Norwich City Council

SCRUTINY COMMITTEE

Item No 7

REPORT for meeting to be held on 19 October 2017

Health inequality in Norwich

Summary: This report will provide background about what initiatives are currently in place which support health equality; this includes Healthy Norwich, and the Lakenham project. In this report are also entries from various organisations which support access to health, such as St Martin's Housing Trust, and Making it Real. Members will also hear from organisations such as Public Health, CCG, and Active Norfolk.

Conclusions: The report should enable the scrutiny committee to determine any recommendations they would wish to make on the council's or other organisations approaches to health inequality in Norwich.

Recommendation: To agree any recommendations

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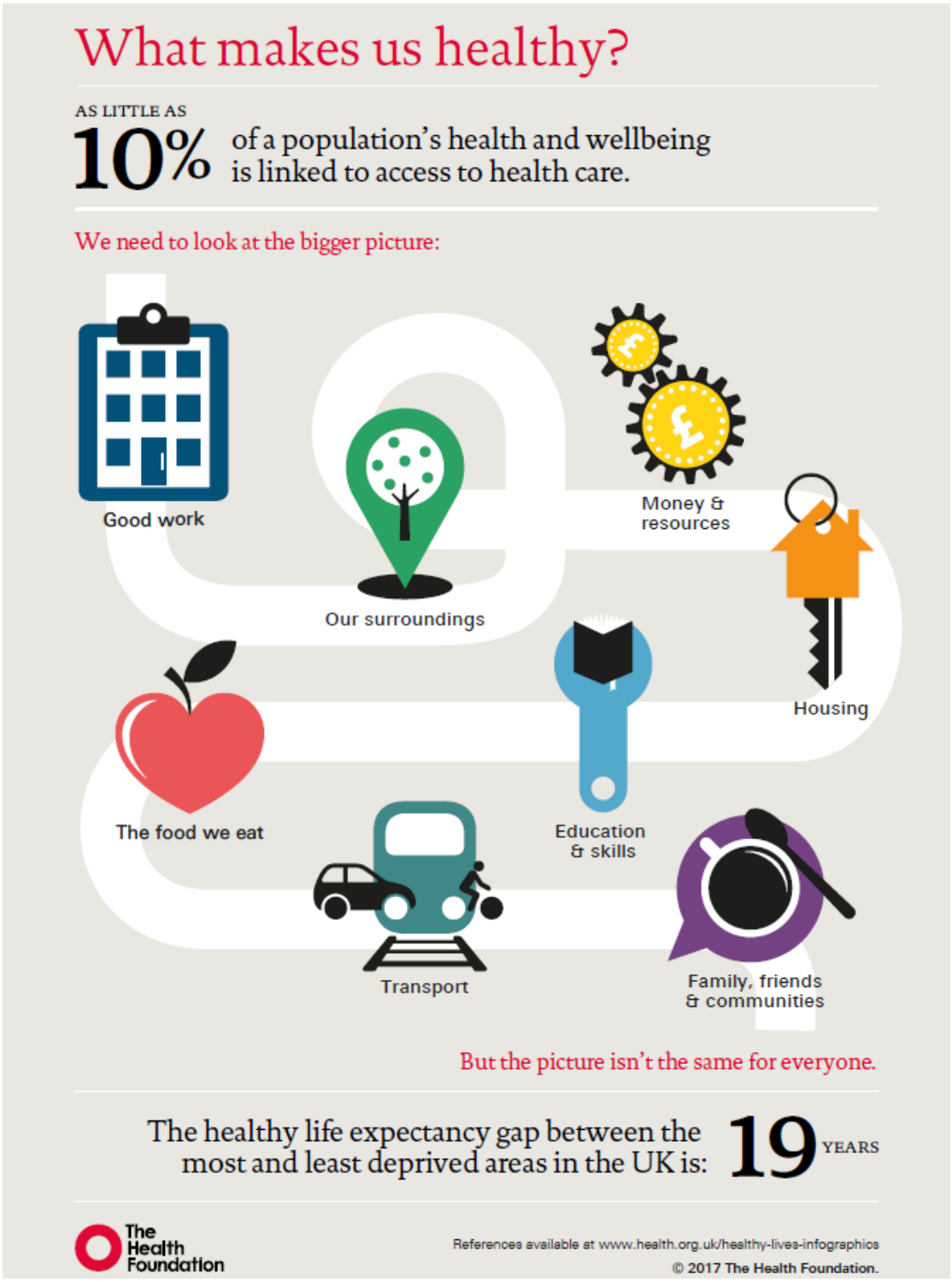
Background

1. What is health inequality?
   Our health is primarily determined by factors other than access to health care. Health inequalities are differences between people or groups due to social, geographical, biological or other factors. These differences have a huge impact, because they result in people who are worst off experiencing poorer health and shorter lives.
   The below infographic shows some causes of heath inequality:

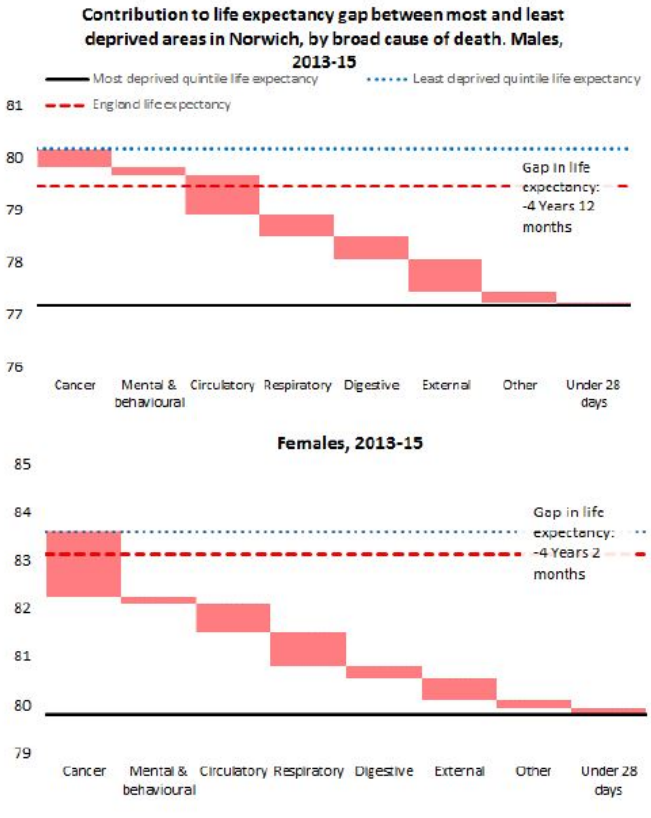


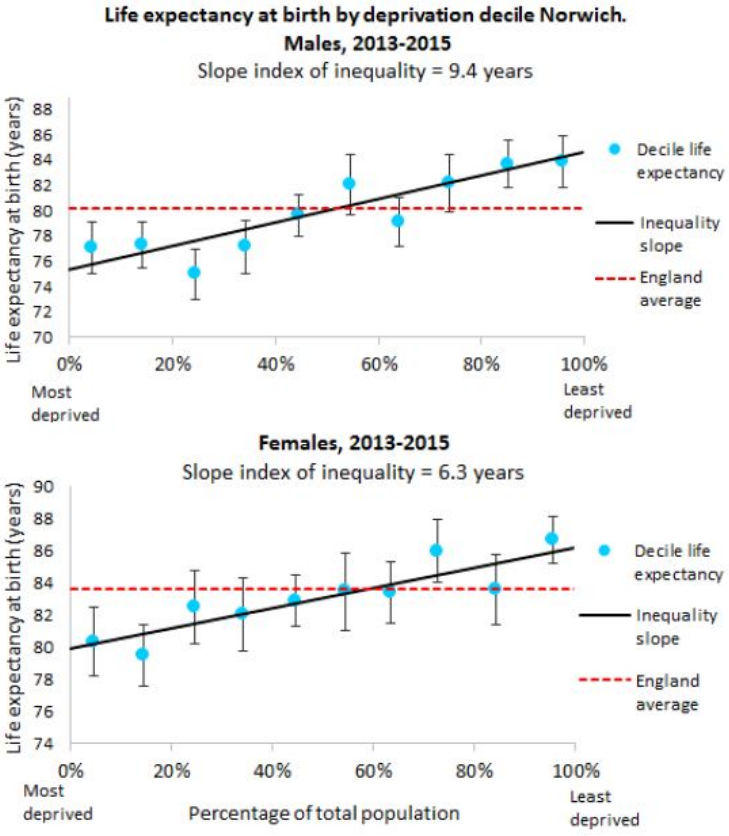
2. What is the pattern of health inequality in Norwich?

   The profile in appendix 1a provided by Norfolk County Council Public Health teams gives a broad picture of the key Health and Wellbeing issues for the district and shows how it compares with Norfolk and England. It is a picture at a single point in time from the information available to enable comparison with respect to outcomes relevant to the Health & Wellbeing Strategy. For more information go to Norfolk Insight www.norfolkinsight.org.uk

   The graphs below on the left show the main causes for those in deprived areas in Norwich having a lower life expectancy than those in more prosperous areas. So for example, the men in most deprived areas in Norwich (black line) live 5 years less than the least deprived (blue line) mainly because they suffer to a larger extent from cancer, mental health issues, circulatory issues etc. and the size of the red block suggests the importance that illness/issue has to the overall life expectancy – circulatory illnesses have a larger effect when looking at the gap compared to respiratory conditions.

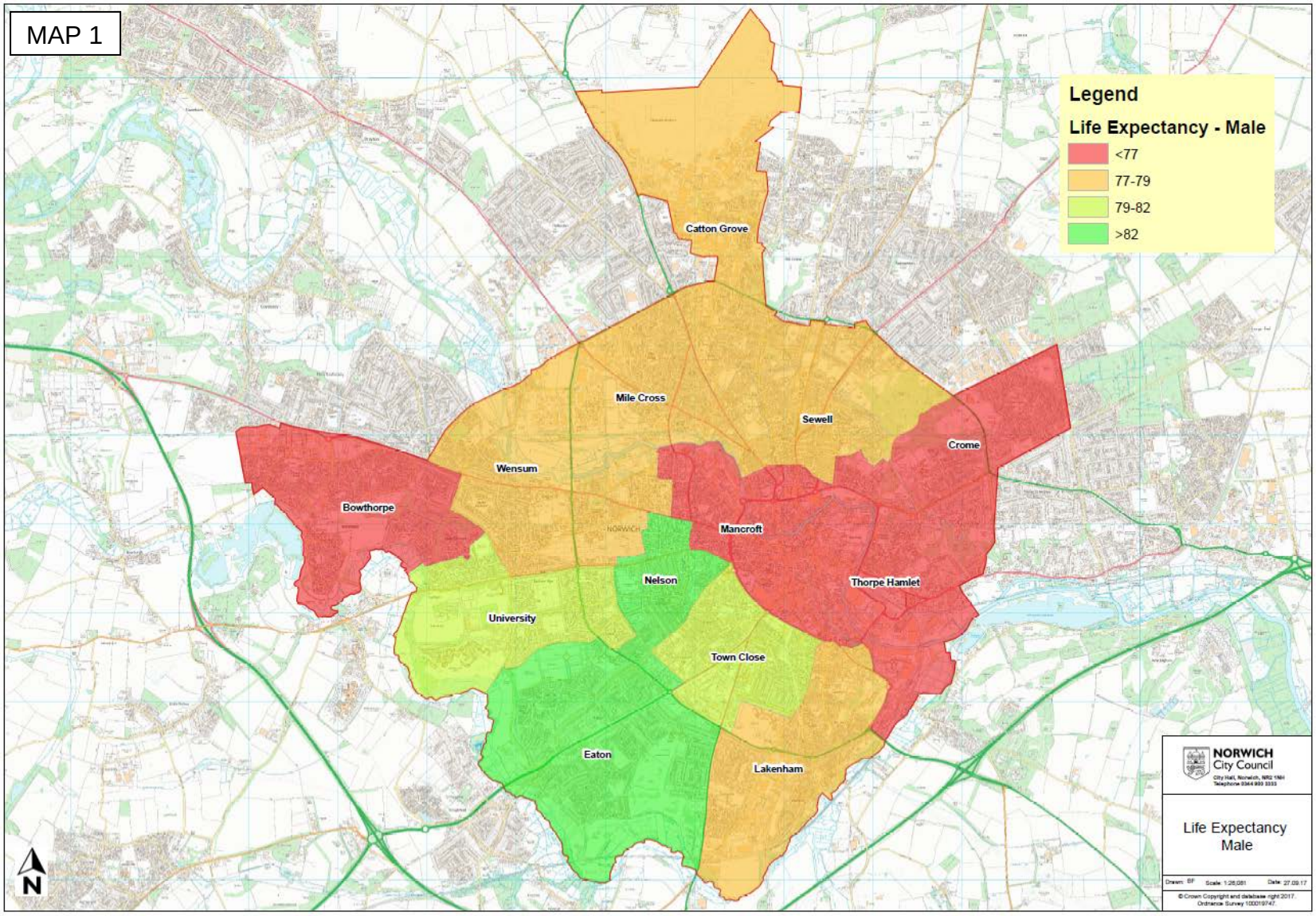
   The graphs on the right are showing that those babies born in Norwich in the deprived areas live to an age below the England average but those born in prosperous areas live longer than the England average

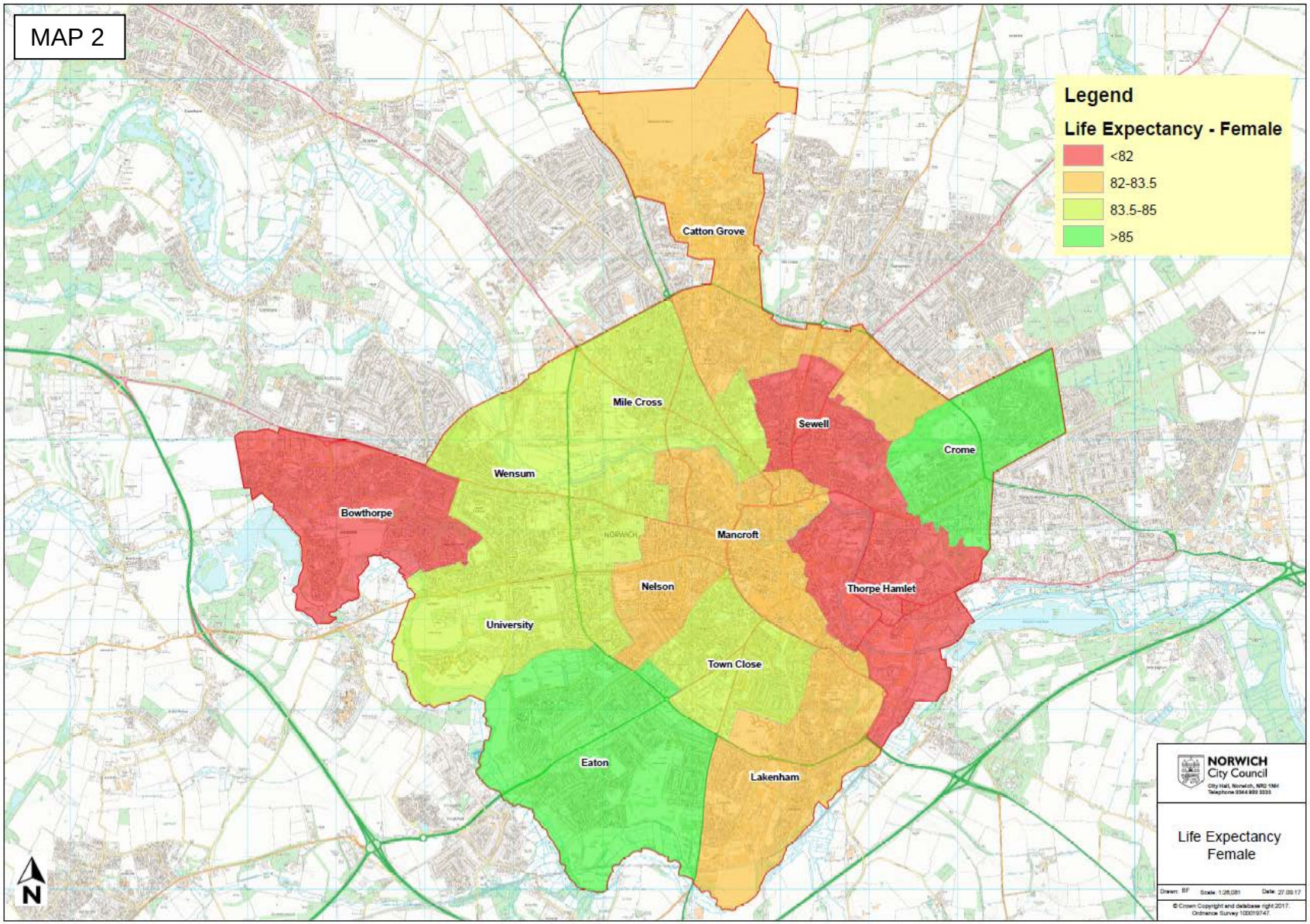




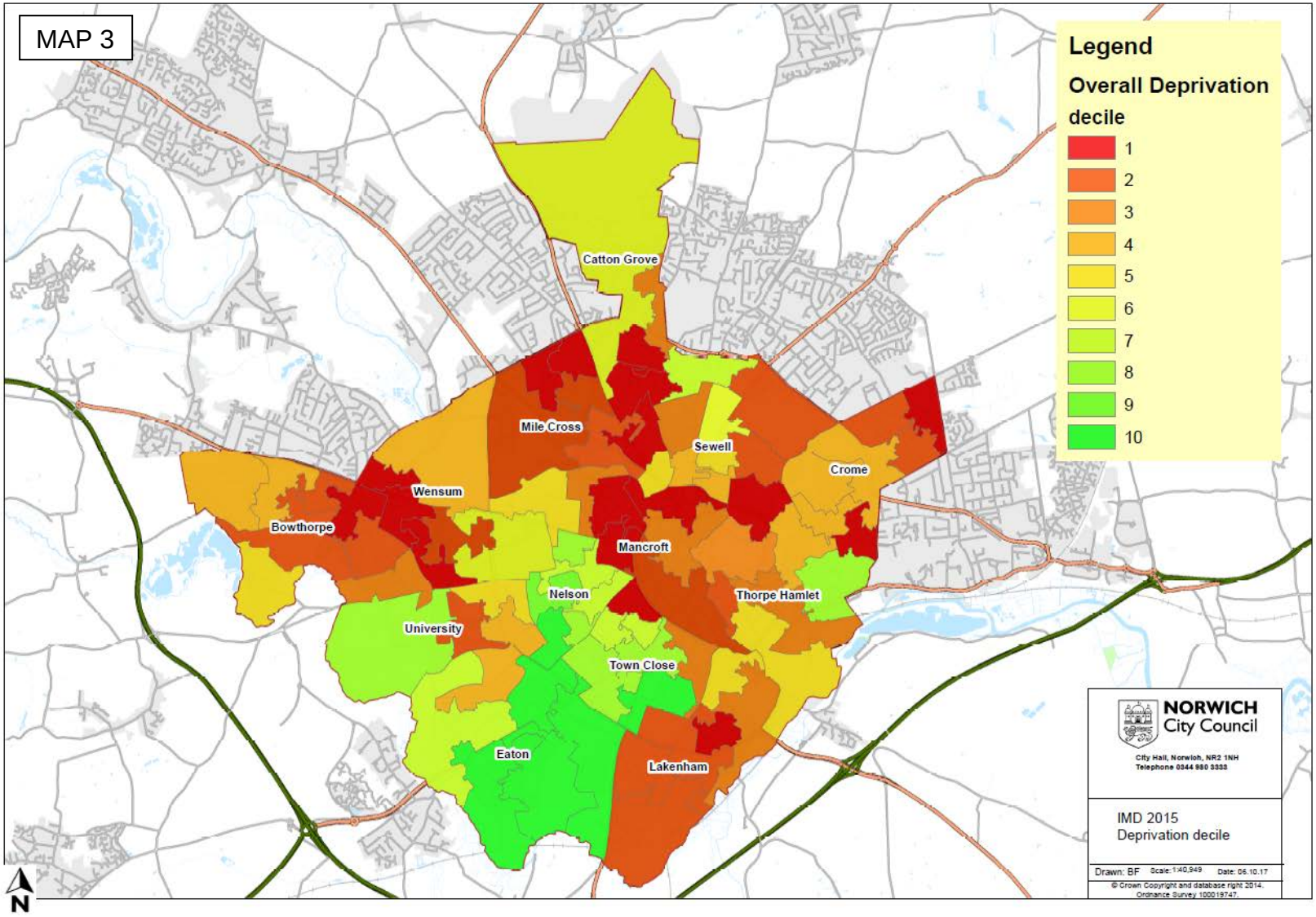
3. Maps 1 and 2 below show the life expectancy variance across the different wards in Norwich, and also show the life expectancy differences between the genders. A stark contract can be seen between wards and between genders, for example in Crome ward, which has a low life expectancy for males of under age 77 against over 82 for men in Eaton, whereas women in Crome ward have a much higher life expectancy of over age 85.

MAP 1




MAP 2
Legend
Life Expectancy - Female
<82
82-83.5
83.5-85
>85
Catton Grove
Mile Cross
Sewell
Crome
Wensum
Bowthorpe
Mancroft
Nelson
Thorpe Hamlet
University
Town Close
Eaton
Lakenham
N
NORWICH
City Council
Life Expectancy
Female

4. The map below shows the overall deprivation across the lower super output areas of Norwich, and the red to green scale indicates the most to least deprived areas. Comparisons can then be drawn between map 3 and the life expectancy differences between males and females as shown in maps 1 and 2 above.



5. What is the experience of health inequalities in Norwich?

   The following extracts are from evidence provided by organisations working with local people who experience poorer health outcomes, namely people sleeping rough and people with disabilities.

   Evidence from: St Martin's Housing Trust general manager, Derek Player: (appendix 2)

   The city is fortunate in having the City Reach primary health care team whose "raison d'etre" is to reach out to marginalised groups such as the homeless, sex workers, travellers and others who may not have access to G.P. services. City Reach is based at premises in Westwick Streeet owned by St Martins and this proximity facilitates easy cross-referral of clients between the two organisations. City Reach also delivers a weekly surgery in Bishopbridge House. Both organisations are experiencing "system blockage" at the moment. St Martins has a record number of "revolving door" clients whose progress along the recovery pathway is either halted by no appropriate service being available for them, or because other agencies (having had their budgets reduced by Norfolk County Council) refuse to take nominated "high risk" clients. City Reach is also retaining more patients than they would wish because G.P. surgeries will often not register them or they are not equipped to deal with them. Consequently their "list" keeps growing and the practice cannot offer the intensity of service to individuals the health practitioners would wish.

   There are an increasing number of single homeless adults who St Martins is in touch with who have multiple and complex needs. These needs are typically a combination of mental and physical ill health issues (often severe and prolonged) and deep-seated substance misuse issues. This latter group forms the majority of rough sleepers in the city and some of them have resisted engagement with the current rough sleepers team (CAPS) or the offer of a bed at Bishopbridge House.

   Evidence from Making it Real Norfolk, Mary Fisher: (appendix 3)
   Making it Real believes the best way to improve services is to ask people who use those services what they need and how best to provide it. Making it Real was asked about their experiences of health inequality and to use their lived experience to suggest ways Norwich City Council could improve health inequality:

   - Housing - Disabled people experience worse health outcomes when they live in unsuitable accommodation. Here are a few examples:-

…"my flat [is] no longer suitable as I use a wheelchair and have 7 steps outside so I am totally house bound. I know qualify for a two

bedroomed bungalow. They seem to be very thin on the ground. The council still send me accommodation on the first floor which is totally useless."

One person was unable to find alternative accommodation whilst building work was carried out "…because there are no hotels in Norwich with overhead tracking hoists and wheel in shower. I had to continue living in a dusty, damp, chemical filled environment." "I feel like a prisoner in my home. The surrounding area has been turned into a building site. There are no pavements for me to use. There are no facilities such as shops, nurseries, chemists, GP services…"

- Insufficient parking for people who use blue badges or require accessible vehicles.
- Exclusion from participating in Norwich life due to lack of properly accessible toilets
- Access to health and social care services, shops and facilities.
- Support and care workers.

6. What is a district council role in addressing health inequality?

   The below information was taken from The King's Fund report 'The district council contribution to public health: a time of challenge and opportunity' https://www.kingsfund.org.uk/publications/district-council-contribution-public-health

Housing

- Access to good-quality housing is critical to good mental and physical health. District councils have an important role to play in delivering this; in 2014/15, 40 per cent of housing completed by district councils was classed as affordable.
- Poor housing conditions are estimated to cost the NHS £2 billion every year and cost the wider economy even more. Yet improving poor homes pays back quickly in reduced costs across the public sector. District councils have a direct role in this, and also through their enforcement powers around the condition of private rented housing.
- District councils' efforts on housing advice and reducing homelessness are also likely to pay back in terms of finance, as well as health. On average, homeless people's health costs are four times those of non-homeless people, costing the NHS an additional £85 million annually.

Leisure and green spaces

- Physical inactivity is one of the biggest health challenges facing us as a nation. A quarter of women and a fifth of men are physically inactive, as are many children. Overall, physical inactivity is responsible for up to one in five premature deaths and is estimated to cost the UK economy more than £7 billion annually. Sport England suggests that the economic value of sport is around £11 billion every year, of which

around £1.7 billion is related to avoidable NHS costs.

- District councils provide leisure services and access to green spaces. Innovative reduced-cost schemes and free access to leisure services suggests that up to £23 in value is created for every £1 invested. More broadly, access to green spaces is increasingly recognised to be as important to mental health as physical health, and has been shown to reduce the impact of income inequalities on mental health and wellbeing.
- District councils' wider role in delivering and lobbying for improvements in local natural habitats is also important. Tentative estimates suggest that a 7 1 per cent fall in sedentary behaviour as a result could produce nearly £2 billion in benefits through reduction in coronary heart disease (CHD), cancers, stroke, depression and anxiety.

Environmental health

- Most aspects of environmental health services are likely to have an impact on health. For example, air and noise pollution are both associated with a number of negative health outcomes, while food-borne diseases can result in hospital visits and time off work.
- Estimates suggest that the health costs arising from man-made pollution could be as high as £20 billion (2005); the UK-wide impact of noise pollution on health is estimated to be in the region of £2 billion to £3 billion per year (2008).
- The district council role in environmental health is potentially vast, covering functions such as monitoring and managing local air quality, noise nuisance, food safety, enforcing the smoking ban, ensuring compliance with occupational health and safety regulations, pest control, and dealing with contaminated land, among others.
- Perhaps because many of these functions are statutory, there is little published evidence on the effectiveness or cost-effectiveness of environmental health interventions. In a period when spending is being cut – particularly, it seems, in environmental health – this kind of evidence is urgently required to better inform difficult decisions about local priorities and to ensure value for money.

Enabling roles

- Beyond delivering the core functions outlined above, we believe that district councils have three enabling roles that underpin good public health. These both affect and shape how other functions are delivered and therefore their impacts on health; in this way, they underpin district councils' support for the development of community wellbeing.

Economic development

- A strong local economy is associated with a wide range of better health outcomes. Communities with higher levels of income deprivation are more likely to have lower life expectancy and poorer health than those with lower levels of income deprivation and for every 10 per cent increase in involuntary unemployment in a community, average life expectancy is one year lower.

- District councils have many levers for sustainable economic development, including the New Homes Bonus and Community Infrastructure Levy, and their role in Local Enterprise Partnerships and City Deals. They also have an important role in delivering the government's Troubled Families programme and benefit systems. They provide a wide range of direct and indirect support to employers, unemployed people, and other vulnerable groups.
- When it is well planned, economic development leads to good-quality stable employment, which helps improve the health of the individual, their family and wider networks. This is true across the life-course, but especially for young people who are less likely to find work later in life and more likely to experience poor long-term health if they are out of the workforce as younger people.
- However, how economic development 'is done' is often just as important to long-term health and wellbeing as the economic development itself. This is where the connection with district councils' other enabling roles – in good planning and community engagement in health – is so critical.

Planning

- Districts are responsible for planning in two-tier areas. Their approach is best viewed as an enabler rather than an intervention, partly because it affects and interacts with most other district functions, and so underpins the health and wellbeing of local communities.
- Planners fulfil a range of functions. These include assessing and processing planning applications, preparing long-term local plans for an area, securing the local infrastructure and investment needed by leveraging section 106 agreements, and applying the Community Infrastructure Levy.
- Evidence suggests that the spatial environment affects people's physical and mental health. Planning can, for example, encourage active commuting through the provision of walkways and cycle lanes; it can ensure an adequate supply of affordable housing and access to green space; it can restrict access to unhealthy food outlets and impose restrictions on traffic; and it can benefit the local economy by creating new local business opportunities and jobs.

Engaging with communities

- District councils have an important role to play in supporting social capital by strengthening social networks and community-centred approaches to health, potentially through enabling greater volunteer involvement in health care support. These approaches have been shown to have strong and direct links to health, being as powerful predictors of mortality in older populations as common lifestyle risks, such as moderate smoking, obesity, and high cholesterol and blood pressure. They are also important in determining or averting health behaviours as well as resilience to, and recovery from, illness.
- However, the direct return on investment evidence of community-centred approaches to health is still developing, and there is limited

evidence on the cost-effectiveness of community engagement interventions (although some reviews have reported cost benefits in some circumstances).

7. What is Norwich City Council doing?

Healthy Norwich aims to improve the health and wellbeing of people living in the city and its surrounding area. It is a partnership between NHS Norwich CCG, Norwich City Council, Broadland District Council and Public Health, at Norfolk County Council. Healthy Norwich has three identified themes for 2017/18 aimed specifically at tackling health inequalities in the city and to promote health and wellbeing messages to the whole population. These thematic areas are:

Promoting healthy weight and lifestyles– improving awareness of the benefits of an active lifestyle, and improving access to activities in the city. Supporting people to make healthier food choices and providing services to people seeking to achieve a healthy weight

To be delivered in 2017/2018:

- Deliver the Daily Mile to Norwich and achieve school sign up of at least 20 primary schools as reported on the Daily Mile national participation map
- Deliver an innovative sugar awareness scheme for Norwich secondary schools, supported by a cutting-edge animation.
- Deliver the National Diabetes Prevention Programme (NDPP) in Norwich, as part of the Central Norfolk CCG wave.
- Deliver a GP breastfeeding friendly accreditation scheme.

Smoking cessation and prevention – helping people to stop smoking through the provision of local smoking cessation services, and reducing the numbers of young people who take up smoking, by denormalising smoking.

To be delivered in 2017/2018:

- Following the successful implementation of smoke-free parks and other supporting activities, ensure the evaluation of this project supports the introduction of smoke free school gates by Norfolk County Council.

Affordable warmth – reducing fuel poverty for Norwich residents through affordable warmth activities.

To be delivered in 2017/2018:

- Deliver a pilot to test ward level prevention activity to reduce excess winter deaths.

Improving mental wellbeing (increasing self-esteem and resiliency, enabling positive social interactions) and reducing health inequalities amongst vulnerable groups and deprived communities underpin all the Healthy Norwich activity.

To be delivered in 2017/2018:

- Deliver a pilot for social prescribing at Tuckswood surgery.
- Deliver a successful mini grants programme via Norfolk Community Foundation for 1) Mental Wellbeing Innovation Fund and 2) Innovation to Support Sustainable Healthy Communities Fund.

Cancer - Prevention and Early Detection

To be delivered in 2017/2018:

- Developing a comprehensive business case and action plan based on targeted activity improve cancer screening and early diagnosis rates.

As well as the Healthy Norwich partnership, the city council also already deploys many of the approaches outlined in the Kings Fund report to address the wider determinants of health, such as:

- Under our Healthy Homes initiative, our Home Improvement Service offers a range of support to enable residents of Norwich to remain living in a warm home that is safe and secure which benefits their health. Services available include:
    - Help with minor adaptations, especially if you or someone you care for is suffering with dementia e.g. changing the colour of things around the home to make furniture and items clearer to identify or locate, or installing extra lighting
    - Help with larger adaptations, repairs or home improvements (e.g. treating damp, adding ramps or stair lifts, emergency repairs): we can help assess what works are needed, refer work to our approved list of building contractors and supervise work to ensure it is completed to a satisfactory standard
    - Help with odd-jobs and small scale repairs via our Handyperson service (over 65s only)
    - Help with applying for grants or funding to make your home healthier or warmer (disabled adaptations grants, safe at home grants, hospital discharge grants, home improvement loans)
    - Help you to reduce your energy bill costs through the Big Switch and Save scheme
    - Financial and energy saving advice, insulation measures, boiler checks, emergency radiators, loft clearance
    - Support to look at alternative housing options if you want to consider moving to more suitable accommodation
    - Signposting or referring you to other agencies to access welfare benefits, concessions or other support or advocacy services

    - The team can also help with poor housing conditions which can become a threat to a person's health, safety or recovery.

- Sports and Leisure provision:
    - working in partnership to support the development and delivery of sport, physical activity and leisure initiatives increasing opportunities for people to lead active and healthy lifestyles
    - developing and managing the Go 4less leisure discount scheme
    - in-house management of The Norman Centre
    - contract monitoring for Riverside Leisure Centre, managed by Places for People Ltd. on behalf of the council
    - contributing strategically to the future provision and sustainability of sport, leisure and cultural facilities and services.

- Using our parks and open spaces to generate health outcomes, such as implementing a ‘voluntary ban’ on smoking on council play areas in the city
- A range of city-wide and locality projects under the Reducing inequalities action plan that address financial and social drivers of poor health
- Building health inequalities into planning and place-based initiatives, such as the River Wensum Strategy, which includes the following objective:

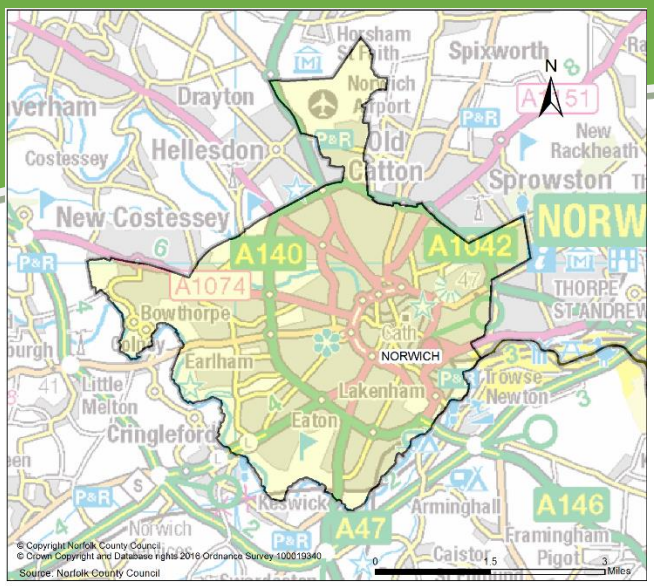
Policy 1: The design of individual projects and implementation of the strategy will address health and social inequalities of local communities adjacent to the river where appropriate and feasible.
The draft strategy is available here:
https://www.norwich.gov.uk/downloads/file/4025/management_and_partnership_working

There are also a range of council initiatives that link directly into health care services, including:

- Facilitating the Norwich Early Help Hub
- Working with adult social care and public health teams to develop the Norwich Social Prescribing model
- Providing a Home Improvement Service caseworker at the Norfolk and Norwich University Hospital to support hospital discharge

Health and Wellbeing Profile June 2017 Norwich

APPENDIX 1A



Current Health and Wellbeing priorities

66% of five year olds have a good level of development

73 people die early each year of circulatory conditions including heart disease and stroke

1,146 of 1,846 estimated dementia cases are diagnosed

Green or red number means significantly better or worse than the England average. Arrows indicate change direction this year, colour represents significant difference.

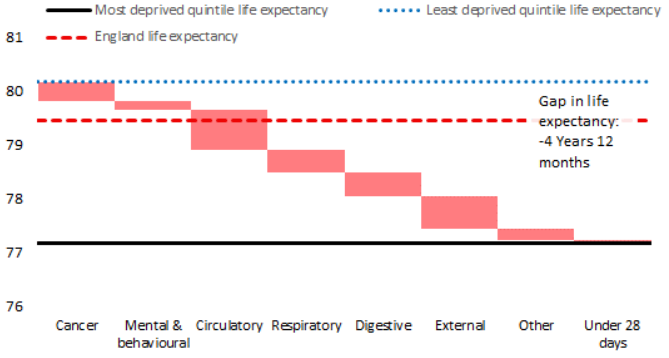
www.norfolk.gov.uk/hwbstrategy

Population 138,900

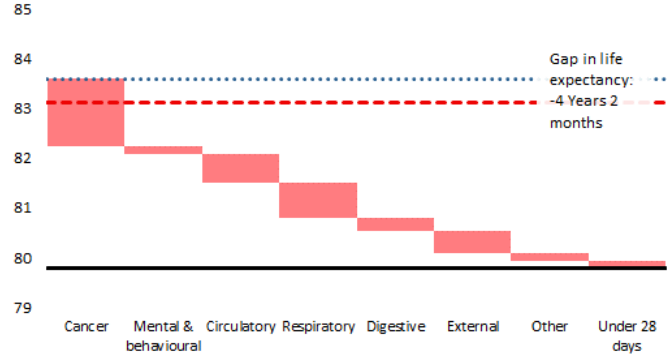
2015 mid-year estimate | Source: Office for National Statistics

If you have any queries about this profile or its data, please email insight@norfolk.gov.uk.

Contribution to life expectancy gap between most and least deprived areas in Norwich, by broad cause of death. Males, 2013-15

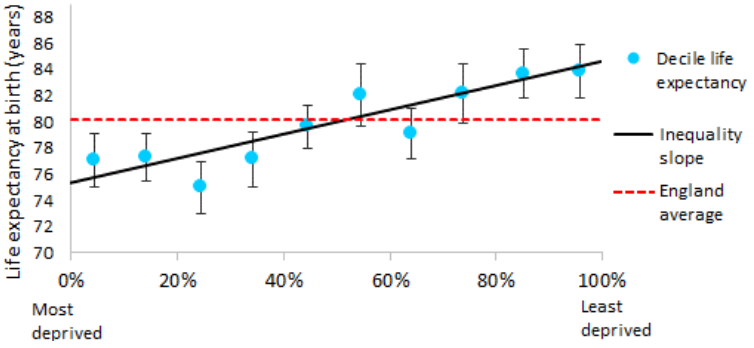


Females, 2013-15



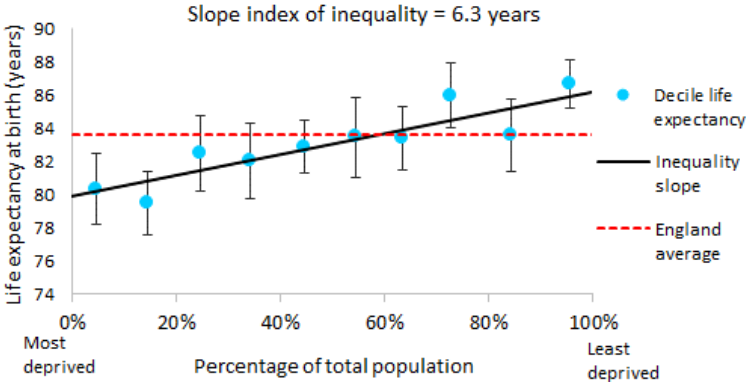
Life expectancy at birth by deprivation decile Norwich. Males, 2013-2015

Slope index of inequality = 9.4 years



Females, 2013-2015

Slope index of inequality = 6.3 years



Source: see indicator notes on page 4

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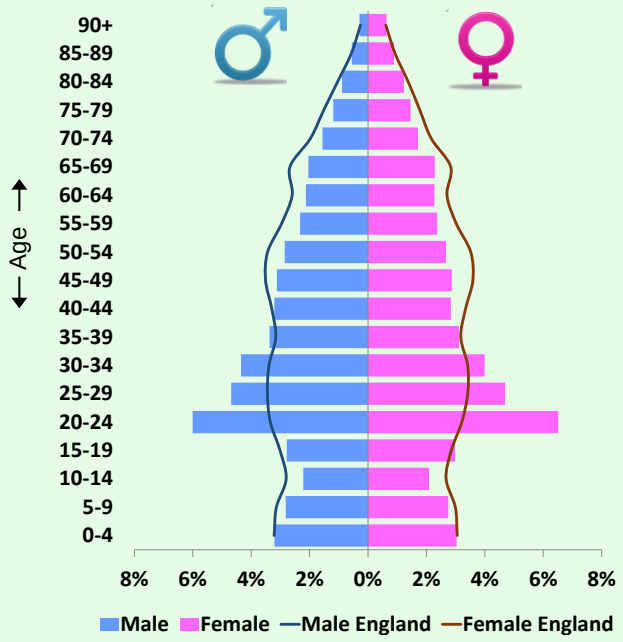
Norfolk County Council

Population – 2015

Age Structure

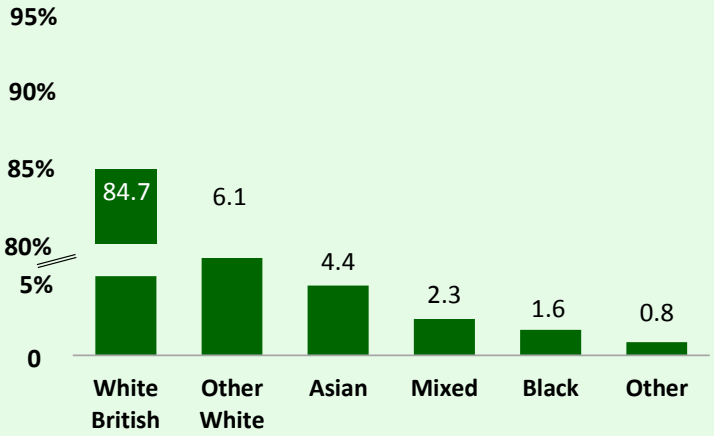
The estimates for mid-2015 show that the population of Norwich is younger than England as a whole, with 30% of the population aged 20-34 compared with 20% in England - See more at: http://www.norfolkinsight.org.uk/jsna/population

Percentage of resident population by five year age groups 2015 compared with England



Source: 2015 mid-year estimates, Office for National Statistics

Percentage of resident population by ethnic group

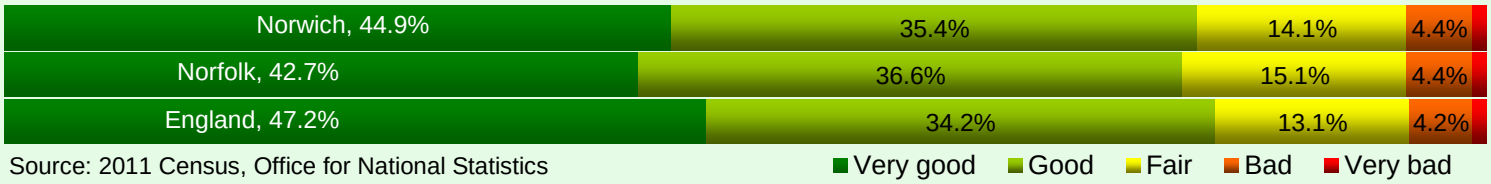


Source: 2011 Census, Office for National Statistics

Health

General Health

General health is a self-assessment of a person's general state of health. This assessment is not based on a person's health over any specified period of time. General health in Norwich is similar to the Norfolk average. 80.3% of people described their health as good or very good, compared with 79.3% in Norfolk, and 5.6% as bad or very bad, as against 5.6% in Norfolk.



Source: 2011 Census, Office for National Statistics

Long-term health problem or disability

A long-term health problem or disability that limits a person's day-to-day activities, and has lasted, or is expected to last, at least twelve months. 8.6% of people in Norwich said that their day-to-day activities were limited by a long term illness or disability, compared with 9.1% in Norfolk and 8.3% in England.

Source: 2011 Census, Office for National Statistics

Norfolk County Council

Health & Wellbeing summary

The chart below shows how the health of people in the district compares with Norfolk and the rest of England. The district result for each indicator is shown as a circle. The value for England is shown by the black line, which is always at the centre of the chart. The range of results for all local areas in Norfolk is shown as a grey bar. A red circle means that the district is significantly worse than England for that indicator; however, a green circle may still indicate an important health problem.

- **Significantly worse than England average**
- **Not significantly different from England average**
- **Significantly better than England average**
- **No significance calculated**
- **Norfolk average**

		Profile for Norwich	Local number per year	District Value	England Average	Norfolk Worst	Norfolk Range	Norfolk Best	Trend Start	Trend	Trend Finish	Change over three years
Our community	1	Life expectancy at birth for males	510	79.6	79.5	73.9		84.3	77.3		79.6	↑
	2	Life expectancy at birth for females	560	82.9	83.1	79.2		88.8	82.8		82.9	↓
	3	Income Deprivation 2015	26,235	18.9	14.6	37.1		5.4	18.9		18.9	-
	4	General Health - bad or very bad	7,499	5.7	5.5	8.9		2.5				-
	5	Teenage conceptions	56	32.6	20.8	97.2		14.2	53.3		36.4	↓
	6	Provision of 50 hours or more unpaid care per week	2,869	2.2	2.4	4.5		0.8				-
	7	Anti-social behaviour incidents	5,817	41.9	n/a	168.9		7.6	81.6		41.9	↓
	8	Domestic Abuse	3,819	33.1	n/a	81.4		7.7				-
	9	Violence against the person	4,527	32.6	n/a	78.9		5.8	22.0		32.6	↑
Early years	10	Child Poverty	6,160	26.5	20.1	40.7		6.3	31.4		26.7	↓
	11	School Readiness	1,066	65.9	69.3	44.8		83.5	39.7		65.9	↑
	12	Admissions for injuries in under 5s	155	177.8	136.0	250.4		47.7	159.9		177.8	↑
	13	Emergency admissions in under 5s	1,604	185.2	150.3	312.5		98.9	143.1		185.2	↑
	14	A&E attendances in under 5s	2,993	345.5	587.9	713.9		222.0	283.6		345.5	↑
	15	Breastfeeding	943	49.3	43.2	37.1		52.4				-
	16	Obese Children (Reception Year)	153	9.8	9.3	15.8		4.7	8.8		9.1	↓
	17	Children with excess weight (Reception Year)	363	23.2	22.1	32.2		14.6	22.9		23.0	↓
	18	Obese children (Year 6)	229	18.6	19.8	26.3		6.5	18.6		18.6	-
	19	Children with excess weight (Year 6)	407	33.1	34.2	44.4		12.6	31.1		33.1	↑
Obesity	20	Early deaths from circulatory conditions	73	78.5	74.6	149.7		21.8	96.8		77.9	↓
	21	Obese adults	23,660	19.6	24.4	31.7		10.7	18.5		18.9	↑
	22	Healthy eating adults	28,817	25.5	26.4	18.6		34.9	53.7		56.8	-
	23	People diagnosed with diabetes	6,837	4.8	6.5	9.9		2.3	4.2		4.8	↑
Dementia	24	Deaths from dementia and alzheimer's disease	91	73.8	102.2	294.0		21.4	44.9		73.8	↑
	25	Estimated diagnosis rate for people with dementia	1,146	62.1	67.6	36.2		129.9	45.9		62.1	↓
Mental health	26	Self harm emergency admissions	605	398.4	196.5	877.1		76.5	320.8		398.4	↑
	27	Suicide	20	16.1	10.1	48.0		3.5	13.8		16.1	↑
	28	Social isolation*	n/a	n/a	45.4	n/a		n/a				-

*Range represents upper tier values in the East of England

Arrows indicate increase or decrease. Green or red arrows mean significantly better or worse than previous. No colour indicates no significant difference.

Norfolk County Council

Health indicator notes

Contribution to life expectancy gap between the most and least deprived LSOA quintiles, by broad cause of death: difference between life expectancy in the most and least deprived areas and the contribution to gap in life expectancy in years. Coloured bars indicate difference in life expectancy if the death rate for that cause was the same as in the least deprived areas. Red shows potential for improvement. Segment tool info.: http://tinyurl.com/z472jtk

Life expectancy at birth by deprivation decile: Life expectancy at birth has been calculated for each population decile from the most deprived 10% of the population to the least deprived 10%. An inequality slope has been calculated (line of best fit using the least squares method) which highlights the life expectancy difference in the district. The England average life expectancy has been included as an illustration of total equality, points below this line show a worse than average life expectancy. Source: ONS PCMD and IMD2010. More information at: tinyurl.com/LEInequality

Health and Wellbeing summary:

1 Average male life expectancy at birth (years) 2013-2015 – Primary Care Mortality Database;
2 Average female life expectancy at birth (years) 2013-2015 – Primary Care Mortality Database;
3 The percentage of the population living in low income families reliant on means tested benefits – IMD 2015;
4 The percentage of respondents who stated 'very bad' or 'bad' when asked about their general health – Census 2011;
5 Conceptions in women aged under 18 per 1,000 females aged 15-17, 2015 – ONS;
6 The percentage of question respondents who stated '50 hours or more of unpaid care per week' when asked if they provided unpaid care – Census 2011;
7 Anti-social behaviour incidents per 1,000 population, 2016 – Norfolk Constabulary;
8 Recorded crime and non-crime domestic abuse incidents per 1,000 population aged 16+, 2016 – Norfolk Constabulary;
9 Violence against the person incidents per 1,000 population, 2016 – Norfolk Constabulary;
10 Children 0–15 living in income-deprived households as a percentage of all children 0–15, 2014 – HM Revenue & Customs;
11 Children defined as having reached a good level of development at the end of the Early Years Foundation Stage as a percentage of all eligible children. 2016 – DfE;
12 Crude rate of hospital admissions caused by unintentional and deliberate injuries in children (aged under 5 years), per 10,000 resident population. 2013/14-15/16 – NHS Digital;
13 Crude rate of emergency hospital admissions for children (aged under 5 years), per 1,000 resident population. 2015/16 – NHS Digital;
14 A&E attendance rate per 1,000 resident population aged 0-4 years. 2015/16 – NHS Digital;
15 The percentage of all infants due a 6-8 week check that are totally or partially breastfed 2015 – PHE;
16 Number of children classified as obese as a percentage of all children measured. Reception year. 2015/16 – NCMP;
17 Number of children classified as overweight or obese as a percentage of all children measured. Reception year. 2015/16 – NCMP;
18 Number of children classified as obese as a percentage of all children measured. Year 6. 2015/16 – NCMP;
19 Number of children classified as overweight or obese as a percentage of all children measured. Year 6. 2015/16 – NCMP;
20 Early deaths from circulatory conditions (deaths aged under 75 including heart attack and stroke) DSR per 100,000 people. 2013-2015 – Primary Care Mortality Database;
21 The percentage of adults classified as obese – APS 2013-15;
22 The estimated percentage of the population aged 16+ that eat healthily. Healthy eating is defined as those who consume 5 or more portions of fruit and vegetables per day – Health Survey for England 2012-14;
23 The percentage of the population registered with GP practices aged 17 and over with diabetes. 2016 – QOF;
24 Directly standardised rate of deaths from Dementia and Alzheimer's disease per 100,000 people (ICD 10 codes F01, F03 & G30) 2013-2015 – PCMD;
25 Estimated diagnosis rate expressed as a percentage (number of people diagnosed/estimated prevalence) 2017 – NHS Digital, ONS SNPP, Alzheimer's Society, CFAS II;
26 Emergency Hospital Admissions for Intentional Self-Harm per 100,000 people. 2015/16 – NHS Digital;
27 Age-standardised mortality rate from suicide and injury of undetermined intent per 100,000 population. 2013-2015 – Primary Care Mortality Database;
28 % of adult social care users who have as much social contact as they would like according to the Adult Social Care Users Survey. 2015/16 – Adult Social Care Survey England.
Notes: Directly Standardised Rate (DSR) – The age-specific rates of the subject population are applied to the age structure of the standard population. This gives the overall rate that would have occurred in the subject population if it had the standard age-profile.

Find out more

Key information links

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fingertips.phe.org.uk

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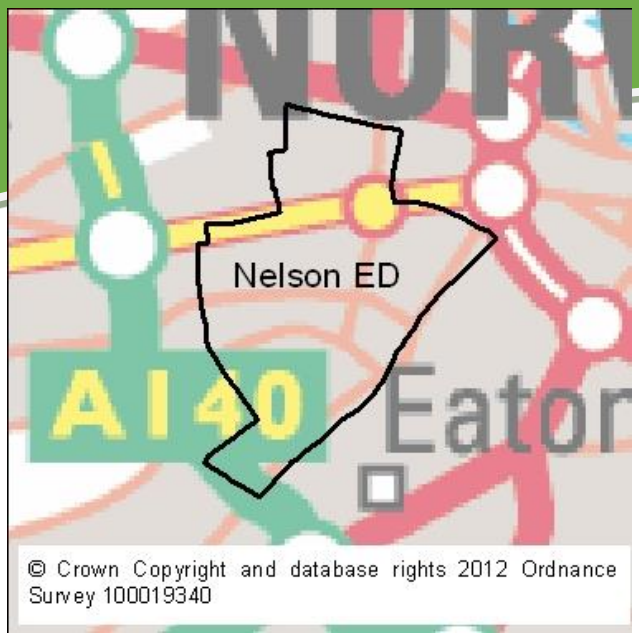
- JSNA profiles and information www.norfolkinsight.org.uk/jsna
- Health and Wellbeing Stratey and information www.norfolk.gov.uk/hwbstrategy

Health and Wellbeing Profile 2017
Electoral Division: Nelson

APPENDIX 1B

Councillor: Jess Barnard Contact: www.norfolk.gov.uk/jessbarnard



Population 9,605

2015 mid-year estimate | Source: Office for National Statistics

If you have any queries about this profile or its data, please email insight@norfolk.gov.uk.

Current Health and Wellbeing priorities

83.5% of five year olds have a good level of development ↓

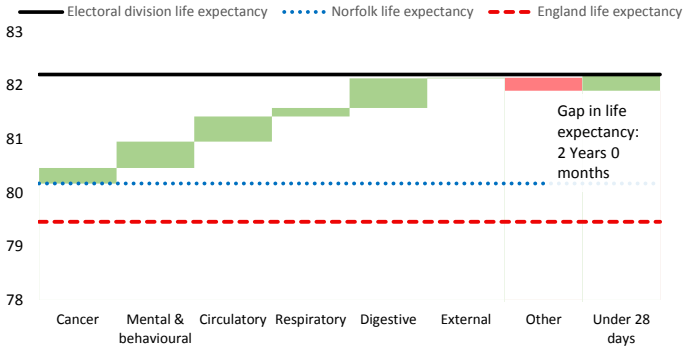
Fewer than 5 people die early each year of circulatory conditions including heart disease and stroke ↓

54 of 68 estimated dementia cases are diagnosed -

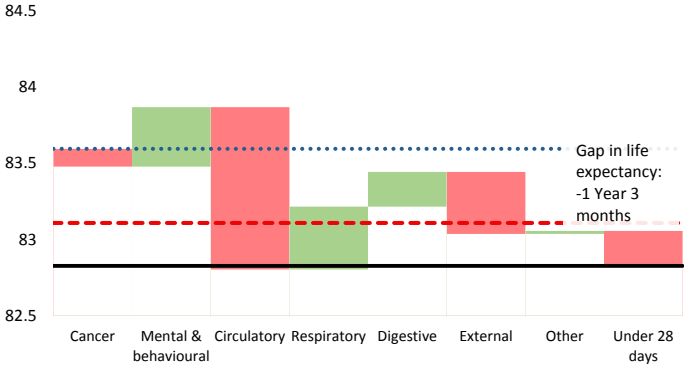
Green or red number means significantly better or worse than the England average. Arrows indicate change direction this year, colour represents significant difference.

www.norfolk.gov.uk/hwbstrategy

Contribution to life expectancy gap between Nelson and Norfolk, by broad cause of death. Males, 2013-15

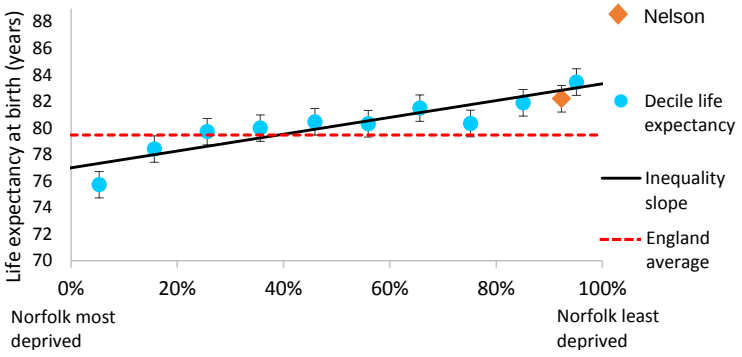


Females, 2013-15



Life expectancy at birth by deprivation decile Norfolk. Males, 2013-2015

Slope index of inequality = 6.3 years



Females, 2013-2015

Slope index of inequality = 4.2 years

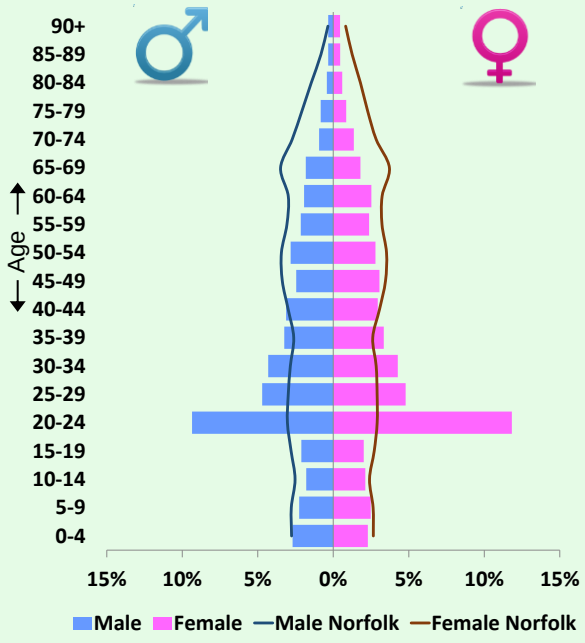
Source: see indicator notes on page 4

This profile gives a broad picture of the key Health and Wellbeing issues for the electoral division and shows how it compares with Norfolk and England. It is a picture at a single point in time from the information available to enable comparison with respect to outcomes relevant to the Health & Wellbeing Strategy. For more information go to Norfolk Insight **www.norfolkinsight.org.uk**.

Norfolk County Council

Population – 2015

Percentage of resident population by five year age groups 2015 compared with Norfolk

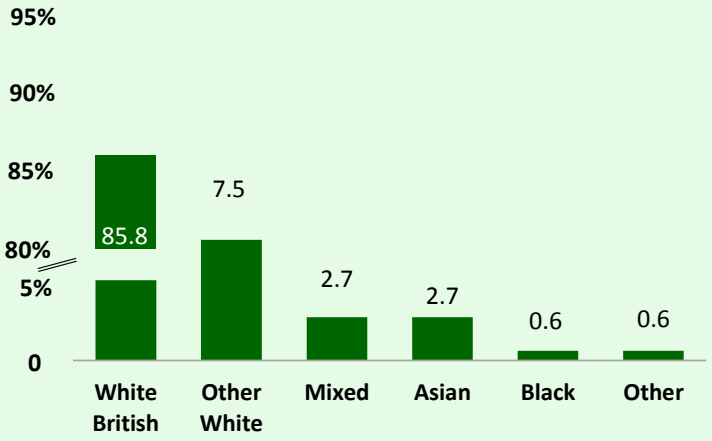


Source: 2015 mid-year estimates, Office for National Statistics

Age Structure

The estimates for mid-2015 show that the population of Nelson is younger than Norfolk as a whole, with 39% of the population below the age of 25 compared with 27% in Norfolk. - See more at: http://www.norfolkinsight.org.uk/jsna/population

Percentage of resident population by ethnic group

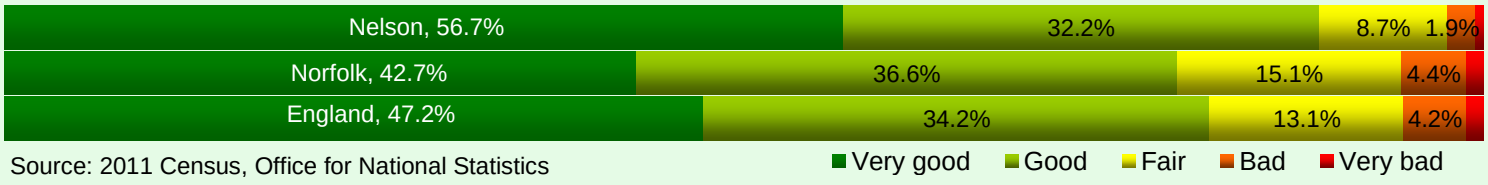


Source: 2011 Census, Office for National Statistics

Health

General Health

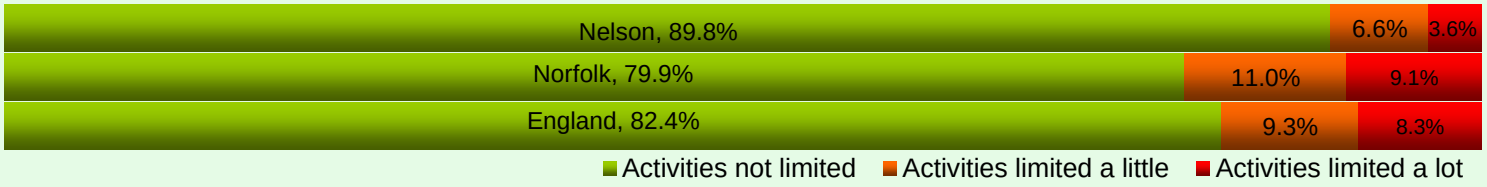
General health is a self-assessment of a person's general state of health. This assessment is not based on a person's health over any specified period of time. General health in Nelson is better than the Norfolk average. 88.9% of people described their health as good or very good, compared with 79.3% in Norfolk, and 2.5% as bad or very bad, as against 5.6% in Norfolk.



Source: 2011 Census, Office for National Statistics

Long-term health problem or disability

A long-term health problem or disability that limits a person's day-to-day activities, and has lasted, or is expected to last, at least twelve months. 3.6% of people in Nelson said that their day-to-day activities were limited a lot by a long term illness or disability, compared with 9.1% in Norfolk and 8.3% in England.



Source: 2011 Census, Office for National Statistics

Norfolk County Council

Health & Wellbeing summary

The chart below shows how the health of the people in the electoral division compares with Norfolk and the rest of England. The electoral division result for each indicator is shown as a circle. The value for England is shown by the black line, which is always at the centre of the chart. The range of results for all local areas in Norfolk is shown as a grey bar. A red circle means that the electoral division is significantly worse than England for that indicator; however, a green circle may still indicate an important health problem.

- **Significantly worse than England average**
- **Not significantly different from England average**
- **Significantly better than England average**
- **No significance calculated**
- **Norfolk average**

		Profile for Nelson Electoral Division	Local Number per Year	Rank in Norfolk (1 = best)	Electoral Division Value	England Average	Norfolk Worst	Norfolk Range	Norfolk Best	Trend Start	Trend	Trend End	Change (higher or lower than previous)
Our community	1	Life expectancy at birth for males	20	12 of 84	82.2	79.5	73.9		84.3	80.0		82.3	↓
	2	Life expectancy at birth for females	30	62 of 84	82.8	83.1	79.2		88.8	83.8		82.6	↑
	3	Income Deprivation 2015	523	1 of 84	5.4	14.6	37.1		5.4	5.4		5.4	-
	4	General Health - bad or very bad	229	1 of 84	2.5	5.5	8.9		2.5				-
	5	Teenage conceptions	<5	26 of 84	20.4	25.0	97.2		14.2	31.0		23.9	-
	6	Provision of 50 hours or more unpaid care per week	76	1 of 84	0.8	2.4	4.5		0.8				-
	7	Anti-social behaviour incidents	131	39 of 84	13.6	n/a	168.9		7.6	36.1		13.6	↓
	8	Domestic Abuse	90	7 of 84	10.9	n/a	81.4		7.7				-
	9	Violence against the person	78	12 of 84	8.1	n/a	78.9		5.8	7.6		8.1	↓
Early years	10	Child Poverty	85	2 of 84	7.1	20.1	40.7		6.3	5.9		7.1	↑
	11	Child Development at age 5	71	1 of 84	83.5	69.3	44.8		83.5	31.4		83.5	↓
	12	Admissions for injuries in under 5s	6	21 of 84	126.1	136.0	250.4		47.7	116.9		126.1	↑
	13	Emergency admissions in under 5s	77	32 of 84	160.8	150.3	312.5		98.9	80.1		160.8	↓
	14	A&E attendances in under 5s	112	8 of 84	233.8	587.9	713.9		222.0	223.4		233.8	↑
	15	Breastfeeding *	943	26 of 84	49.3	43.8	37.1		52.4				-
	16	Obese Children (Reception Year)	6	18 of 84	7.1	9.3	15.8		4.7	2.8		7.1	↑
	17	Children with excess weight (Reception Year)	17	23 of 84	20.0	22.2	32.2		14.6	12.2		20.0	↓
Obesity	18	Early deaths from circulatory conditions	<5	16 of 84	43.1	74.6	149.7		21.8	43.0		43.1	↓
	19	Obese adults	880	1 of 84	10.7	24.4	31.7		10.7				-
	20	Healthy eating adults	2,766	2 of 84	33.7	26.4	18.6		34.9				-
	21	People diagnosed with diabetes	349	2 of 84	4.1	6.5	9.9		2.3	4.1		4.1	↑
Dementia	22	Deaths from dementia and alzheimer's disease	<5	23 of 84	56.3	102.2	294.0		21.4	45.1		56.3	↑
	23	Estimated diagnosis rate for people with dementia	54	8 of 84	80.1	67.6	36.2		129.9	61.6		80.1	-

* Figures relate to district in which electoral division lies

Arrows indicate increase or decrease. Green or red arrows mean significantly better or worse than previous. No colour indicates no significant difference.

Norfolk County Council

Health indicator notes

Contribution to life expectancy gap between electoral division and Norfolk, by broad cause of death: difference between life expectancy in the area and Norfolk and the contribution to gap in life expectancy in years. Coloured bars indicate difference in life expectancy if the death rate for that cause was the same as in Norfolk. Red shows potential for improvement. Segment tool info.: http://tinyurl.com/z472jtk

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13) Crude rate of emergency hospital admissions for children (aged under 5 years), per 1,000 resident population. 2015/16 – NHS Digital;
14) A&E attendance rate per 1,000 resident population aged 0-4 years. 2015/16 – NHS Digital;
15) The percentage of mothers breastfeeding at 6 to 8 weeks 2014/15 – NCHC and ECCH;
16) Number of children classified as obese as a percentage of all children measured. 2013/14-2015/16 – NCMP;
17) Number of children classified as overweight or obese as a percentage of all children measured. 2013/14-2015/16 – NCMP;
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APPENDIX 2

Derek Player
General Manager
St Martins Housing Trust

'Statutory and third sector organisations providing services to socially excluded individuals in the city are faced with a much-changed policy landscape – notably the introduction of Universal Credit and Job Seeker Allowance sanctions (both of which impact disproportionately on homeless people), pressure on local authority and NHS budgets (resulting in increasingly difficult access to services by homeless people), the ever-widening gulf between supply and demand of affordable rent accommodation, and a reduced level of support for prisoners being discharged from prisons.

The model of support in Norwich to rough sleepers and those single adults at risk of homelessness, many of whom live chaotic lives, has not changed for at least a decade. It has been based on the procurement of services by the housing authority (Norwich City Council) including "temporary accommodation" and "street outreach" (caseworkers employed to engage and support rough sleepers on the streets). From an adult social care perspective Norfolk County Council has funded support services in various settings – including the city's direct access hostel (Bishopbridge House –which sees over 200 departures every year). Taken together these settings have formed a "recovery pathway". The pathway begins with the offer of a bed at Bishopbridge House, progresses through supported housing placements and typically concludes with some form of tenancy or other semi-permanent accommodation.

St Martins is currently working with the City Council, YMCA, The Salvation Army, Pubic Health and other statutory agencies to initiate a new way of collaboratively planning and delivering services to the current generation of homeless and socially excluded in the city – particularly those individuals who have refused to engage with the present range of services open to them.

The city is fortunate in having the City Reach primary health care team whose "raison d'etre" is to reach out to marginalised groups such as the homeless, sex workers, travellers and others who may not have access

to G.P. services. City Reach is based at premises in Westwick Streeet owned by St Martins and this proximity facilitates easy cross-referral of clients between the two organisations. City Reach also delivers a weekly surgery in Bishopbridge House. Both organisations are experiencing "system blockage" at the moment. St Martins has a record number of "revolving door" clients whose progress along the recovery pathway is either halted by no appropriate service being available for them, or because other agencies (having had their budgets reduced by Norfolk County Council) refuse to take nominated "high risk" clients. City Reach is also retaining more patients than they would wish because G.P. surgeries will often not register them or they are not equipped to deal with them. Consequently their "list" keeps growing and the practice cannot offer the intensity of service to individuals the health practitioners would wish.

There are an increasing number of single homeless adults who St Martins is in touch with who have multiple and complex needs. These needs are typically a combination of mental and physical ill health issues (often severe and prolonged) and deep-seated substance misuse issues. This latter group forms the majority of rough sleepers in the city and some of them have resisted engagement with the current rough sleepers team (CAPS) or the offer of a bed at Bishopbridge House.

As the present provider of the Drugs and Alcohol Service in the county moves towards the end of its contract access to their services is becoming more difficult for St Martins clients.

Finally we are finding nomination routes for our clients to the services of the Norfolk and Suffolk Foundation Mental Health Care Trust also problematic. Six out of ten rough sleepers suffer from some form of mental ill health and these conditions (which sometimes would be a severe and enduring mental health condition) never improve whilst the person is homeless. In theory a mental health assessment could be made on a street sleeper but this is rarely done.'

APPENDIX 3

Making it Real in Norfolk- Our future in our hands

About Us

Making it Real believes the best way to improve services is to ask people who use those services what they need and how best to provide it. Making it Real has five years experience of working with Adult Social care as a key partner. We also have three Norfolk Council Members on our Board.

Case studies we have been involved with:-

1. Healthwatch Norfolk – Access to mainstream services for adults with a physical disability
2. Norfolk Adult Social Care – review on social care practice [known as the SCIE review]

Report for Norwich City Council Scrutiny Committee on Health Inequalities

Making it Real was asked about their experiences of health inequality and to use their lived experience to suggest ways Norwich City Council could improve health inequality.

1. **Housing** - Disabled people experience worse health outcomes when they live in unsuitable accommodation. Here are a few examples:-

…"my flat [is] no longer suitable as I use a wheelchair and have 7 steps outside so I am totally house bound. I know qualify for a two bedroomed bungalow. They seem to be very thin on the ground. The council still send me accommodation on the first floor which is totally useless."

One person was unable to find alternative accommodation whilst building work was carried out " …because there are no hotels in Norwich with overhead tracking hoists and wheel in shower. I had to continue living in a dusty, damp, chemical filled environment."

"I feel like a prisoner in my home. The surrounding area has been turned into a building site. There are no pavements for me to use. There are no facilities such as shops, nurseries, chemists, GP services…"

2. **Insufficient parking for people who use blue badges or require accessible vehicles.** *"There are fewer disabled parking places in Norwich following the recent work to pedestrianize parts of the city centre. How come disabled people weren't asked to help design this?"*

3. **Exclusion from participating in Norwich life due to lack of properly accessible toilets.** Groups of disabled people are unable to take part in the social and community life that the rest of society enjoy or are unable to go to big events. *"When I get left out of things it means my mental health deteriorates."*

4. **Access to health and social care services, shops and facilities.** Health inequality can arise from going into the city where there are too few disabled toilets and none for people with complex needs. This means that people cannot access health services, GPs, chemists etc.
"I risk bladder infections if I stay too long or I do not attend and feel excluded."

5. **Support and care workers**. There are insufficient care workers in the community which is having a big impact on the health of groups of people who require support to live independently, especially those with complex needs. With too few qualified staff people often find themselves being supported by staff who are unsuitable for the work.
"I am living at home with progressive MS and quadriplegia. I cannot access reliable care and support and this has serious impact on my health and could force me into an emergency admission against my will."
"I don't think the standard I receive is good enough for my needs. Having better care and more time would help prevent people having to go back into residential care"
"I had support staff who abused me verbally and financially."
"It's not all about the money, it's about the passion that people need to have for their work."

What we would like to see Norwich City Council do

1. **Put conditions on planning approval so that:-**
   - New build hotels must include rooms with overhead tracking hoists and wheel in showers. *"This would also be good for the tourist trade!"*

- People already living in the area will not be unduly affected by the building work or have their health damaged.
- There are adequate facilities to support people who will live in the new estates.
- Private sector builders are required to ensure disabled people have access the community.
- Big events organisers are required to provide facilities for disabled people including designated parking, accessible toilets with overhead hoists and changing table.

2. **Build affordable housing for care and support workers** to help ease the shortage of staff in Norwich.
3. **Look again at plans for the community hospital site** and build affordable housing for outreach care workers and a short-term Re-Able centre.
4. **Provide better facilities for disabled people in Norwich** including the provision of high dependency unit mobile toilets.
5. **Provide more designated disabled parking spaces and parking for accessible vehicles** and provide accessible toilets with overhead hoists and changing table for visitors to Norwich.
6. **Norwich City Council to adopt The Care & Support Charter and mandate staff to use it.** The charter will help staff to identify people who are disproportionately affected by reorganisation and rationing policies. See https://www.norfolk.gov.uk/care-support-and-health/care-and-support/harwood-care-charter

Making it Real believes that Norwich City Council should work in partnership with people who have lived experience to improve health inequalities. We would be happy to talk to councillors about the way we work in partnership with Norfolk Adult Social Care.

Mary Fisher
On behalf of the Making it Real Board
Facebook MakingitRealNorfolk
Twitter @MakingitRealNfk