JSNA Chapter – Evidence Summary

Topic information	
Topic title	Evidence Summary
Topic owner	Shade Agboola, Consultant in Public Health
Topic author(s)	Amy Pellow, Assistant Strategic Insight Researcher
Topic endorsed by	JSNA Steering Group
Current version	March 2019
Replaces version	March 2018
Linked JSNA topics	Demography (2018) Asylum Seeker, Refugee and Migrant Health (2018) Dementia – Working Age and 55+ (2018) Domestic and Sexual Violence and Abuse (2018) Suicide (2018) Sexual Health and HIV (2018)

Executive summary

Introduction

This Evidence Summary presents an overview of the health and wellbeing needs in Nottingham City using the key findings from Nottingham City's Joint Strategic Needs Assessment (JSNA).

JSNAs are local assessments of current and future health and social care needs. The aim of a JSNA is to improve the health and wellbeing of the local community and reduce inequalities for all ages through ensuring commissioned services reflect need. It is used to help determine what actions local authorities, the NHS and other partners need to take to meet health and social care needs and to address the wider determinants that impact on health and wellbeing.

Nottingham City's JSNA chapters each consider a particular health and social care issue or the health and social care needs of specific groups. The full JSNA can be accessed at www.nottinghaminsight.org.uk. It is only possible to present a brief overview of this information in this Evidence Summary and so it should be used in conjunction with the full JSNA.

All supporting data and information for this Evidence Summary, including references, can be found in individual chapters.

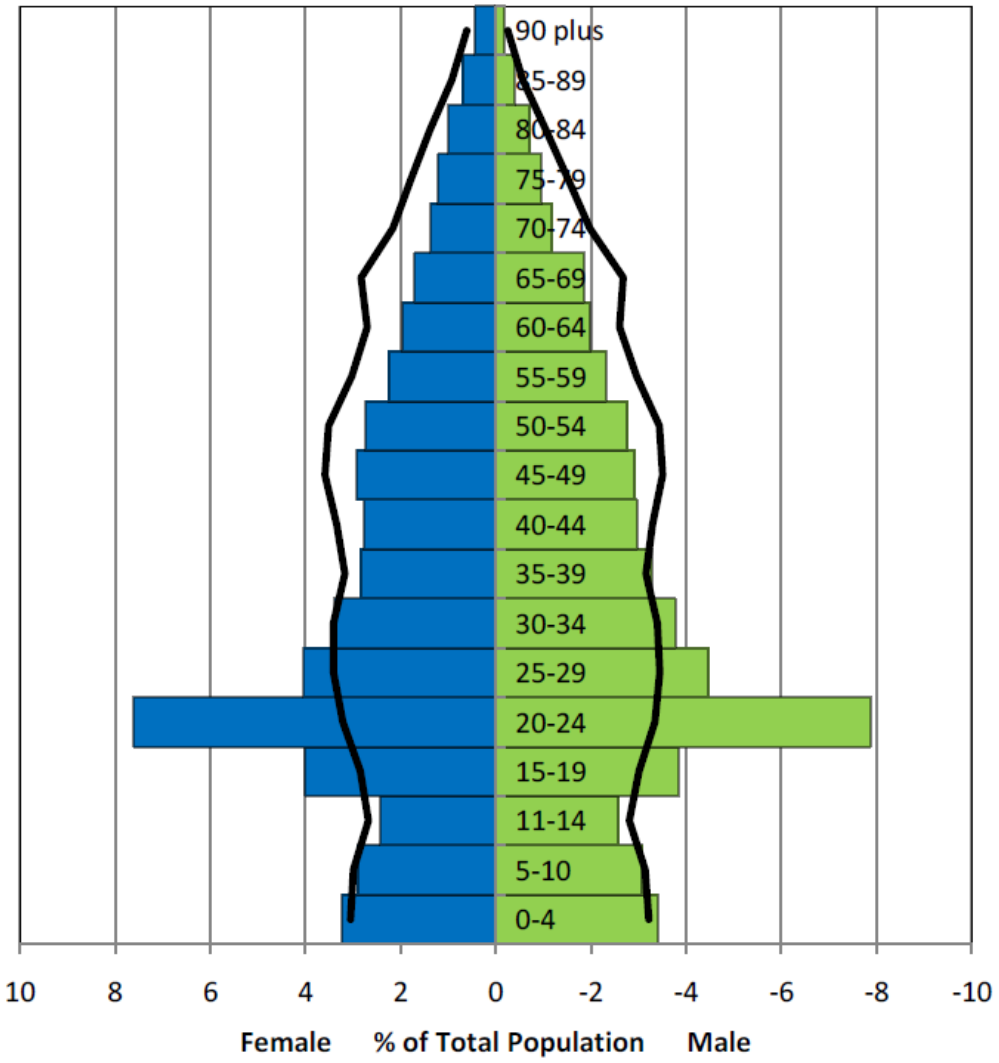
GENERAL RESOURCES

Demography: Demographic context

The latest estimate of the City's resident population is 324,800, having risen by 5,800 since 2015. The population is projected to rise to 342,000 in 2026 and to 363,700 in 2041. International migration (recently from Eastern Europe) and natural change (the excess of births over deaths) are the main reasons for the population growth recently. The number of births has remained static in the past few years, but is higher than the start of the 2000s.

29% of the population are aged 18 to 29. Full-time university students comprise about 1 in 8 of the population. The percentages in other age-groups are lower than the average for England, with the proportions of those between 65 and 79 being particularly low. Compared to some other Local Authority areas, Nottingham is unlikely to show much ageing or population growth in the short term to 2026.

Figure 1: Age structure of Nottingham (bars) and England (lines), 2016



Source: ONS Mid-Year Estimates, 2016

The City gains young adults due to migration, both international and within Britain, whilst losing all other age groups - this includes losing families with children as they move to the

surrounding districts. There is a high turnover of population - 21% of people living in the City changed their address in the year before the 2011 Census.

The 2011 Census shows 35% of the population as being from Black and Minority Ethnic (BME) groups. This is an increase from 19% in 2001.

The Asian/Asian British group is the largest BME group in Nottingham, making up 13% of the total population; Black/African/Caribbean/Black British, mixed or multiple ethnicity and White (not White British) groups each account for 6 – 7% of the total population.

Despite its young age structure, Nottingham has a higher than average rate of people with a limiting long-term illness or disability.

White ethnic groups have higher rates of long term health problems or disability overall, although this varies with age, with some BME groups having higher rates in the older age groups.

Demography: Social and Environment Context

Nottingham is ranked 8th most deprived out of 326 districts in England in the 2015 Index of Multiple Deprivation (IMD), a relative decline on 20th in the 2010 IMD. About a third of the super output areas in the City are in the worst 10% nationally. 34% of children and 25% of people aged 60 and over live in areas affected by income deprivation. There are high levels of child poverty in the City. In 2015/16, 42,100 children and young people lived in workless or low income households.

13% of people aged 16-64 have no qualifications, higher than the national average of 8%. The difference is most evident in the 50-64 age group where some 20% have no qualifications, compared to 11% nationally. 30% of 16 to 64-year-olds have qualifications at NVQ4 level – degree level or above – compared with 38% in England.

The employment rate for the City was 57% in 2017, compared with 75% for England. This figure is deflated by the presence of so many university students, but even if they are excluded the rate is still low (69% compared with 78% nationally). 8% of the population aged 16-64 were claiming Employment and Support Allowance, Incapacity Benefit or Severe Disablement Allowance in November 2017, compared with 6% nationally. 3.% were unemployed (claiming Job Seekers Allowance or Universal Credit claimants not in employment) in March 2018, compared with 2% nationally.

Full JSNA for Demography

ADULTS

Asylum Seeker, Refugee and Migrant Health

Asylum seekers, refugees and migrants are distinct groups of people with the common factor being that they have all migrated from their country of origin. An asylum seeker is a person who has asked the Government for refugee status and is waiting to hear the outcome of their application. A refugee is a person who has fled his or her country due to persecution, war or violence. A migrant is a person who has chosen when to leave and where to go, rather than being forced from his or her home.

In 2017 there were between 900 and 1,000 asylum seekers living in Nottingham who received financial and/or housing support from United Kingdom Visa and Immigration

(UKVI). The number of failed asylum seekers is unknown and many continue to live in destitution rather than return to their country of origin.

Using national estimates applied to Nottingham, it is estimated that there are around 500 destitute asylum seekers and around 7,000 refugees living in the City.

Asylum seekers in Nottingham are predominantly young, with 75% of principal applicants being aged 18-39. 45% of principal applicants are male and more than half of these are single. In contrast, 85% of female principal applicants have arrived as part of a family group.

Radford, Arboretum and Leen Valley has the greatest number of asylum seekers, followed by Bridge and Dales and then by Mapperley and St Ann's.

Table 1: Where asylum seekers are housed in Nottingham City

Area/Postcode	**Number of properties**	**Percentage of people housed**
NG1 (City Centre)	Less than 5	1.2
NG2 (Bridge and Dales)	39	5.7
NG3 (Mapperley and St Ann's)	37	2.8
NG5 (Berridge, Sherwood, Bestwood)	17	1.4
NG7 (Radford, Arboretum, Leen Valley)	99	6.8
NG8 (Aspley, Wollaton, Bilborough)	22	1.5
NG9 (Wollaton East)	7	1.0
NG11 (Clifton)	Less than 5	0.8

Source: Nottingham City Council/G4S, June 2018

National Insurance numbers (NINo) issued to migrants show the number of new migrants applying for work when they enter the UK. In 2017, 5,469 people registered for a NINo in Nottingham, a 17.7% reduction from 2016. Countries with the biggest numbers of registrations were Romania (956), Poland (644) and Italy (413).

At the time of the 2011 census, 59,234 (19.4%) of City residents were born outside the UK.

The lack of data around the number of asylum seekers, failed asylum seekers and deportees makes it difficult to determine the needs of this group and to commission appropriate services. It is known that some groups of migrants face a number of barriers to accessing healthcare services, including language and a poor understanding of the system and healthcare entitlements. There are challenges around GP registration due to a lack of necessary documentation and also around accessing dental services due to the associated costs for those with no recourse to public funds. Mental health provision is not tailored to meet the needs of asylum seekers, who commonly experience anxiety, depression, post-traumatic stress disorder and sleep problems as a result of the trauma that they have experienced. Pregnant women who are recent migrants, asylum seekers or refugees are the least likely to access maternity services within the recommended timescales. Other issues affecting physical and mental health include delays in accessing employment and benefits leading to poverty and destitution and being exploited by being made to work long hours for low pay.

It is recommended that more sophisticated data-gathering techniques are developed in order to better understand the demographics of asylum seekers, refugees and migrants in Nottingham and to help plan and develop appropriate services. Health care services should also engage more with this group in order to better understand its needs. Partnership working between public services, community groups and the private sector is essential in improving physical and mental health. Accessing services should be made easier, including improving interpreting services, which are currently not meeting the needs of asylum seekers, refugees and migrants. It is recommended that targeted mental health work with asylum seeker and refugee communities is considered, with a view to encouraging access to mainstream mental health services. Capacity building is also important, with more specialist workers and support services needed, as well as better training for staff in relation to the social and health needs of migrant communities and the support services available.

Full JSNA for Asylum Seeker, Refugee and Migrant Health

Dementia – Working Age and 65+

Dementia encompasses a range of brain disorders resulting in a progressive and severe loss of brain function. It affects 5% of people over the age of 65. Dementia has superseded cardiovascular disease (CVD) as the leading cause of death.

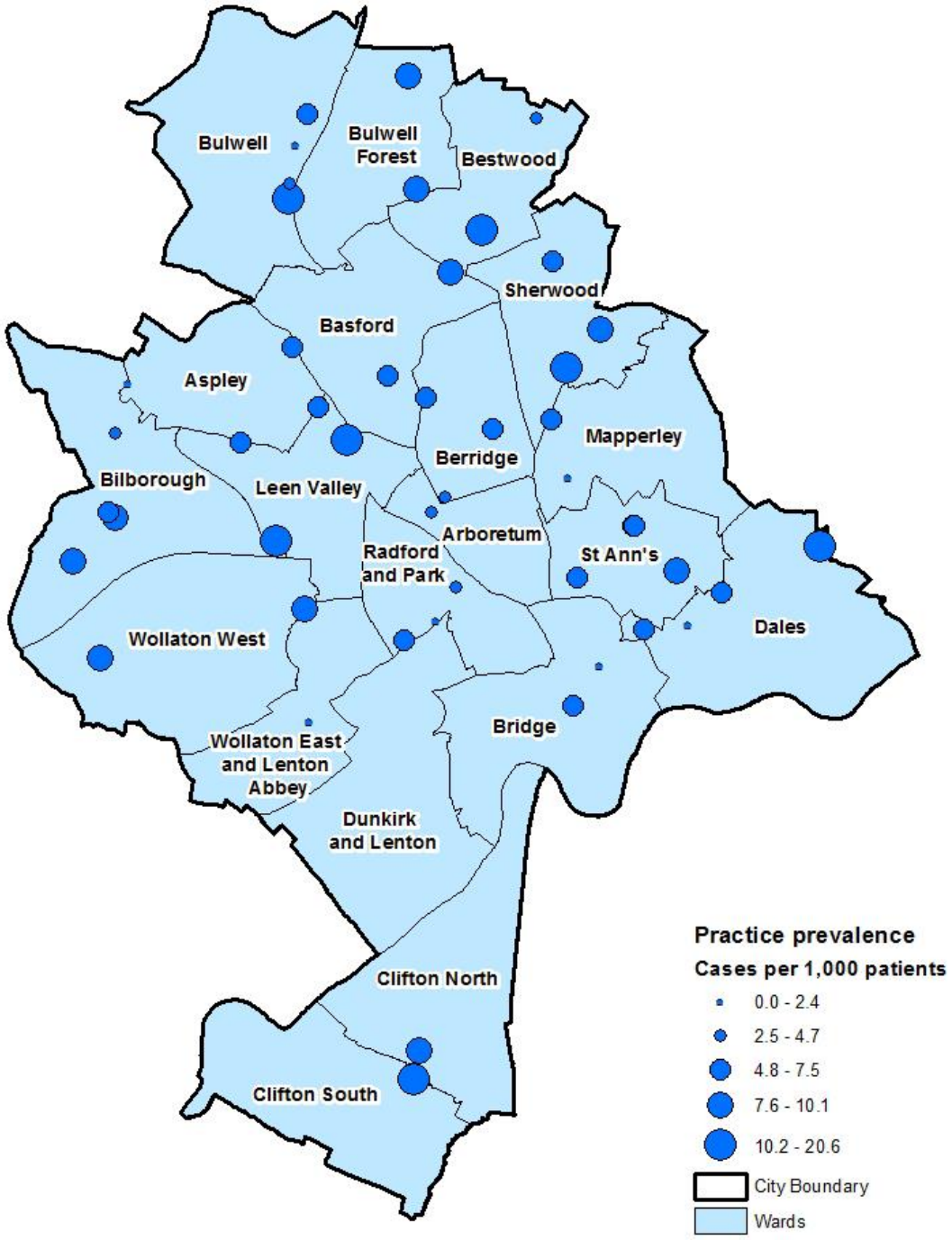
The prevalence of dementia in Nottingham is 5.4%, significantly higher than the East Midlands region (4.4%) and England overall (4.3%). Although this is a decrease from 6.5% in 2013, the aging population means that the number of people living with dementia in Nottingham will continue to rise, reaching over 4,000 by 2035, almost doubling from 2017.

In 2017, Nottingham had nearly double the age-standardised prevalence of early-onset dementia (4.87 per 10,000) compared to England overall (2.94 per 10,000). This could be due to the diverse local population as there is a greater representation of BME individuals in people with early-onset dementia. People from BME communities are less likely to present to diagnostic services and less likely to receive support when they do so.

The proportion of people with dementia in Nottingham using inpatient services fell between 2012 and 2016, but at a slower rate than the national average. Currently, 58% of people diagnosed with dementia in Nottingham use inpatient services, compared with 54% nationally.

Socioeconomic status may indirectly increase the risk of dementia through inequalities in CVD risk. It may also create inequalities in dementia death through life course events such as leaving full time education at an earlier age. In Nottingham dementia is more prevalent in deprived neighbourhoods, with the highest number of dementia patients per GP practice seen in the most deprived districts.

Figure 2: Distribution of dementia patients by GP practice, weighted by practice size.



Source: David Millington, NCC, NHS digital dementia diagnosis workbook, March 2017)

The diagnosis rate for dementia continues to improve. In Nottingham, 83% of people aged over 65 who should receive a diagnosis of dementia are correctly diagnosed. This is higher than the England benchmark of 67% and an improvement from 2014 (57%).

There are a number of unmet needs and service gaps relating to dementia in Nottingham. There is a poor awareness of risk factors for dementia among the general public. NHS

Health Checks present an opportunity for prevention through education and risk-factor modification, but coverage is poor nationally (9%) and worse locally (4%). Although there has been an increase in the number of activities to raise awareness of dementia among BME communities, BME groups continue to experience inequalities in access to diagnostic services and social support and there are few options for support which are sensitive to cultural needs. There is poor awareness that dementia is a terminal illness, both among the general public and health professionals. This results in a lack of advanced care planning and limited access to palliative care services.

It is recommended that GPs and healthcare workers are trained in the risk factors for, and the interventions that can help prevent, dementia. Both the general public and health professionals should be made aware that dementia is a terminal illness. Service provision needs to be mapped to identify gaps and areas of duplication. There needs to be an increased uptake of diagnostic services in BME groups, possibly through community outreach programmes. It is recommended that the percentage of care homes rated as 'Good' or 'Outstanding' by the Care Quality Commission be increased from 45% to 60% by 2019. There should be specialist end of life care for people with dementia through palliative care services integrated in the community. The ageing workforce and rising retirement age will increase the number of people with dementia who continue to work, resulting in a need to develop a dementia-friendly employer framework. If Nottingham is to achieve dementia-friendly community status, it is recommended that the local authority reviews its existing healthy living plans and ensures the built environment, commissioned services and local businesses reflect the needs of people living with dementia.

Full JSNA for Dementia

Domestic and Sexual Violence and Abuse

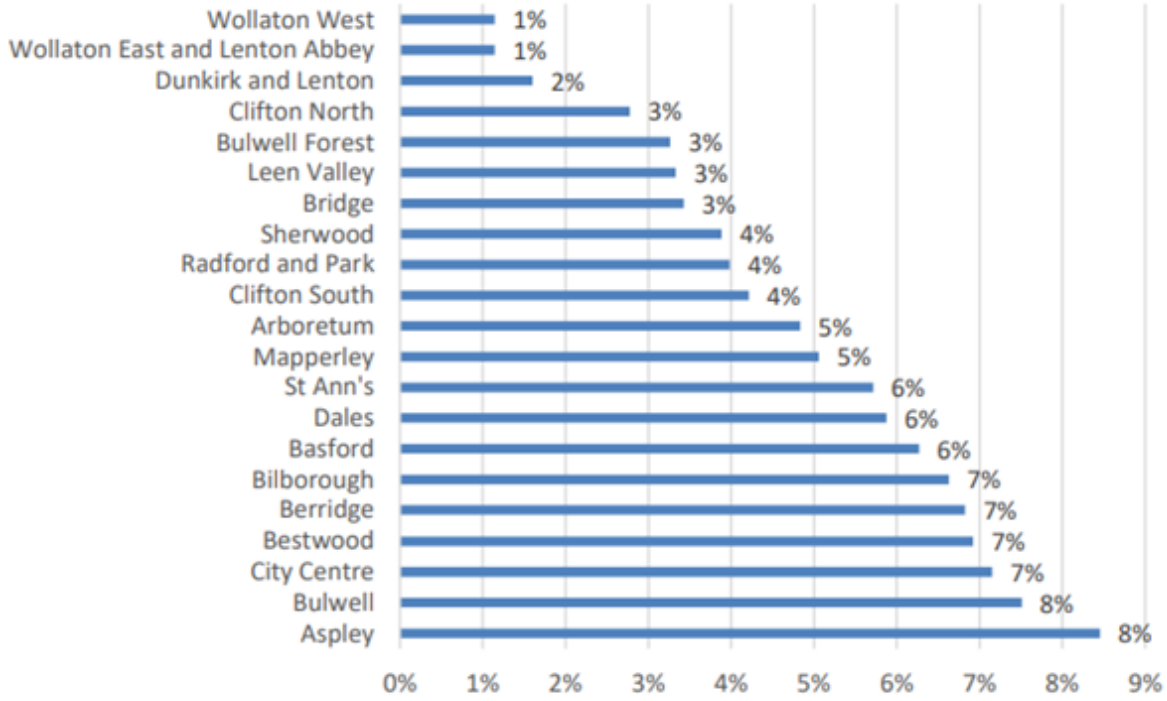
An estimated 1.9 million adults aged 16-59 experienced domestic abuse in the UK last year: 1.2 million women and 713,000 men. This equates to around 5% of the adult population, or 1 in 20.

It is estimated that 3.1% of women (510,000) and 0.8% of men (138,000) aged 16-59 experienced sexual assault in the last year – 1 in 25 adults. Most victims of sexual assault choose not to report it.

Extrapolations based on the Crime Survey for England and Wales indicate that around 15,500 Nottingham City residents aged 16-59 are likely to experience some form of domestic abuse each year, almost 8,000 (62%) of these women and 5,000 (38%) men. This equates to around 7% of the adult population, or 1 in 14. However, local analysis based on the prevalence of risk factors for domestic abuse in the City has estimated the prevalence to be much higher.

Aspley and Bulwell have the highest proportion of domestic violence reports of all wards in the City, at 8% respectively; however Aspley has seen the largest increase in numbers of reported incidences year on year. This may be due to a rise in reporting generally. There has also been some targeted work in some areas of the City, including Aspley, to increase reporting.

Figure 3: Locality of domestic violence incidences reported



Survivors of domestic violence tend to be a younger age demographic than perpetrators, with 42% of survivors aged 18-29 and 38% of offenders aged 18-29. 42% of survivors were BME in 2016-17 – this is an over-representation when compared to the BME population in Nottingham of 35%. Of survivors who disclosed if they had a disability or not, 49% had a disability. Of those who disclosed what their disability was, mental health was most commonly cited, with 39% citing this. This shows over-representation of disability in the domestic violence survivor population – 18% of Nottingham's population has a long-term limiting illness.

The biggest age group for survivors of sexual violence is the under-18 category (33% in 2016/17) followed by the 18-24 category (26% in 2016/17). Sexual violence is a gendered crime – 9 out of 10 recorded survivors were female in 2015/16. There is a strong link between sexual violence and the night time economy, with 40% of recorded sexual violence offences occurring in the early hours (00.00 – 05.59).

There are a number of unmet needs and service gaps relating to domestic and sexual violence and abuse in Nottingham. The demand for refuge is at risk of outweighing supply, with the number of households moving out of refuge having decreased by 58%. Not all schools provide healthy relationships education so prevention activity is inconsistent across the City. There is a gap in mental health support for survivors of domestic abuse and a lack of long term specialist therapeutic and psychological support for victims of sexual violence and abuse. There is evidence that survivors do not feel believed when disclosing to health and other professionals. While sexual violence is a gendered crime, men are victims too and this presents challenges for commissioners and providers in ensuring that services are accessible to all that need support. There are several knowledge gaps that warrant further exploration, including the reasons behind the increase in repeat domestic abuse calls, the increase in sexual violence reporting and whether LGBT groups are effectively supported by existing services in the City.

It is recommended that commissioners explore ways in which to move women through refuges in a more timely manner and that housing options are publicised to survivors in refuge.

Schools should be encouraged to engage specialist services to deliver healthy relationship education. It is important that health and social care staff are trained to encourage, and effectively respond to, disclosures. Mental health support should be linked to specialist services and referral pathways established and known. Work with BME groups may be needed to encourage reporting of domestic abuse. It is recommended that pathways are put in place for those experiencing familial (e.g. parent and child) domestic violence and abuse. It is important to consider Trans survivors and ensure services are LGBT friendly. There should be a continuation of the work with the universities to raise awareness around sexual violence and to consider extending this to further education. Working with younger groups will help to prevent attitudes that may facilitate sexual violence and explore consent. Services should be linked with mental health support.

Full JSNA for Domestic and Sexual Violence and Abuse

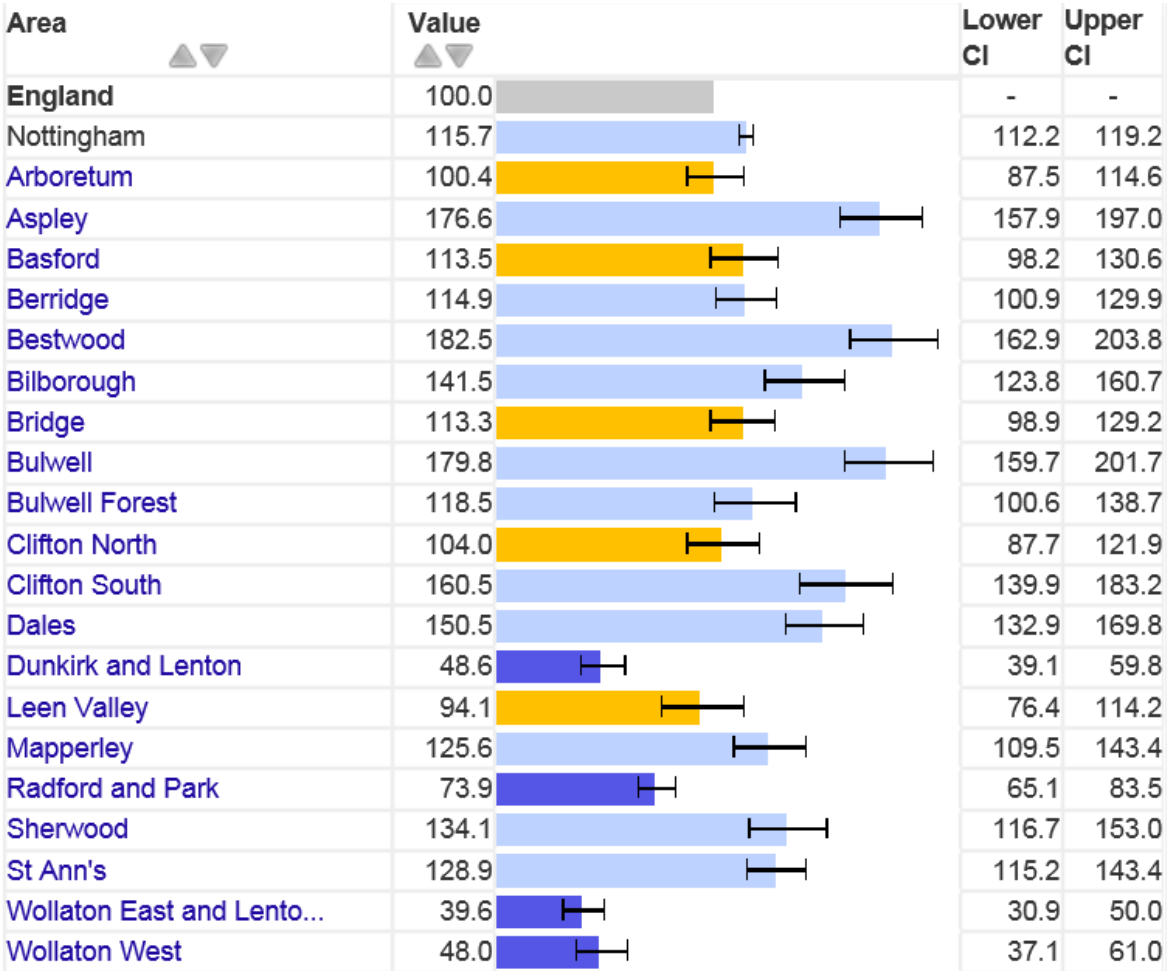
Suicide

In England in 2016 there were 4,575 deaths by suicide, a rate of 9.5 per 100,000. The rate in the East Midlands was 8.4 (13.6 for men, 3.6 for women). Men account for around 75% of suicides.

On average, 28 people die by suicide every year in Nottingham. In the most recent three-year period, 67 deaths in the City were recorded as suicide, over 84% (56) of who were men. This is similar to the national picture. The age standardised suicide rate for Nottingham during 2014-16 was 9 per 100,000 overall: 14.9 per 100,000 for men and 3 per 100,000 for women.

Self-harm statistics are based on hospital admissions. Nottingham's rates of self-harm are significantly higher than England, but similar to the majority of its statistical neighbours. England is allocated a figure of 100. Nottingham's figure is 115.7, meaning that its admission rate is more than 15% higher than that of England. Some ward areas have significantly higher rates than the City as a whole, especially Aspley, Bestwood, Bulwell, Clifton South and Dales.

Figure 4: Hospital admissions for self-harm: standardised emergency admission ratio (all ages) 2010/11 - 2014/15



Area	Value	Lower CI	Upper CI
England	100.0	-	-
Nottingham	115.7	112.2	119.2
Arboretum	100.4	87.5	114.6
Aspley	176.6	157.9	197.0
Basford	113.5	98.2	130.6
Berridge	114.9	100.9	129.9
Bestwood	182.5	162.9	203.8
Bilborough	141.5	123.8	160.7
Bridge	113.3	98.9	129.2
Bulwell	179.8	159.7	201.7
Bulwell Forest	118.5	100.6	138.7
Clifton North	104.0	87.7	121.9
Clifton South	160.5	139.9	183.2
Dales	150.5	132.9	169.8
Dunkirk and Lenton	48.6	39.1	59.8
Leen Valley	94.1	76.4	114.2
Mapperley	125.6	109.5	143.4
Radford and Park	73.9	65.1	83.5
Sherwood	134.1	116.7	153.0
St Ann's	128.9	115.2	143.4
Wollaton East and Lento...	39.6	30.9	50.0
Wollaton West	48.0	37.1	61.0

Source: PHE public health profiles based on HES data

Nottingham City has high levels of risk factors for mental health problems. Aspects of the City's profile, such as high levels of deprivation, ethnic diversity, rates of children looked after, rates of contact with the Criminal Justice System, levels of disability and employment benefits, levels of substance and alcohol abuse and increasing homelessness, all contribute to increasing risks of suicide and self-harm.

Those at increased risk of suicide are: men aged 35-59 years; people in the care of mental health services; people with a history of self-harm, untreated depression or alcohol misuse; people facing economic difficulties; people going through divorce or separation; those with a long-term physical illness; people in contact with the Criminal Justice System; children and young people who have experienced abuse or neglect; LBGT people; and older people experiencing social isolation and loneliness.

There are a number of unmet needs and service gaps relating to suicide. It is recommended that there be improved access to mental health crisis intervention services for all ages and improved early identification and treatment of depression for older people and those experiencing long term physical conditions. Establishing targeted health promotion

initiatives towards men in middle age would encourage help-seeking behaviour and reduce stigma around talking about mental health.
There should be targeted suicide prevention programmes to those groups and organisations in contact with people who may be higher risk, and training on self-harm and suicide awareness for frontline staff. There is a need for risk assessment and safety planning as part of routine clinical care provided by frontline staff dealing with high-risk groups, especially in primary care and A&E. The means of self-harm and suicide should be monitored through timely surveillance in order to put in place targeted strategies and interventions. Consideration should be given to design safety with regard to suicide prevention, e.g. on tall buildings and at railway crossings. There should be improved access to support services for those bereaved by suicide.

Full JSNA for Suicide

BEHAVIOURAL FACTORS AND WIDER DETERMINANTS OF HEALTH

Sexual Health and HIV

In 2017 there were 422,147 new STI diagnoses made at sexual health services in England, the most commonly diagnosed being chlamydia (48%), followed by genital warts (14%) and gonorrhoea (11%).

Nottingham is similar to the rest of the country when considering key sexual health outcomes. The overall rate of STI diagnoses between 2015 and 2017 has seen little change, in line with the national trend. However, there has been a year on year increase in syphilis diagnoses (an 18% increase between 2015 and 2017) and gonorrhoea diagnosis rates have increased by 9%.

Local authorities are ranked according to their chlamydia detection rate, HIV testing coverage, total prescribed Longer Action Reversible Contraception (LARC) rate, under 18s conception rate and STI testing rate. In 2018, Nottingham was ranked 3rd out of its statistical neighbours and 39th out of 152 local authorities (with 1st being the highest).

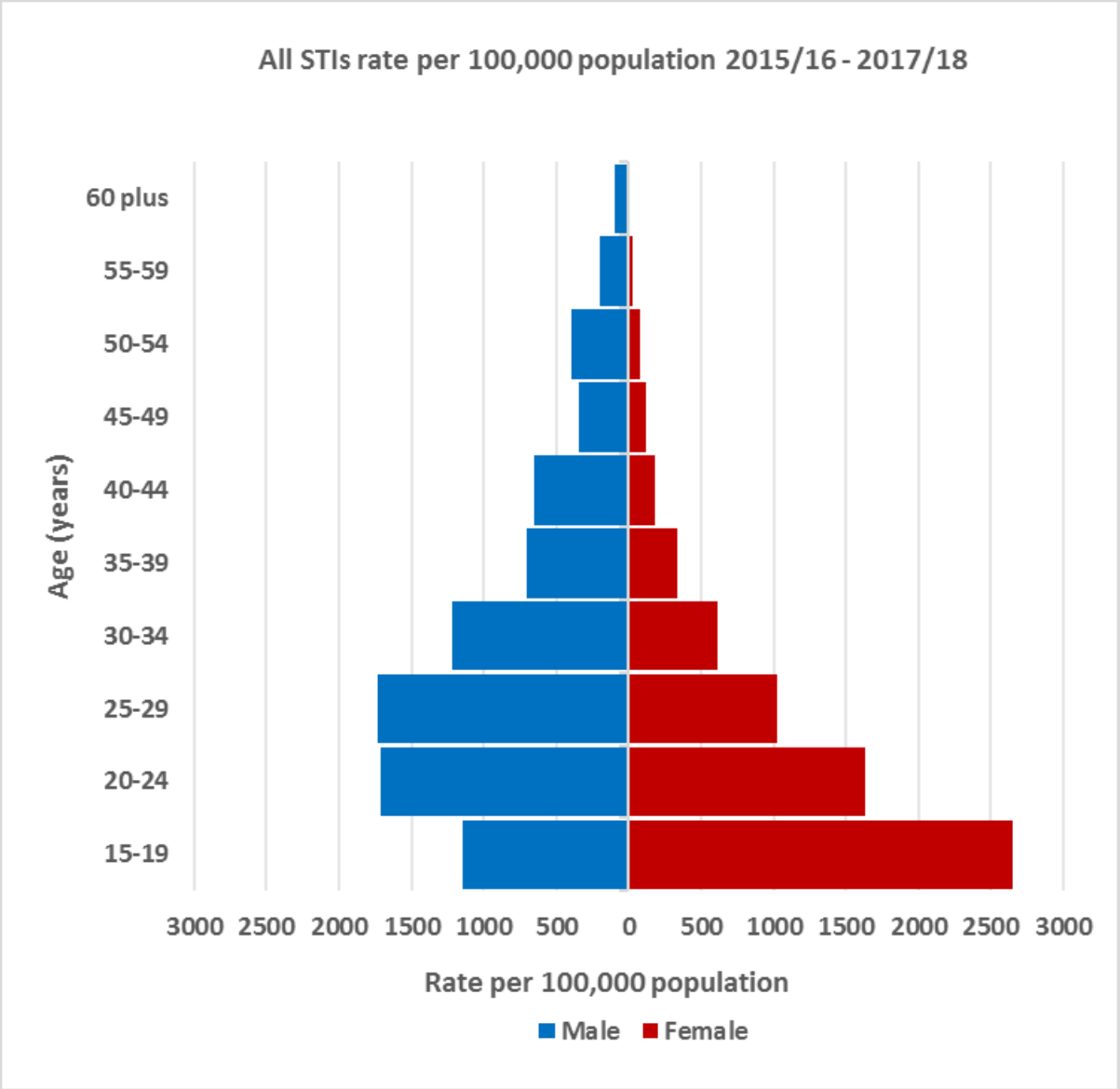
In Nottingham, HIV testing coverage in specialist sexual health services dropped significantly from 77.4% in 2014 to 71.8% in 2016 but increased again to 73.4% in 2017. This was higher than the national average and the 6th highest amongst its 16 statistical neighbours. There was no significant change in diagnosis rates between periods 2014-16 and 2015-17, with around 42% of diagnoses being classed as late. This is similar to both the national picture and that of the statistical neighbours. Prevalence among Nottingham residents aged 15-59 years living with HIV was around 3 per 1,000 in 2016.

In 2017, 181,281 abortions were performed in England. Nottingham City CCG patients accounted for 1,176 of these. The Nottingham rate of 14.5 per 1,000 women was lower than the national rate of 17.2.

Groups at higher risk of poor sexual health are young people aged under 25; people with a mental health problem; people with a learning disability and/or autism; people with non-traditional gender identity; BME communities; LGBT people; people who inject drugs; people who are homeless; people in the Criminal Justice System; people involved in sex work; and people experiencing social inequality.

In Nottingham there is a strong relationship between socio-economic deprivation and rate of new STIs. Females aged 15-29 and males aged 20-34 appear to be more susceptible to STIs.

Figure 5: All STIs rate by age and gender



Source: GUMCAD 3 years pooled, 2015/16 - 2017/18 by ward

There are a number of unmet needs and service gaps relating to sexual health and HIV in Nottingham. National data systems do not always provide an accurate picture of activity as an indication of need, meaning that work often needs to be done at a local level. Emerging threats such as antimicrobial resistance arrive with risks around STIs, increased demand and increased cost. It is challenging to manage demand and pathways across services to ensure effective and efficient delivery of sexual health services. Increasingly, diverse populations and sexual lifestyles increase complexity in understanding need and planning provision that meets the needs of citizens equally. Access to, and effective use of, contraception continues to be a priority in preventing unplanned pregnancy.

There are several recommendations with regards to sexual health and HIV in Nottingham. It is important to understand and plan for issues on the horizon, such as testing for emerging STIs, e.g. Mycoplasma genitalium. Commissioners should work with a range of partners from within the healthcare system to establish clear pathways between primary care and integrated sexual health services so that citizens can continue to receive the right care in the right place at the right time. Further evaluations/audits are needed, including engagement with specific sexual health needs of at-risk groups. Efforts should be made to ensure that men who have sex with men (MSM) are being tested for HIV and STIs regularly, as per current guidance. There needs to be improved recording of ethnicity and of sexual orientation to obtain a better picture of the burden of STIs within different population groups. Commissioners should plan support in preparing for Relationship and Sex Education (RSE) becoming a statutory subject in 2020.

Full JSNA for Sexual Health and HIV