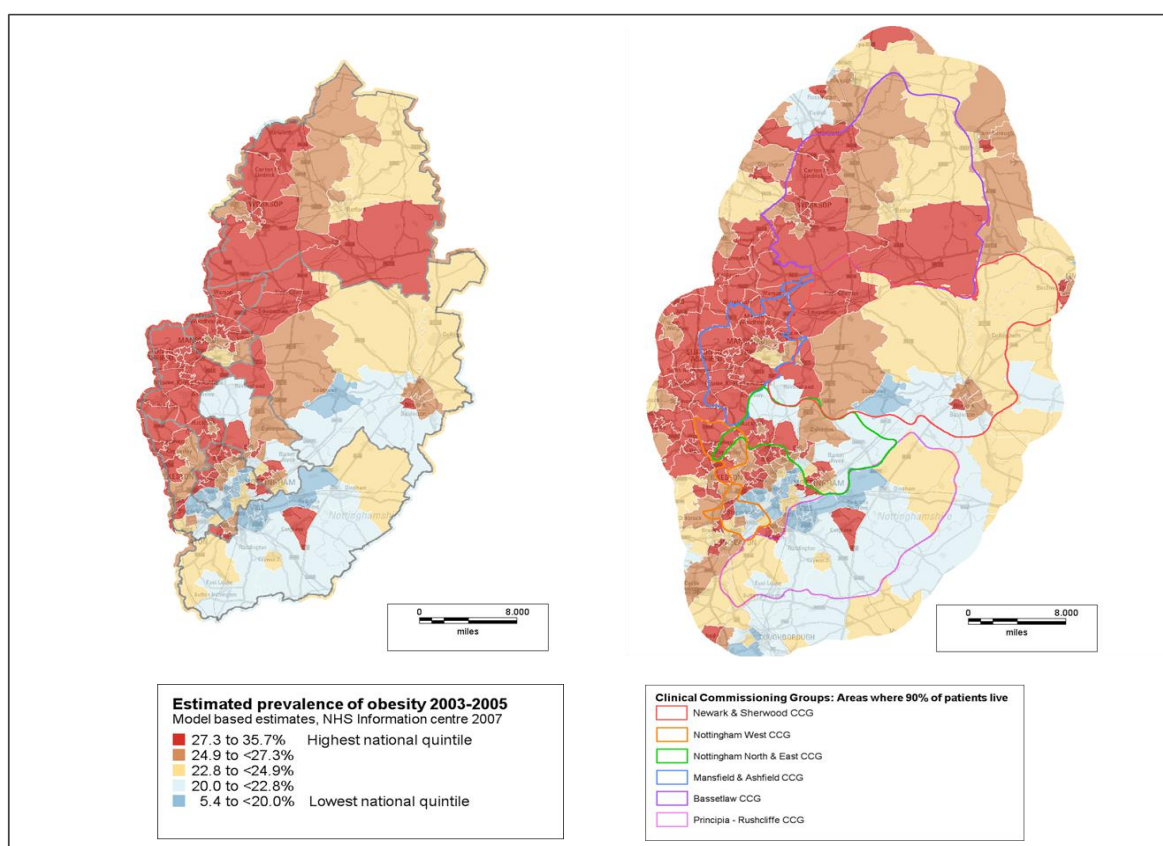
Error bars shown are 95% Confidence Intervals, calculated using the Wilson score method. Indicators that have Confidence Intervals that do not overlap (for different areas or different time periods) can be described as significantly different.

Source: Health Survey for England 2003 to 2005

None of the local authority areas in the County have an estimated prevalence of obesity significantly different to the East Midlands.

Figure 3.4.2- Estimated prevalence of adult obesity at Ward level across Nottinghamshire (2003-2005).

Local Authority boundaries (to left) and CCG Populations (to right).



The figure 3.4.2 shows that adult obesity remains high in the areas of Mansfield, Ashfield, parts of Bassetlaw and specific wards of Gedling, Broxtowe and Rushcliffe.

Future Trends

It is predicted that by 2050, 60% of adult men, 50% of adult women and 25% of children may be obese²⁰. Recently reported modelling suggests that by 2030 41-48% of men and 35-43% of women could be obese if trends continue unchecked. Foresight (2007) predicts that it will take at least 30 years to reverse the current obesity prevalence rate before reductions in associated diseases can be seen.

Foresight uses the health Select Committee's estimate of the current total costs attributable to overweight and obesity, namely £7 billion per year, of which £1 billion is direct health service costs. By 2050 the NHS cost of overweight and obesity could rise to £6.5 billion, with the wider cost to society being £45.5 billion.

Change4Life

The Change4Life social marketing programme was launched by the Department of Health in January 2009. Originally it was developed as part of the childhood obesity

²⁰ Government Office for Science (2007) FORESIGHT: Tackling Obesity: Future Choices

prevention strategy targeting parents of children aged 5 to 11. Although the programme is government instigated it sought to inspire a broader societal movement through which everyone who had an interest in combating obesity could work together under a common banner. Partners included the commercial sector as well as local communities. It was estimated that between February 2009 and May 2009 14.3% of NHS Nottinghamshire residents and 3.14% of Bassetlaw residents had registered with the Change4Life movement.

The Change4Life branding continues to be used extensively to promote healthy eating and physical activity messages through:

- The development of Change4Life roadshows in partnership with Nottinghamshire County Council has engaged with schools around the campaign with activity focused on healthy eating
- The development of the Change4Life convenience store project with one store in Mansfield taking part. The aim is to increase access to fresh fruit and vegetables, particularly in deprived communities
- Local Walk4Life activities in schools and communities
- Branded physical activity projects such as Swim4Life in Mansfield
- The branding of workplace wellbeing schemes
- The rebranding of local obesity training programmes
- The creation of social marketing projects with local communities to help reduce the consumption of sugar sweetened beverages.

A Change4Life three year social marketing strategy²¹ has been developed which focuses on taking a 'lifecourse' approach whereby trusted brands and programmes will deliver advice, information and support on all topics relevant to people at specific stages in their lives.

Change4Life and Start4Life is centrally funded and provides health advice, information and support for families and adults in midlife. This will incorporate messages for:

- above limits alcohol consumption
- broader benefits of physical activity
- all nutritional information.

A New Level of Ambition

In October 2011 the Department of Health issued the Healthy Lives, Healthy People: a call to action on Obesity in England²². This document sets out the new approach to public health to enable effective action on obesity and encourages a wide range of partners to play their part.

The new level of ambition involves adopting a 'lifecourse' approach from pre-conception through to older age. There are specific opportunities and challenges at each stage of

²¹ Department of Health (2011) Change4Life Three Year Social Marketing Strategy

²² Department of Health (2011) Healthy People, Healthy Lives: a call to action on obesity in England

the life course and action is needed at all ages to avert the short and long-term consequences of excess weight and to ensure health inequalities are addressed. Action needs to encompass an appropriate balance of investment and effort between prevention, treatment and support.

There is a new national ambition for tackling obesity in adults:

- A downward trend in the level of excess weight averaged across all adults by 2020.

The main components of this new approach are:

- Empowering individuals
- Giving partners the opportunity to play their full part
- Giving local government the lead role in driving health improvement and harnessing partners at local level
- Building the evidence base.

Public Health Outcomes Framework

Published by the Department of Health, January 2012, there are three indicators directly relating to adult obesity:

- Diet (the indicator needs further development at a national level).
- Excess weight in adults (probably derived from Sport England's Active People Survey).
- Proportion of physically active and inactive adults (from the Sport England's Active People Survey).

Nottinghamshire Obesity Strategy

A revised local obesity strategy is currently under development, incorporating the new national ambition for tackling obesity in adults and the indicators from the Public Health Outcome Framework. As part of this, the services that are currently commissioned by Public Health (exercise referral schemes and community nutrition services, currently provided by some district councils and County Health Partnerships) will be reviewed.

There is a plethora of good, evidence-based work taking place at a local level. A mapping exercise of what other services, local action and initiatives are taking place in relation to diet and nutrition and physical activity is being undertaken. This will identify any gaps and unmet needs to inform the development of our commissioning intentions for 2013 onwards to ensure resources are allocated in the most effective way. This will form part of the obesity strategy.

3.5. Physical Activity

Key Messages

- Participation in physical activity across the county shows the lowest rates to be in Gedling, and the highest in Rushcliffe.

Physical activity is a critical public health issue. Improving physical activity levels has the potential to improve both physical and mental health. Lack of physical activity is associated with increasing risks to health, including heart disease, diabetes, cancer, obesity and musculoskeletal conditions such as osteoporosis. Heart disease, stroke and cancer are the major causes of death in England, accounting for almost 60% of premature deaths.

As well as its impact on an individual's health, improving physical activity can also save money by significantly easing the burden of chronic disease on health and social care services.

According to the World Health Organisation lack of physical activity has been identified as the fourth leading risk factor for global mortality causing an estimated 3.2 million deaths globally.²³

The benefits of regular physical activity are well evidenced. For adults doing 30 minutes of at least moderate intensity physical activity on at least 5 days a week helps to prevent and manage over 20 chronic conditions including coronary heart disease and stroke.

The estimated direct cost of lack of physical activity to the NHS across the UK is £1.06 billion. (This cost based on five conditions; coronary heart disease, stroke, diabetes, colorectal cancer and breast cancer).²⁴

Lack of physical activity also creates costs for the wider economy through sickness absence and through the premature death of productive individuals. In England the costs of lost productivity have been estimated at £5.5billion per year from sickness absence and £1billion per year from the premature death of people of working age.

Active travel, or making everyday journeys on foot or by bike, is one of the easiest ways to increase the amount of physical activity into a person's daily routine. It also contributes to reductions in emissions, safer and more pleasant streets, improved air quality and reduced congestion.

What is physical activity?

Physical activity includes all forms of activity such as everyday walking and cycling, work-related activity, active recreation such as exercising in the gym, dancing, gardening, playing active games as well as organised and competitive sport.

²³ World Health Organisation, http://www.who.int/topics/physical_activity

²⁴ Department of Health, (2011) Healthy People, Healthy Lives: a call to action on obesity in England

Guidelines for adults and older adults

'Start Active, Stay Active'²⁵ sets out physical activity guidelines across the lifecourse on the levels of activity required to achieve general health benefits.

This includes:

- Adults should aim to be active daily. Over a week activity should add up to 150 minutes (2 ½ hours) of moderate intensity activity in bouts of 10 minutes or more
- Comparable benefits can be achieved through 75 minutes of vigorous activity spread across the week or a combination of moderate and vigorous intensity activity. Applicable to older adults if already moderately active
- Adults should also undertake physical activity to improve muscle strength on at least two days a week
- All adults should minimise the amount of time spent being sedentary (sitting) for extended periods.

How active are we?

Each year Sport England carries out an Active People's Survey. In 2011 the survey was in its fifth year and the results were published in December.

The survey provides a large sample size for a sport and recreation survey and allows levels of detailed analysis previously unavailable. It identifies how participation varies from place to place and between different groups in the population. The survey also measures; the proportion of the adult population that volunteer in sport on a weekly basis, club membership, involvement in organised sport/competition, receipt of tuition or coaching, and overall satisfaction with levels of sporting provision in the local community. The questionnaire was designed to enable analysis of the findings by a broad range of demographic information, such as gender, social class, ethnicity, household structure, age and disability.

The measure shows the percentage of the adult population (age 16 years and over) in a local area who participate in sport and active recreation, at moderate intensity, for at least 30 minutes on at least 12 days out of the last 4 weeks (equivalent to 30 minutes on 3 or more days a week).

Figure 3.5.1 shows the percentage of the respondents in District Councils in Nottinghamshire who said that they participate in at least 30 minutes of sport and active recreation (including recreational walking and cycling) of at least moderate intensity on at least 3 days a week.

²⁵ Department of Health, (2011) Start Active, Stay Active: A report on physical activity for health from the four home countries Chief Medical Officers

Figure 3.5.1: Adult Participation in Sport and Active Recreation (16+)

*** = Active People Survey**

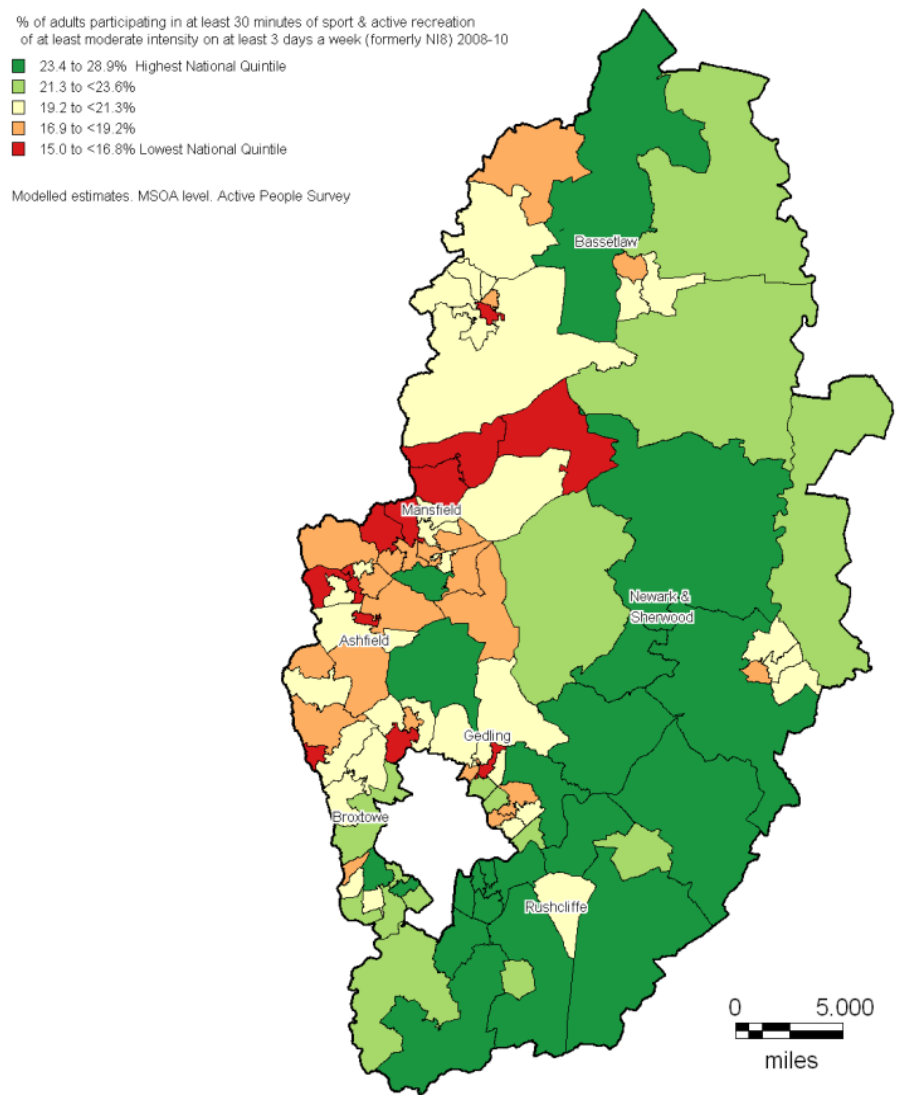
Area	APS* Oct 2005 – Oct 2006 (%)	APS* Oct 2007- Oct 2009 (%)	APS* Oct 2010 – Oct 2011 (%)	Any significant change?
Ashfield	20	18.5	22.4	No change
Bassetlaw	20	23.5	22.3	No change
Broxtowe	23.3	20.3	22.4	No change
Gedling	20.1	23.7	18.3	No change
Mansfield	17.8	18.4	20.5	No change
Newark & Sherwood	19.9	21.2	24.5	Increase
Rushcliffe	27.1	27.9	24.1	No change

Source: Sport England Active People Survey

Regular participation has been in sport has been provided at a lower level, middle super output area, by Sport England, and is shown in figure 3.5.2. Areas within the district of Rushcliffe still have the most consistent levels of participation in sport and active recreation, whilst large areas of Ashfield and Mansfield report much lower levels, alongside pockets of poor participation across all other areas of the county.

The reasons for these low levels of participation may vary across the county; demographics such as age of the population and economic status may play important roles alongside the number of accessible opportunities for recreational activity. Nationally, the Health Survey for England showed that activity was higher for men than women, activity declined with age, and overall activity levels decreased with decreasing household income.

Figure 3.5.2 Percentage of adults reporting participation in at least 30 minutes of sport and active recreation at least 3 days a week



Source: Sport England, Active Peoples Survey

3.6. Sexual Health- Sexually Transmitted Infections, HIV and Abortion

Key Messages

- There is considerable geographic variation in the distribution of sexually transmitted infections (STI), with the highest rates seen in urban areas of higher deprivation.
- The impact of poor sexual health is greatest in young heterosexual adults and in men who have sex with men.
- Diagnosed rates for the region broadly reflect those at County level with the highest diagnosed STI rates for chlamydia (350 per 100,000) and genital warts (125 per 100,000), and the lowest for syphilis and gonorrhoea (below 25 per 100,000).
- The picture varies at district level. For genital warts Mansfield and Bassetlaw are within the top 25% nationally for diagnosis; for diagnosis of Herpes Bassetlaw, Gedling, Ashfield and Mansfield are in the top 25% nationally; for diagnosis of Gonorrhoea Ashfield, Mansfield and Gedling are in the top 25% nationally.
- There has been a year on year rise in the number of new diagnoses of HIV seen for treatment in Nottinghamshire (0.53 per 1,000 people aged 15-59 in 2010).
- The rise in the incidence of chlamydia locally is due to the increased application of more sensitive tests and to the expansion of chlamydia testing.
- Health promotion and education remain the cornerstone of STI and HIV prevention through improving public awareness and encouraging safer sexual behaviour.
- Rates of legal abortions in Nottinghamshire are lower than East Midlands and national averages. However, the proportion which are carried out in under ten weeks is notably lower than the national average (Nottinghamshire NHS - 61%; England - 76%).

Sexually Transmitted Diseases may cause, life threatening complications including cancers, infertility, ectopic pregnancy, spontaneous abortions, stillbirth, low birth weight, neurologic damage and death.

Sexual Health is a national and local priority. The National Strategy for Sexual Health and HIV (DH 2001)²⁶ highlighted significant inequalities in sexual health and set out a blueprint for the development of sexual health services. Improving sexual health was identified as one of the key national priorities in the White Paper, Choosing health (2004)²⁷, and it has remained one of the priorities for the NHS. The White Paper 'Our Health, Our Care, Our Say (Department of Health 2006)²⁸ and associated consultation paper 'Commissioning Framework for Health and Well Being' 2007 adopts the themes and principles of person centred services, better understanding of the needs of

²⁶ Better Prevention, Better Services, Better Sexual Health: The National Strategy for Sexual Health and HIV. DH July 2001 Refreshed 2008 by the Independent Advisory Group for Sexual Health (<http://www.dh.gov.uk/assetRoot/04/07/44/86/04074486.pdf>)

²⁷ Choosing Health: Making Healthier Choices easier. Department of Health November 2004

²⁸ Effective Commissioning of Sexual Health and HIV Services, Department of Health 2003

populations and individuals, preventative services that emphasise healthy living and well-being and more effective joint planning and service delivery. It also builds on principles within the National Strategy for Sexual Health and HIV (Department of Health 2001) and Effective Commissioning of Sexual Health and HIV Services (DH 2003)²⁹. These include improved health and social care for people with HIV and AIDS, reducing health inequalities within sexual health, reducing stigma and involving service users in plans and developments.

Sexual health is an important issue for a number of reasons:

- Many Sexually Transmitted Infections (STI's) have long term effects on health
- There has been an increase in risky sexual behaviour, with continued ignorance about possible consequences
- The highest burden of sexually related ill health is borne by women, gay men, teenagers, young adults, black and minority groups, and more deprived communities
- Increasing demand for termination of pregnancy
- Sexual ill health costs the NHS alone more than £700 million a year

Targets and Indicators include the following:

- Access to Genitourinary Medicine (GUM) within 48 hours of request to be seen (GUM is concerned with the study and treatment of diseases of the genital and urinary organs, esp sexually transmitted diseases).
- Increasing the percentage of NHS funded abortions undertaken up to and including 9 completed weeks' gestation
- A 50% reduction in the under 18 conception rate by 2010 (from the baseline of 46.4 per 1,000). This is covered in the Children and Young People's chapter, but for all ages in this chapter
- Screening 15-24 years olds for asymptomatic Chlamydia (this is covered in this Children and Young People's chapter but for all ages in this chapter).

3.6.1. Sexually Transmitted Infections

The main STIs are Chlamydia, Gonorrhoea, Syphilis, Human Immunodeficiency Virus (HIV), Genital Herpes and Genital Warts. HIV and other STIs are a major concern in the UK. In 2009, it is estimated 86,500 people were living with diagnosed HIV infection representing a threefold increase since 1999³⁰. A quarter of these people were unaware of their infection. Of the newly diagnosed HIV cases in 2009, 1,130 probably acquired their infection heterosexually within the UK; accounting for a third of heterosexuals diagnosed. Uptake of HIV testing was 77% among STI clinic attendees in England and the East Midlands.

²⁹ The White Paper 'Our Health, Our Care, Our Say' Department of Health 2006

³⁰ HIV and Sexually Transmitted Infections within the East Midlands, Annual Report 2009. Health Protection Agency 2010

The East Midlands rates for the main STIs have continued to be lower than the national rates and have followed a similar pattern for the last three years. It is important to note that the data presented is for the East Midlands but there are variations within districts of disease prevalence. The data only highlights the prevalence for those individuals who are accessing services, not for those who do not access sexual health services. Therefore, we do not know nationally or locally the amount of undiagnosed prevalence. There has always been a stigma attached to accessing sexually health services for the treatment and management of sexually transmitted infections and although this is reducing due to the normalisation of testing it remains a significant issue. The diagnosed prevalence could therefore be far too low to offer a comprehensive picture.

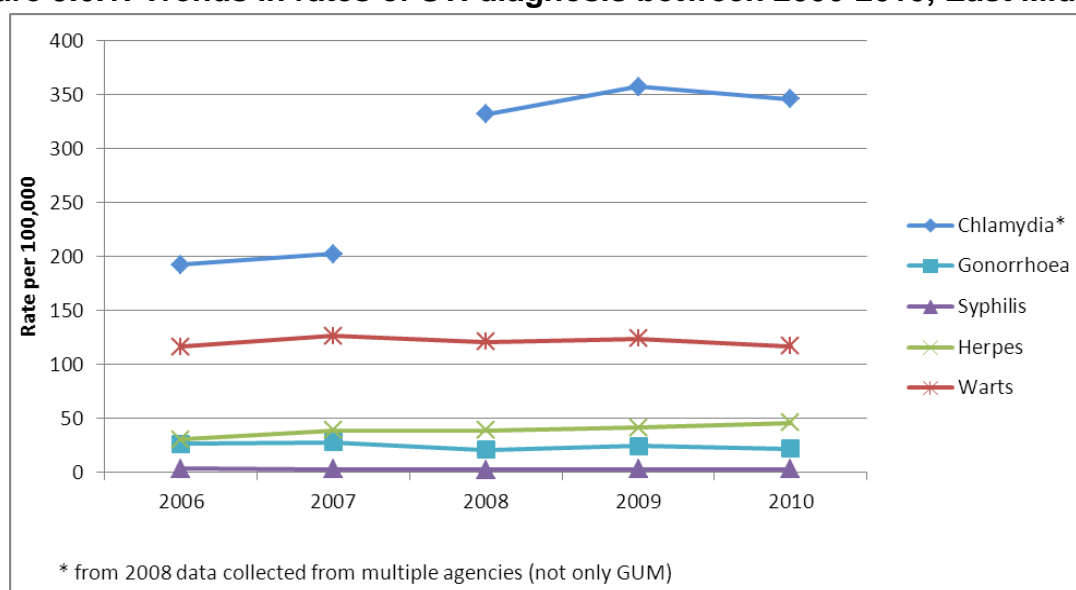
Who is at Risk?

There is a clear relationship between sexual ill health, poverty and social exclusion¹. Groups who are most at risk of poor sexual health and may experience barriers to accessing services include; young people; single homeless people; gay and bisexual men; sex workers; looked after young people; drug injecting users; people with learning difficulties; people in prisons and youth offending institutions.

Rates of HIV in Nottinghamshire have risen over the last 5 years (2005-2010), with the most recent population rate of 0.53 per 1000 persons aged 15-59 (2010).

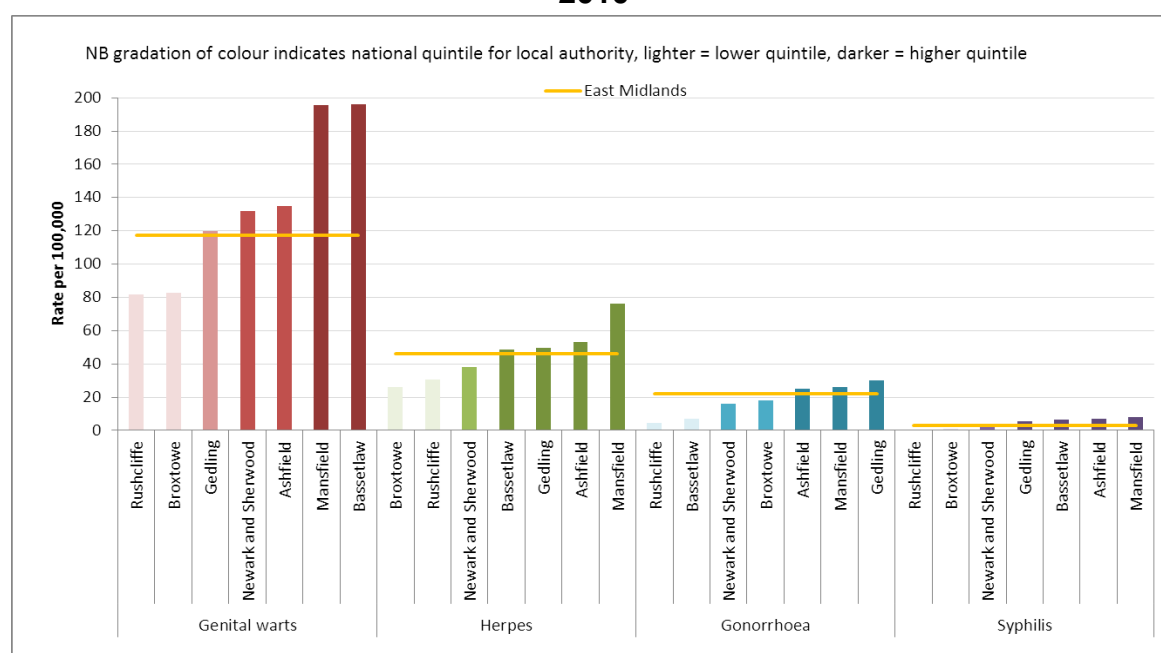
Figure 3.6.1 shows the rates of new diagnosis of the most common STIs at a regional level. These changes are reflected at a national level where rates of chlamydia, have increase significantly over the last 4 years. However, rates of STIs in the East Midlands are generally lower than in England. Across England, in both men and women chlamydia is the commonest STI diagnosed followed by genital warts, and then herpes.

Figure 3.6.1: Trends in rates of STI diagnosis between 2006-2010, East Midlands



Source: Health Protection Agency

Figure 3.6.2: Rates of STI diagnosis per 100,000 population by local authority in 2010



Source: Health Protection Agency

Figure 3.6.2 highlights which districts within Nottinghamshire County are within the highest 25% nationally for diagnosis of Sexually Transmitted diseases. For genital warts Mansfield and Bassetlaw are within the top 25% nationally for diagnosis; for diagnosis of Herpes Bassetlaw, Gedling, Ashfield and Mansfield are in the top 25% nationally; for diagnosis of Gonorrhoea Ashfield, Mansfield and Gedling are in the top 25% nationally. Caution should be used when interpreting the following figures as the actual numbers involved can be quite small. For example in 2010 in Bassetlaw the rate of new Syphilis

diagnoses was 5.4 per 100,000 population compared to the East Midlands rate of 3.2 per 100,000 population, but when the actual numbers are examined there were only 6 new Syphilis diagnoses.

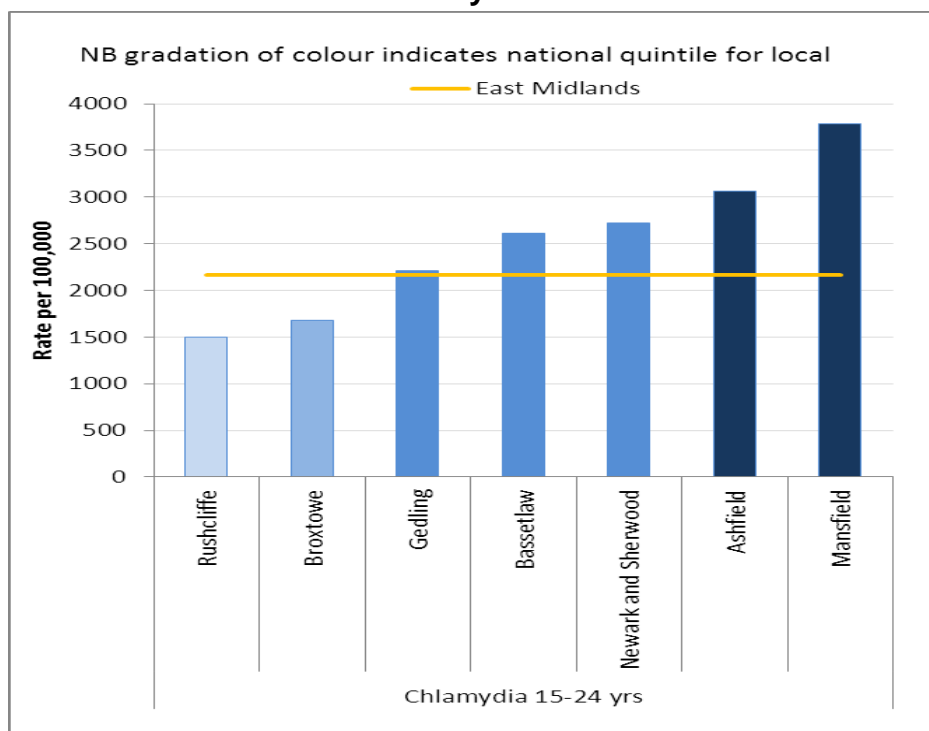
Chlamydia

Of the five main STIs, the incidence of Chlamydia is the highest amongst men and women nationally and regionally, affecting approximately one in ten of sexually active young people, with rates rising:

- It is asymptomatic in 75% of women and 50% of men
- Untreated infection can lead to serious health problems, particularly for women
- It may cause pelvic inflammatory disease (PID), ectopic pregnancy and infertility
- In men it can cause urethritis (inflammation of the urethra- the tube that carries urine from the body), epididymitis (inflammation of the testicle) and Reiter's Syndrome (arthritis)

Figure 3.6.3 shows Mansfield, Ashfield, Newark and Sherwood, Bassetlaw and Gedling all have rates of chlamydia diagnosis per 100,000 in the 15 -24 year age group higher than the East Midlands with Mansfield and Ashfield districts significantly higher rates per 100,000 population in the 15-24 year olds. In the East Midlands prevalence is highest in young sexually active adults especially women aged 15-19 years and men 20-24 years (Figure 3.6.4), this pattern also applies in Bassetlaw and Nottinghamshire County.

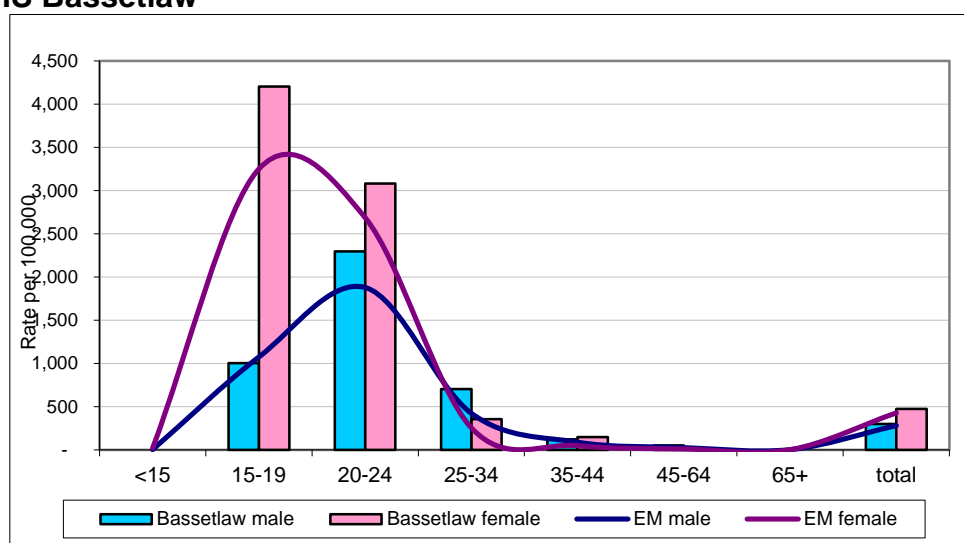
Figure 3.6.3: Rates of Chlamydia diagnosis per 100,000 population by local authority in 2010



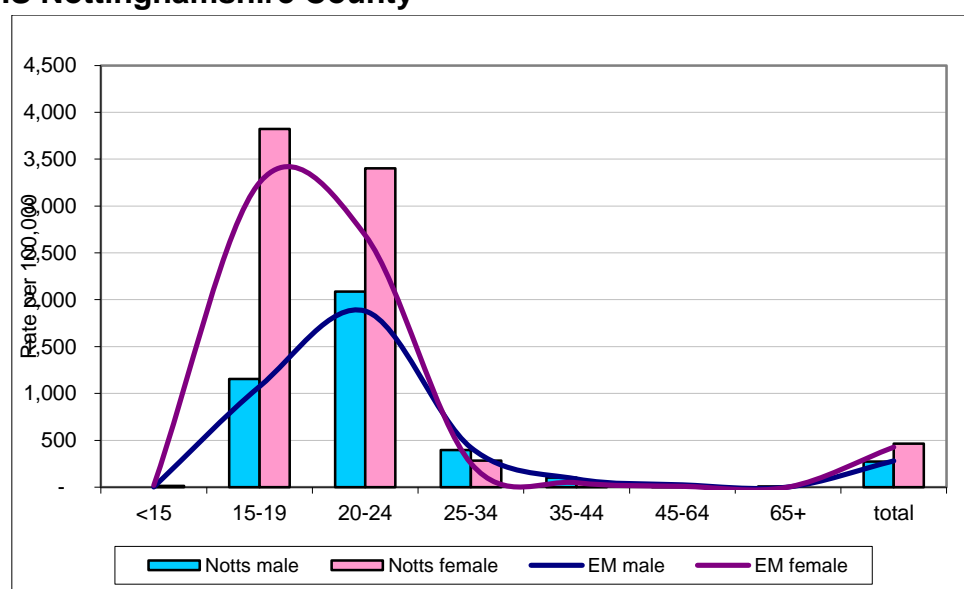
Source: Health Protection Agency

Figure 3.6.4 Rates of Chlamydia diagnosis per 100,000 population by age and gender 2010, NHS Bassetlaw and NHS Notts County.

a) NHS Bassetlaw



b) NHS Nottinghamshire County



Source: Health Protection Agency

Syphilis

Syphilis is a relatively uncommon STI, however:

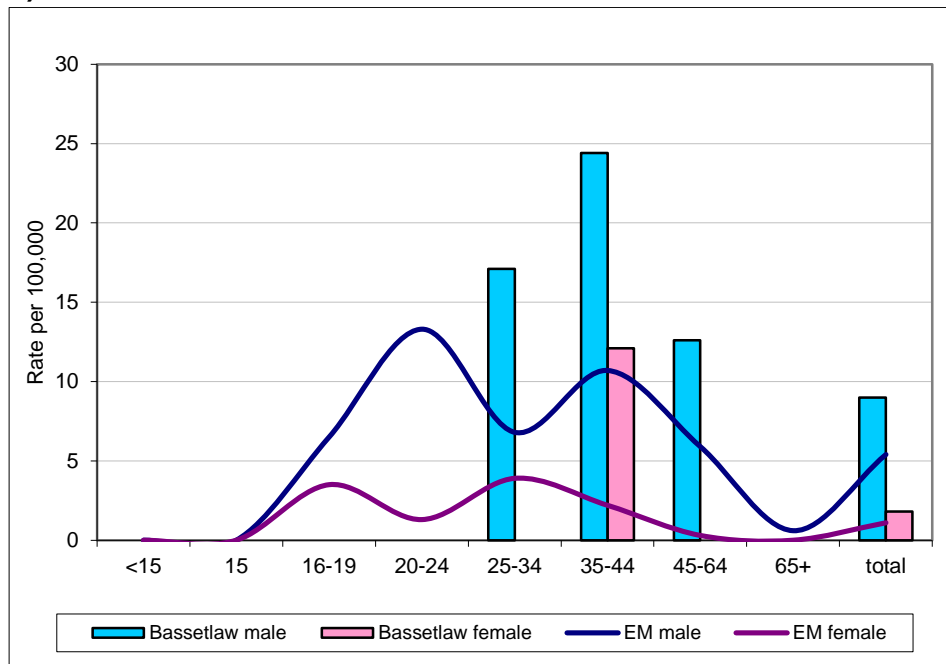
- Infection during pregnancy usually results in miscarriage, still birth or a congenitally infected baby
- Maternal infection is detectable and entirely treatable which prevents transmission to the baby
- If left undetected syphilis will eventually lead to tertiary (late) syphilis in about 30% of people. Tertiary syphilis is the most advanced stage of syphilis, resulting in infections of the cardiovascular and neurologic systems and marked by destructive lesions involving many tissues and organs.

The rate of increase over the last ten years in the new diagnosis of Syphilis has been high, with the East Midlands having a higher than national rate of change. However whilst the rate of change has been large the total numbers are small with Syphilis only representing 2% of all new diagnosis of all the main STIs.

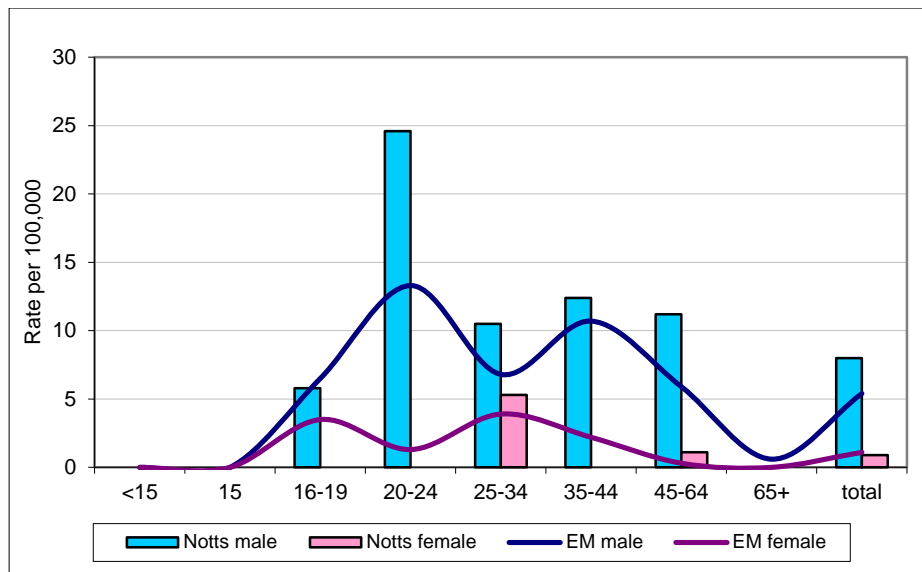
In 2010 the Syphilis was the highest in men, particularly the within the subgroup of men who have sex with men. This is a particular vulnerable group and usually relates to sexual practices. Figure 3.6.5 shows the gender and age groups most affected. The prevalence in Bassetlaw is highest in men and women in the 35-44 year age group, in Nottinghamshire County it is highest in men in the 20-24 year age group and 25-35 year age group in women.

Figure 3.6.5: Rates of syphilis diagnosis per 100,000 population by age and gender 2010, NHS Bassetlaw and NHS Notts County

a) NHS Bassetlaw



b) NHS Nottinghamshire County



Source: Health Protection Agency

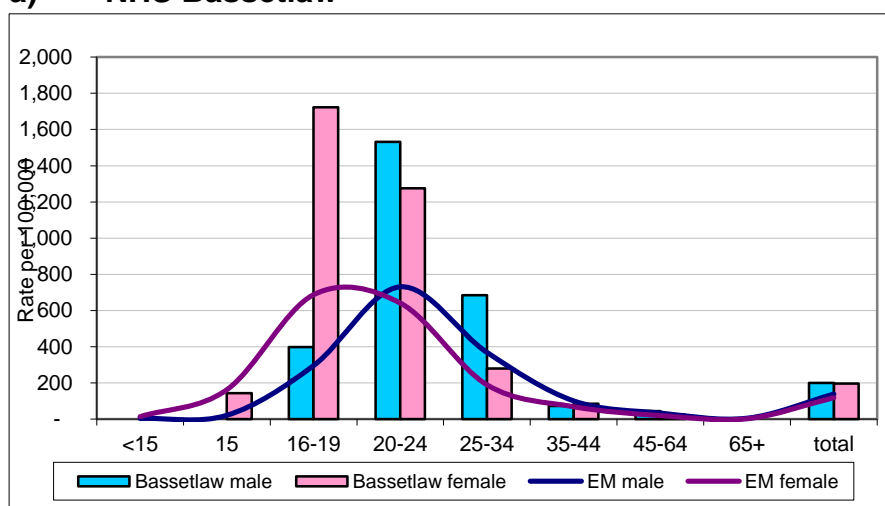
Genital Warts

There are many (over one hundred) types of Human Papillomavirus (HPV) of which are sexually acquired and can infect the genital tract. Certain genital HPV infections can cause cervical cancer, other cancers and warts.

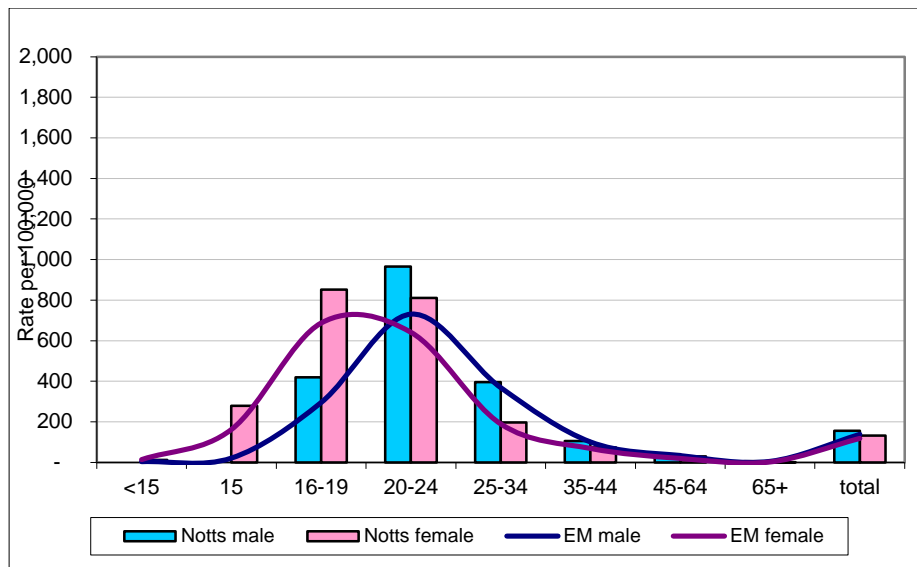
The number of new infections for Genital Warts within Nottinghamshire County has remained static. The highest proportion of occurs in heterosexuals, however it must be noted that not all clients disclose their sexual orientation.

Figure 3.6.6: Rates of Genital Warts diagnosis per 100,000 population by age and gender 2010, NHS Bassetlaw and NHS Notts County

a) NHS Bassetlaw



b) NHS Nottinghamshire County



Source: Health Protection Agency

The age pattern for the East Midlands and Nottinghamshire County shows the highest rate in males occurs in 20-24 year olds overall. For females it is more variable with higher rates being divided between the 16-19 year olds and the 20-24 year olds (Figure 3.6.6). In Bassetlaw the prevalence is highest in women in the 16-19 and 20-24 year age groups.

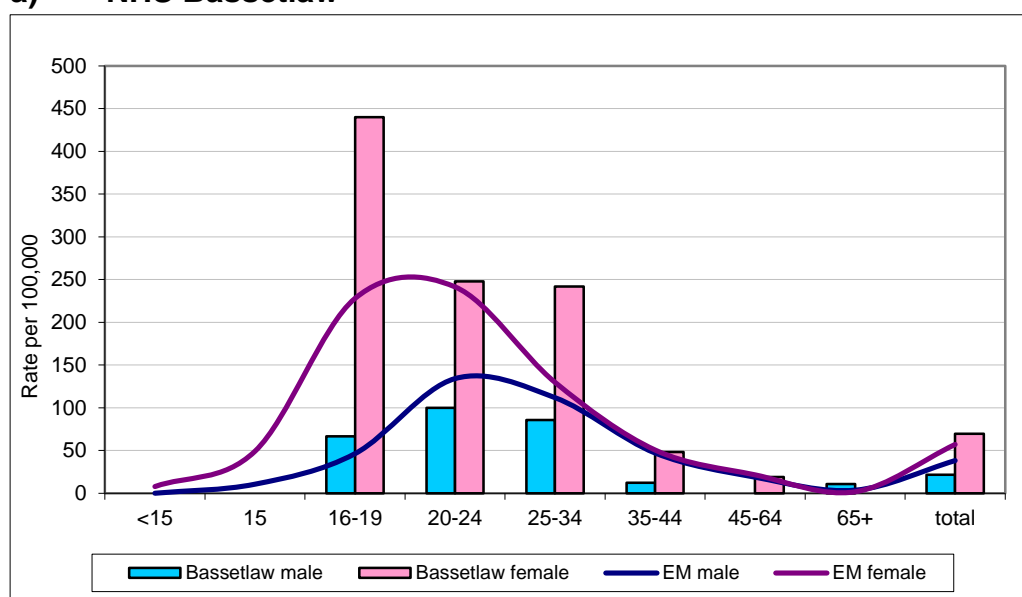
Herpes

Heterosexual individuals are the group most at risk of Herpes. The virus can cause severe systemic disease in neonates (newborn and Infants) and people with a suppressed immune system. It may facilitate HIV transmission.

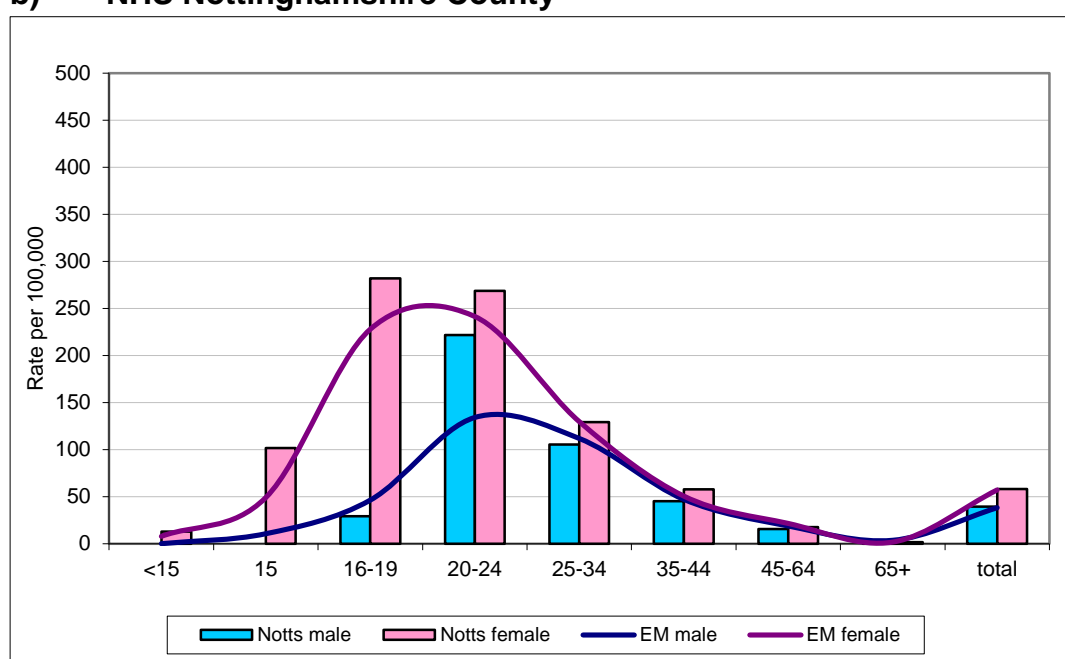
In the East Midlands and Nottinghamshire County the highest rates in males occur in the 20-24 year olds, the pattern in females is more variable with higher rates being divided between the 16-19 years and 20-24 years. In Bassetlaw women in the 16-19 & 25-34 year age groups show high prevalence whereas males in Bassetlaw show a similar pattern to East Midland males. Between 2008-10 both Bassetlaw and Nottinghamshire County show a similar trend to the East Midlands.(Figure 3.6.7).

Figure 3.6.7: Rates of Herpes diagnosis per 100,000 population by age and gender 2010, NHS Bassetlaw and NHS Notts County

a) NHS Bassetlaw



b) NHS Nottinghamshire County



Source: Health Protection Agency

Gonorrhoea

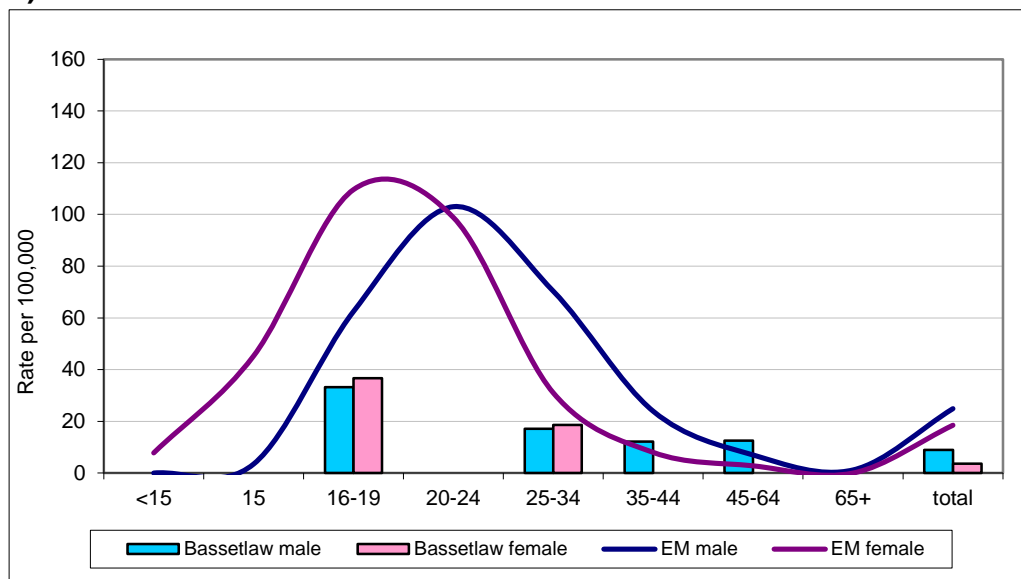
Nationally, gonococcal infection has a highly unequal distribution within the population. It is concentrated in people in urban areas, among young people, men who sleep with men and minority ethnic groups, the Black/Black British ethnic group in particular.

Gonorrhoea can have especially serious effects for young women if left untreated. Young women with Gonorrhoea can develop pelvic inflammatory disease.

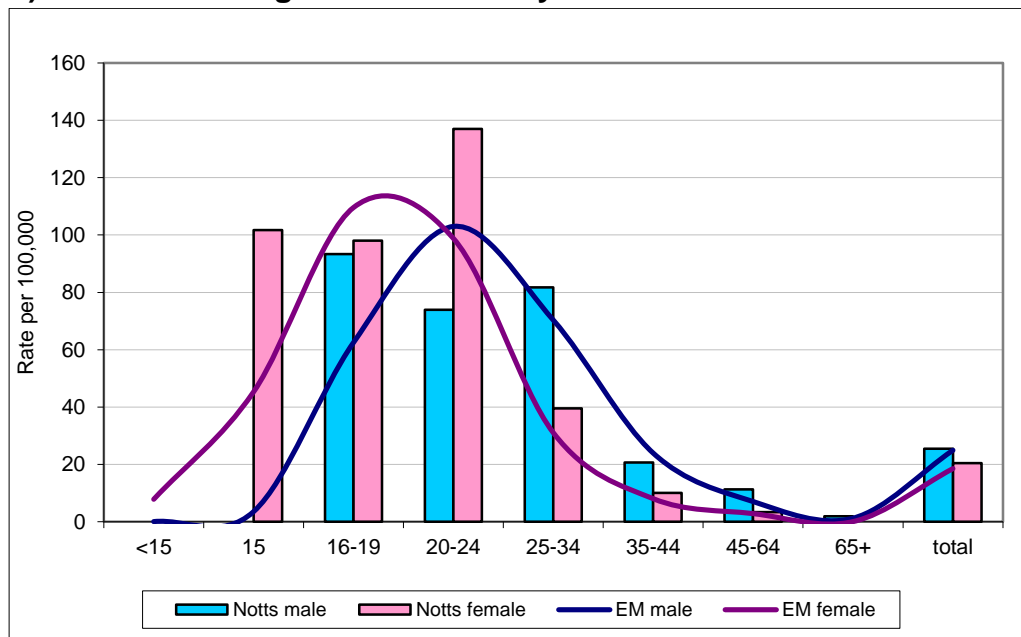
The peak age group for the East Midlands, Bassetlaw and Nottinghamshire County is 16-19 and 20-24 year old males. The prevalence in females was highest in the 16-19 year age group for Bassetlaw and the East Midlands, Nottinghamshire County females showed a high prevalence over several age groups from 15- 24 year olds.

Figure 3.6.8: Rates of gonorrhoea diagnosis per 100,000 population by age and gender 2010, NHS Bassetlaw and NHS Nottinghamshire County

a) NHS Bassetlaw



b) NHS Nottinghamshire County



Source: Health Protection Agency

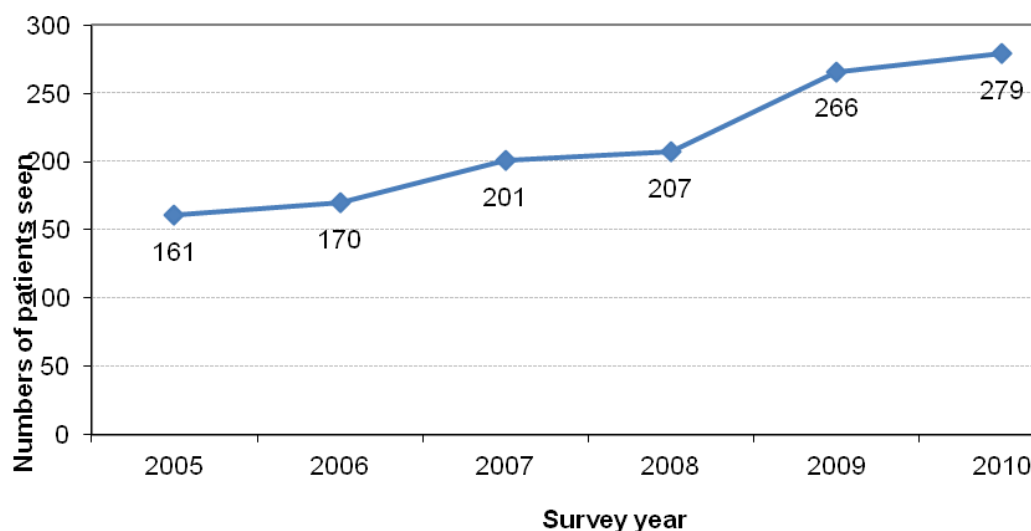
HIV

Human Immunodeficiency Virus (HIV) continues to be one of the most important communicable diseases in the UK. It is an infection associated with serious morbidity, high costs of treatment and care, significant mortality and high number of potential years of life lost. Each year, many thousands of individuals are diagnosed with HIV for the first time. The infection is still frequently regarded as stigmatising and has a prolonged 'silent' period during which it often remains undiagnosed. Highly active antiretroviral therapies have resulted in substantial reductions in AIDS incidence and deaths in the UK.

Anyone can be infected with HIV, but some communities have been more affected than others. The UK gay community and other men having sex with men have been the group most affected. Recent sharp rises in Sexually Transmitted Infections (STI's) among gay men have given rise to concern that high risk sexual behaviour amongst gay men is increasing.

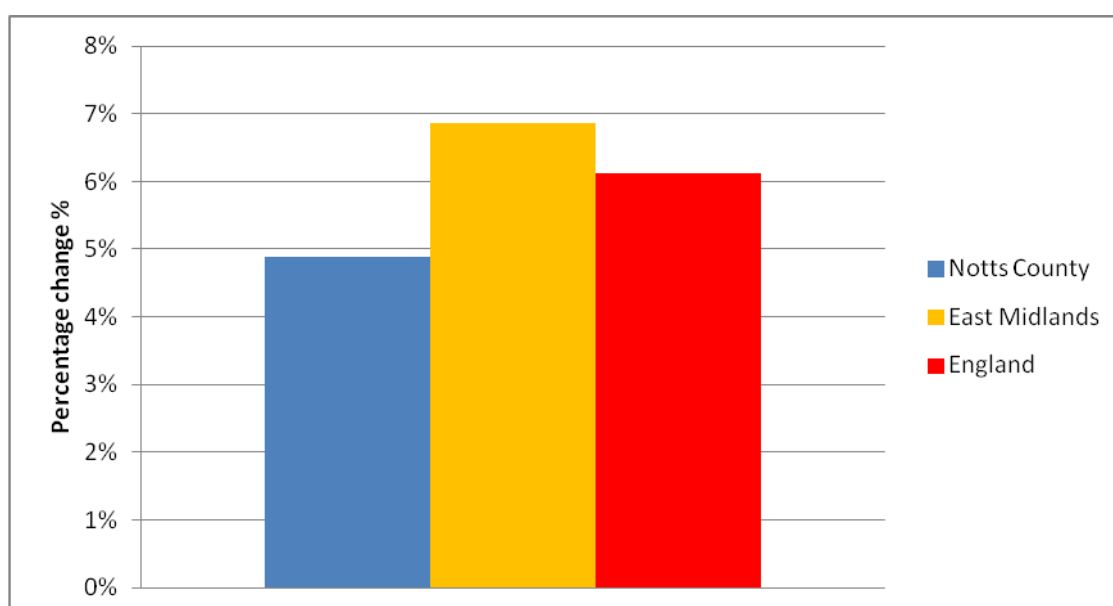
There has also been an increase in the number of heterosexuals becoming infected by HIV reported in the UK. Since 1999 the number of new HIV diagnoses acquired heterosexually has been higher than the number of people diagnosed through sex between men. The majority of these cases – about 80 per cent – are thought to have been acquired abroad, particularly in sub-Saharan Africa.

Figure 3.6.9: Trend in numbers of diagnosed HIV – infected individuals living in Nottinghamshire (inc Bassetlaw)



Source: SOPHID 2010

Figure 3.6.10: Percentage change between 2009 and 2010 of numbers diagnosed with HIV in Nottinghamshire, East Midlands SHA and Nationally

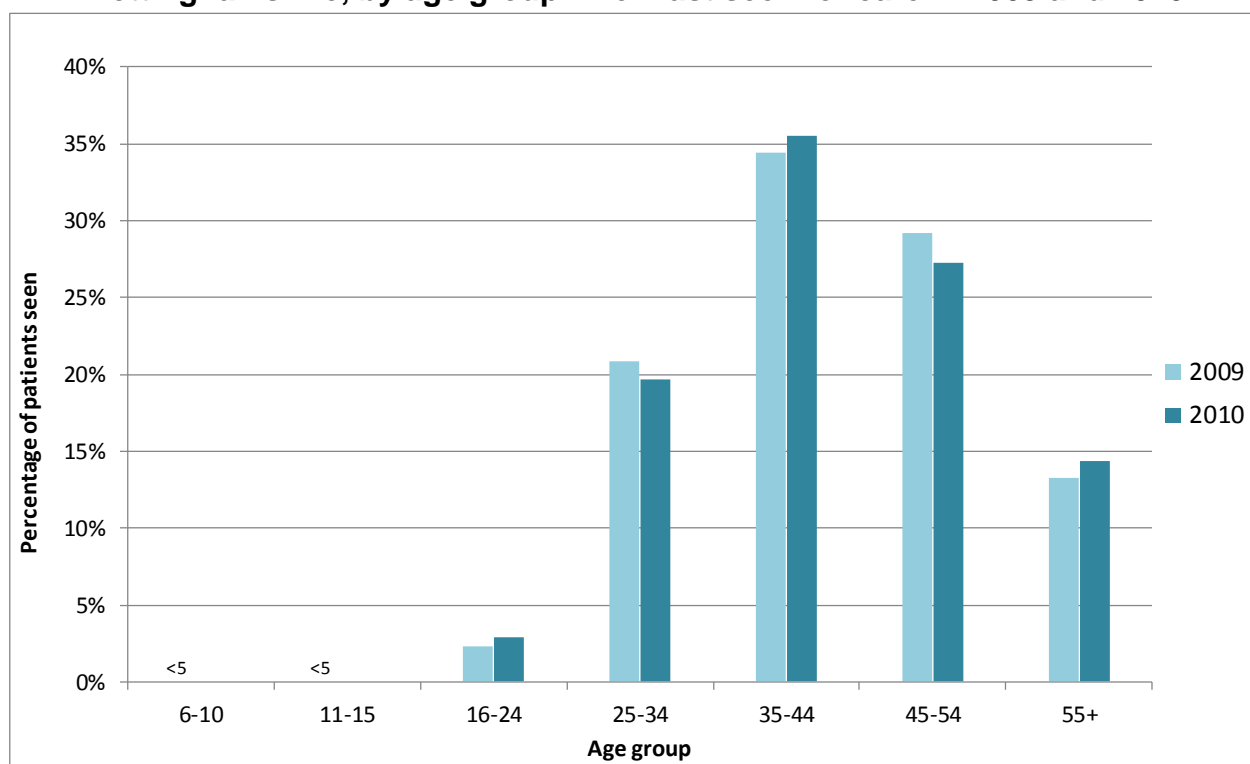


Source: SOPHID 2010

Figure 3.6.9 highlights that, in 2010, 279 people diagnosed with HIV who were resident in Nottinghamshire accessed HIV related care, of which 12% were resident within Bassetlaw. This is a 5% increase from 2009 (Figure 3.6.10).

The increase in the number of people diagnosed with HIV and seen in 2010 could be due to an increase in the number newly diagnosed people (data not available), migration of people into Nottinghamshire, uptake of treatment from those not previously known to services or a decrease in the numbers dying. No patient diagnosed with HIV in Nottinghamshire died in 2010.

Figure 3.6.11: Percentage of diagnosed HIV –infected patients living in Nottinghamshire, by age group when last seen for care in 2009 and 2010



Source: SOPHID 2010

The majority of people diagnosed with HIV infection who are resident in Nottinghamshire are aged between 25 to 55 years. There has been a slight increase in the age group 55+years (Figure 3.6.11). This could be due to more effective treatment. The geographical spread of the 279 people diagnosed with HIV infection across Nottinghamshire shows 45% of people are resident in South Nottinghamshire, a further 43 % are resident in Central Nottinghamshire and the remaining 12% of people accessing care are in Bassetlaw. Gedling district has the highest numbers within Nottinghamshire

STI Treatment and Management (including HIV)

HIV in patient management comes under the responsibility of specialised commissioning. For outpatient services, that includes the management and treatment of HIV and STIs, GUM has a significant responsibility.

For this reason satellite GUM clinics in a community setting have opened across the county to improved access to testing for STIs. Also, in conjunction with the Local Authorities additional social support for HIV and on the spot testing for HIV has been commissioned for this small but growing population group.

It is vital for all sexually transmitted infections that partner notification is carried out. This is where the partner(s) of all those diagnosed with an STI are contacted, tested and treated. This is to reduce the onward transmission of infection to other partners and to

prevent re-infection of the current partner. This is routinely undertaken in GUM services across the county and nationally. All GUM services meet the current quality standards.

Access to Specialist Services

In order to try and reduce the high rates of STIs, GUM clinics are required to improve access by reducing the time people wait for diagnosis and treatment and to ensure that 100% of new patients contacting the service are offered an appointment within 48 hours. GUM is an open access service. The main service accessed by residents of Bassetlaw PCT is at Retford Hospital but residents can also access services in Worksop. Residents of NHS Nottinghamshire County are likely to access a service either at Kings Mill Hospital or the City Hospital, Nottingham. Both Nottinghamshire County and Bassetlaw PCT are meeting the 'offered' target of an appointment within 48 hours to all clients to increase access to services and ensure early treatment

Predicted Need

Recent data shows that the trend for STI diagnosis is fairly stable over the last five years within Nottinghamshire County, other than for the number of diagnosis for Chlamydia. However, the number of diagnosis needs to be seen alongside the number of people accessing services. Also clients also choose to access STI services outside of the area where they live. We would also need to take into account of any population increases that may have an impact on access to services and also social factors such as the increase in the number of divorces which lead to changes in sexual partners.

Increase in the awareness of improved sexual health may also have an impact on the level of provision required.

The number of HIV diagnoses is increasing steadily year on year, antiviral therapy is costly and with the advances in this area of treatment the life expectancy for those people living with HIV is almost that of someone who does not have HIV. The evidence also suggests there are significant numbers of HIV cases that remain undiagnosed.

3.6.2. Abortion

The level of abortion is often used as an indicator of the degree of failure to use contraception, or failure of the contraception itself. Table 3.6.12 shows that NHS Nottinghamshire County has a slightly lower abortion rate (13 per 1000 women aged 15-44 years) than the East Midlands (13.9 per 1000) and England and Wales (17.5 per 1000). There were 1,545 abortions in NHS Nottinghamshire County in 2010, 53% (818) of which were in women aged under 25 years. NHS Bassetlaw also has a slightly lower abortion rate (13.5 per 1000 women aged 15-44 years) than the East Midlands (13.9 per 1000) and England and Wales (17.5 per 1000). There were 244 abortions in NHS Bassetlaw in 2010, 54% (133) of which were in women aged under 25 years

Table 3.6.12 : 2010 legal abortion rates (number) by age

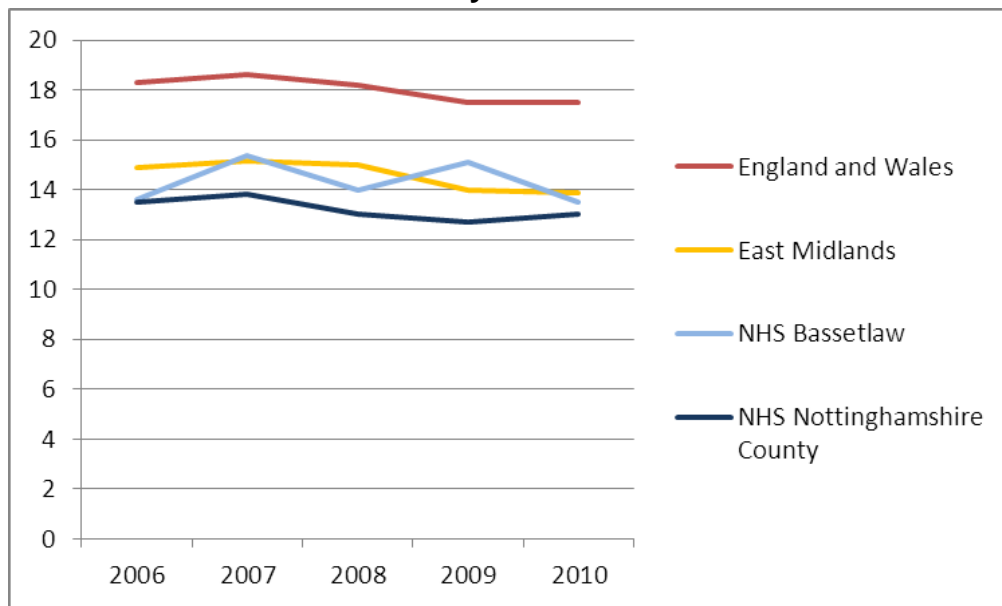
	Total number of abortions	Rate per 1,000 women resident aged 15 – 44 ASR*	Crude rate (number) per 1000 women					
			Age Group					
			Under 18	18-19	20-24	25-29	30-34	35+
England and Wales	189,574	17.5	16.5 - 16,460	30.7 - 21,809	30.2 - 55,841	22.5 - 40,800	16.5 - 27,978	6.7 - 27,046
East Midlands	11,869	13.9	14 -1,146	25 - 1,535	23 - 3,492	18 - 2,416	14 - 1,677	5 - 1,603
NHS Bassetlaw	244	13.5	12 -26	24 -31	27 -76	15 -38	15 -40	4 -33
NHS Notts County	1545	13	14 -167	27 -215	23 -436	16 -309	11 -215	4 -203

Source: (DH Statistical Bulletin May 2011)

*ASR = age standardised abortion rate

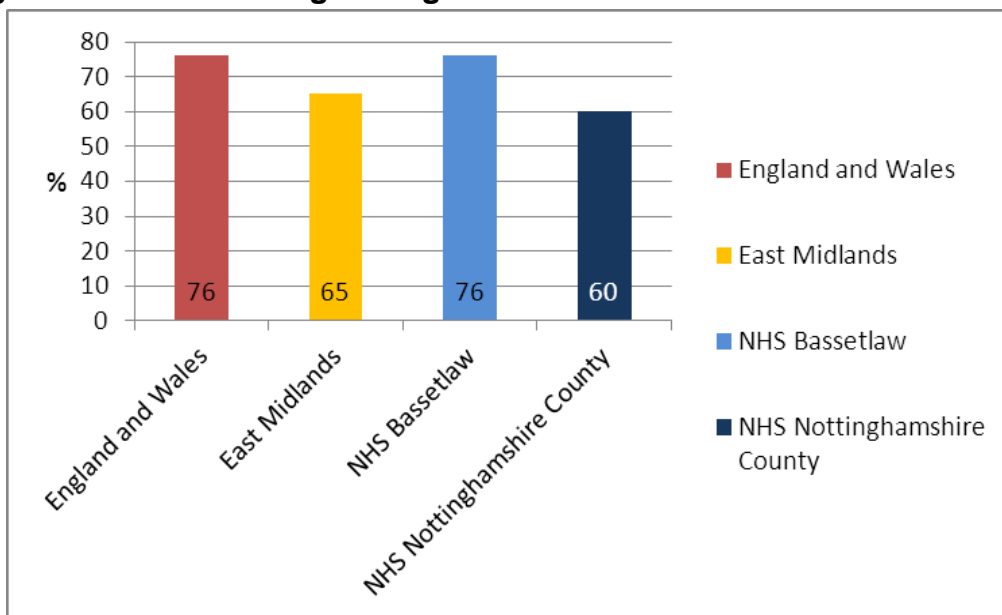
It is important for those women who are legally entitled to access an abortion to be able to access the procedure as soon as possible. Figure 3.6.13 highlights that over the 5 year period from 2006 to 2010 the overall trend in the number (and rate) of abortions locally, regionally and nationally is downwards. NHS Nottinghamshire County and NHS Bassetlaw have consistently had a lower rate than England and Wales over the last 5 years. NHS Nottinghamshire County (3.1%) and NHS Bassetlaw (3.2%) have experienced a greater reduction in the number of abortions between 2006 and 2010 than England and Wales (2.2%) and the East Midlands (2.8%).

Figure 3.6.13: Trend in standardised abortion rate per 100,000 women aged 15-44 years



Source: (DH Statistical Bulletin May 2011)

Figure 3.6.14: Percentage of legal abortion carried out at under 10 weeks



Source: (DH Statistical Bulletin May 2011)

If a woman can access the service before she is nine weeks pregnant, she can have a choice of abortion method. The earlier in pregnancy an abortion is performed, the lower the risk of complications. Locally, regionally and nationally in 2010 the vast majority (between 89-92%) of abortions are performed at under 13 weeks. Nationally there has been a continuing increase in the proportion of abortions that are performed under 10 weeks since 2002. In 2010, 76% of abortions in England and Wales were performed under 10 weeks compared to 75% in 2009 and 58% in 2000. However, NHS Nottinghamshire County's proportion (61%) is lower than the regional and national

proportion of abortions taking place under 10 weeks. The gestation times at which abortions are performed in NHS Bassetlaw is very similar to that of England and Wales and more abortions are performed earlier than the in the East Midlands. .

Access to Abortion Services

In order to achieve the number of terminations undertaken under 10 weeks Nottinghamshire County (excluding Bassetlaw as they already meet the target) have procured a new service to undertake pre-termination assessment and early medical abortions as part of an improved care pathway within community settings across the county. Bassetlaw are meeting the requirement for the number of terminations carried out under 10 weeks.

3.6.3 Future challenges

- Improved data collection and analysis through the collection of the GUMCAD dataset.
- Strengthening the targeting of provision and interventions in hotspot areas and with the most vulnerable.
- The early identification of young people most at risk of teenage pregnancy in order to provide early intervention(part of Children and People chapter)
- Ensuring that services are developed in line with patient need, including locations and timings of services
- Improved health promotion to those in high risk groups

JOINT STRATEGIC NEEDS ASSESSMENT FOR NOTTINGHAMSHIRE 2012

Adults and Vulnerable Adults

4. Health and Social Care

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Adults: Health and Social Care

4. Adult Health and Social Care

4.1. Which illnesses/long-term conditions are people living with?

Key messages

- In general, the prevalence of many long-term conditions in Nottinghamshire is similar to the national average.
- The most common long-term conditions are hypertension, common mental health disorders, asthma, chronic kidney disease, diabetes, chronic back pain and coronary heart disease. Most long-term conditions are more prevalent in more deprived communities.
- The estimated number of hypertension sufferers in the county is 210,285, well above the next most common long-term condition (mental health with 86,220 sufferers). It is estimated that just under half of the hypertension cases in Nottinghamshire remain undiagnosed and therefore untreated and at risk.
- Other long-term conditions where there are a relatively high proportion of undiagnosed people include diabetes, COPD (Chronic Obstructive Pulmonary Disease), dementia and chronic kidney disease¹.

Introduction

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 factors².

How many people suffer from long-term conditions?

In this section numbers refer to total registered populations in both NHS Nottinghamshire and NHS Bassetlaw unless otherwise stated.

Figure 4.1.1 gives an overview of the relative burden of the most common long-term conditions in Nottinghamshire's population. It does not include co-morbidities, where a person may suffer from more than one condition at the same time. The commonest long-term conditions are hypertension, common mental health disorders, asthma, chronic kidney disease, diabetes, chronic back pain and coronary heart disease. Figure

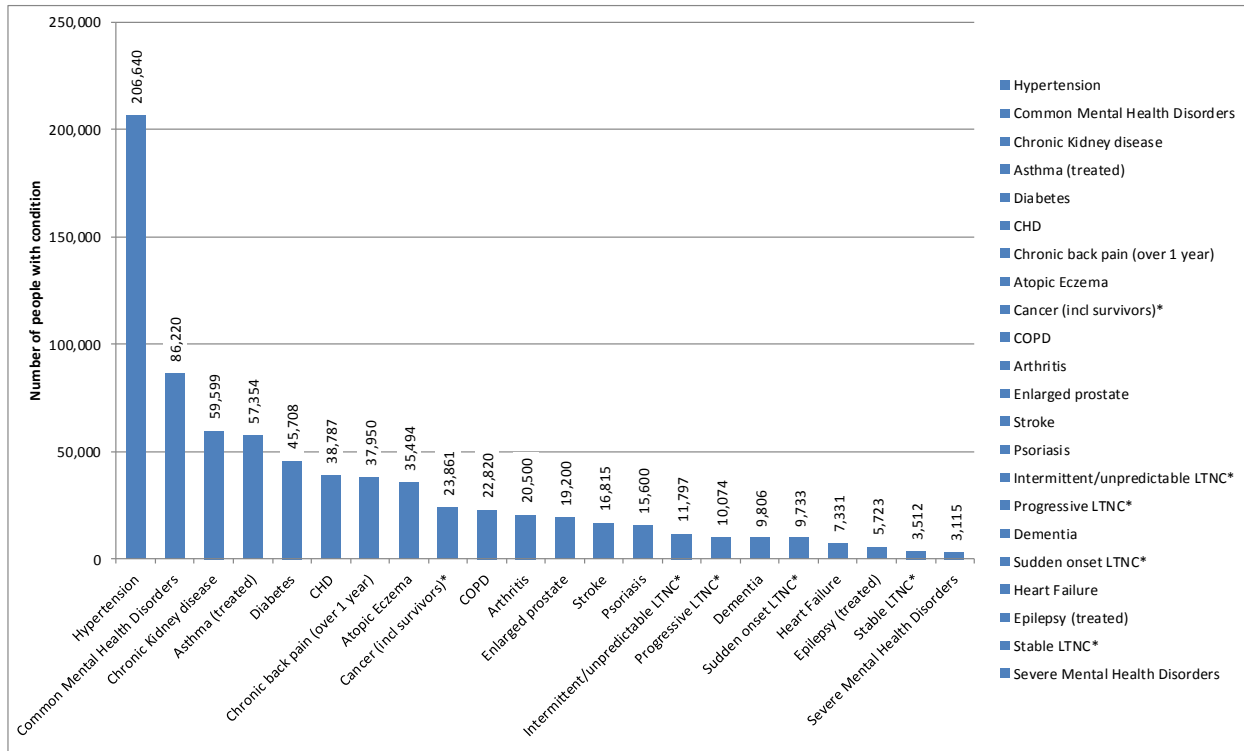
¹ It has not been possible to assess unmet need for all long-term conditions, e.g. common mental health disorders.

² Generic choice model for long term conditions. Department of Health Choice Policy Team 2007.

4.1.2 gives a further breakdown by CCG. Detailed reports regarding the key long-term conditions will be provided as part of the on-going JSNA work programme.

Figure 4.1.1 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 co-morbidities (where one person may suffer from a number of conditions at the same time)



Sources: different prevalence models (contact author for details), Notts registered population July 2011

*prevalence estimates include children

LTNC=long term neurological conditions

CHD=coronary heart disease

COPD=chronic obstructive pulmonary disease

Figure 4.1.2 Estimates of relative burden of long-term conditions in Nottinghamshire's Clinical Commissioning Groups

	Bassetlaw	Mansfield and Ashfield	Nottingham North & East	Newark & Sherwood	Nottingham West	Principia
Hypertension	30,448	48,358	38,439	34,487	24,385	30,523
Common Mental Health Disorders	10,840	22,670	17,460	12,540	11,290	11,420
Chronic Kidney disease	8,371	13,312	11,201	9,980	7,336	9,399
Asthma (treated)	8,171	13,345	10,560	9,369	7,015	8,895
Diabetes	6,400	10,352	8,587	7,547	5,553	7,269
CHD	5,957	9,903	7,063	6,552	4,394	4,918
Chronic back pain (over 1 year)	5,361	8,877	7,062	6,204	4,596	5,927
Atopic Eczema	1,072 - 8,935	1,775 - 14,796	1,412 - 11,770	1,241 - 10,340	919 - 7,661	1,185 - 9,878
Cancer (incl survivors)*	4,037	3,142	5,207	3,629	3,403	4,443
COPD	3,179	5,499	4,832	3,506	3,268	2,536
Arthritis	8,749	13,559	11,409	10,311	7,581	9,756
Enlarged prostate	2,816	4,211	3,530	3,247	2,330	3,044
Stroke	2,503	4,141	3,080	2,814	1,987	2,290
Psoriasis	1,098 - 3,293	1,829 - 5,486	1,443 - 4,328	1,272 - 3,816	931 - 2,794	1,216 - 3,647
Intermittent/unpredictable LTNC*	911-1,537	1,518-2,560	1,197-2,020	1,056-1,781	773-1,304	1,009-1,702
Progressive LTNC*	1,410-1,432	2,348-2,385	1,853-1,867	1,634-1,659	1,196-1,215	1,561-1,586
Dementia	1,386	2,166	1,863	1,645	1,319	1,634
Sudden onset LTNC*	1,372	2,285	1,803	1,590	1,164	1,520
Heart Failure	1,031	1,598	1,357	1,214	946	1,186
Epilepsy (treated)	814	1,325	1,055	935	701	893
Stable LTNC*	385-605	642-1,008	506-795	446-701	327-513	427-670
Severe Mental Health Disorders	439	731	577	509	372	486

Sources: different prevalence models (contact author for details), Notts registered population July 2011

*prevalence estimates include children

LTNC=long term neurological conditions

CHD=coronary heart disease

COPD=chronic obstructive pulmonary disease

Hypertension (elevated blood pressure)

Hypertension or elevated blood pressure is a risk factor for stroke, coronary heart disease, chronic kidney disease and heart failure. Hypertension is the commonest long-term condition for people in Nottinghamshire (figure 4.1.1). Many people remain undiagnosed and untreated with this condition (figure 4.1.8).

Elevated blood pressure in people less than 50 years old is associated with increased cardiovascular risk. Dietary salt is a significant factor in raising blood pressure in people with hypertension and in some people with normal blood pressure. Although increasing blood pressure is part of aging, a healthy low salt diet, physical activity and maintaining a healthy weight can reduce the risk of this happening.

Mental Health Disorders

It is estimated that about a third (30%) of all consultations in general practice have a significant mental health component, and the vast majority 90% of all mental health conditions are managed entirely in primary care. Common Mental Disorders (CMDs) include different types of depression and anxiety; they cause appreciable emotional distress and can interfere with daily function, but do not usually affect insight or cognition. In May 2008 the Mental Health Observatory published a technical brief³ describing a method for estimating numbers of people suffering from CMDs within local populations. These estimates have been used to estimate that around 86,550 people in Nottinghamshire suffer from common mental disorders. Mental health disorders, including severe mental health disorders are considered in more detail in section 2.5.

Chronic kidney disease

Chronic kidney disease (CKD) describes abnormal kidney function and/or structure. It is common, frequently unrecognised and often exists together with other conditions (for example, cardiovascular disease and diabetes). The risk of developing CKD increases with increasing age. Hypertension, cardiovascular disease and diabetes are some of the risk factors for developing CKD. CKD can progress to established renal failure in a small but significant percentage of people.

CKD is usually asymptomatic, but it is detectable. There is evidence that treatment can prevent or delay the progression of CKD, reduce or prevent the development of complications and reduce the risk of cardiovascular disease. However, because of a lack of specific symptoms people with CKD are often not diagnosed, or diagnosed late when CKD is at an advanced stage⁴.

It is estimated that 57,101 people in Nottinghamshire suffer from CKD, however around 27% remain undiagnosed.

Diabetes

Diabetes is a chronic disease and a major cause of premature morbidity and mortality. It is a group of disorders, sharing the common feature of raised blood glucose due to a shortage of, or an inability to respond to, insulin. Insulin is a hormone produced by the pancreas which assists in the transportation of glucose from the blood into cells. Hyperglycaemia, or raised blood sugar, is a common effect of uncontrolled diabetes and over time leads to serious damage to many of the body's systems, especially the nerves and blood vessels.⁵

³ Glover G (2008). Estimating the prevalence of common mental health problems in PCTs in England: a first approximation of the expected caseload for the new psychological therapy services. NEPHO <http://www.nepho.org.uk/mho/briefs>

⁴ NICE clinical guideline 73 – Chronic kidney disease. NICE, Sept 2008.

⁵ Diabetes fact sheet no. 312. WHO Aug 2011.

Categories of diabetes are listed and described below:

- Type 1 is caused by the lack of insulin production; it starts in childhood and daily administration of insulin is required.
- Type 2 is caused by the body's ineffective use of insulin. It comprises 90% of people with diabetes around the world, and is largely the result of excess body weight and physical inactivity. Until recently, this type of diabetes was seen only in adults but it is now also occurring in children.
- Gestational is caused by increased blood glucose during pregnancy

It is estimated that 45,708 people in Nottinghamshire County are living with diabetes, however, 23% are estimated to remain undiagnosed with this condition (figure 4.1.8).

Back pain

Back pain is a relatively common condition in the UK⁶. It is estimated that 40% of the adult population in the UK had suffered at least one day of back pain in the previous 12 months. The proportions of men and women with pain were roughly equal. Nearly 40% of back pain sufferers had consulted a GP about the problem and 5% of people of working age with back pain had taken time off work due to pain during the previous month. 15% of back pain sufferers said they were in pain throughout the year (chronic back pain). Applying these estimates to the Nottinghamshire population suggests that over 253,000 adults in Nottinghamshire suffer from back pain with 37,950 suffering from chronic back pain lasting 12 months or more.

Cardiovascular diseases

Cardiovascular diseases (CVD), which includes coronary heart disease (CHD) and stroke is common and as a premature cause of ill-health, largely preventable. Although death rates from CVD are falling, it is still the major cause of premature death in the UK (see section 4.6) It is also a major cause of ill-health and the British Heart Foundation estimates that over 1.5 million men and 1.2 million women in the UK suffer from angina or have had a heart attack.

There are two main events that lead to CVD. The first of these is atherosclerosis, which causes narrowing of the blood vessels, commonly referred to as “furring of the arteries”. This is caused by the formation of multiple plaques within the blood vessel, which lead to a reduced flow of blood to the heart. This may cause chest pain (angina), particularly during exercise. The second event is called thrombosis. This is when a plaque ruptures and causes an obstruction of the artery. If it stops the blood supply from reaching the heart this is a heart attack. If it stops the blood supply from reaching the brain, this is a stroke.

⁶ Department of Health Statistics Division. The prevalence of back pain in Great Britain in 1998.

London: Government Statistical Service, 1999 URL:

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4054015.pdf

It is estimated that there are 37,667 people in Nottinghamshire suffering from CHD and 16,491 suffering from stroke. After a stroke around 30% of people will make a full recovery, 30% will experience some level of disability and 30% will experience severe disability.

Cancer

1 in 3 people will develop some form of cancer during their lifetime. Between 1979 and 2008, incidence rates for cancer in Great Britain increased by 26% with a 13% increase in men and a 34% increase in women. However, in the last decade incidence rates have remained fairly constant.

There are more than 200 different types of cancer, but four of them - breast, lung, large bowel (colorectal) and prostate - account for over half (54%) of all new cases. Breast cancer is the most common cancer in the UK even though it is rare in men⁷.

There were 4,177 new cases of cancer diagnosed in Nottinghamshire County per year between 2006 and 2008. The incidence (new cases) of the most common cancers in males and females in Nottinghamshire compared with the England average shows some differences. For example in males, melanoma skin cancer and prostate cancer show significantly lower rates, whereas stomach and leukaemia show significantly higher rates than England (fig 4.1.3). In females, incidence largely mirrors national rates, but is significantly lower in Nottinghamshire for melanoma skin cancer (fig 4.1.3). Figure 4.1.4 also gives a breakdown of the estimated prevalence of cancers by clinical commissioning group. These estimates include people who are currently suffering from cancer or who are survivors of cancer (total prevalence).

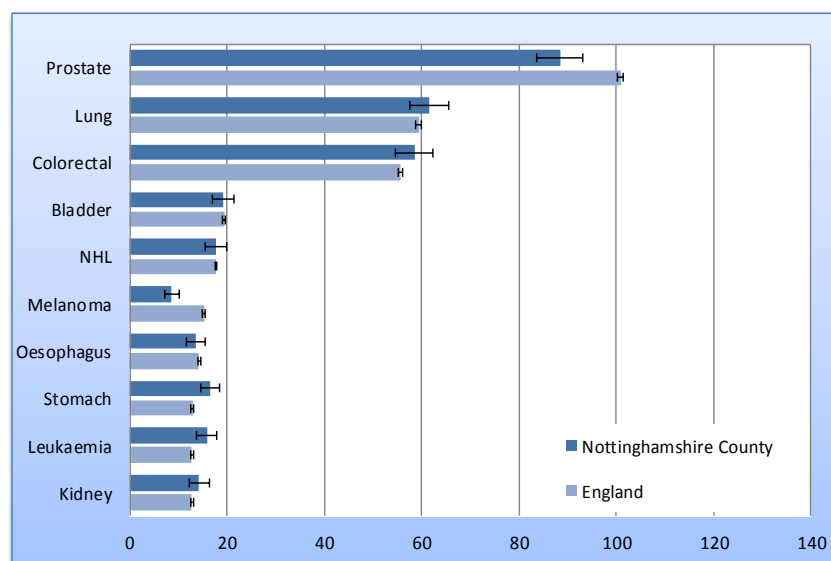
Cancer occurs predominantly in older people, with three quarters (75%) of cases diagnosed in people aged 60 and over, and more than a third of cases in people aged 75 and over. Around 1 in 10 of all cancer cases occur in adults aged 25-49 years. The most common cancers diagnosed in this age group include breast, malignant melanoma, bowel cancer and cancer of the cervix. Breast cancer accounts for nearly half (45%) of all cancers diagnosed in UK women aged 25-49 years.

Survival of cancers, measured as the relative 5 year survival rate, has increased in Nottinghamshire recently however survival rates in Nottinghamshire compared with the national average are lower for both males and females (fig 4.1.5).

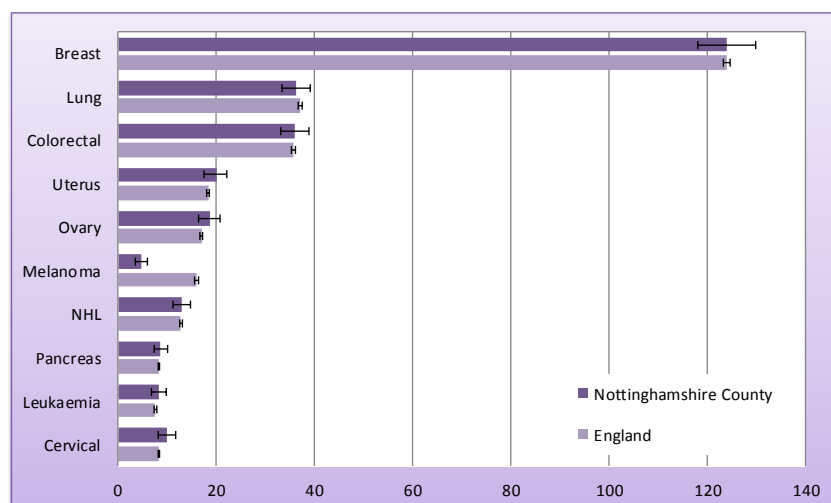
⁷ Cancer in the UK: December 2011. Cancer Research UK <http://info.cancerresearchuk.org/cancerstats/keyfacts/>
JSNA 2012, Adults and Vulnerable Adults, 4. Health and Social care

Figure 4.1.3 Incidence of cancers in Nottinghamshire by gender, age standardised rates per 100,000 population, 2006-2008.

Males



Females



Source: Health and Wellbeing Board Cancer Profiles. Trent Cancer Registry Nov 2011.

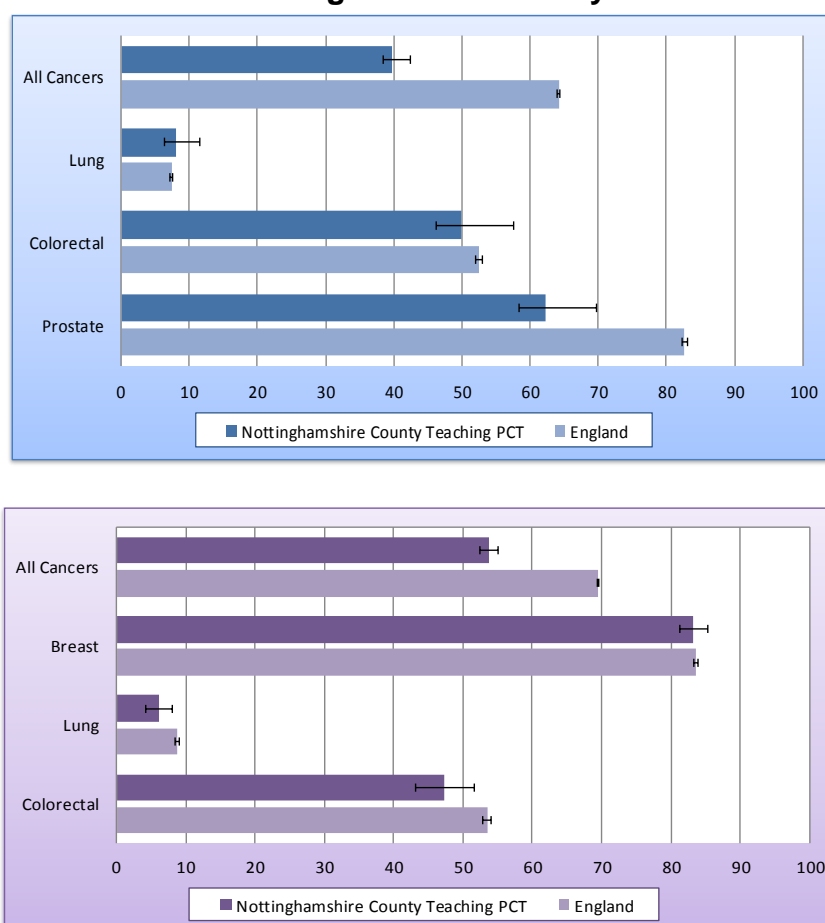
NHL: Non-Hodgkins Lymphoma

Figure 4.1.4: Prevalence of cancer, including survivors, by cancer site and clinical commissioning group in Nottinghamshire, 2010.

	Nottingham					Principia -	
	Bassetlaw CCG	Mansfield & Ashfield CCG	North & East CCG	Newark & Sherwood CCG	Nottingham West CCG	Rushcliffe CCG	
Males							
Colon, rectum, anus	265	298	333		304	215	284
Lung, bronchus, trachea	84	95	105		97	68	90
Prostate	553	630	692		635	450	591
All other malignant neoplasms	838	906	1,060		959	681	904
All malignant neoplasms	1,741	1,929	2,190		1,995	1,414	1,870
Females							
Breast	1,073	655	1,407		1,261	925	1,201
Colon, rectum, anus	221	62	292		213	196	250
Lung, bronchus, trachea	48	18	64		43	43	55
All other malignant neoplasms	954	477	1,254		644	826	1,068
All malignant neoplasms	2,296	1,213	3,017		1,633	1,989	2,573

Source: J Maddams et al. Cancer prevalence in the United Kingdom: estimates for 2008. *British Journal of Cancer* (2009) 101, 541 – 547

Figure 4.1.5 -Year Relative Survival Rates: 2000-2004 by gender in Nottinghamshire County.



Source: Health and Wellbeing Board Cancer Profiles. Trent Cancer Registry Nov 2011.

Arthritis

Arthritis is an important condition as it can result in disability especially in older people. It affects more females than males and increases with age. The two most common forms of the disease are osteoarthritis and rheumatoid arthritis. Osteoarthritis is uncommon under the age of 40, risk factors include being overweight or sustaining a previous injury. Rheumatoid arthritis is an immunological condition and commonly starts between the ages of 30-50. Treatment ranges from pain relief and physiotherapy, through to disease modifying drugs (for rheumatoid arthritis) and surgery.

Although routine information is not collected on the number of people with arthritis it is possible to produce estimations based on East Midlands' prevalence from the Health Survey for England (HSE)⁸. The HSE estimates that 32% of men and 52% of women over the age of 65 have arthritis in the East Midlands. Table 4.1.2.2 below uses this to estimate that over 61,000 people in Nottinghamshire may suffer from arthritis.

Respiratory diseases

COPD is a chronic (long-term) condition which describes a group of diseases (including bronchitis and emphysema) where damaged airways in the lungs, cause them to become narrower making it harder for air to get in and out of the lungs. It is most often due to tobacco smoking, but can be due to other airborne irritants such as coal dust, asbestos or solvents^{9,10}. It is estimated that 20,500 adults suffer from COPD across Nottinghamshire. It is estimated that approximately 35% of people with COPD remain undiagnosed (see figures 4.1.2.1).

Enlarged prostate

Benign prostatic hypertrophy is an enlargement of the prostate gland caused by an overgrowth of prostate cells. This enlargement constricts the flow of urine making it increasingly difficult to empty the bladder. These are common in older men and are found in 25% to 40% of men aged more than 60. Treatment options are varied, conservative treatment, drug treatment or surgery¹¹.

Skin conditions

Skin conditions are very common and it is estimated that 1/4 to 1/3 of the total population are affected¹². Two of the more common diseases are eczema and psoriasis. Atopic eczema is an inflammatory skin disorder characterized by itching, involvement of the skin creases and onset in early life. The prevalence is increasing and there is a wide range in the estimates of how many people are affected (between 1% and 10% of the

⁸ Health Survey for England 2005

⁹ Respiratory disorders. BMJ. July 2006. <http://www.bma.org.uk/ap.nsf/Content/HAresdisorder>

¹⁰ ABC of chronic obstructive pulmonary disease. Definition, epidemiology, and risk factors. Devereux G. BMJ. 2006 May 13;332(7550):1142-4.

¹¹ Health Care Needs Assessment. The epidemiologically based needs assessment reviews. Radcliffe Oxford. Chapter 6 Benign Prostatic Hypertrophy URL: <http://hcna.radcliffe-oxford.com/> accessed 15.05.08

¹² Health Care Needs Assessment. The epidemiologically based needs assessment reviews. Radcliffe Oxford. Chapter 6 Dermatology URL: <http://hcna.radcliffe-oxford.com/> accessed 15.05.08

population). Psoriasis is a chronic inflammatory skin disorder characterized by red scaly areas and tends to affect areas such as the knees, elbows, lower back and scalp. Onset of psoriasis is usually either in early adulthood or in later life. Adult males and females are affected equally but age of onset may be earlier in females. European studies suggest that around 1-3% of the population have psoriasis.

Long-term neurological conditions

Long-term neurological conditions are very common. An estimated 10 million people in the UK are affected which is about 1 in 6 people⁷. Out of the total number of 10 million, about 8 million people have migraine and 2 million have other neurological conditions.

The number of people with neurological long-term conditions has also been estimated from existing research¹³. Neurological long-term conditions have been defined as:

‘Conditions that result from any disease or injury to central/peripheral nervous system and will affect the individual and their family for the rest of their lives’¹⁴,

Long-term neurological conditions can be broadly categorised as follows:

- sudden onset conditions
 - acquired (non traumatic) brain injury
 - traumatic brain injury
 - spinal cord injury
 - stroke
- intermittent and unpredictable conditions
 - epilepsy
 - certain types of headache (migraine)
 - early multiple sclerosis
 - Myalgic encephalomyelitis (ME)
- progressive conditions
 - motor neurone disease
 - Parkinson’s disease
 - later stages of multiple sclerosis
 - Essential tremor
 - Charcot-Marie-Tooth Disorder
 - Muscular dystrophy
 - Spina Bifida and Congenital Hydrocephalus
 - Huntingdon’s disease
 - Dementia (see Older People’s Chapter section 4.1)

¹³ Neuro Numbers a brief review of the numbers of people in the UK with a neurological condition. Published by the Neurological Alliance April 2003

¹⁴ Department of Health LTC NSF team, The National Service Framework for Long-term conditions. 2005, DH.

- stable neurological conditions, but with changing needs due to development or ageing:
- post-polio syndrome
- cerebral palsy in adults
- Dystonia

‘There is a wide variety of long term neurological conditions and people have very different experiences. Conditions may be present at birth (eg cerebral palsy) and some of these may be associated with varying degrees of learning disability. Other conditions appear in childhood (eg Duchenne’s muscular dystrophy) or develop during adulthood (eg Parkinson’s disease).’⁷

Long-term neurological conditions cause a range of problems for those affected including: physical, sensory, cognitive/behavioural, communication, psychosocial and emotional effects.

Association with deprivation

The relationship between common neurological long-term conditions and deprivation is summarised in table 4.1.6. Estimates of the prevalence of LTNC are given in table 4.1.7.

Table 4.1.6 Social deprivation and common neurological long term conditions

Condition	Association with deprivation
Stroke	Higher in deprived populations
Epilepsy	Higher in deprived populations
Parkinsonism including Parkinson’s disease	Not found
Spinal cord injury	Not found
Multiple sclerosis	Not found
Motor neuron disease	Not found
Cerebral palsy	Higher in deprived populations
Muscular dystrophies	Higher prevalence of Duchenne in deprived populations
Huntington disease	Not found
Traumatic Brain Injury	Higher in deprived populations
Acquired (non traumatic) Brain Injury	-

Estimates of prevalence of long-term neurological conditions

Table 4.1.7 Estimates for Long term neurological conditions based on 2011 registered population (crude national prevalence rates provided by EMPHO)

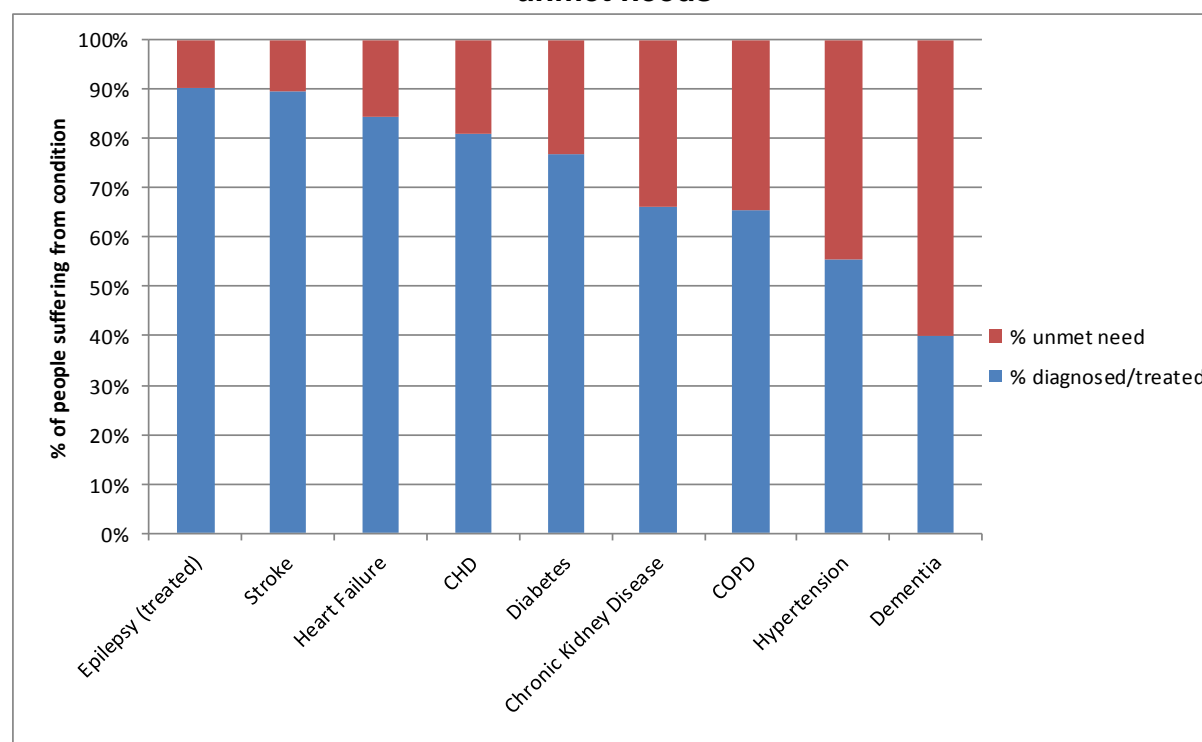
	Rate per 100000	Bassetlaw	Mansfield and Ashfield	N&E Nottingham	Newark & Sherwood	Nottingham West	Principia	NHS Notts County + NHS Bassetlaw
Sudden onset	-	1372	2285	1803	1590	1164	1520	9733
Traumatic brain injury	1200	1317	2194	1731	1526	1117	1459	9344
Spinal Cord Injury	50	55	91	72	64	47	61	389
Intermittent/unpredictable	-	911-1,537	1,518-2,560	1,197-2,020	1,056-1,781	773-1,304	1,009-1,702	9,578-14,016
Epilepsy	430-1,000	472-1098	786-1829	620-1443	547-1272	400-931	523-1216	3349-7,788
Migraine	400	439	731	577	509	372	486	3114
Myalgic encephalomyelitis (ME)	400	439	731	577	509	372	486	3114
Stable	-	385-605	642-1008	506-795	446-701	327-513	427-670	2,733-4,291
Cerebral Palsy	186	204	340	268	237	173	226	1449
Post-polio syndrome	100-300	110-329	183-549	144-433	127-382	93-279	122-365	779-2,336
Dystonia (Primary idiopathic)	65	71	119	94	83	61	79	506
Progressive	-	1,410-1,432	2,348-2,385	1,853-1,867	1,634-1,659	1,196-1,215	1,561-1,586	10,003-10,144
Essential Tremor	850	933	1554	1226	1081	792	1033	6620
Parkinson's Disease	200	220	366	289	254	186	243	1558
Multiple Sclerosis	100-120	110-132	183-241	144-347	127-442	93-412	122-500	779-2,074
Muscular dystrophy	50	55	91	72	64	47	61	389
Charcot-Marie-Tooth Disorder	40	44	73	58	51	37	49	312
Spina Bifida and Congenital Hydrocephalus	24	26	44	35	31	22	29	187
Huntingdon's Disease	13.5	15	25	19	17	13	16	105
Motor Neurone Disease	7	8	13	10	9	7	9	55

How many people are being treated for long-term conditions (unmet need)?

The previous section gave estimates of the number of people across Nottinghamshire with a number of long-term conditions. However, not everyone with a long-term condition has been diagnosed and is receiving treatment; some may be unaware they are living with their condition(s). When disease registers are compared with estimates of prevalence, it is possible to quantify met and unmet needs (i.e. actual versus estimated).

Figure 4.1.8 shows the overall prevalence of a number of conditions and shows where there is unmet need. Conditions where there is a relatively high proportion of unmet need include dementia, hypertension, COPD, chronic kidney disease and diabetes. It has not been possible to assess levels of unmet need for all long term conditions.

Figure 4.1.8: Estimated proportion of adults Nottinghamshire with long-term conditions and illnesses who have been diagnosed/treated and those with unmet needs



Sources: different prevalence models (contact author for details), Nottinghamshire registered population as at July 2011, QOF 2010/11

A further breakdown of unmet needs at clinical commissioning group level, where possible, is given in table 4.1.9. There are notable variations in levels of unmet need across the CCGs.

Table 4.1.9: Percentage disease diagnosed prevalence by Clinical Commissioning Group 2010/11

	Coronary Heart Disease			Stroke			Hypertension			Chronic Obstructive Pulmonary Disease			Diabetes			Chronic Kidney Disease		
Clinical Commissioning Group	Numbers on QOF disease registers	Expected	%	Numbers on QOF disease registers	Expected	%	Numbers on QOF disease registers	Expected	%	Numbers on QOF disease registers	Expected	%	Numbers on QOF disease registers	Expected	%	Numbers on QOF disease registers	Expected	%
Bassetlaw	4,535	5,957	76.1%	2,149	2,503	85.9%	15,879	30,448	52.2%	2,472	3,179	77.8%	5,504	6,400	86.0%	5,917	8,371	70.7%
Mansfield & Ashfield	7,887	9,903	79.6%	3,348	4,141	80.9%	28,153	48,358	58.2%	4,178	5,499	76.0%	8,714	10,352	84.2%	7,384	13,312	55.5%
Nottingham North & East	5,635	7,063	79.8%	2,902	3,080	94.2%	21,396	38,439	55.7%	2,688	4,832	55.6%	6,741	8,587	78.5%	10,540	11,201	94.1%
Newark & Sherwood	5,168	6,552	78.9%	2,406	2,814	85.5%	18,351	34,487	53.2%	2,369	3,506	67.6%	5,563	7,547	73.7%	5,355	9,980	53.7%
Nottingham West	3,826	4,394	87.1%	1,916	1,987	96.4%	13,792	24,385	56.6%	1,741	3,268	53.3%	4,178	5,553	75.2%	4,597	7,336	62.7%
Principia - Rushcliffe	4,375	4,918	89.0%	2,323	2,290	101.4%	16,758	30,523	54.9%	1,463	2,536	57.7%	4,373	7,269	60.2%	5,631	9,399	59.9%
Nottinghamshire	31,426	38,787	81.0%	15,044	16,815	89.5%	114,329	206,640	55.3%	14,911	22,820	65.3%	35,073	45,708	76.7%	39,424	59,599	66.1%

Source: Information Centre & APHO prevalence models

4.2. Admissions to Hospital

Key messages

- Planned hospital admissions have increased over the last four years, whereas emergency admission rates have remained relatively stable.
- Rates of admissions to hospital vary across the districts and largely reflect levels of deprivation: more deprived areas have higher rates of all admissions and in particular, emergency admissions.
- Older people are three times more likely to have an emergency admission than any other age group.
- The main reasons for hospital admissions include cancers, respiratory conditions, circulatory diseases and injury/poisoning, which account for 30% of all admissions.
- Emergency readmissions to hospital have increased over the last four years both locally and nationally, though Nottinghamshire rates were significantly lower than the national average.

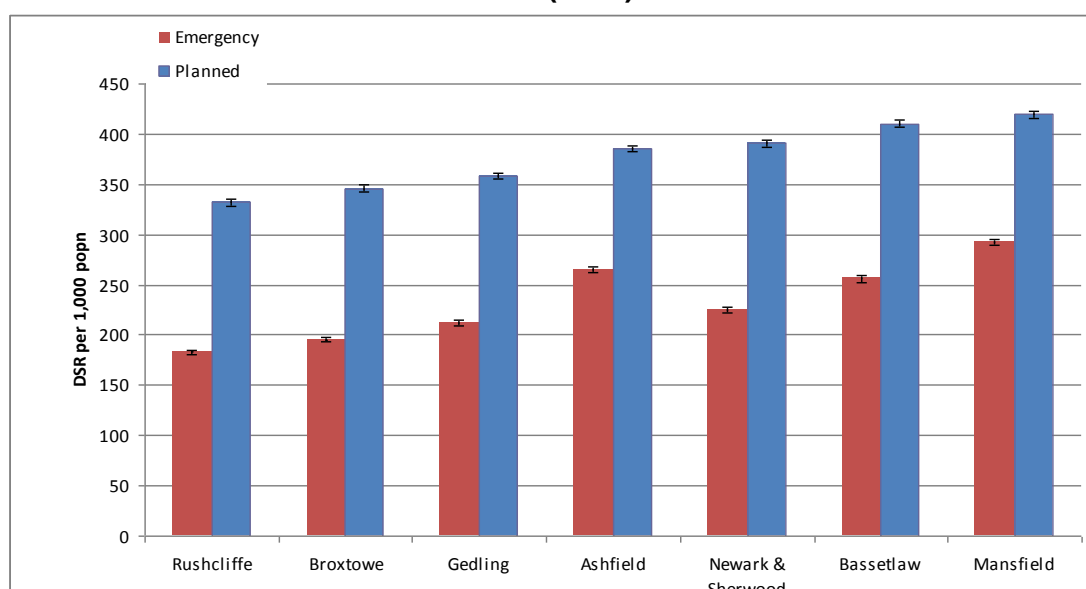
Admissions patterns are potentially informative regarding populations and the services that support their health and social care needs. The emergency admission rate is an important measure of the effectiveness of preventative strategies, intermediate care (both admission prevention and post-acute rehabilitation), community care arrangements and hospital discharge arrangements. As these arrangements must be jointly agreed between health and Social Services, it is an indicator of how well these agencies are working together. There is anecdotal evidence that pressure for early discharge, inadequate rehabilitation and recovery, poor discharge arrangements or inadequate community care and prevention arrangements lead to unnecessary emergency admissions.

Comparisons of elective to non-elective admissions point to patterns of planned versus emergency care. Across Nottinghamshire, the rate emergency and elective admissions varied across the districts, with higher rates of admissions for both emergency and planned admissions in the districts in the north of the county (Fig 4.2.1). Emergency admissions for Bassetlaw, Mansfield and Ashfield were significantly higher than the national average in 2009/10 (data not shown). Figure 4.2.2 shows emergency and elective admissions for clinical commissioning groups (CCGs).

There was an apparent relationship between emergency and elective admission rates and deprivation with more deprived areas showing higher rates of both emergency and elective admissions. In addition the ratio between emergency and planned admissions was higher in more deprived areas of Nottinghamshire (fig 4.2.3). In summary, people from more deprived areas of Nottinghamshire are more likely to be admitted to hospital and more likely to be admitted as an emergency rather than a planned admission.

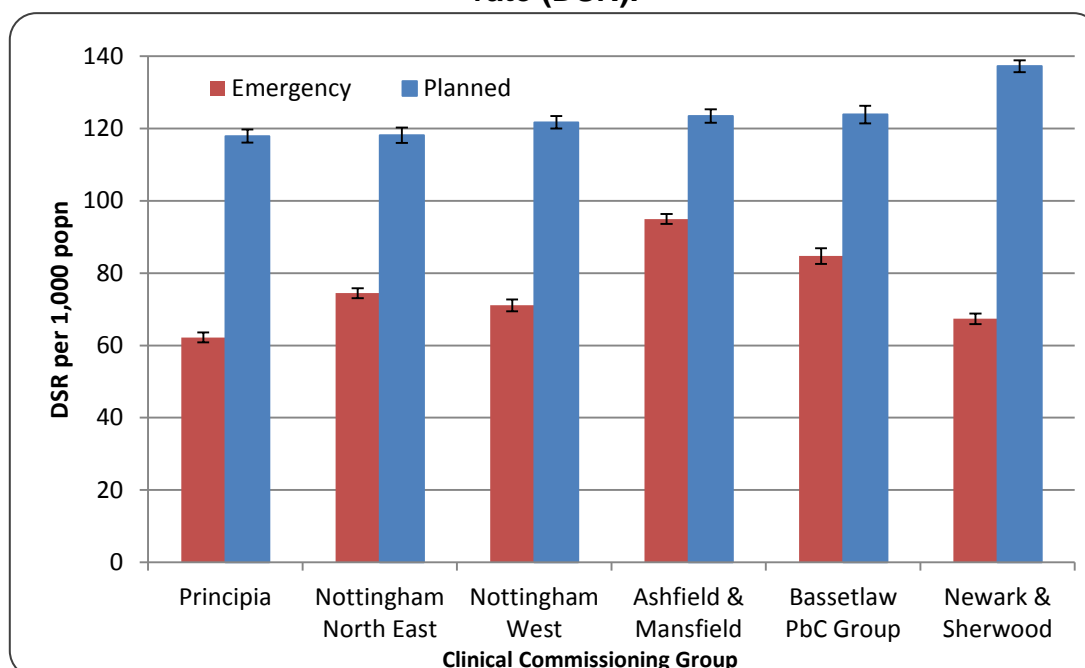
Emergency admission rates have remained relatively stable over the past 8 years, whereas planned admission rates have increased steadily (fig 4.2.4).

Figure 4.2.1. Planned and emergency admissions to hospital between Jan 2008-Dec 2010 for residents of Nottinghamshire districts, directly standardised rate (DSR)



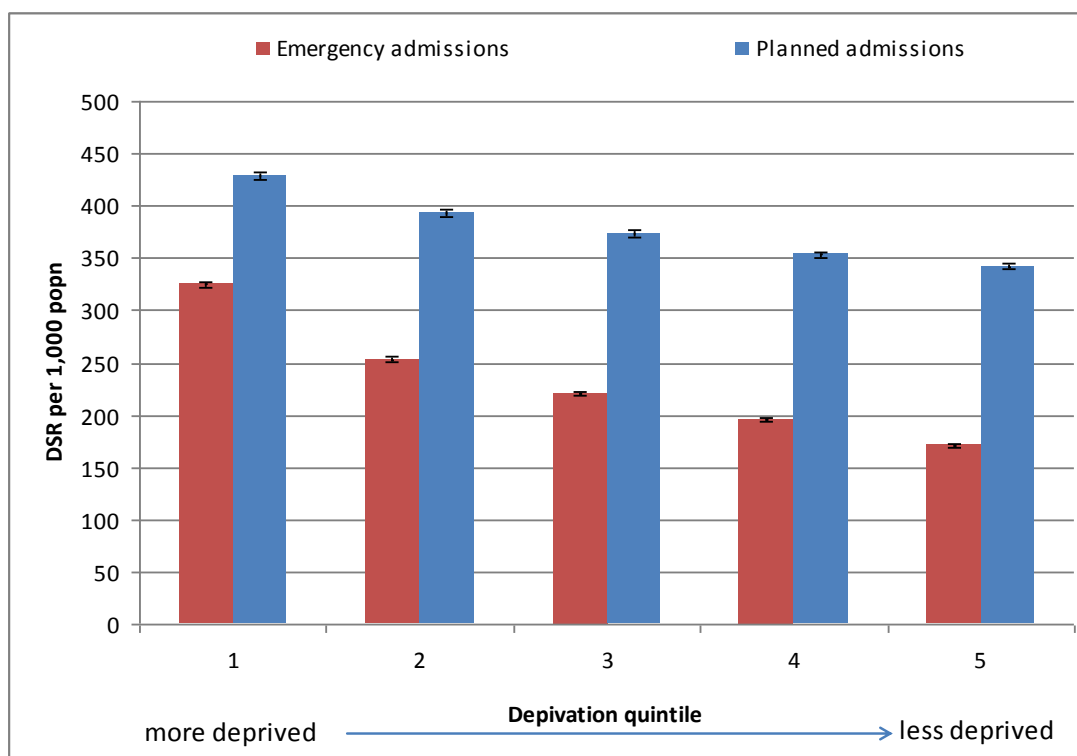
Source: SUS admitted patient care minimum dataset on eHealthScope

Figure 4.2.2. Planned and emergency admissions to hospital between Jan 2010 Dec 2010 for Nottinghamshire CCGs, directly standardised rate (DSR).



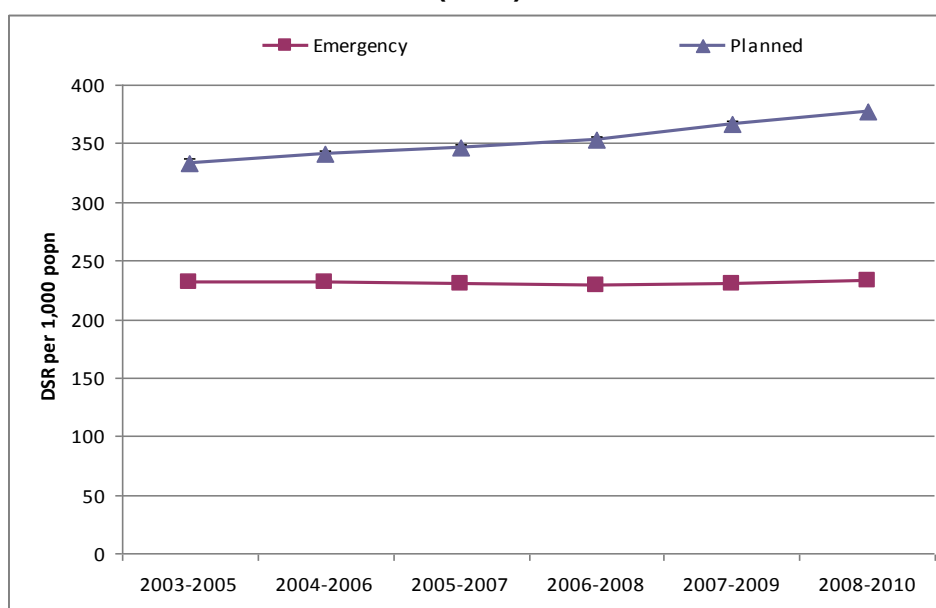
Source: SUS admitted patient care minimum dataset on eHealthScope.

Figure 4.2.3. Planned and emergency admissions to hospital between Jan 2008-Dec2010 for Nottinghamshire residents by deprivation of residence, directly standardised rate (DSR)



Source: SUS admitted patient care minimum dataset on eHealthScope

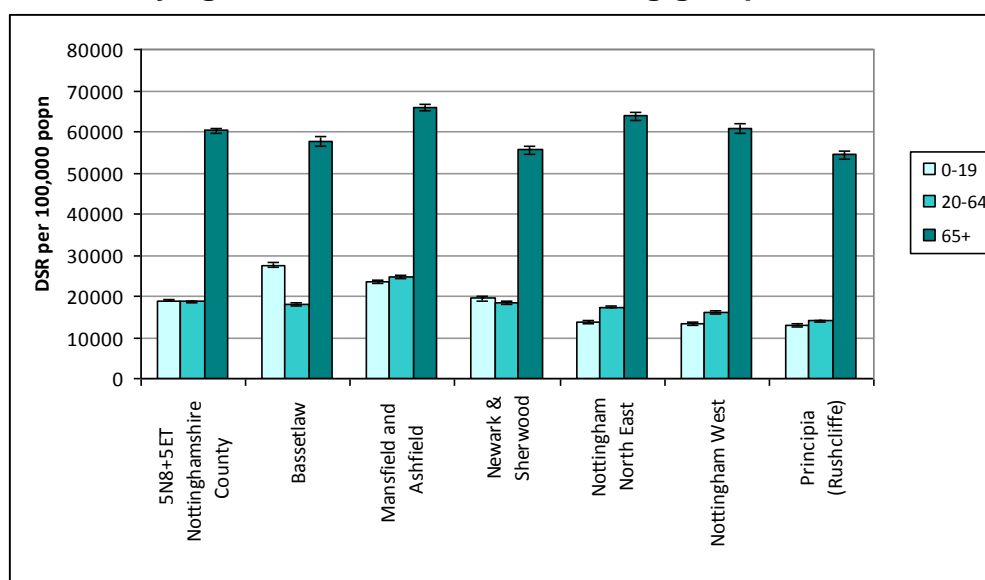
Figure 4.2.4. Trend in planned and emergency admissions to hospital for Nottinghamshire residents by 3 year rolling average, directly standardised rate (DSR)



Source: SUS admitted patient care minimum dataset on eHealthScope

The rate of emergency admissions per 100,000 population (DSR) varies with age across Nottinghamshire's clinical commissioning groups. Rates are approximately three times higher for older people compared with other age groups and this pattern is clear across all CCGs (figure 4.2.5).

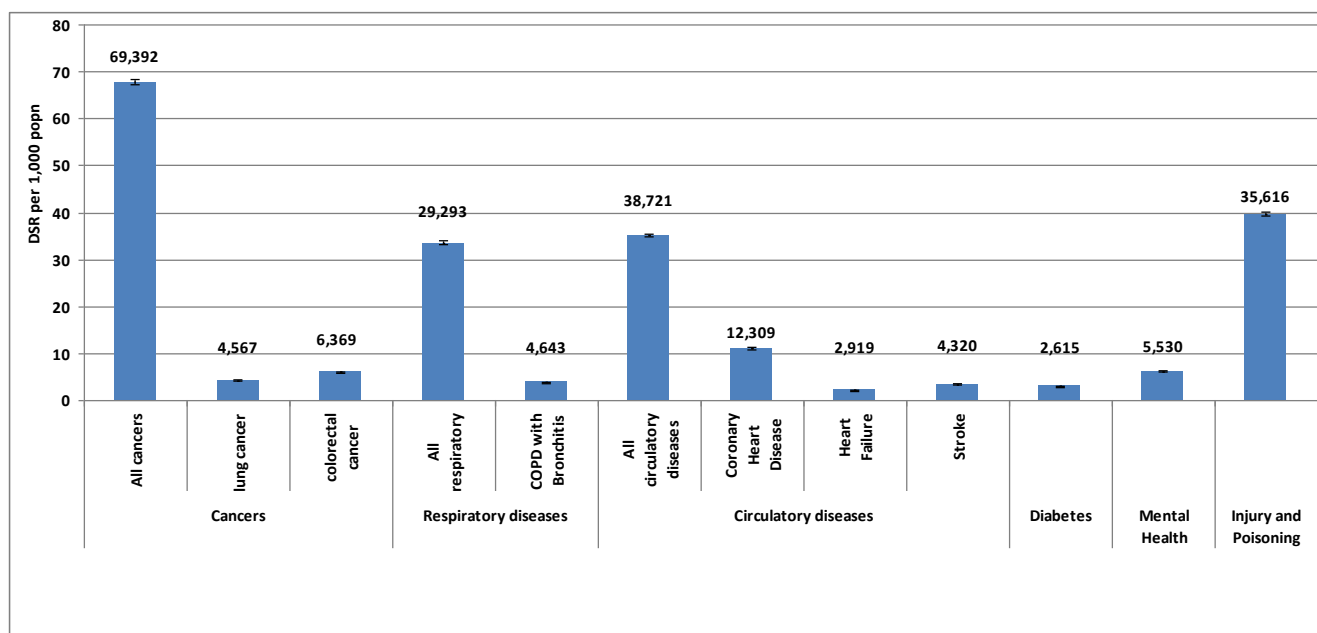
Figure 4.2.5. Emergency admission rates (DSR) for Nottinghamshire populations by age and clinical commissioning group, Jan 2008-Dec 2010



Source: Source: data warehouse

The main reasons for hospital admissions are shown in figure 4.2.6 and include cancers, respiratory conditions, circulatory diseases and injury and poisoning, which account for 30% of all admissions. A further detailed breakdown by cause and population demographics will be provided in a separate report.

Figure 4.2.6. Hospital admissions (emergency & planned) by primary diagnosis for Nottinghamshire County residents between Jan 2008-Dec 2010, directly standardised rate (DSR) and number.



Source: SUS admitted patient care minimum dataset on eHealthScope

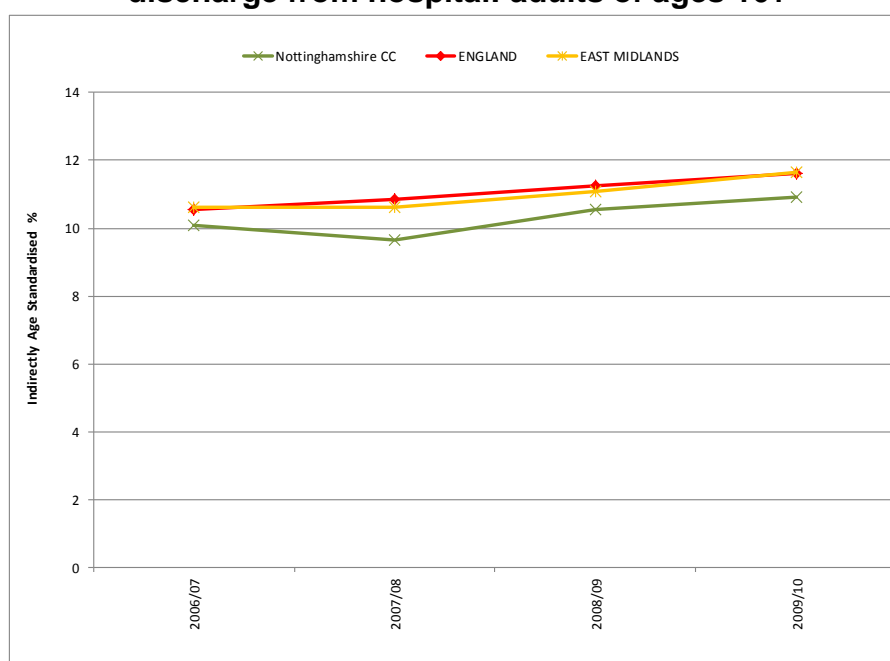
Main diagnosis groups only shown. Total admissions over period = 568,347

Emergency readmissions to hospital are sometimes avoidable. They may reflect implementation of effective structured discharge planning, self-discharge against medical advice, and levels of primary care and community resources available to manage care outside hospital.

Emergency readmissions are defined as the percentage of emergency admission to any hospital in England occurring within 28 days of the last, previous discharge from hospital after admission.

Figure 4.2.7 shows that there seems to have been a general increase in the rate of readmissions over the past four years. The rate of change across Nottinghamshire is similar to the national average, although the percentage of readmissions is significantly lower in Nottinghamshire (figure 4.2.8).

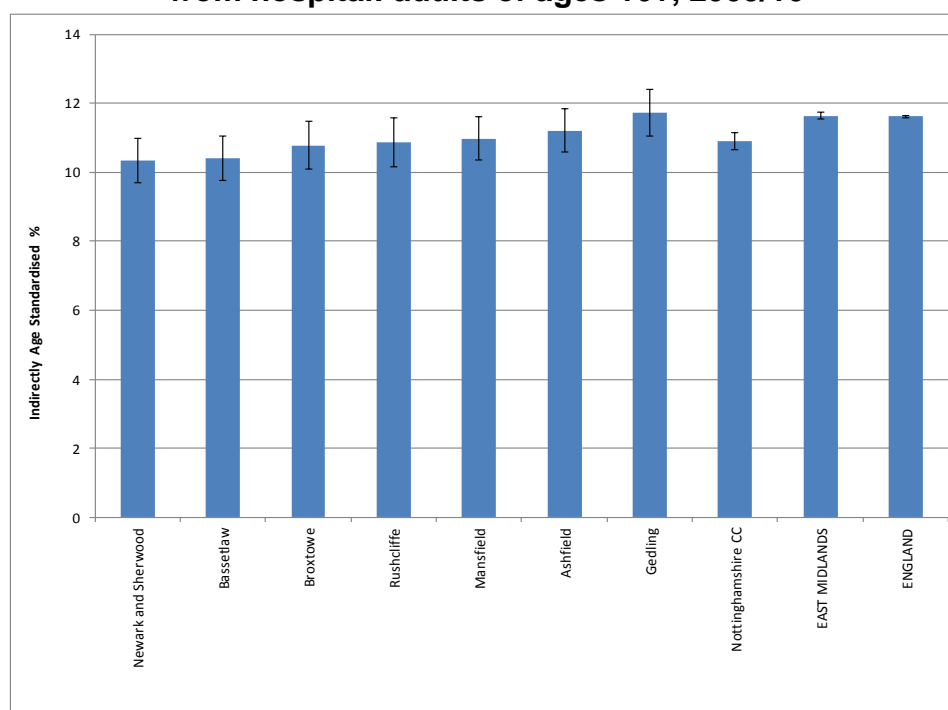
Figure 4.2.7 Trend in emergency readmissions to hospital within 28 days of discharge from hospital: adults of ages 16+



Source: *Compendium of Public Health Indicator/Hospital Episode Statistics(HES)*.

This data excludes obstetrics, mental health specialties and cancer as these may be a part of planned care.

Figure 4.2.8 Emergency readmissions to hospital within 28 days of discharge from hospital: adults of ages 16+, 2009/10



Source: *Compendium of Public Health Indicator/Hospital Episode Statistics(HES)*.

This data excludes obstetrics, mental health specialties and cancer as these may be a part of planned care.

Forecasts of emergency and planned admissions will be provided in a future, more detailed analysis of hospital admissions within Nottinghamshire.

4.3. Health at Work

Key Messages

- Work is generally good for physical and mental health and well-being. Work can be therapeutic and can reverse the adverse health effects of unemployment.
- The longer someone is out of work due to ill-health, the lower their chance of getting back into work.
- In the East Midlands each worker took an average of 1.3 days off for work related injury or ill health.
- Families without a working member are more likely to suffer persistent low income and poverty.
- Health at Work Network has produced guidelines designed to help affected people remain in work and those on long-term sickness absence to return.
- Nottinghamshire's Fit for Work Service, which supports local people to stay healthy and in work dealt with 278 cases between April-Nov 2011, 75% of whom presented with mental health conditions.

Why is Health, Work and Wellbeing important?

Health and wellbeing at work is not a peripheral issue, but central to national economic policy. As well as this, there is a strong evidence base showing that work is generally good for physical and mental health and well-being¹⁵. On the other hand, worklessness is associated with poorer physical and mental health and well-being. Work can be therapeutic and can reverse the adverse health effects of unemployment. That is true for healthy people of working age, for many disabled people, for most people with common health problems and for social security beneficiaries. The provisos are that account must be taken of the nature and quality of work and its social context; jobs should be safe and accommodating. Overall, the beneficial effects of work outweigh the risks of work, and are greater than the harmful effects of long-term unemployment or prolonged sickness absence. It can be concluded that work is generally good for health and well-being.

For all age groups, work generally:

- makes people healthier
- helps people with a health condition get better
- improves the health of people returning to work from unemployment.

Far more people gain health benefits from work than suffer negative effects:

- the long-term unemployed or those who have never worked are two to three times more likely to have poor health than those in work

¹⁵ Dame Carol Black, (2011) "Health at Work – an independent review of sickness absence" TSO

- people are twice as likely to become psychologically distressed after going from work to unemployment.

The costs of sickness absence and ill-health are threefold:

- **Employers** (Statutory Sick Pay; costs of staff turnover; time spend managing absence; Occupational Health where offered)
- **State** (worklessness benefits; foregone taxes, extra healthcare)
- **Individuals** (loss of income; emotional and physical costs of ill-health).

Most common health problems can be accommodated by employers. Common health problems account for two-thirds of longer-term sickness absence, incapacity for work and ill-health retirement. By addressing Health, Work and Well-being this can lead to an improvement in the health of individuals and a decrease in the cost to businesses and the economy.

In March 2008, Dame Carol Black's review of the health of Britain's working age population highlighted the importance of integration between health and employment bodies at a local and regional level in forwarding and promoting the health and work agenda¹⁶.

National Situation

In 2010/11, 22.1 million days were lost due to work-related illness and 4.4 million due to workplace injuries.¹⁷ On average, each person suffering took 15 days off work, 19 days for ill health and 7.2 days for injuries on average.

Stress, depression or anxiety and musculoskeletal disorders accounted for the majority of days lost due to ill health, 10.8 and 7.6 million days respectively. The average days lost per case for stress, depression or anxiety (27 days) was higher than for musculoskeletal disorders (15 days).

There are many people who are unable to work due to ill health: 2.6 million people are currently claiming incapacity benefits, with 600,000 coming on to the benefit each year, while 1.4 million people aged 50-59 have already retired due to ill-health.

The Centre for Mental Health¹⁸ reported that the total cost of mental ill health in England was £105.2 billion, including £21.3 billion in health and social care costs, £30.3 billion in lost economic output and £53.6 billion in human suffering.

Absence has further health implications too - the longer someone is out of work due to ill-health, the lower their chance of getting back into work:

¹⁶ Dame Carol Black, (2008) "Review of the Working Population: Working for a healthier tomorrow." TSO

¹⁷ "Health and Safety Executive. Annual Statistics Report 2010/11",

www.hse.gov.uk/statistics/sources/index.htm

¹⁸ Centre for Mental Health, (October 2012) www.centreformentalhealth.org.uk

- If you're off sick for six months, you have an 80% chance of being off for five years.
- 90% of people making a claim for incapacity benefits expect to return to work, **but if you claim for two years or more, you are more likely to retire or die than return to work.**

Nottinghamshire Data

There is no data relating to sickness and absence rates available at a county level. However, the Office for National Statistics (ONS) publishes results at a regional level. These figures can be used as a proxy measure for Nottinghamshire, as Nottinghamshire tends to mirror the East Midlands.

In 2010/11 in the East Midlands, an estimated 89,000 people, who worked in the last year, believed they were suffering from a work related illness, according to the Labour Force Survey.¹⁹ An estimated 2.4 million working days were lost to workplace injury and work-related ill health, which equates to an estimated 1.3 days per worker.

Work and Health Inequalities

Work is known to be the best route out of poverty. Families without a working member are more likely to suffer persistent low income and poverty. There is also evidence of a correlation between lower parental income and poor health in children.²⁰

The Marmot Review (2010)²¹ highlighted one of it's objectives as being; 'To create fair employment and good work for all.' The review stated that being in good employment is protective of health and conversely unemployment contributes to poor health. However, the Review went on to say that insecure and poor quality employment is associated with increased risks of poor physical and mental health. One of the policy recommendations is that guidance on the implementation of stress management and the effective promotion of well-being and physical and mental health at work is required.

Health at Work Network

The increased prevalence of long-term but controlled health problems like diabetes, cancer, and heart disease means that businesses have to manage people with these conditions in their workforce. The Health at Work Network has developed guides for employers/line managers and for employees, with advice on the support employees might need. The guides recommend a common-sense approach that reflects the minimum expected in a trusting, respectful line manager/employee relationship. They are designed to help affected people remain in work and those on long-term

¹⁹ Health and Safety in the East Midlands. Work related ill health and injury statistics 2010/11.

www.hse.gov.uk/statistics/

²⁰ Dame Carol Black. "Review of the Working Population: Working for a healthier tomorrow." (2008) TSO

²¹ Department of Health (2010) "The Marmot Review: Fair Society, Healthy Lives."

sickness absence to return. Although chronic medical conditions may persist throughout working life, maintaining work can greatly help to reduce their impact.

Public Health Outcomes Framework

The coalition government is committed to refocusing the public health system to focus on achieving positive health outcomes for the population and reducing health inequalities. The Framework,²² published January 2012, has two indicators directly relating to health at work:

- employment for those with a long-term health condition including those with a learning difficulty/disability or mental illness
- sickness absence rate.

It is anticipated that Public Health England will regularly publish data on the indicators measures to inform the development of local strategies to improve health and wellbeing.

‘Wellbeing @ Work’: Bassetlaw’s Workplace Health Award Scheme:

It is acknowledged that those individuals who go to work spend a great deal of their time in the respective working environment. Therefore in order to impact upon an individual’s health and well being and contribute to a healthier workforce, it is good practice to enable and support employees to make healthier lifestyle choices.

As a key action for the Bassetlaw public health team, within the LSP Partnership for Health, has been the development of the NHS Bassetlaw ‘Well-being @ Work’ workplace award scheme; developed in partnership with key agencies such as individual workplaces, Bassetlaw CVS and the Bassetlaw District Council.

The organisations signed up to the scheme are working towards achieving, bronze, silver and gold awards, covering 6 key themes which are: smoking, healthy eating, physical activity, alcohol and drugs, mental health and wellbeing, also safe workplaces.

Some of the larger workplaces are now promoting the core concepts of the scheme across their wider organisations in other parts of the country.

Since the formal launch event in June 2010 14 workplaces have signed up to the scheme and a range of interventions have derived from the workplaces, which include:

- Award scheme and supporting toolkit developed, the scheme has 6 themes: healthy eating, smoking, physical activity, mental health and wellbeing, alcohol and substance misuse and safety in the workplace. There are 3 levels of award for an organisation to achieve - Bronze, Silver & Gold.
- A steering group established and action plan developed

²² Department of Health (2012) “A public health outcomes framework for England, 2013-2016.”

- A workplace champion steering group has established to enable all of the workplace health champions to be able to network/share ideas/coordinate programmes.
- Health fairs delivered to all organisations signed up to the scheme
- Weight management and smoking cessation clinics offered in the workplace.
- All of the workplaces engaged are now working through the bronze, silver and gold phases of the scheme.
- Around 45 people from the organisations have received training to be workplace health champions, and have since undertaken accredited 'Health Trainer' training, to enable them to be able to provide health and well-being support to colleagues within the workplace.
- 30 workplace health champions have undertaken Holistic Brief intervention training , in line with the 'Every contact Counts' agenda, to enable them to conduct a holistic brief intervention, and signpost to local supporting services, within their respective workplaces and amongst families and wider peers. Many of these have expressed interest in attending a wider range of training and are committed to the promotion of healthy lifestyle messages within their workplace.
- A recognition evening is held annually to celebrate success, present the bronze, silver and gold awards, to network and share good practice.

Further details regarding the award are available on at www.bassetlaw-pct.nhs.uk

Nottinghamshire Health and Work Steering Group

NHS Nottinghamshire County is a member of the Nottinghamshire Health and Work Steering Group (HWSG). This has been in existence since 2008, bringing together the health, employment and skills agendas for its parent partnerships, the Nottinghamshire: City and County Employment and Skills Board (NCCESB) and ONE Nottingham. The purpose of HWSG is to lead on the delivery of a joint strategy which aims to:

- promote health and well-being in the workplace; and
- provide support to people with a health condition to both access and sustain employment, training and education.

Building on these two key aims, the Health and Work strategy seeks to:

- Increase the employment rate by reducing the flow of fresh benefit claimants through targeted awareness raising and on-going business engagement. The partnership aims to promote a culture of early supportive intervention between the employer and their employees, and healthcare professionals, in regards to work and well-being;
- Develop more innovative, joined up and personalised approaches to meet the needs of long term clients/service users out of work due to a health condition.

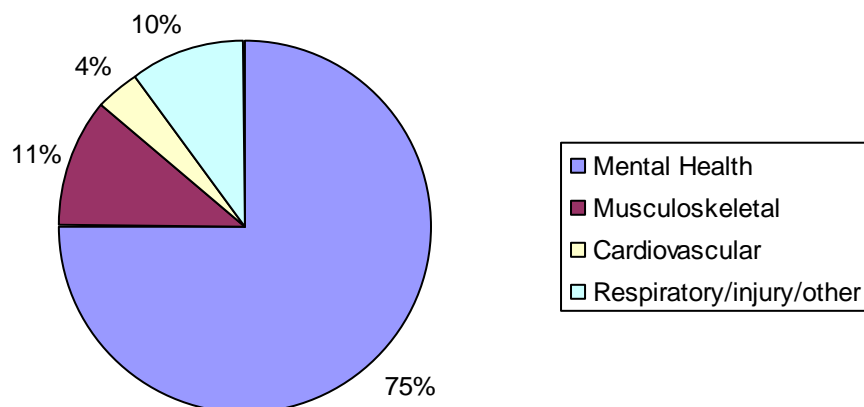
The starting point for the HWSG's work was to support a 'cause and effect' approach towards health and unemployment, recognising that ill-health is a major causal factor for people losing employment and moving onto benefits. This was underlined by the fact that the chances of an individual becoming ill whilst claiming out of work benefits is far greater than for those that are in employment.

Nottinghamshire Fit for Work Pilot

The Nottinghamshire Fit for Work Service (FFWS) is one of 11 Government pilots funded by the Department of Work and Pensions, until March 2013. It was developed following the Dame Carol Black Review of the health of the UK population. The service supports local people to stay healthy and in work on a case management basis. It focuses on early intervention and a dual approach to retaining people in employment with individuals and employers.

At the end of November 2011 the service had exceeded its target of 250 cases (April 2011 – March 2012) with 278 cases. Of these 75% of cases were presenting with mental health conditions. The pie chart shows the breakdown of conditions of people that presented themselves to the Fit for Work service. This shows the majority (75%) of people presented with mental health problems.

Main conditions presenting to the Fit for Work for Work Pilot, April - October 2011



4.4 Communicable diseases

Key messages

- Nottinghamshire NHS and Bassetlaw NHS both have relatively low incidences of TB, with rates of 4.0 and 3.6 per 100,000 per year respectively in 2008-2010. This compares to an incidence rate of 15.0 per 100,000 per year in England.
- At the district level, higher rates of TB tend to be seen in Mansfield and Broxtowe districts, with lower rates in other areas, though rates tend to vary from year to year.
- In 2011, there were 94 notifications of Hepatitis B in Nottinghamshire, with the majority of cases in Bassetlaw, Ashfield and Broxtowe districts. The increase in rates in 2011 compared to previous years is due to better reporting.
- There were 228 notifications of Hepatitis C in Nottinghamshire in 2011, with the majority of these from Bassetlaw and Mansfield districts²³.
- Further work is required to determine the needs of the county's population with respect to communicable diseases within the wider health protection agenda.

Introduction

In historical terms, there are now relatively few people in the UK who die of communicable diseases. This is due to improvements in a range of favourable environmental factors (e.g. standards of sanitation, nutrition, housing, working environment, and healthcare) as well as prevention and control measures such as vaccination, good hygiene, infection control measures and effective treatment. Nevertheless, communicable disease continues to represent a significant burden of disability and death, much of which is avoidable.

Through surveillance undertaken by the Health Protection Agency (HPA), there is some data on numbers of notified and laboratory confirmed cases of a number of communicable diseases. However, relatively little data exists on the burden of disease as well as the morbidity associated with some of these diseases. Further work would be required to understand the needs of the population in respect of communicable diseases.

Three key communicable diseases are highlighted below to illustrate some of the local needs.

4.4.1. Tuberculosis

Tuberculosis (TB) is an infectious bacterial disease which can affect a number of organs. Although only 10% of those infected will develop active disease, TB which is left untreated can be fatal. TB is transmitted by inhaling droplets containing the bacterium that have been coughed or sneezed out from someone with TB affecting their lungs.

²³ The high number of cases from Bassetlaw and Mansfield districts historically tends to reflect a more robust notification system. Notification from other districts has improved in recent years.

Distribution of disease

TB in the UK, and other industrialised nations, declined rapidly last century but never went away. Most countries are now affected by a global resurgence of TB caused primarily by increasing poverty and poor access to health services, migration and infection with the Human Immunodeficiency Virus (HIV).

Although TB is increasing in the UK it remains quite rare and is predominantly confined to the major cities. Anyone can catch TB but those at most risk are: close contacts of an infectious case; those who have lived in places where TB is still common (e.g. parts of South Asia and Africa); those whose immune system is weakened by HIV or other medical conditions; people who experience chronic poor health through lifestyle factors such as homelessness, alcoholism and drug abuse; young children and the very elderly are more susceptible.

NHS Nottinghamshire County and NHS Bassetlaw both have relatively low incidences of TB, with rates of 4.0 and 3.6 per 100,000 per year respectively in 2008-2010. This compares to an incidence rate of 15.0 per 100,000 per year in England (Figure 4.4.1)

Figure 4.4.1 Tuberculosis rates per 100,000 population

	2008	2009	2010
NHS Bassetlaw*	2.7	4.5	2.7
NHS Nottinghamshire County*	2.6	4.8	4.2
Nottinghamshire total	2.6	4.8	4.0
England†	15.4	15.7	14.9

*Source: Health Protection Agency: East Midlands Enhanced Tuberculosis Surveillance Annual reports 2004-2009; 2010

†Source: Health Protection Agency: Enhanced Tuberculosis surveillance

<http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/Tuberculosis/TBUKSurveillanceData/EnhancedTuberculosisSurveillance/TBEnhanced01country/>

At the district level, higher rates of TB tend to be seen in Mansfield and Broxtowe districts with lower rates in other areas, though rates tend to vary from year to year (Figure 4.4.2).

Figure 4.4.2 Three-year average tuberculosis rates per 100,000 population by Local Authority, 2000-2010

District	2000-02	2004-2006	2008-2010
Ashfield	0.9	3.5	2.6
Bassetlaw	1.9	2.7	3.6
Broxtowe	5.6	2.7	5.4
Gedling	4.5	3.6	4.4
Mansfield	5.1	6.1	4.0
Newark and Sherwood	0.9	1.8	1.8
Rushcliffe	2.8	0.9	3.6

Source: Health Protection Agency Enhanced Tuberculosis Surveillance

<http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/Tuberculosis/TBUKSurveillanceData/EnhancedTuberculosisSurveillance/TBEnhanced03localarea/>

In Bassetlaw, TB tends to occur in an older and mainly white population. In Nottinghamshire County, TB is seen in both older and younger age groups. TB in the younger age groups is seen more in residents that belong to minority ethnic groups, predominantly Asians from the Indian subcontinent and Black Africans, while in the older age groups TB is more prevalent in the White population²⁴. TB in the older White population tends to reflect re-activation of disease due to exposure in childhood.

Prevention and treatment of TB

TB is curable if the correct drug regime is provided and adhered to. In addition, the BCG (Bacillus Calmette-Guérin) vaccination provides effective protection to individuals in high-risk groups, especially infants born in areas with a high incidence of TB, infants with a parent or grandparent born in a country with a high incidence of TB, older unvaccinated children with risk factors for TB²⁵.

In 2004, the Department of Health published an action plan from the Chief Medical Officer for the control of tuberculosis. The aims of the action plan were to reduce the risk of people being newly infected with tuberculosis in England, provide high quality treatment and care for all people with TB and to maintain low levels of drug resistance²⁶.

Recommendations on the diagnosis and management of individuals with confirmed or suspected TB and on the vaccination and case-finding of individuals at risk from infection is set out in the National Institute of Clinical Excellence (NICE) Clinical Guidance²⁷.

Immunisation rates

There is no reliable data on uptake rates of BCG immunisation in high risk groups. Although data is collected on the number of doses of BCG given²⁸, uptake rates cannot be calculated as the denominator is not known. A local pathway is in place to

²⁴ Health Protection Agency: East Midlands Enhanced Tuberculosis Surveillance Annual reports 2004-2009; 2010

²⁵ Department of Health. Immunisation Against Infectious Diseases Online Edition. Tuberculosis http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_128356.pdf

²⁶ Department of Health (2004) Stopping Tuberculosis in England An Action Plan from the Chief medical Officer http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4100860.pdf

²⁷ NICE 2011. Tuberculosis: Clinical diagnosis and management of tuberculosis, and measures for its prevention and control <http://guidance.nice.org.uk/CG117/Guidance>

²⁸ NHS Information Centre 2011. NHS Immunisation Statistics England 2010-11 http://www.ic.nhs.uk/webfiles/publications/003_Health_Lifestyles/Immunisation%20Stats%202010-11/Immunisations_Bulletin_2010_11_v1_2.pdf

identify high risk neonates but the processes for identifying older at risk children are less clear.

Treatment completion rates

The Chief Medical Office Action Plan recommended that treatment outcome should be recorded for all cases with the aim of a treatment completion level of 85%. In 2010, the treatment completion rate for NHS Bassetlaw was 20%. This low rate was due to the fact that treatment outcome was not recorded for 80% of cases. In contrast, the treatment completion rate for NHS Nottinghamshire County for 2010 was 90.6%ⁱ.

Current arrangements

In 2007, the Department of Health published a toolkit for Tuberculosis to enable PCT commissioners to plan and commission high-quality TB services for their local population, and monitor their delivery²⁹. It sets out a framework for assessing local needs, and identifying how services can be best provided to meet those needs. It also contains models of best practice aimed at TB service providers, including laboratories and public health teams.

Within Nottinghamshire a local strategy and policy have been developed using the toolkit that aims to reduce local rates of infection through raising awareness of TB, especially amongst high-risk group, and ensuring consistent, high quality screening, diagnosis and treatment services across Nottinghamshire. This is delivered through services commissioned from local NHS hospitals.

Further action

- The implementation of the recently approved TB policy needs to be monitored.
- Review arrangements for screening of neonates and older at risk children for BCG vaccination across Nottinghamshire.

4.4.2. Hepatitis B & C Viruses

Hepatitis is inflammation of the liver. In some cases it is associated with long-term damage to the liver. Common causes of hepatitis in the UK include infection with Hepatitis B or Hepatitis C virus which are transmitted through the blood of an infected person. Both viruses may affect the liver but cause distinct diseases.

²⁹ Department of Health 2007. Tuberculosis prevention and treatment: a toolkit for planning, commissioning and delivering high quality services in England

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_075638.pdf

Hepatitis B

Many people with Hepatitis B Virus have no symptoms while others experience a flu-like illness. Acute infection causes abdominal discomfort and jaundice. Chronic infection with Hepatitis B Virus can cause long term liver damage. For people infected during childhood the risk of death from HBV-related liver cancer and cirrhosis is approximately 25%.

Distribution of Hepatitis B

The virus may be transmitted by contact with infected blood or body fluids: e.g. through household or sexual contact with an infected person; by sharing or use of contaminated equipment during injecting drug use (IDU); vertical transmission (mother to baby) from an infected mother to her unborn child; receipt of infected blood (via transfusion) or infected blood products (for example clotting factors); needlestick or other sharps injuries (in particular those sustained by hospital personnel); tattooing and body piercing. Overall in the UK, the prevalence in the general population is estimated to be 0.3%³⁰.

In 2011, there were 94 Notifications of Hepatitis B in Nottinghamshire with the majority of cases in Bassetlaw, Ashfield and Broxtowe districts³¹ (Figure 4.4.3). The increase in rates in 2011 compared to previous years is due to better reporting via electronic laboratory reporting to the HPA.

Figure 4.4.3 Reported Hepatitis B infections by Local Authority (rates per 100,000 population)

District	2009	2010	2011**
Ashfield	1.7	1.7	15.5
Bassetlaw	1.8	8.1	16.3
Broxtowe	0.9	0.9	16.1
Gedling	0.9	0.9	11.5
Mansfield	6.0	4.0	9.0
Newark and Sherwood	5.3	2.7	6.2
Rushcliffe	1.8	0.0	9.0
Nottinghamshire Total	2.6	2.6	12.1

Source: Health Protection Agency. East Midlands North Co-Surv/HPZone reports of Hepatitis B infections **Provisional data

There is very little National or local data on the burden of Hepatitis B disease. Further work is required to get a better estimate of local need.

³⁰ Department of Health. Immunisation Against Infectious Diseases. Online Edition. Hepatitis B http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_108820.pdf

³¹ Health Protection Agency 2011. East Midlands North HPZone provisional reports of Hepatitis B infections

Prevention and treatment of Hepatitis B

HBV infection can be prevented by vaccination. Offering the accelerated hepatitis B vaccination course to the most at risk groups is effective. Public health action includes targeted preventative work (e.g. harm reduction messages focussed on reducing injecting drug behaviour and support for safe injecting, promotion of safe sex), Hepatitis B screening for all pregnant women, safe handling and disposing of sharps and surgical instruments. Treatment is also available and is effective in a proportion of cases³².

Current arrangements and further action for Hepatitis B

Access to harm reduction advice and messages, and clean injecting paraphernalia, for Injecting drug users (IDU) is available widely available across Nottinghamshire, through targeted outreach and pharmacy needle and syringe exchange programmes. Hepatitis B testing and vaccination is available within all Nottinghamshire drug treatment primary care and community settings and delivered by harm reduction nurses. Hepatitis B vaccination for defined at-risk groups, including babies born to infected mothers, is delivered through primary care.

Further action is required to:

- Maintain provision of targeted harm reduction advice and prevention, pending publication in 2012 of NICE guidance on best practice for promoting testing.
- Ensure there is a pathway for the Hepatitis B antenatal screening and the newborn immunisation programme as recommended in the best practice guidance produced by the Department of Health in 2011³³

Hepatitis C Virus

Some people infected with Hepatitis C virus (HCV) clear the infection naturally. However, for the majority, Hepatitis C infection is a slowly progressive disease which, if left untreated, can develop into serious disease of the liver leading to liver failure or primary liver cancer. Nevertheless, many of those infected will not be aware of any symptoms. This means that a large proportion of the estimated 216,000 people in the UK currently infected with the virus will be unaware³⁴, so do not access the treatment which can reduce the risk of subsequent more serious disease.

³² NICE 2006. TA96 Hepatitis B (chronic) - adefovir dipivoxil and pegylated interferon alpha-2a: guidance.
<http://guidance.nice.org.uk/TA96/Guidance/pdf/English>

³³ Department of Health 2011. Hepatitis B Antenatal Screening and Newborn Immunisation programme. Best Practice Guidance
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_126200.pdf

³⁴ Health Protection Agency 2011. Hepatitis C in the UK – 2011 Report
http://www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1309969906418

Distribution of Hepatitis C

Transmission of the virus is through the blood of an infected person. This can take place where needles, razors, or other blood-contaminated equipment is shared. Unlike Hepatitis B, this virus is rarely transmitted by sexual contact. In the UK, most of those infected are past or present intravenous drug users (IDU) or are members of ethnic populations with close links to areas of the world where the virus is most prevalent.

In 2011 there were 228 HCV notifications in Nottinghamshire, with the majority of these from Bassetlaw and Mansfield districts³⁵. The high number of cases from Bassetlaw and Mansfield districts historically tends to reflect a more robust notification system. Notification from other districts has improved in recent years (Figure 4.4.4).

Figure 4.4.4 Reported Hepatitis C infections by Local Authority (rates per 100,000 population)

District	2009	2010	2011**
Ashfield	20.6	24.1	32.6
Bassetlaw	20.6	33.2	57.3
Broxtowe	1.8	9.0	12.6
Gedling	1.8	12.4	17.7
Mansfield	41.1	48.1	48.1
Newark and Sherwood	17.7	32.0	32.0
Rushcliffe	0.0	2.7	7.2
Nottinghamshire Total	14.4	22.7	29.4
England and Wales [§]	16.4	15.0	Not available

Source: Health Protection Agency. East Midlands North Co-Surv/HPZone reports of Hepatitis C infections **Provisional data

§ Source: Health Protection Agency. Hepatitis C Epidemiological Data. Laboratory Reports. <http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/HepatitisC/EpidemiologicalData/hepcLabRegion/>

Obtaining accurate local data on the disease burden of Hepatitis C disease can be difficult. The majority of current data sources are incomplete although the increase in testing in recent years has helped. The Health Protection Agency has produced a toolkit to assist commissioners in estimating HCV prevalence and numbers requiring treatment in Drug Action Team areas³⁶.

³⁵ Health Protection Agency 2011. East Midlands North HPZone provisional reports of Hepatitis C infections

³⁶ Health Protection Agency. [Commissioning template for estimating HCV prevalence and numbers eligible for treatment by Drug Action Team Area \(Excel Spreadsheet, 740 KB\)](#)

Prevention and Treatment of Hepatitis C disease

In 2004, the Department of Health published the Hepatitis C Action Plan for England with recommendations on surveillance, increasing awareness and reducing undiagnosed infections, high quality health and social services and prevention³⁷.

In many cases, Hepatitis C Virus is responsive to treatment. Public health action is focused on the prevention of new infections (e.g. harm reduction messages focused on reducing injecting drug behaviour and support for safe injecting), raising awareness in the population and amongst healthcare professionals of current risk and possible past exposure (especially amongst IDUs), and increasing diagnosis and access to treatment.

Current arrangements and further action for Hepatitis C

Local action plans were developed to reduce the rate of HCV infection in NHS Nottinghamshire County and NHS Bassetlaw following a review of services in 2010. The action plans focus on increased screening of at-risk groups (including injecting drug users, migrants from countries with high prevalence and prisoners) and provision of consistent, high-quality treatment services. Access to harm reduction advice and clean injecting paraphernalia for IDU is widely available across Nottinghamshire, through targeted outreach and pharmacy needle and syringe exchange programmes. Hepatitis C testing is available within all Nottinghamshire drug treatment primary care and community settings and delivered by harm reduction nurses.

Nottingham University Hospitals are commissioned to provide HCV treatment services across north and south Nottinghamshire. Similar services are also commissioned from Doncaster and Bassetlaw Hospitals for NHS Bassetlaw. Next steps include improving access to treatment services addressing developing affordable options for ensuring effective provision in the north of the County.

Actions highlighted in the recently published East Midlands Hepatitis Action Plan need to be addressed, including a review of access to treatment services in the north of the county.

³⁷ Department of Health 2004. Hepatitis C Action Plan for England
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4084713.pdf

4.5 Life Expectancy and Main causes of Mortality

Key messages

- All-age, all-cause mortality and life expectancy at birth are important indicators of health and well-being.
- In Nottinghamshire, AAACM is falling over time, with a corresponding increase in life expectancy.
- The rate of improvement varies by gender and by deprivation. The male AAACM rate improved faster than for females between 1999 and 2009.
- The gap in life expectancy between the most and least deprived communities in Nottinghamshire (9 years for men and 7.6 years for women) increased for women between 2001 and 2010, but not for men.
- In the short-term (2-3 years), case-finding, secondary prevention for cardiovascular disease and stopping smoking will have the largest impact on AAACM / life expectancy and contribute most to closing the inequalities gap.

Introduction

All Age All Cause Mortality (AAACM) and life expectancy at birth are closely associated indicators that can be used to measure the overall health of a population and to assess the causes of death responsible for health inequalities. These measures are complemented by the slope index of inequality (SII) for life expectancy, which measures the gap in life expectancy between the most and least deprived populations in a particular area.

- **All age all cause mortality (AAACM)** is the mortality (death) rate taking into account all causes of death and for all ages. It is often calculated for males and females separately and is expressed as a rate per 100,000 population. This rate is standardised so that populations with different proportions of older and younger people can be compared fairly.
- **Life expectancy (LE) at birth** in an area is the average number of years a new-born baby would survive if they experienced the mortality rate for a particular area and time period throughout their life. It has a slight bias towards earlier/younger deaths.

This summary measure is internationally accepted and widely used to compare populations with different age-structures, both between areas and through time.

- These measures are related: in general if life expectancy increases, then AAACM will decrease and vice versa.
- **Slope index of inequality (SII)** for life expectancy is a measure of the gap in years of life expectancy between the most and least deprived groups in a

given population. It is based on a statistical analysis of the relationship between life expectancy and deprivation scores across that population³⁸.

Why are these measures important?

Life expectancy and AAACM are important, high-level indicators of health and well-being. This has been recognised at a national level since the 1990s: either or both of these indicators have been consistently used within local health, local authority and partnership performance management frameworks.

The SII for life expectancy is a more recent measure and was adopted nationally from 2008 onwards. It is one of the few consistent measures of inequality at a local level and is monitored for males and females separately.

At the time of writing (January 2012), a Public Health Outcomes Framework is due for final release, however the draft framework signals a continued focus on health inequalities, with the high-level vision: “To improve and protect the nation’s health and wellbeing and for improving the health of the poorest fastest.”³⁹

Trends in AAACM

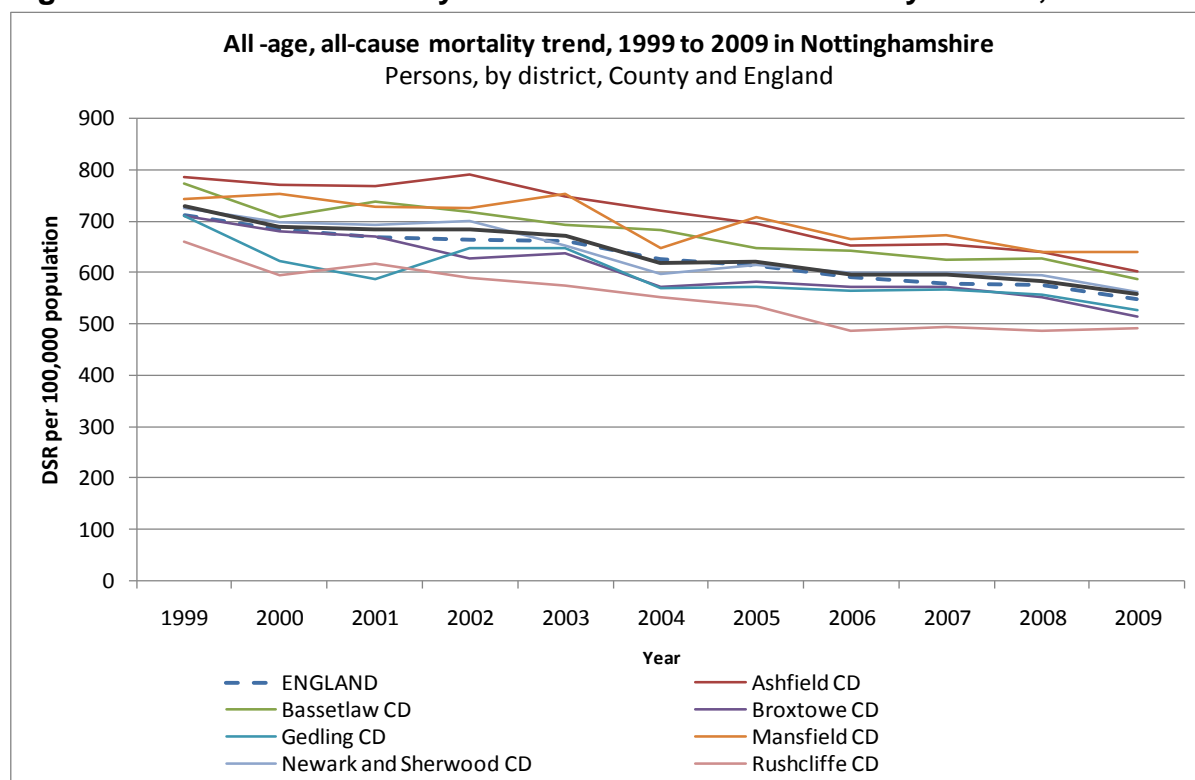
Between 1993 and 2009, AAACM reduced (with a corresponding increases in life expectancy at birth), for males and females in all districts in Nottinghamshire and across the County as a whole (Figure 4.5.1). Life expectancy has also increased (AAACM reduced) in all areas of the County, whatever the levels of deprivation. This follows a national trend of improvement. There are, however, differences in the rate of reduction for males compared to females and by deprivation (see 4.5.2 below).

Figure 4.5.2 shows that the AAACM rate for males in Nottinghamshire was consistently higher than the rate for women between 1999-2009, but the inequality gap between the genders is reducing: the male mortality rate is improving faster than that for females). This is similar to the national trend.

³⁸ Fryers et al, “World Class Commissioning Assurance Framework, Health Inequalities Indicator, Guide to Interpretation”, September 2009, APHO

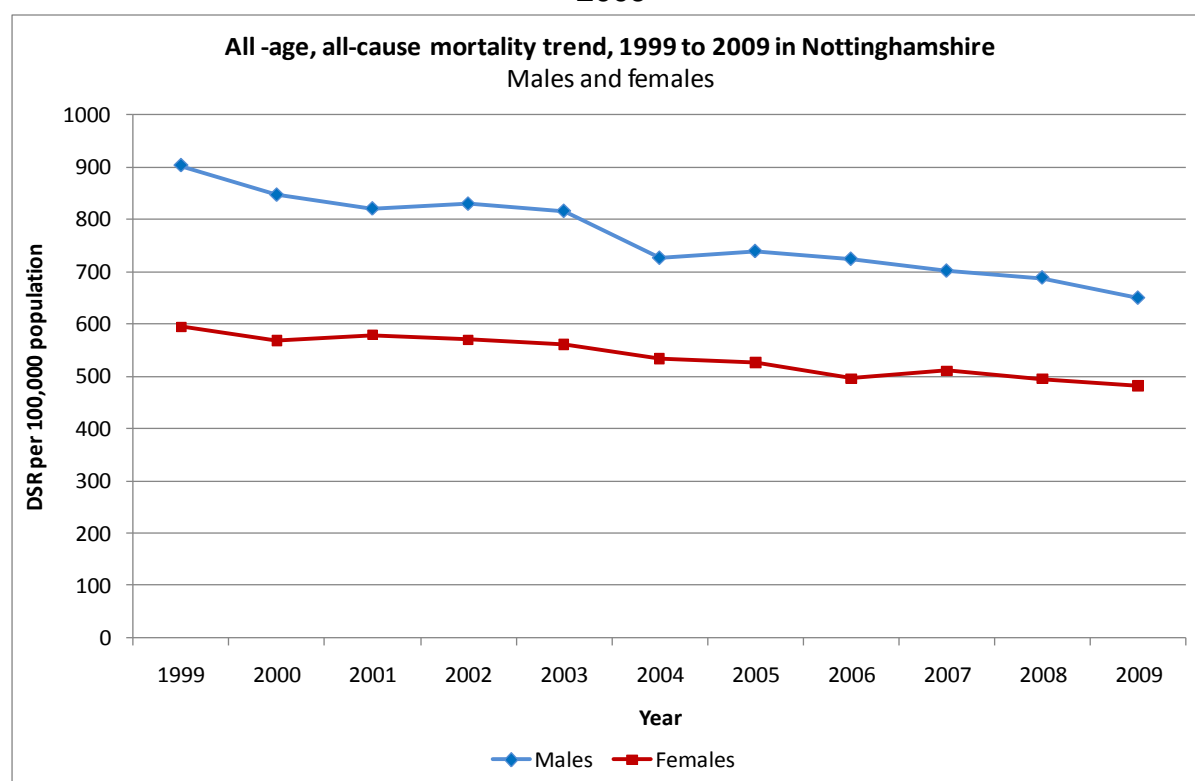
³⁹ Public Health Development Unit “Healthy Lives, Healthy People: Transparency in Outcomes. Proposals for a Public Health Outcomes Framework. A Consultation Document”, December 2010, Department of Health

Figure 4.5.1: Trend in directly standardised AAACM rates by district, 1999-2009



Source: NHS Information Centre portal, <https://indicators.ic.nhs.uk/> accessed 10/1/2012

Figure 4.5.2 Trend in AAACM for males and females in Nottinghamshire, 1999-2009



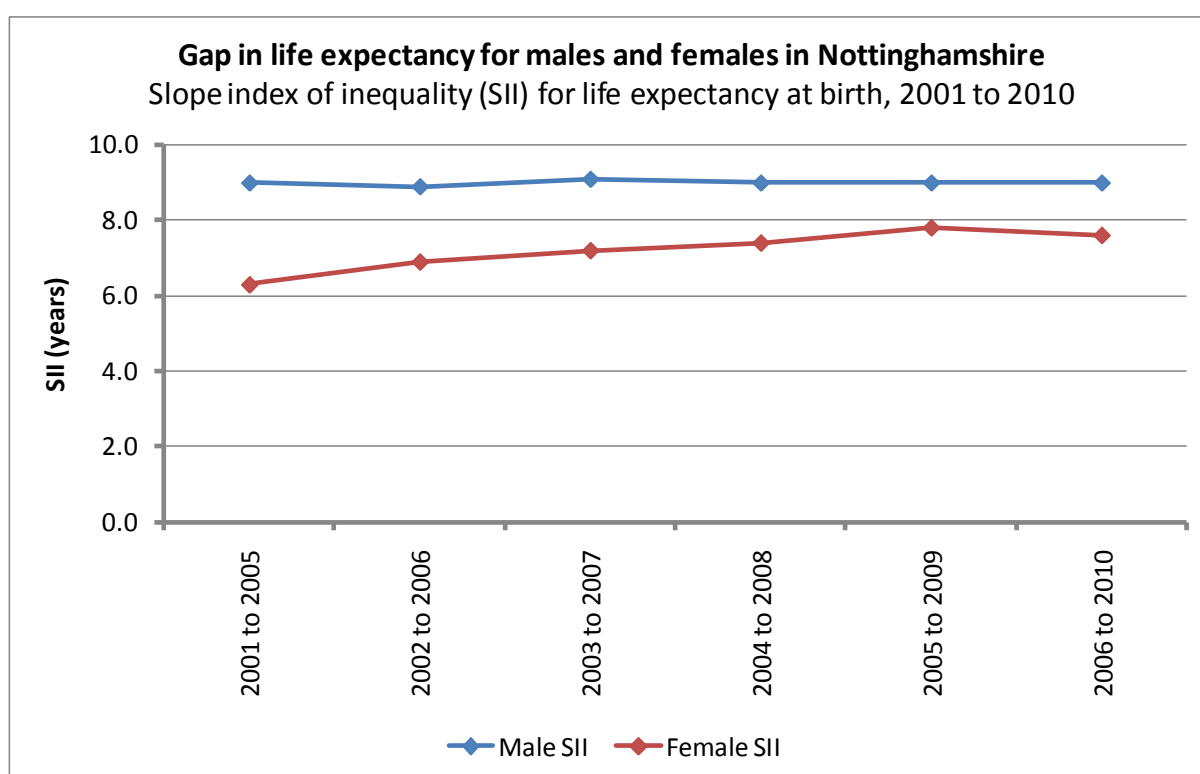
Source: NHS Information Centre portal, <https://indicators.ic.nhs.uk/> accessed 10/1/2012

Slope Index of Inequality (SII)

The SII (gap in life expectancy) is higher for men across Nottinghamshire than for women (9.0 years and 7.6 years respectively for 2006-2010). Figure 4.5.3 shows that the gap for females appears to have widened (SII increased) between 2001 and 2010; the male SII has not changed over the same timescale. One possible explanation for the increase in female SII is that life expectancy for women in the least deprived areas in Nottinghamshire is increasing much faster than those in the most deprived populations.

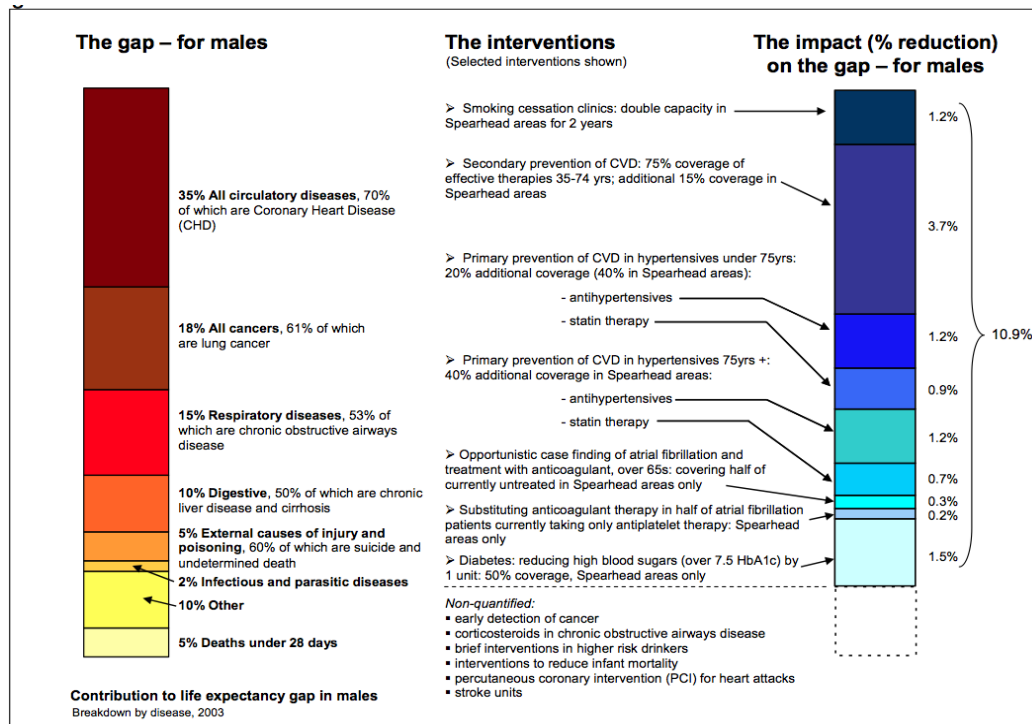
The main contributors to the gap in AAACM/ life expectancy were circulatory diseases, cancers and respiratory diseases. These diseases accounted for around one half of the gap in men and women. Diabetes is known to be an important contributor to circulatory diseases. Tobacco use is a key driver of the gap in inequality; smoking significantly contributes to top 3 main causes of death and explains 50% of the difference in life expectancy across the county.

Figure 4.5.3: Slope index of inequality change over time



Figures 4.5.4. & 4.5.5 (taken from the national Health Inequalities Unit update⁴⁰) show the diseases that account for the gap in life expectancy between less affluent areas and England alongside national modelling of effective interventions. The figures illustrate the effects of the selected interventions to narrow the life expectancy gap. The biggest contributors to the life expectancy gap are cardiovascular disease, cancers and respiratory disease. Together differences in deaths from these causes contribute to over 60% of the gap for males and females.

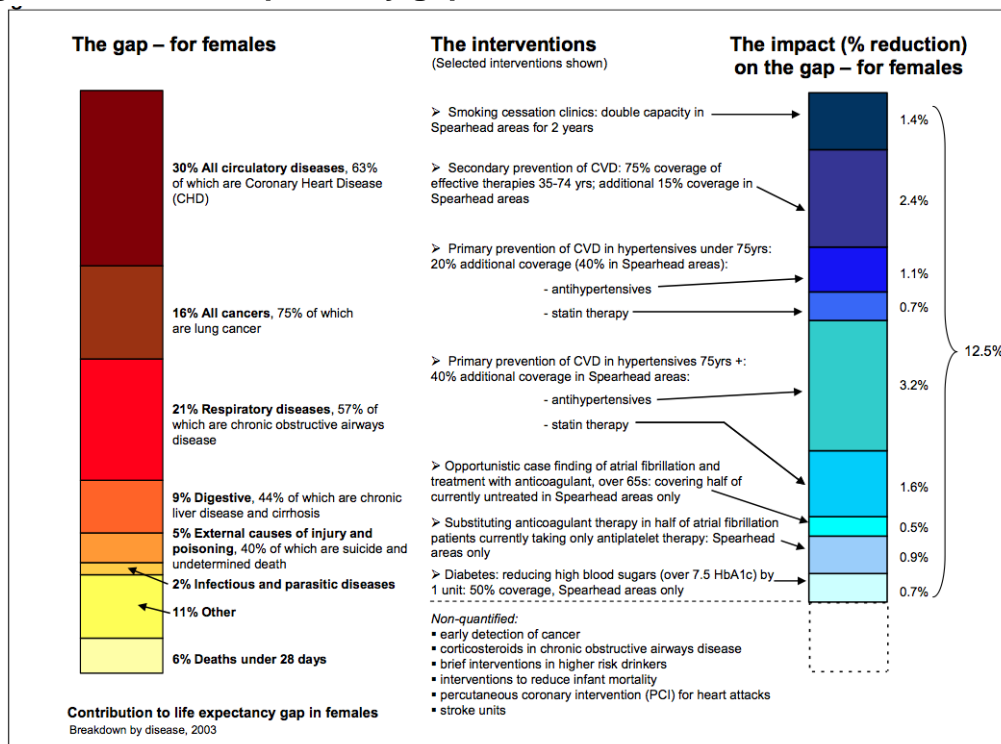
Figure 4.5.4: Life Expectancy gap for males and effective interventions



Source: Source: Health Inequalities Unit, 2009

⁴⁰ Health Inequalities Unit "Tackling Health Inequalities: 2006-08 Policy and Data Update for the 2010 National Target", December 2009, Department of Health

Figure 4.5.5: Life Expectancy gap for females and effective interventions



Source: Health Inequalities Unit, 2009

In the short term (2 to 3 years), gains can be made by addressing the main contributors to AAACM and in particular cardiovascular disease. The main priorities are:

- Case-finding (identifying patients with disease who are not accessing treatment services)
- Secondary prevention (ensuring that all patients with disease have preventative treatment)
- Stopping smoking.

In the longer term, further improvements will only be achieved by tackling wider influences on health poverty and wider determinants of ill-health. The key for local partners is ensuring interventions are implemented systematically with sufficient scale to make a difference at population level. Action is needed across Nottinghamshire and all partner organisations can make a contribution. Table 4.5.6 lists areas for interventions across partner agencies which can increase life expectancy.

Table 4.5.6: Actions to increase life expectancy across partner agencies.

Pregnancy / Early Years

- Good antenatal / Obstetric care
- Smoking and Obesity in Pregnancy
- Reduce Teenage Pregnancy
- Family Planning
- Breast Feeding
- Vaccination

Children and Young People

- Educational Attainment
- Prevent uptake of smoking
- Childhood Obesity

Adults and Older People

- NHS Health Checks
- Lifestyle – Smoking
- Lifestyle – Exercise
- Lifestyle – Diet
- Lifestyle – Alcohol
- Road Traffic Accidents

LTC Management / Pathways / Self Management

- Cardiovascular Disease & Diabetes (inc reducing BP, HbA1c, Cholesterol, detect AF)
- Respiratory Disease / COPD (inc detect, diagnosis, manage)

Employment

Reducing Disability

LA and NHS as good employers

Cancer Prevention

Lifestyle – 30% Smoking

Lifestyle – 30% Diet

Lifestyle - Alcohol

Cancer Early Detection & Treatment

Screening

Education

Early Referral

Effective Treatment

4.6 End of Life Care

Key messages

- Nearly 7,000 people die in Nottinghamshire each year, of whom more than 80% are over 65. The main causes of death are circulatory disease, cancers and respiratory disease.
- Over half of these people die in hospital, but many of them have no clinical need of hospital care.
- Nationally, older people, people who have a non-cancer diagnosis, people who live in an area of multiple deprivation, people from ethnic minorities, and people who live in rural areas are less likely to die at home.
- It is estimated that around 40% of all deaths could be anticipated, and these people could therefore be offered the opportunity of advance care planning.
- Locally, one in five people in Nottinghamshire NHS and one in four people in Bassetlaw NHS die in their own home.

Most people would prefer to die in their own home, but over half of people in Nottinghamshire die in hospital. Many of these have no clinical need of hospital care and could be supported in a community setting if that is their choice. Without advance recognition, planning and coordination of care during the last year(s) of life, the majority of deaths will continue to occur in hospital. End of life care should be available for all diagnoses and in all settings.

Definition and drivers

The Nottinghamshire End of Life Care Pathway for All Diagnoses⁴¹ defines End of Life Care as encompassing the following:

- Adults with any advanced, progressive, incurable illness (e.g. advanced cancer, heart failure, COPD, stroke, chronic neurological conditions, dementia)
- Care given in all settings (e.g. home, acute hospital, residential/care home, nursing home, hospice, community hospital, prison or other institution)
- Care given in the last year(s) of life
- Patients, carers and family members (including care given after bereavement).

Improving end of life care became a national and local priority with the publication of the National End of Life Care Strategy⁴² (2008) and “Our NHS Our Future” report by the Nottinghamshire End of Life Advisory Group⁴³. Furthermore, end of life care is one of the NHS Quality, Innovation, Productivity and Prevention (QIPP) workstreams.

⁴¹ “Nottinghamshire End of Life Care Pathway for All Diagnoses”, 2010

<http://www.nottspct.nhs.uk/nhsservices/endoflifecare.aspx>

⁴² “End of Life Care Strategy, Promoting high quality care for all adults at the end of life”, Department of Health, 2008

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_086277

⁴³ Our NHS Our Future: Developing a vision for healthcare in Nottinghamshire”, End of Life Advisory Group Report, 2008 <http://www.nottspct.nhs.uk/shapingyournhs/ONOF/ONOFreports.aspx>

Cause of death

Nearly 7,000 people die in Nottinghamshire each year, of whom more than 80% are over 65 years old. In 2010 there were 1,734 deaths across Mansfield and Ashfield, 1,107 in Bassetlaw, 818 in Broxtowe, 1,208 in Gedling, 1,030 in Newark & Sherwood, and 934 in Rushcliffe. The main causes of death are from circulatory disease, cancers and respiratory disease (Table 4.8.2.1).

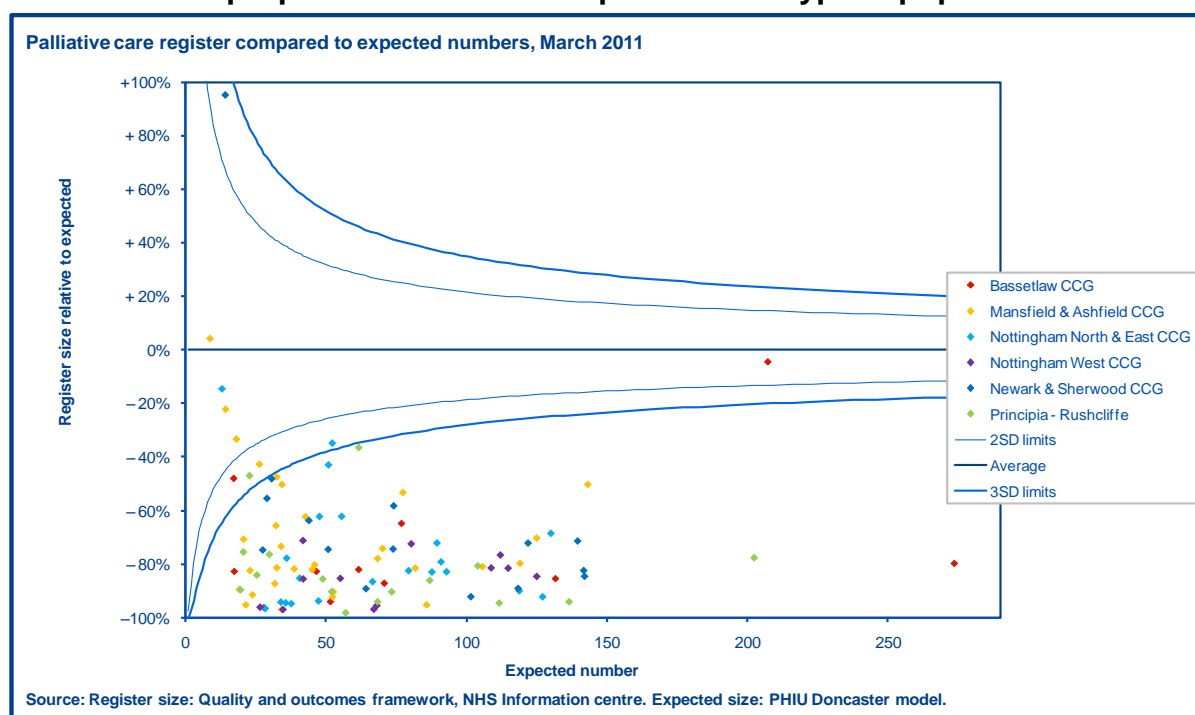
Table 4.6.1: Main causes of death in Nottinghamshire, mean per year for 2005-2008

Males		Females	
Circulatory disease	34.1%	Circulatory disease	32.9%
Cancer	31.2%	Cancer	24.6%
Chest disease	13.0%	Chest disease	13.7%

It is estimated that around 40% of all deaths could be anticipated⁴⁴, and these people could therefore be offered the opportunity of advance care planning - a discussion of wishes and preferences for future care, which is known to increase the chance of achieving these. Only a small proportion of people with end of life care needs across Nottinghamshire is identified (Figure 4.6.2) and can therefore be offered the opportunity to engage in advance care planning. Those practices lying outside the 'funnel' limits in Nottinghamshire had significantly fewer people on their palliative care registers than expected.

⁴⁴ "Cohort Model for End of Life Care in Community Settings", NHS National End of Life Care Programme, 2011
www.endoflifecare-intelligence.org.uk/models

Figure 4.6.2 Number of people on palliative care registers in Nottinghamshire as a proportion of number expected for a typical population



Source: Nottinghamshire County Public Health Information & Intelligence using data sources as mentioned in figure.

Place of death

The majority of deaths occur in hospital, despite the fact that most people would prefer to die at home. Place of death is therefore used as a proxy measure of the quality of end of life care. Older people, people who have a non cancer diagnosis, people who live in an area of multiple deprivation, people from ethnic minorities, and people who live in rural areas are less likely to achieve a home death⁴⁵.

Due to the priority given to end of life care across Nottinghamshire, there are now challenging targets in place for increasing the number of deaths in the usual place of residence and for decreasing hospital admissions for people in the last days of life, where this would not be their preferred place of death. Table 4.6.3 shows where people died last year in Nottinghamshire.

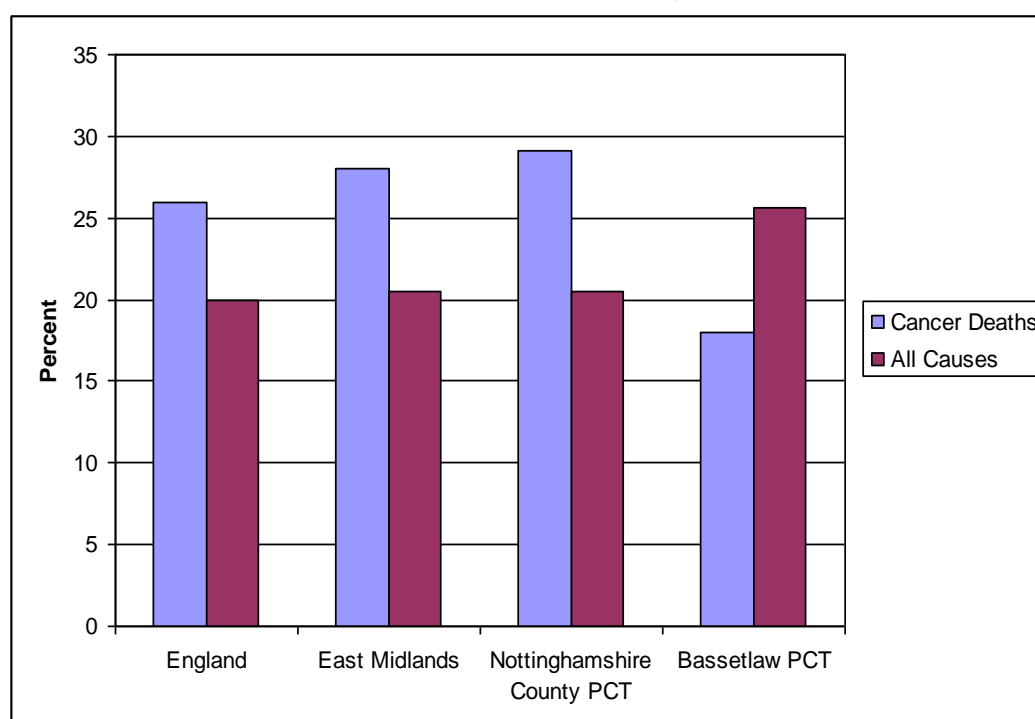
⁴⁵ Gomes, B., & Higginson, I.J. 2006 "Factors influencing death at home in terminally ill patients with cancer: systematic review", British Medical Journal, vol. 332, no. 7540, pp. 515-521

**Table 4.6.3: Place of death for Nottinghamshire registered patients, 2010
(number and proportion)**

	Hospital	Home	Care home	Other
NHS Nottinghamshire County	3,335 53%	1,439 23%	1,325 21%	183 3%
NHS Bassetlaw	488 49%	212 21%	199 20%	105 10%

The likelihood of achieving a home death for people with cancer is greater than for people dying of other causes, and in Nottinghamshire the difference is greater than the national and regional averages. In Bassetlaw this pattern is reversed with less likelihood of dying at home with cancer than other causes (Figure.4.6.4).

Figure 4.6.4: PCT comparison with national and regional average for home deaths – cancer and all causes, 2007 - 2009



Source: NHS Information Centre

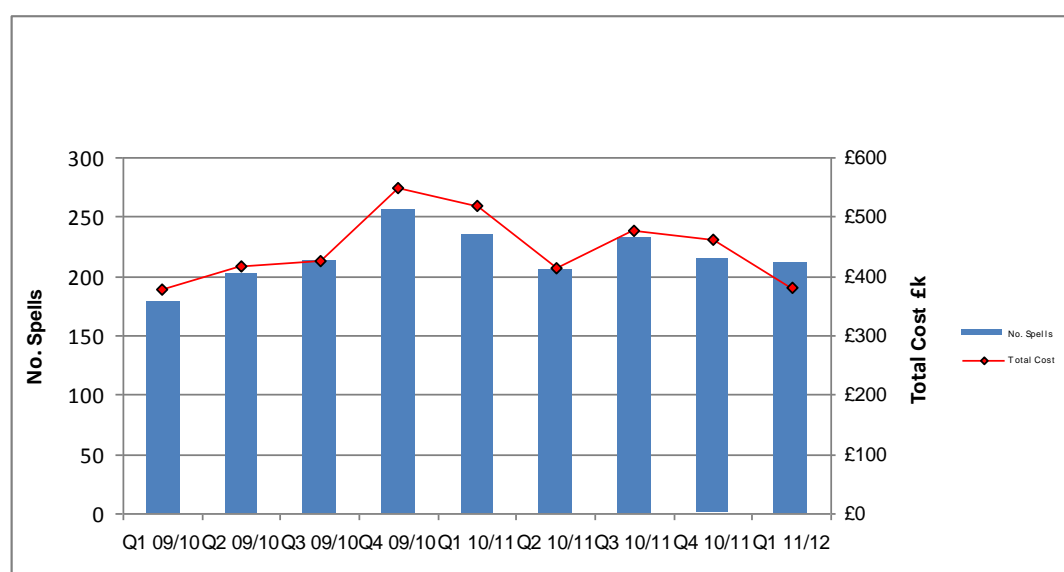
Hospital Utilisation

It has been estimated that end of life care accounts for at least one fifth of NHS spending and that the costs will rise by 25% by 2030⁴⁶. A National Audit Office

⁴⁶ "Dying for Change" Demos, 2010 <http://www.demos.co.uk/publications/dyingforchange>

report in 2008 found that 40% of people that died in hospital had no medical need to be there⁴⁷. Modelling for the populations of Newark & Sherwood and Principia Rushcliffe CCGs suggests that if the current model of care continues, hospital admissions and costs for end of life care will rise continuously for the next 10 years⁴⁸. These projections are likely to hold true across the county. Figure 4.6.5 shows the number and cost of emergency hospital admissions in the last days of life for the last two years.

Figure 4.6.5.: Nottinghamshire County Hospital Spells, Last Days of Life, April 2009 – June 2011



Source: HES (NEL admission, LOS < 4 days, in-hospital death, excluding external causes)

Compassionate Communities

Successful provision of the majority of end of life care in the community will require considerable resources that cannot be provided by statutory services alone, given the fact that we are living longer, and that the number of deaths will rise from 2012 as the “baby boomer” generations approach the end of life (see Older People’s Chapter section 1.2)

While the public sector continues to meet the rising costs of essential services within limited resources, the national end of life care strategy recognises that a whole society approach is required⁴⁹ because a significant proportion of care will fall to unpaid carers. To enable and sustain them in this role, the support of the wider community is essential. The community and voluntary sector has a good track

⁴⁷ “WSP Cohort Model for End of Life Care in Community Settings Early Adopter report: Principia and Newark & Sherwood Clinical Commissioning Groups”, 2011

⁴⁸ “End of Life Care”, National Audit Office, 2008

http://www.nao.org.uk/publications/0708/end_of_life_care.aspx

⁴⁹ “Compassionate Communities: A review of the literature and feasibility of implementing such a model”, (unpublished), NHS Nottinghamshire County, 2011

record in delivering palliative and end of life care in partnership with statutory services and with close ties to local communities, and in supporting unpaid carers e.g. relatives and friends.

Compassionate communities is a nationally recognised model which encourages communities to spread the message that death, dying and bereavement is everyone's business and become actively involved with end of life care in their society. Further work is required to scope the feasibility and effectiveness of implementing this model within Nottinghamshire in order to meet the future care needs of an increasingly frail older population.

JOINT STRATEGIC NEEDS ASSESSMENT FOR NOTTINGHAMSHIRE 2012

Adults and Vulnerable Adults

5. Safety

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#

Adults and Vulnerable Adults: Safety

5. Safety

5.1 Crime

Key messages

- Crime and fear of crime affects particular communities - for example those suffering from deprivation - and groups of people - for example young people, older people and BME communities - disproportionately.
- Although some crime rates have fallen in recent years, Nottinghamshire still has significant crime and anti-social behaviour issues across the county.
- Mansfield, Ashfield and Bassetlaw had the highest crime rates in the county in 2010/11 (83.8, 74.5 and 71.4 per 1,000 population respectively).
- Important county issues include violence and domestic violence.
- Theft offences in Nottinghamshire have increased (in line with the national average), domestic burglary has reduced and vehicle crime is stable and below the national level.
- There is a relationship between alcohol and drug use and crime rates and anti-social behaviour, with alcohol in particular being a driver of violent crime and anti-social behaviour.

Introduction

Crime and community safety remains a key concern to local citizens. Previous MORI surveys showed little difference in concerns between all adult respondents and older cohorts, and they were most worried about having their homes broken into, having their cars stolen or having things stolen from their cars, and being mugged and robbed.

Nottinghamshire has adopted a geographic approach to tackling crime and disorder issues. This holistic approach enables the causes of crime as well as symptoms to be addressed in each geographical area. Given current financial and resource concerns, this offers an efficient means of tackling crime; ensuring resources are targeted where they will have the largest impact on crime reductions and on communities.

Over the last two years there has been significant change to the picture of crime and disorder in Nottinghamshire.

Local statistics

Recent data on crime and community safety shows a good position when the county's performance is contrasted with regional and national figures. There have been significant reductions in the levels of crime in Nottinghamshire over the last 12-18 months. For example:

- Nottinghamshire has lower rates of all crime than its comparable county group, below both regional and national averages – In November 2011 it appeared 6th out of 15 in the national group (8% below the average) and regionally was ranked 4th out of 9 (18% below the regional average)
- Nottinghamshire police jointly with Leicestershire police, achieved the highest level of crime reduction in 2010/11 in England and Wales (source: Home Office)
- Domestic burglary offences were reduced over the last 12 months by 41% (to end August 2011), which has placed Nottinghamshire 3rd in its regional group. This has slipped to 5th by the end November 2011, but remains 11% below the regional average. Home Office figures show that Nottinghamshire police had the highest level of crime reduction in 2010/11
- Vehicle crime rates are now below the national average and are remaining stable (source: Home Office).
- Adult re-offending rates are in line with the national average. Nottinghamshire Probation Trust is the 7th best performing trust out of 35 based on the most recently released national data (source: Ministry of Justice).

There are number of emerging issues and challenges for Nottinghamshire. These include:

- Alcohol is a driver of much of the violent crime and ASB in the county – alcohol related hospital admission rates have increased across all districts over from 2008/9 to 2009/10, although further research suggests this is linked to chronic not acute alcohol abuse.
- Violent crime is a particular concern, despite improving against both regional and national averages. Mansfield and Ashfield have the highest rates of violence against the person offences in the county.
- Theft offences have increased in line with national averages, in particular theft of metal and driving off without paying for petrol. These crime types tend to increase in times of recession. It is hoped that a new private members' Bill will make the disposal of stolen metal for cash very difficult.

Table 5.1.1: Crime rate for each district in Nottinghamshire for 2009/10 and 2010/11.

District	Crime rate for all recorded offences 2009/10 (per 1,000 population)	Crime rate for all recorded offences 2010/11 (per 1,000 population)
Ashfield	96.2	74.5
Bassetlaw	88.9	71.4
Broxtowe	58.9	51.3
Gedling	65.5	57.1
Mansfield	100.6	83.8
Newark and Sherwood	67.0	54.0
Rushcliffe	49.9	43.2
Nottinghamshire county	75.0	61.9

Source: mid 2009 population figures from ONS: Crown Copyright

There has been much research and analysis of the data on community safety issues over the last few months in preparing the Nottinghamshire Community Safety Strategic Assessment, (<http://www.nottinghamshire.gov.uk/home/youandyourcommunity/staysafe/communitysafety.htm>) which has highlighted the community safety 'hotspots' across the county; there has been recognition by the community safety partnerships that approximately 30% of all crime occurs in a small number of geographic locations; through the strategic assessment process these have been developed as 'Partnership Plus' areas. The Partnership Plus areas have become the subject of concerted and joined-up activity by all partners, in order to deliver the relevant reductions in crime and anti-social behaviour in those areas.

The strategic assessment process has highlighted the following priorities for Nottinghamshire:

- Serious acquisitive crime
- Violent crime
- Domestic violence (see section 5.2)
- Anti-social behaviour
- Drugs and alcohol (see section 3.1)
- Youth issues
- Hate crime

There is a relationship between alcohol and drug use and crime rates and anti-social behaviour, with alcohol in particular being a driver of violent crime and ASB. Crime and fear of crime affects particular communities - for example those suffering from deprivation - and groups of people – for example young people, older people and BME communities – disproportionately; fear of crime particularly impacts upon people's sense of well-being and mental and emotional health. Older people in Nottinghamshire (65+) tend to be more positive about their local area (source: Ipsos Mori – 2008/9) than their younger counterparts. Residents of Ashfield and Mansfield are most likely to feel unsafe after dark whilst residents of Rushcliffe and Newark & Sherwood are most likely to feel safe.

The outcomes of the serious case review into the tragic deaths of Fiona Pilkington and her daughter in Leicestershire have raised the profile of Hate Crime and in particular the importance of recognising disability Hate Crime and related anti-social behaviour (ASB). It is clear that there are significant levels of Hate Crime against disabled people in Nottinghamshire.

A questionnaire was carried out in summer 2010 by the Safer Communities and Safeguarding Adults and Mental Capacity Act Teams (SAMCAT) at Nottinghamshire County Council, to provide a broad picture of the nature and extent of disability Hate Crime. Almost three-quarters (73%) of respondents had experienced being frightened or attacked because of their disability. Many people felt that this is part of their everyday life about which they can do little.

5.2. Domestic Violence

Key messages

- Women are substantially more at risk of being a victim or survivor of domestic violence. Young women, especially teenage mothers, are especially at risk.
- Across Nottinghamshire, approximately 32,000 women will experience domestic violence each year.
- There were over 11,000 domestic incidents and domestic violence crimes in the county reported to the police in 2010/11, the highest number in Mansfield and Ashfield and the lowest in Rushcliffe.
- During 2010/11 in Nottinghamshire, 856 high risk domestic violence cases were taken to a MARAC (Multi Agency Risk Assessment Conferences). 22 of these were male victims.
- Local data indicates that women in the 20-30 year age range make up 36% of all adult domestic violence victims.
- Access to local specialist domestic violence support services (including referral to MARACs) by disabled women, older women, lesbian, gay, bi-sexual and trans-gendered people is low.
- Women from BME groups accessing Nottinghamshire specialist domestic violence services (10.5% of all service users) represent a higher proportion of service users compared with the county's BME population as a whole.
- The implementation of agreed standardised data collection sets across agencies would improve ability to assess need and plan for the future.

Definition

The Safer Nottinghamshire Board has adopted the following definition of domestic violence:

Domestic violence can include physical, sexual, psychological or financial violence that takes place within an intimate or family-type relationship and that forms a pattern of coercive and controlling behaviour. This can include forced marriage and so-called 'honour crimes'. Domestic violence may include a range of abusive behaviours, not all of which are in themselves inherently 'violent'.¹

¹ Women's Aid Federation England <http://www.womensaid.org.uk>

Introduction

Domestic violence is a significant problem in our society. At least one in four women will experience domestic violence during their lifetime and about one in ten women, in any given year². This means that across Nottinghamshire at least 31,920 women will experience domestic violence every year³. The consequences for victims can be very serious including mental ill-health and homelessness as well as physical injury. Domestic violence usually escalates as a relationship continues, so where there are concerns, it is important to assess risk levels regularly.

Whilst domestic violence occurs across all sections of society, men are far more likely to be the perpetrators and women the victims. Combined analysis of national police statistics and the British Crime Survey results show that 73% of domestic violence is perpetrated by men against women and that 80% of domestic violence victims are women.² Women are also considerably more likely to experience repeated and severe forms of violence, including sexual violence. The violence they experience is also more likely to have a sustained psychological/emotional impact or result in injury or death.⁴

It is for this reason and because of an understanding that domestic violence is one of a range of forms of violence and abuse perpetrated against women and girls that the coalition government has made a long-term commitment to work across departments and with key partners to address the causes and consequences of all forms of violence against women and girls. Their overarching strategy is set out in the paper *Call to End Violence Against Women and Girls* and is supported by a detailed action plan⁵ organised around four key themes:

- Prevention of violence against women and girls by challenging the attitudes and behaviours which foster it and intervening as early as possible
- Provision of adequate levels of support where violence does occur
- Action to reduce the risk to victims and ensure that perpetrators are brought to justice.
- Partnership work to obtain the best outcome for victims and their families

Whilst the links with other forms of male violence against women are acknowledged, for the purposes of this needs assessment the focus is on *domestic violence* as

² British Crime Survey Crime In England and Wales 2009/10

³ All figures for Nottinghamshire exclude Nottingham City

⁴ Povey D, Coleman K, Kaiza P and Roe S (2009) Homicides, Firearm Offences and Intimate Violence 2007/08 (Supplementary Volume 2 to Crime In England and Wales 2007/08) London: Home Office

⁵ HM Government (March 2011) www.homeoffice.gov.uk/vawg

defined above. However, there will be a need to examine separately issues such as sexual violence, female genital mutilation, trafficking, grooming and prostitution with a view to eventually joining these up under a comprehensive strategy to address violence against women and girls. Further, whilst existing services and priorities for children and young people affected by domestic violence are mentioned in this section, a separate chapter of the JSNA is dedicated to this issue.

National Data

Although domestic violence is chronically under-reported, national research and data show that:

- Each week in England and Wales, at least 2 people are killed by their partner or ex-partner.⁶
- At least 1 in 4 women in the UK will experience domestic violence in their lifetime and about 1 in 10 women will experience it in any given year.⁷
- Police in the UK receive 1,400 calls every day about domestic violence⁸ yet on average, women experience 35 separate incidents of abuse before they first contact the police.⁹
- Sexual assaults against women are more likely to be perpetrated by current or former partners (45% and 9% respectively) than strangers – 17%.¹⁰
- Less than 6% of rape offences reported to the police result in an offender being convicted of an offence.¹¹
- The United Nations estimates that every year 5,000 women are victims of honour-killings internationally.¹²
- In 2009, the forced marriage unit provided direct support to victims in the UK and overseas in 377 cases.¹³

⁶ British Crime Survey: Crime In England and Wales 2009/10

⁷ Ibid

⁸ Stanko B (2000) Everyday Violence: How women and men experience sexual and physical danger Pandora: London

⁹affe P, Wolfe D, Telford A, and Austin G (1986) The impact of police charges in incidents of wife abuse *Journal of Family Violence* 1 (1) : 37-49

¹⁰ Walby S and Allen J (March 2004) Domestic Violence, Sexual Assault and Stalking: Findings from the British Crime Survey Home Office Research Study 276

¹¹ Ibid

¹² www.homeoffice.gov.uk/vawg

¹³ Ibid

Data for Nottinghamshire (excluding Nottingham City)

- Between March and October 2011 there were five domestic homicides in Nottinghamshire.
- Every year at least 31,920 women living in Nottinghamshire will experience domestic violence.³²

During the year 2010-2011:

- Nottinghamshire Police recorded 7,689 domestic violence incidents.
- 856 high risk cases were discussed at a Multi Agency Risk Assessment Conference (MARAC). These cases involved 1,244 children.
- 1,005 new referrals to Children's Social Care identified domestic violence as a concern
- 3,250 callers to the 24 hour Domestic Violence Helpline identified a Nottinghamshire County location (local helpline to support women experiencing domestic violence)
- 166 women and 248 children received crisis accommodation and support from Nottinghamshire County refuges

Table 5.2.1: Breakdown of Domestic Violence reported to Nottinghamshire Police 2010-11¹⁴

District	Domestic Incidents	Domestic Violence Crimes
Ashfield	1,372	762
Bassetlaw	1,304	418
Broxtowe	890	392
Gedling	1,113	466
Mansfield	1,408	759
Newark & Sherwood	1,005	466
Rushcliffe	597	253
Nottinghamshire County	7,689	3,516

¹⁴ Notts CC analysis of Police data 2011

Risk Factors for Experiencing Domestic Violence

Gender and Pregnancy

The data cited in the introduction clearly shows that being a woman or girl is the most significant risk factor for becoming a victim of domestic violence and that this is also associated with experiencing more repeated and severe forms of violence. In addition, there are certain times in women's lives or experiences that women and girls may have which elevate their risk. Pregnancy, for example can be a particularly vulnerable time; more than 30% of domestic violence cases start during pregnancy and where violence and abuse is already being experienced it may intensify.¹⁵

Whilst it is not as prevalent, men do experience violence and abuse within their relationships and this can be serious. Locally, during the year 2010/2011, 856 high-risk domestic violence cases were discussed at a Multi Agency Risk Assessment Conference (MARAC). Of these, 22 were male victims (representing 3.5% of all victims).

Age

Whilst people can be at risk of domestic violence at any age, research shows that rates of domestic violence amongst younger women are particularly high. Local data indicates that women in the 20-30 year age range make up 36% of all adult domestic violence victims.¹⁶

A recent National Society for the Protection of Cruelty to Children study revealed that teenagers as young as 13 are experiencing domestic violence within their own relationships and that rates of physical violence against teenage girls are the same as for adult women – 1 in 4.¹⁷ Being a teenage mother appears to increase vulnerability further with recent research findings showing that 70% of teenage mothers experience violence in their relationships.¹⁸

National Police data indicates relatively low rates of domestic violence amongst the over 60 population, however, this is likely to be the result of a range of factors that prevent reporting and identification of domestic violence in this age group. A recent serious case review of the death, in Essex, of an 81 year old woman following an alleged assault by her 88 year old husband has highlighted how little is known about domestic violence involving old people, and how easy it is for professionals to miss the signs.¹⁹ Locally, data from specialist domestic violence services in

¹⁵ Lewis, Gwynneth, and Drife, James (2005) Why Mothers Die 2000-2002 - Report on confidential enquiries into maternal deaths in the United Kingdom (CEMACH).

¹⁶ Bassetlaw, Newark and Sherwood CSP Analysis of Domestic Abuse January-December 2010

¹⁷ NSPCC (2009) Partner Exploitation and Violence in Teenage Intimate Relationships

¹⁸ Harrykisson et al (2008) cited in Women's Aid, Safe, Issue 26, 2008, p.7

¹⁹ <http://www.guardian.co.uk/society/2011/dec/23/police-domestic-abuse-older-couples>

Nottinghamshire shows that the number of older women accessing their services is very low – during 2009-2010 only 2.5% of service users were over 60.

Disability

Disabled people are at significantly increased risk of experiencing domestic violence and may be particularly vulnerable if, as is often the case, the perpetrator is also the “carer”.

Research shows that rates of domestic violence may be twice as high for disabled women (50%) as for non-disabled women (25%).²⁰ One of the consequences of domestic violence can of course be an injury resulting in disability – this then contributes to the high rate of domestic violence amongst disabled people. Currently, disabled people’s access to domestic violence services in the county is generally very low compared to the increased rate at which disabled people experience domestic violence. Diversity data shows that just 36 disabled people (6%) were referred to a Nottinghamshire MARAC during 2010-2011. The rate at which disabled women access specialist domestic violence services is variable ranging from less than 1% of all service users to 24% (2009-2010 data).

Race and Ethnicity

Domestic violence affects women of all races, nationalities and ethnic backgrounds.

However, there are some issues that are of particular concern to certain Black, Minority Ethnic and Refugee (BME) communities such as forced marriage and so-called “honour” crimes. Further, access to domestic violence services may be affected by a range of issues that disproportionately affect or impact on women from BME groups, for example, racism, language barriers, cultural issues, and having no recourse to public funds.

Analysis of the diversity data for referrals to MARACs (2010-2011) indicates that referrals from BME groups represent 9.1% of all referrals. Women from BME groups accessing Nottinghamshire specialist domestic violence services (10.5% of all service users) represent a higher proportion of service users compared with the county’s BME population as a whole.²¹

²⁰ Presentation at Nottinghamshire Domestic Violence Forum Seminar by Dr R Thiara (2010) on findings from research focusing on disabled women’s experiences of domestic violence and seeking help

²¹ This statistic excludes women being supported through Roshni Women’s Aid - a specialist domestic violence service for South Asian women.

Sexual Orientation

Survey data indicates that 1 in 4 people in same sex relationships probably experience domestic abuse at some time – similar to figures for heterosexual domestic abuse against women.²²

Increasing access to services from the lesbian, gay and bisexual (LGB) communities remains a challenge for services in Nottinghamshire. The MARAC diversity data for 2010-2011 shows that just 1.1% of referrals were from LGB groups.

The Impact of Domestic Violence

Domestic violence has an impact on so many individuals and families and in so many aspects of their lives that it needs to be included in all agencies' service planning, training and evaluation.

Health and Health Care Needs

Domestic violence becomes the most significant health issue for women up reaching reproductive age. It can have very serious consequences of victims including permanent disability, physical injuries, long-term mental illness and death. During 2009/10 in England and Wales, 94 women and 21 men were killed by their partner, ex-partner or lover.²³ In Nottinghamshire this year (2011) there have been five domestic homicides.

Physical injuries commonly resulting from domestic assaults include: bruises, cuts and abrasions (particularly facial injuries), fractured bones, burns, lost teeth and internal injuries. Findings from the British Crime Survey²⁴ show that rates of injury are high. Women reported that during the worst incident experienced in the previous year, 46 per cent sustained a minor physical injury, 20 per cent a moderate physical injury, and six per cent severe injuries. Among men, 41 per cent sustained a minor physical injury, 14 per cent a moderate physical injury and one per cent severe injuries.

When pregnant both the woman and her unborn child are at risk. Injuries are likely to be inflicted to the breasts and abdomen and can result in miscarriage and foetal brain damage. During 2000-2002, 14% of all the women who died during or immediately after pregnancy (43 women) had reported domestic violence to a health professional during the pregnancy.²⁵

²² Henderson (2003) Prevalence of Domestic Violence Among Lesbians and Gay Men.

²³ 2009/10 British Crime Survey

²⁴ Ibid

²⁵ Lewis, Gwynneth, and Drife, James (2005) Why Mothers Die 2000-2002 - Report on confidential enquiries into maternal deaths in the United Kingdom (CEMACH)

Domestic violence can also have extremely adverse effects on women's mental health and is linked to increased levels of substance use. A meta-analysis of 18 studies found an average rate of post-traumatic stress disorder among victimised women of 64%, a rate of depression of 48% and a suicide rate of 18%.²⁶ Abused women are also 15 times more likely to use alcohol and 9 times more likely to use drugs than non-abused women.²⁷

The Financial Cost of Domestic Violence

It is estimated that domestic violence costs the UK at least £16 billion pounds per year.²⁸ Nearly £4 billion of this is made up of costs to public services. Each domestic violence homicide costs the state over £1 million.

Figure 5.2.2: The Cost of Domestic Violence to Public Services

Services	Cost £m
Criminal justice system	1261
Health care	1730
Social services	283
Housing and refuges	196
Civil legal services	387
Total	3856

Source: S Walby (2009) *Cost of Domestic Violence: Update*

Whilst these figures demonstrate that domestic violence has a significant financial cost for society, they are acknowledged to represent a considerable under-estimate as the calculations are based only on costs that can be verified and exclude many costs such as those resulting from the long-term effects on children, Adult Social Care work with vulnerable adults, costs to education services, and the cost of therapeutic and other support in the voluntary sector. Furthermore, the data used to

²⁶ Golding (1999) cited in Itzin C (2006) Tackling the health and mental health effects of domestic and sexual violence. Home Office

²⁷ Barron J (2004) Struggle to survive: Challenges for delivering services on mental health, substance misuse and domestic violence Women's Aid Federation England

²⁸ Walby S, (2009) Cost of Domestic Violence: Update www.lancs.ac.uk/fass/sociology/profiles/34/

calculate the number of domestic violence victims is known to significantly under represent the true number.²⁹

Social and community care needs

The consequences of domestic violence for victims are often wide-ranging and can include:

- poverty
- homelessness
- loss of income or work
- loss of opportunity
- isolation from family/friends
- poverty and financial hardship

Research carried out by the homeless charity, Shelter, found that domestic violence is "the single most quoted reason for becoming homeless". The study found that 40% of all homeless women stated domestic violence as a contributor to their homelessness.³⁰

The British Crime Survey showed that more than one fifth of women (21%) who were employed and who had suffered domestic violence took time off work as a result of the worst incident.³¹

Perpetrators of domestic violence often seek to control the family finances and may also amount debt in their partners' names. They frequently isolate their partners from friends and family as a means of asserting and extending their control over them. Perpetrators may also ensure there are limited opportunities for women to disclose what is happening by, for example, monitoring their partner's movements and accompanying them to appointments with agencies. In their efforts to hide what is happening, women might themselves avoid social contact. Women's isolation reduces their opportunities for talking about what is happening and exploring possibilities for leaving the violent relationship. It can increase women's negative feelings about themselves and incur a sense of helplessness.

Feelings of isolation can also occur having left a violent relationship since women might have had to move to a new area away from friends and family. Building new

²⁹ The study used data from the main British Crime Survey. This data is known to significantly under represent the true rate of domestic violence. For example, self-completion questionnaires used during the 2001 BCS revealed a rate of domestic violence that was five times higher than that recorded during the main survey. Ibid

³⁰ Cramer H and Carter M (2002) Homelessness: what's gender got to do with it? London: Shelter

³¹ British Crime Survey: Crime In England and Wales 2009/10

social networks and pursuing new work or educational opportunities whilst recovering from the effects of a violent relationship can be very hard.

Local Specialist Domestic Violence Services

Nottinghamshire has benefited from a well-established specialist domestic violence voluntary sector delivering a wide range of support services to women, children and more recently male victims of domestic abuse across all levels of risk. In consultations with service users, these services are the one type of agency to be consistently positively evaluated. Further, as important as the crisis support is, women also emphasise the value of their holistic approach – one that supports them throughout their journey and equips them with the skills and confidence needed to move on in their lives.

A comprehensive domestic violence service review undertaken by the Safer Nottinghamshire Board (2010/11) resulted in the County Council reviewing its strategic priorities and devising a series of proposals for re-structuring the commissioning of domestic violence services. The proposals were consulted on and have resulted in a new geographical model for domestic violence service delivery being agreed. The new model will commence in August 2012 and will result in the organisation and delivery of key services over two areas: North Nottinghamshire encompassing Bassetlaw, Newark and Mansfield; and South Nottinghamshire encompassing Ashfield, Broxtowe, Gedling and Rushcliffe.

This model will result in there being one or two large specialist domestic violence services providing key services, particularly to those in crisis and assessed as being at high risk. Whilst there are many advantages to this new model, there are also benefits to be gained from retaining a network of smaller, community embedded services. These include: choice and accessibility for victims; and the potential for organisations to successfully bid for funding thereby increasing the overall level of domestic violence service provision in Nottinghamshire.³²

Local Priorities

The Safer Nottinghamshire Board, in consultation with partner agencies and service users, has identified key priorities for work on domestic violence over the next two years (2011-13). These have been organised around the four key areas of work identified in the government's strategy and action plan and are summarised in the table below.

³² In 2010-11, domestic violence services secured additional funding of £471,400 from charitable trusts and other external sources. This represented 24% of overall income for domestic violence services.

Figure 5.2.3 Priorities for Addressing Domestic Violence (DV) 2011-13

Prevention & Early Intervention	<ul style="list-style-type: none"> • Provision of an effective multi-agency DV training programme • Develop media and public awareness campaigns • Educational work with children and young people to promote healthy relationships • Improving routine enquiry and recording to encourage disclosure.
Specialist Support for Victims of Domestic Violence and their Children	<ul style="list-style-type: none"> • Commitment to working to limit the impact of budget reductions on domestic violence services • Commitment to ensuring DV specialist services continue to be central to multi-agency strategies to address DV.
Reducing Risk of Serious Harm and Bringing Perpetrators to Justice	<ul style="list-style-type: none"> • Multi-agency management of high risk cases of domestic violence through MARACs • Continued operation of the specialist domestic violence courts • Ensuring lessons are learned from domestic violence homicide reviews • Continued operation of the Integrated Domestic Abuse Programme (IDAP) for convicted offenders of DV related offences • Consideration of the use of an Integrated Offender Management Approach to serial perpetrators of DV
Partnership	<ul style="list-style-type: none"> • Establishment of a countywide multi-agency DV strategy group • Ensuring involvement of DV specialist services in partnership work • Embed processes for hearing and learning from survivors of DV • Implement targeted DV work in partnership plus areas • Review and improve information sharing protocols and procedures • Improve data collection, sharing and analysis.

Source: Safer Nottinghamshire Board Domestic Violence Framework 2011-13

5.3. Road Traffic Collisions and Avoidable Injury

Key messages

- Road casualty rates in Nottinghamshire are reducing year on year and are currently lower than the national average.
- Comparing 2010 with 2009, the number of people killed in road accidents fell by 17% nationally and by 45% in Nottinghamshire.
- All severities of casualties fell by 6% nationally and 10% in Nottinghamshire.

It is widely reported that areas experiencing higher levels of disadvantage and deprivation have a higher incidence of road traffic collisions. In Nottinghamshire, as many of these areas have historically been treated with accident remedial measures, this is not the case.

In 2000, the government set all highway authorities a target of reducing the number of people killed and seriously injured by 40% by the end of 2010, using the 2004-2008 average as a baseline. In Nottinghamshire this target was surpassed as a 50% reduction was achieved.

The user groups and behaviours where casualties remain high are;

- car driver and passengers aged 17 – 25
- motorcycle riders
- inappropriate speed

New casualty reduction aspirations have been discussed by central government for 2020, with emphasis being placed on local authorities to set their own local targets. In Nottinghamshire a target of a 40% reduction in all people killed and seriously injured has been agreed, using 2005 – 2009 as a baseline.

Figure 5.3.1 below shows the accident and casualty figures for each category by district. Comparing the figures with 2009, all districts have seen a reduction in the number of people killed and seriously injured, with the exception of Ashfield and Gedling, where there was an increase of 7 and 2 people. The number of people who received *slight injuries* reduced in all districts and overall a reduction of 30% was across the county.

Whilst overall casualties have reduced by 10%, there are areas of the population which have not seen reduction in casualties. Pedal cycle riders and passenger casualties increased by 9% and motorcyclists who were killed or seriously injured reduced by 9%. Car drivers aged 17-24 comprised 15% of all road casualties across Nottinghamshire. Figures 5.3.2 to 5.3.6 show road traffic casualties for different categories and severity of injury.

Working with Partners across Nottinghamshire, targeted behavioural change programmes are needed to address these identified issues. Speed management and taking ownership for your actions on the road are key areas for development.

Figure 5.3.1 Injury Accident and casualty Analysis by District Jan – Dec 2010

	Ashfield	Bassetlaw	Broxtowe	Gedling	Mansfield	Newark	Rushcliffe
ALL INJURY ACCIDENTS							
Fatal Accidents	2	6	0	3	1	5	1
Serious Accidents	53	63	39	39	38	67	54
Slight Accidents	261	295	196	221	215	277	216
TOTAL ACCIDENTS	316	364	235	263	254	349	271
FATAL + SERIOUS Accidents	55	69	39	42	39	72	55
ALL CASUALTIES							
Fatal Casualties	2	8	0	4	1	6	2
Serious Casualties	59	75	41	44	40	76	59
Slight Casualties	370	427	279	307	302	392	318
TOTAL CASUALTIES	431	510	320	355	343	474	379
KSI Casualties	61	83	41	48	41	82	61
CHILD CASUALTIES (0-15yrs)							
Fatal Casualties	0	0	0	0	0	0	0
Serious Casualties	3	5	3	2	4	5	4
Slight Casualties	33	48	31	29	45	45	21
TOTAL CASUALTIES	36	53	34	31	49	50	25
KSI Casualties	3	5	3	2	4	5	4

KSI = Killed or Seriously Injured

Figure 5.3.1 cont...

	Ashfield	Bassetlaw	Broxtowe	Gedling	Mansfield	Newark	Rushcliffe
PEDESTRIANS							
KSI Casualties	6	3	8	9	9	12	12
Slight Casualties	24	21	30	24	29	27	15
TOTAL CASUALTIES	30	24	38	33	38	39	27
Child peds (0-15 yrs) KSI Casualties	3	1	3	1	4	2	4
Child peds (0-15 yrs) Slight Casualties	10	9	11	6	15	12	6
Elderly peds (over 60 yrs) KSI Casualties	0	1	4	3	3	4	1
Elderly peds (over 60 yrs) Slight Casualties	1	2	2	4	0	2	1
PEDAL CYCLISTS - RIDERS AND PASSENGERS							
KSI Casualties	4	12	5	4	4	6	7
Slight Casualties	23	31	21	23	16	35	13
TOTAL CASUALTIES	27	43	26	27	20	41	20
MOTOR CYCLISTS (incl. Mopeds) RIDERS AND PASSENGERS							
KSI Casualties	15	18	12	20	11	18	9
Slight Casualties	35	18	27	18	25	24	13
TOTAL CASUALTIES	50	36	39	38	36	42	22
CAR DRIVERS & PASSENGERS (incl. Taxis)							
KSI Casualties	33	49	11	15	15	45	32
Slight Casualties	257	310	174	220	209	266	255
TOTAL CASUALTIES	290	359	185	235	224	311	287

KSI = Killed or Seriously Injured

Figure 5.3.2 All accidents by District between 1 January - 31 December 2010

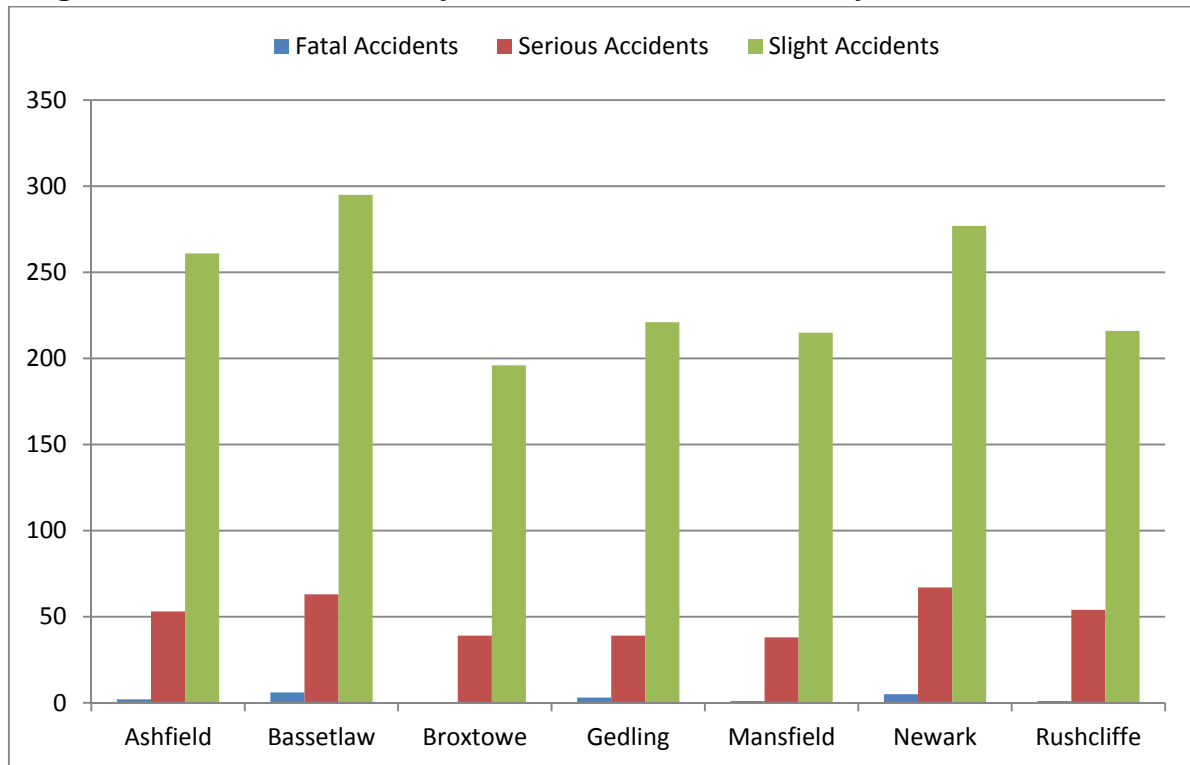


Figure 5.3.3 All casualties by District 1 January - 31 December 2010

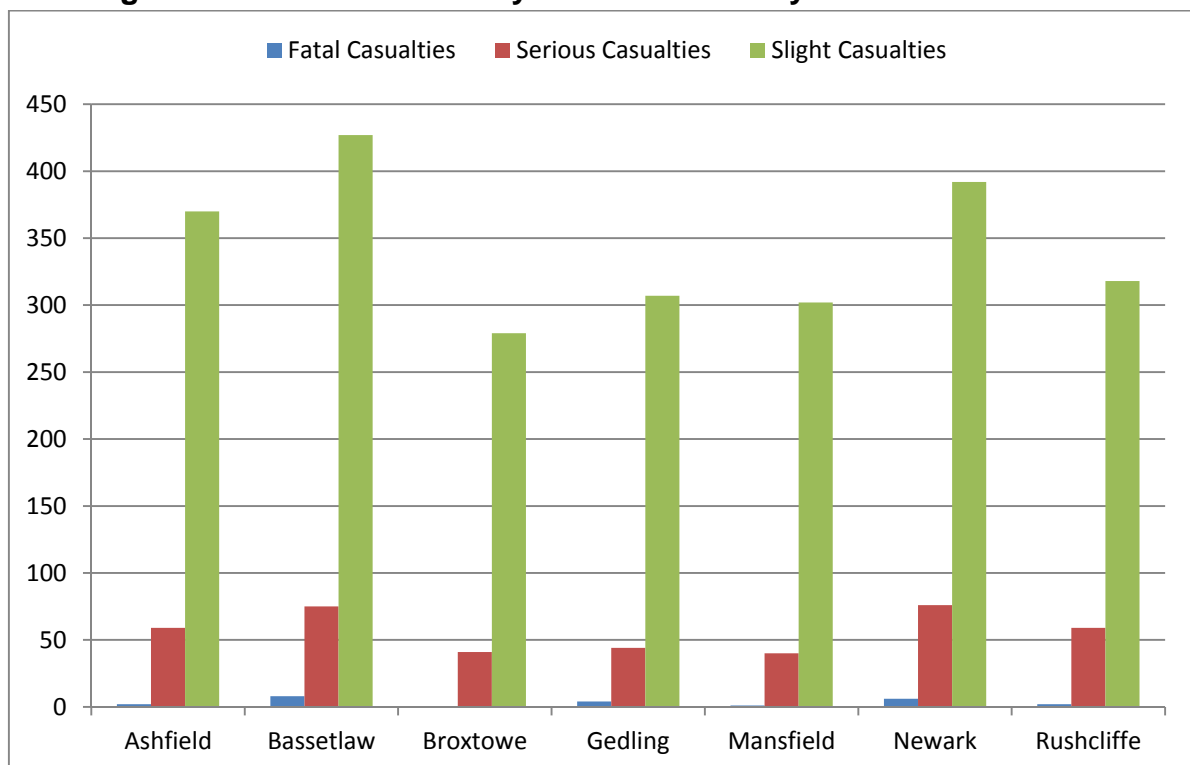


Figure 5.3.4 Child casualties by District 1 January - 31 December 2010

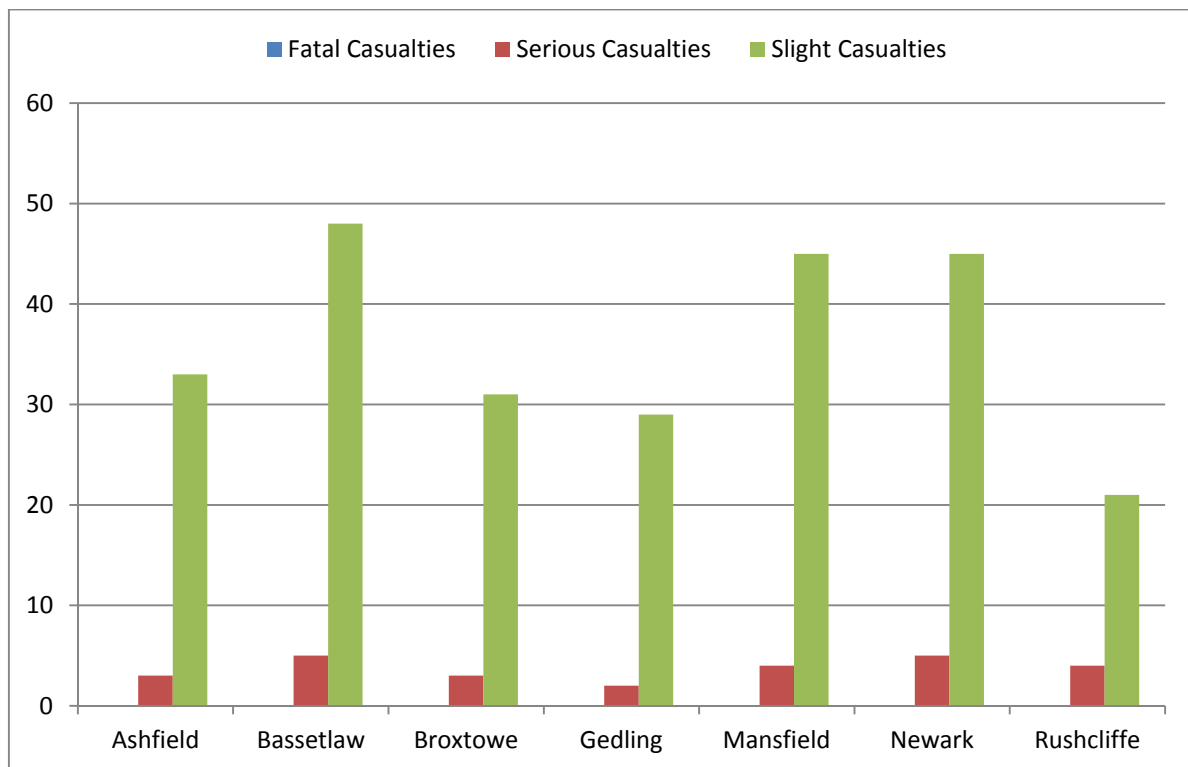


Figure 5.3.5 Child/Elderly pedestrians KSI casualties by District 1 January - 31 December 2010

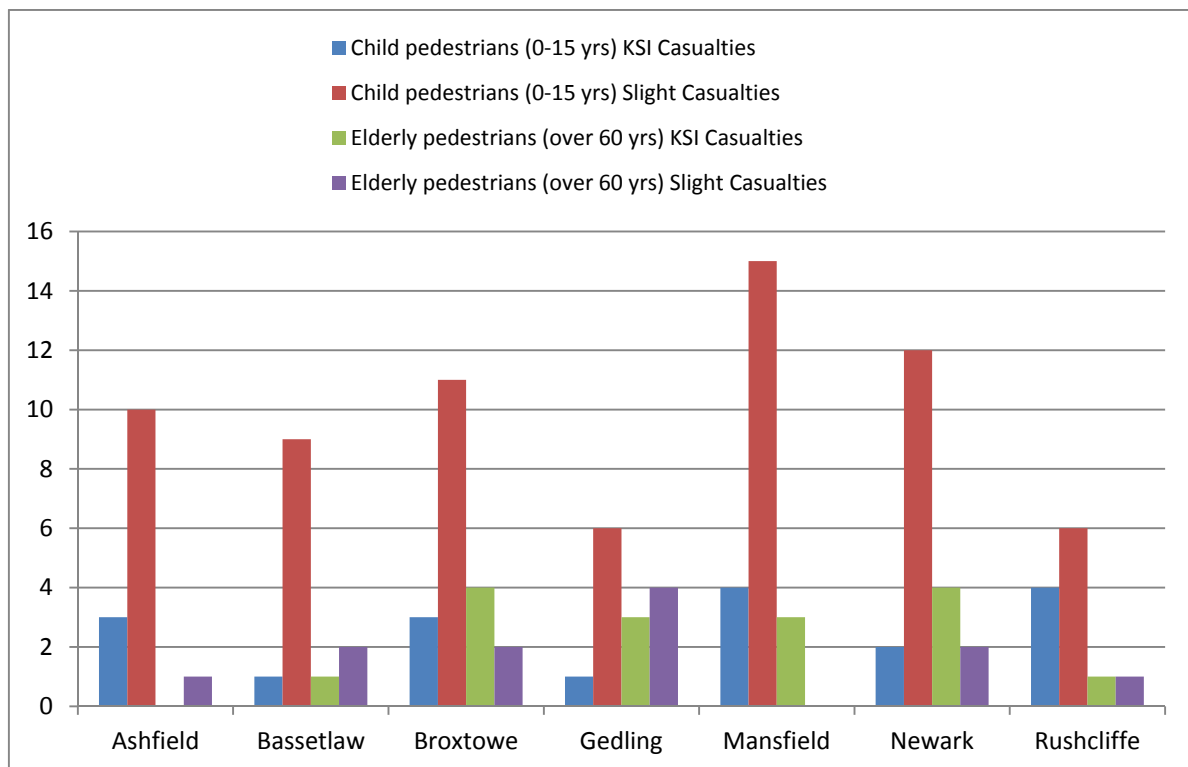
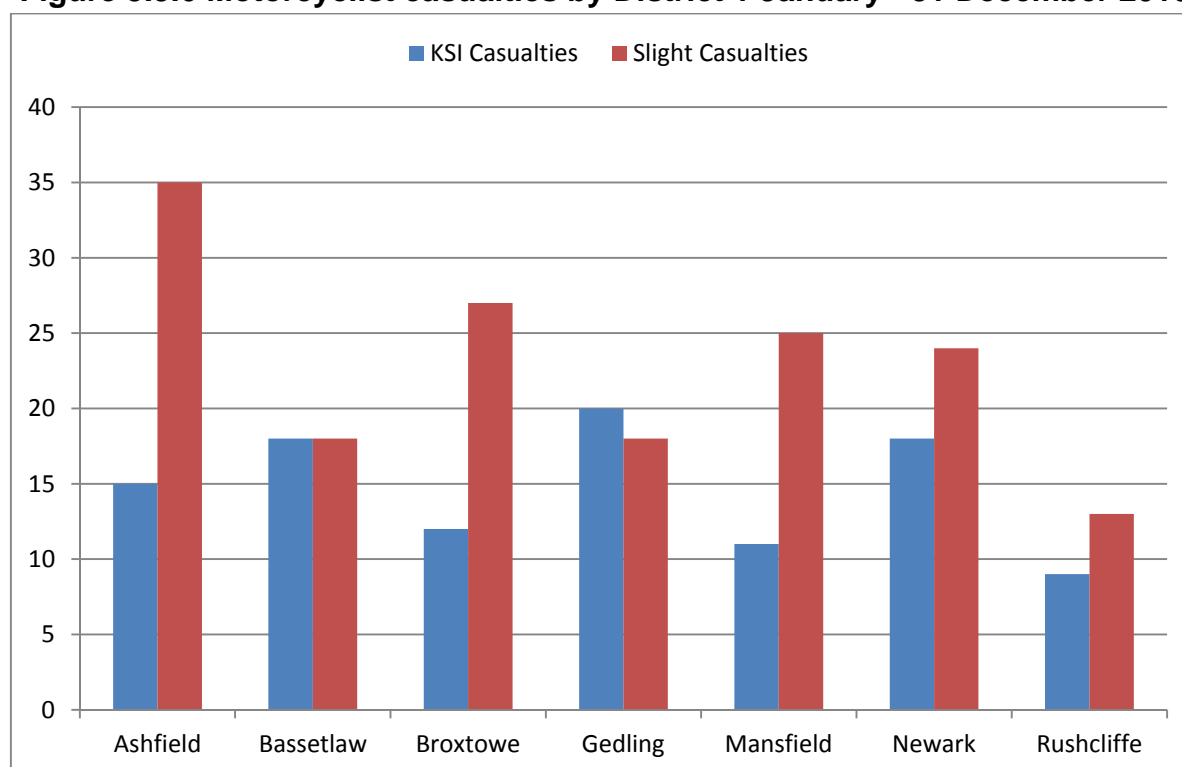


Figure 5.3.6 Motorcyclist casualties by District 1 January - 31 December 2010



The size, population and road length in each district varies considerably.

A straight comparison with other districts is therefore inappropriate.

5.4. Adult Abuse

Key messages

- There were 2,357 referrals relating to the abuse of vulnerable adults in Nottinghamshire in 2010/11, up from 1,550 in 2008/09.
- 40% of those referrals led to an assessment, down from 56% in 2009/10. This drop was most prominent in younger adults.
- There has been a significant increase in the proportion of older people being referred, compared to decreasing referrals in other service user groups. More than half of the total referrals in 2010/11 were for people aged 65+.
- The most common type of abuse of vulnerable adults being reported is physical abuse, which is significantly higher than any other form of abuse. However, reports of neglect are increasing.

Introduction

The term abuse of vulnerable adults needs to be clearly explained in order to ensure that all agencies have a common understanding of their role in safeguarding vulnerable people from abuse.

In Nottinghamshire there is a shared multi-agency policy which all agencies have adopted, this is the “Nottingham and Nottinghamshire Safeguarding Adults Multi Agency Policy, Procedure and Guidance” <http://www3.nottinghamshire.gov.uk/caring/protecting-and-safeguarding/safeguardingadults/policy-and-procedure/>. This document currently takes its definition of a vulnerable adult from the Department of Health’s “No Secrets” (2000) document which states:

‘A person aged 18 years or over who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation.’

Significant harm is defined as:

‘Ill treatment (including sexual abuse and forms of ill treatment that are not physical); the impairment of or an avoidable deterioration in physical or mental health; and the impairment of physical, emotional, social or behavioural development.’³³

³³ “Who decides?” Law Commission 1997

In Nottinghamshire, since data collection relating to the abuse of vulnerable adults began in 2001, the number of referrals increased rapidly year on year until 2010-2011 when there was a slight reduction in the number of referrals. As a comparison there were 2357 referrals during 2010-2011, 2416 referrals during 2009-2010 and 1550 during 2008-2009. This is compared to 146 in 2001-2002. The increase from 2001 may be a reflection of the increasing awareness of safeguarding through information and training.

The number of referrals going onto an assessment has dropped considerably across all service areas from 1350 in 2009-2010 to 944 in 2010-2011. This is most prominent in younger adults where there has been a drop from 640 in 09/10 to 382 in

Figure 5.4.1 Number of alerts, referrals, repeat referrals and completed referrals by service users aged between 18-64 years by primary client group

	Referral	Referrals leading to assessment	Repeat Referrals	Completed Referrals
Physical disability, frailty and sensory impairment (Total)	225	112	15	71
Of which: Sensory Impairment	10	7	0	5
Mental Health (Total)	270	80	6	59
Of which: Dementia	17	4	0	3
Learning Disability	455	155	11	89
Substance misuse	8	0	0	0
Other Vulnerable People	80	35	5	30
Total	1038	382	37	249

Source: Abuse of Vulnerable Adults (AVA) return 2010-11 (Note: AVA returns use the term 'alert' instead of referral)

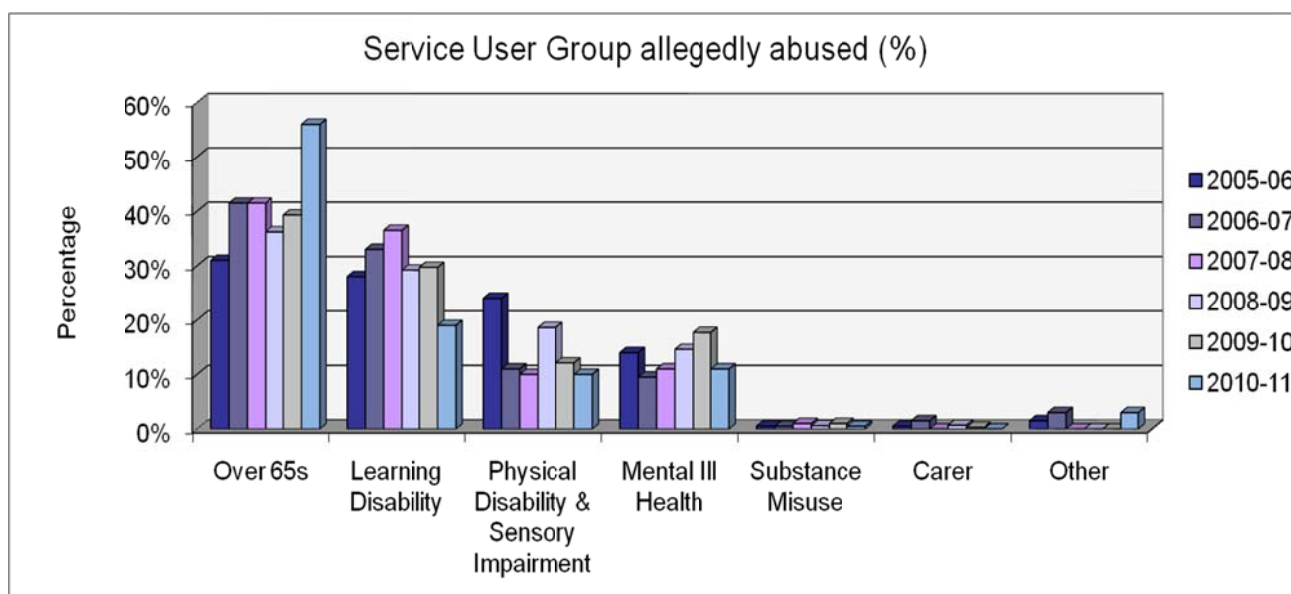
Figure 5.4.2 Number of alerts, referrals, repeat referrals and completed referrals by service users aged 65+ by primary client group

Age group 65+	Referrals	Referrals leading to assessment	Repeat Referrals	Completed Referrals
Physical disability, frailty and sensory impairment (Total)	846	365	20	267
of which: Sensory Impairment	51	29	3	23
Mental Health (Total)	404	175	13	131
of which: Dementia	339	79	9	108
Learning Disability	43	8	0	6
Substance misuse	0	0	0	0
Other Vulnerable People	26	14	1	9
Total	1319	562	34	413

Source: Abuse of Vulnerable Adults (AVA) return 2010-11 (Note: AVA returns use the term 'alert' instead of referral)

Figure 5.4.3 below shows a breakdown of referrals for service user groups which clearly demonstrates a significant increase in the proportion of older people being referred compared to decreasing referrals in other service user groups.

Figure 5.4.3 Service user group allegedly abused for all service users aged over 18 years by primary client group.

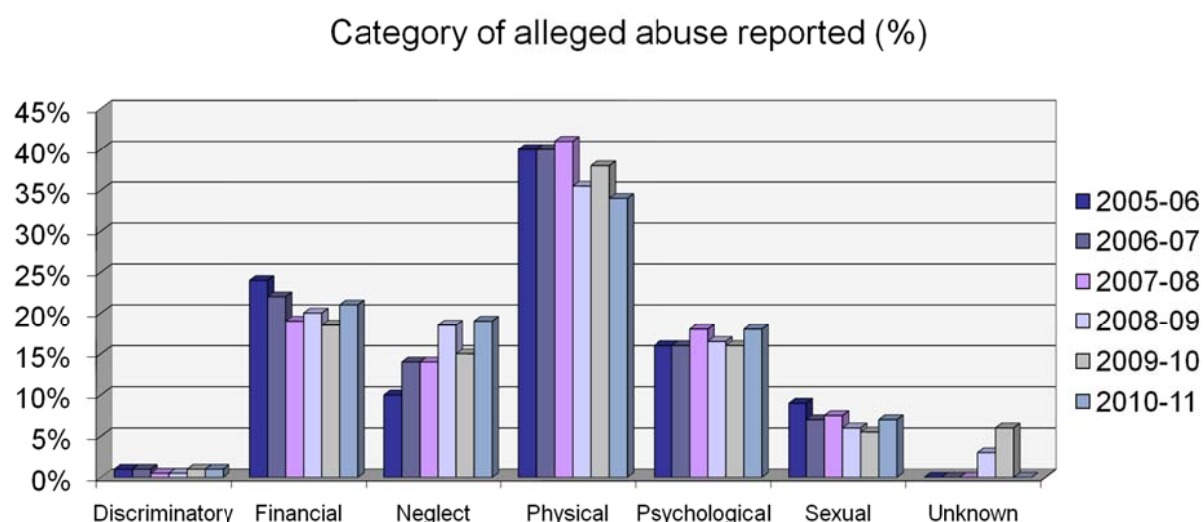


Source: Nottinghamshire Safeguarding Adults Board Annual Report 2009-10 and Abuse of Vulnerable Adults (AVA) return 2010-11

Figure 5.4.4 also shown below shows the types of abuse being reported. The most common type of abuse being reported is physical abuse which is significantly higher

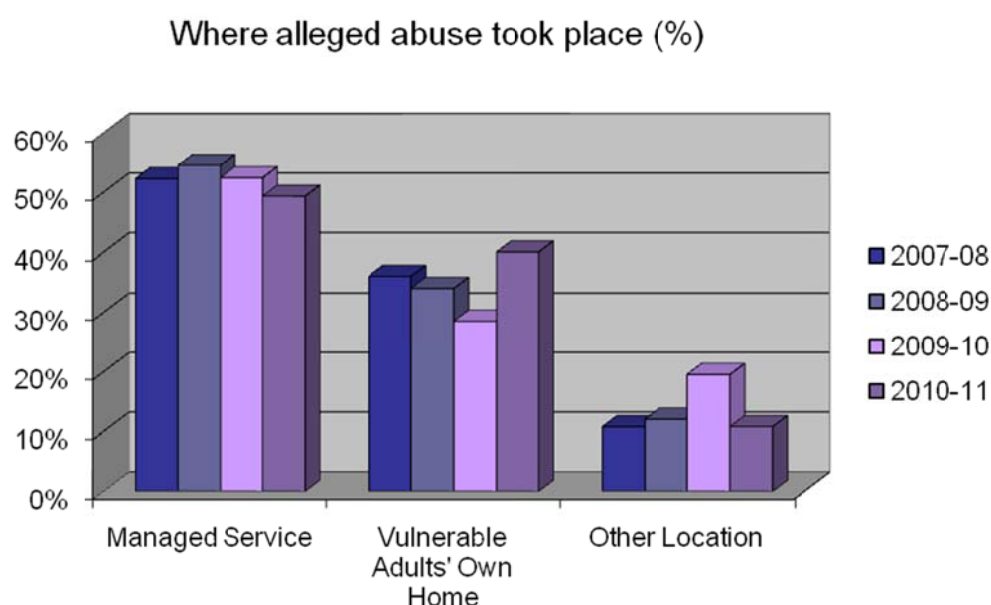
than any other form of abuse; however reports of neglect are increasing. The location of alleged abuse is reflected in figure 5.4.5, this demonstrates that whilst the highest number of referrals are within a managed service, these have been declining, yet the number of referrals from own home has significantly increased in 2010-11.

Figure 5.4.4 Category of alleged abuse reported for all service users aged over 18 years by primary client group.



Source: Nottinghamshire Safeguarding Adults Board Annual Report 2009-10 and Abuse of Vulnerable Adults (AVA) return 2010-11

Figure 5.4.5 Where alleged abuse took place



Source: Nottinghamshire Safeguarding Adults Board Annual Report 2009-10 and Abuse of Vulnerable Adults (AVA) return 2010-11

Referrals from managed services (e.g. care homes, nursing homes) have decreased proportionately in recent years, whilst there has been a rise in the number of referrals about people in their own home in 2010-11.

It is difficult to draw clear conclusions from these statistics as to whether this reflects a change in trends or is the result of publicity campaigns for the general public and increased awareness through training in different sectors of the health and social care workforce.