PLACE BASED NEEDS ASSESSMENT

NUNEATON CENTRAL

EMERGING THEMES, ISSUES AND RECOMMENDATIONS

Warwickshire Joint Strategic Needs Assessment 2019

Report produced by Public Health Warwickshire

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Warwickshire County Council

INTRODUCTION

Following the review of routine datasets and local intelligence/surveys of health and wellbeing needs and issues across Nuneaton Central area, four key themes were identified. These themes were then discussed in more detail to gain local stakeholder insight at an event held on 12th September 2018 and at a number of community engagement sessions throughout September and October 2018.

The four themes under discussion were:

1. Deprivation (including home ownership, child poverty, financial inclusion) and Regeneration (planning and transport)
2. Mental health and wellbeing
3. Children and young people (early years, education, young mothers)
4. Living with long term conditions – self management, CVD, COPD, support for families, presenting late, screening uptake

Stakeholder summaries, engagement event reports and a full list of stakeholder comments are available in the stakeholder report. Stakeholder engagement and surveys are a way to attempt to capture residents views on the data and to get further details on the area they live and work in to enable **solutions to be found and services to be designed collectively**. There was a request to ensure maximum engagement from stakeholders and the public in this work, continuing to seek ways to engage.

A professional and public survey was also carried out between 1st June and 16th November 2018 to capture views of those unable to attend local engagement events.

The following is a summary of the themes discussed and arising from the data and survey, This has informed the high level recommendations outlined below. A more detailed action plan will also be developed to deliver these recommendations.

GENERAL AND OTHER

ISSUES

Overall, **health and wellbeing indicators** in the area were amongst the **poorest in the County**, significantly below the Warwickshire rate and many below the England average. There was a general **consensus and recognition of the themes** identified through the data gathering exercise, but there was a feeling that this is very **negative** and there is a need to promote and present the positives. The data is also very high level and can be **impersonal.** The stakeholder engagement and surveys are a way to attempt to capture residents views of data and **find solutions and design services together**, while respecting those that don't wish to engage. There was a request to ensure maximum engagement from stakeholders and the public in this work, continuing to seek ways to engage. Rates of **domestic abuse**, while falling are still higher in the area than Nuneaton and Warwickshire as a whole.

There was discussion around the need to **highlight the inequalities in the report** between areas more clearly. For example:

- Lower school entry skills, e.g. reading, writing, speech and language
- Data around eviction, rent arrears, homelessness etc. and the effects universal credit
- Air quality and less access to green space.
- Lower level of car ownership, so local hubs are important for family support and issues - links to food banks, suicide prevention work and P.H.I.L
- Impact of children's centre closures
- Inappropriate emergency admissions high

An ongoing theme in all discussions and engagement is how we **communicate** with people who do not use the internet or digital technology, and also how we target those who are not accessing any services. Linked to this was a concern around the lack of a joined up approach to assets and services in either **communicating** the existence of services, keeping information up to date, or working together, leading to some duplication of effort. Other issues raised through consultation were around the environment – cleaner, more outdoor activities Community activities/social networks.

RECOMMENDATIONS

- Expand use of customer referral forms to support signposting and raising awareness of a range of services locally.
- Develop a single point of access to share information on services for older people using a range of formats e.g. digital, care navigators, leaflets/displays/posters, word of mouth.
- Increase support for all carers including older carers.
- Review the social prescribing offer including services that support mental wellbeing and look to expand the offer to reflect local needs.
- Consider the establishment of local worker forums to share good practice, raise awareness of issues and provide networking. E.g. local services, volunteering opportunities etc.
- Continue to monitor air quality in the area and review measures to reduce emissions from road traffic.
- Share information from the JSNA widely with partners for planning and actions.
- Seek additional information to provide evidence on concerns raised on:
    - Best start, including pregnancy loss, pre-birth education and mental health impact
    - Substance misuse
    - Prescribing (antidepressants and methadone use)
    - Employment/unemployment
    - Carers, especially those not registered or recognised
    - Suicides - linking to age, gender, aspirations
    - Hard to reach groups with multiple and complex needs, homeless, gypsy and traveller communities/transient residents, minority groups
    - 999 call out data - for correlation between hospital admissions and obesity

DEPRIVATION

ISSUES

There is long standing deprivation in the area with 3 lower super output areas (LSOAs) being in the most deprived 10% of LSOAs in England – Abbey Town Centre, Middlemarch & Swimming Pool and Hilltop. Poorer mental and physical health, unemployment, poor housing conditions and high crime rates homelessness and lower school attainment are underpinning themes.

There was recognition that some of these issues are long standing and there is a need to be able to **understand** and **measure** why there has been no change and improvement in the data related to deprivation . It was recognised that a whole family approach is required to tackle issues around deprivation. Low aspirations of young people was reported as a problem in Nuneaton Central. There was a feeling that engagement with schools by public sector organisations and parts of the community sector has declined in recent years compounding this..There is a need to understand what **prevention measures are** in place in what areas and what is working/making a difference by **benchmarking** the **effectiveness of interventions.** Also services need to be more targeted, as some prevention work isn't getting through to specific communities e.g. Gurkhas and veterans leading to gaps in focused/targeted support with these communities.

The proportion of children in **low income households** is high in many LSOAs Nuneaton Central and use of local food banks is increasing. The main reasons cited are low income and benefits delays. There has also been an increase in fuel poverty in almost half of the LSOAs in Nuneaton Central and an increase in individuals seeking support from Citizens Advice. Concern about **access to affordable housing** was highlighted, particularly a concern that there is not enough extra care housing.

There are a limited number of larger industries in the area. The majority of jobs available in the area are in the health and retail sectors and were described as **low skilled.** A perceived barrier exists to accessing larger industry and more skilled jobs. There was thought to be a particular gap in IT skills locally, for example skills in coding.

RECOMMENDATIONS

- Develop strategies to address long standing deprivation, including increasing access to employment opportunities (other than jobs that are 'low-skilled').
- Address the gap in IT skills locally and offer employability skills opportunities to bridge skill gaps e.g. learning how to code.
- Map current assets/ best practice of organisations working with young people and schools in the area.
- Review type and amount of social housing in the area to be shared with stakeholders

- Review property standards/warmth and SAP (Standard Assessment Procedure for the energy rating of dwellings) ratings for households in the area and develop a plan to improve these aspects
- Target resources to engage with hard to reach groups to understand their challenges/needs in more detail with a view to co-designing services and implementing partnership initiatives to address issues
- Adopt a more targeted support approach for vulnerable communities reflecting need identified from the engagement work, mapping initiatives and services over the last 10 years e.g. Passport to Health, #onething, Big Local and any evaluation associated with the projects.
- Plan for long term sustainability in the area.
- Promote use of green spaces, including parks, canals and outdoor groups.
- Review community safety in parks and take appropriate action to reduce crime.

MENTAL HEALTH

ISSUES

Poor mental health is a significant challenge in the area, for both young people and those in work. Keeping up-to-date with services available to improve mental health remains a challenge to organisations. In addition to statutory services, there are a number of third sector led services, such as befriending services, which can support people. CAVA have a directory of mental health services in the area.

The data and local insight suggest that **depression rates are underestimated** in the area. There is a need to be clearer on the **root causes** of depression and anxiety. There is a need to **improve identification** of patients and get the right **level of support** at the right time, particularly for individuals who don't come into contact with services. Patients often have **complex needs** and services need to be designed in a way to meet those needs, e.g. alcohol services and mental health services supporting patients with both needs.

A number of people raised concerns around ability to access **crisis support**. This includes lack of weekend provision and thresholds for support being too high. In addition, the **stigma** attached to mental health, results often in people waiting until crisis point is reached and also to **lack of awareness** and how to access **support** needed before crisis (lack of communication and gaps in crisis intervention). There was a perception that **social workers** are often unable to meet very severe needs so hospitals are then contacted, but if more support was available, there was a feeling that more crises could be avoided. Stakeholders described a **gap between first and second tier mental health services** and a large volume of low level mental health issues that won't be dealt with by current services. Another concern is the **delay between referral and treatment.** There are services that can help people waiting for an appointment e.g. MIND, but this needs to be promoted more widely to patients.

There was a discussion around the need for more **support for young people** at particular life stages, for example around **transition** between schools and from school; while services are in place for both adults and children in the area, feedback was that transition between the services is not always seamless.

RECOMMENDATIONS

- Support partners to ensure community assets and services are mapped and shared, with a mechanism to keep this information up to date. Include support/services available for young people and transition services.
- Ensure patients get the right level of support at the right time.
- Increase training and awareness raising of all mental health services, especially third sector, including Mental Health First Aid training for front line staff.Ensure mental health organisations are easy to access for all.
- Gather further local intelligence to find out the root causes of depression and anxiety (the data and local insight suggest that depression rates are underestimated).
- Improve the design of services to address complex needs e.g. alcohol services and mental health services supporting patients with both needs.
- Improve access to crisis support, weekend provision and review thresholds.
- Implement strategies to reduce stigma attached to mental health.
- Raise awareness around the importance of access to support to prevent crisis.
- Develop skills of social workers to meet severe needs to avoid hospital admissions.
- Address the gap between first and second tier mental health services.
- Reduce the delay between referral and treatment and promote services that can help people waiting for an appointment e.g. MIND .
- Provide more support for young people around transition between schools and transition between children and adult services.
- Services for frequent attenders and vulnerable people (right support, right time).
- Utilise and build on Year of Wellbeing to promote local mental health services and raise awareness of the issues around mental health.
- Improve perinatal and postnatal mental health.
- **Training** and **awareness of mental health services** could be improved including training frontline staff e.g. those in A&E and GPs around Mental Health First Aid.

CHILDREN AND YOUNG PEOPLE

ISSUES

Mental health was seen by stakeholders to be a particular challenge in the area for young people. There are **services** in the area for young people but again **signposting** is an issue. However a number of s**ervices** have been reduced or removed from the area, including Sure Start Centres and secondary care services at the hospital, which has had an impact on the community and lack of health services locally. Other issues include A&E attendance; obesity & overweight – and a tendency to increase in weight between reception and year 6; young carers; children looked after, Child protection etc.; child poverty; educational

attainment. Tra**vel** is an issue for parents of small children. Affordable **child care** remains a challenge in the area for many families. Keeping in touch with young people was identified as a challenge, there is a need to look at different **ways of engaging** with the population to make them aware of services, but also to ensure their involvement and planning and shaping of services e.g. social media.

RECOMMENDATIONS

- Gather further information on the emerging mental health concerns for children and young people.
- Address gaps left by de-commissioned services e.g. Sure Start where removal of the service had an effect on community sense of belonging.
- Review and look at strategies to address the lack of affordable childcare in the area.
- Local governments to build stronger relationships and engagement with schools.
- Review transport options for parents who are required to travel to UHCW.
- Improve signposting and information to services for young people.
- Ensure young people have access to support to ensure smooth school transition.
- Improve communication with young people e.g. through use of social media e.g. "Chat health" to reach more young people.
- Extend 'Preparing for Life Skills' for looked after children.
- Promote parenting programmes and consider including young people.
- Take forward learnings from promotion of 'Tour of Britain'.
- Promote the Daily Mile initiative in schools.
- Support the Libraries working with families to help children prepare for school.
- Undertake work to promote the benefits of volunteering for young people and source suitable opportunities for young people.
- Support and increase the number of young people who have higher aspirations.
- Improve access to psychological support e.g. waiting times, accessibility and data referrals.

LONG TERM CONDITIONS AND HEALTH

ISSUES

The proportion of patients registered with a **long term condition** is higher than in other areas, especially for diabetes, obesity and chronic kidney disease. Hypertension and smoking are also an issue. In addition, **emergency admissions to hospital are high** particularly for heart and respiratory disease. In some areas there was a perception that hospitals provided a space of safety for many, although it was possible that care needs could be met in other settings. Overall health outcomes for life expectancy and healthy life expectancy are poorer than the rest of Warwickshire and England. There was a feeling from front line staff that there is an acceptance of life as it is, with a lot of residents having low aspirations and a lack of ambition and enthusiasm to progress. In addition, **social care use** is highest in the area. Late presentation is an issue locally and s**creening** for bowel cancer is also lower than Warwickshire and national figures, however people report issues

accessing screening, including fear, pride and stigma. A theme emerging from conversations with stakeholders and the public was that information was often very clinical and needed to be simpler and clearer. It was suggested that a buddying system could help with **messages and the voluntary and community sector** have a vital role to play but the sector needs to be sustained. The proportion of patients with diagnosed dementia are higher in parts of Nuneaton Central so patients and carers need to be linked to the support available. There are a high number of carers in the area but lack of support and education for **carers** was perceived to be an issue. Transport is a barrier for people who wish to access local services.

- Review and develop clearer strategies to reduce emergency admissions, keep people out of hospital, independent and at home with quality support, including hospital discharge support.
- Review support and education offer for carers and raise awareness of the offer.
- Different models of care for the elderly need to be looked at - more innovative, cohesive, engaged.
- Review ways to promote screening programmes, including settings and ensuring information is culturally sensitive and from trusted sources.
- Increase understanding around diagnosis and the management of conditions, especially for BAME communities, including travellers.
- Extend the use of social prescribing including buddies and navigators across a range of settings.
- Provide information in a range of settings about community based (VCS) services.
- Appropriate services for younger people with long term conditions.
- Take action to ensure information is ‘accessible’ for all, including ensuring health information is presented in a non clinical way.
- Access to Physiotherapy/appropriate exercise made easier and more sustained.
- Increase signposting to Fitter Futures and widening of referral pathway.
- Address the lack of/ limited bus services - even for those living in central Nuneaton.
- More information on low cost healthy food options, including myth busting around fresh/frozen foods and costs.
- Health education needs to be tailored to local communities, out of hospitals/medical settings to be more relevant to local people.
- Ensure more is done to sustain community based providers.
- Increase information available in pharmacies, surgeries and community centres to ensure early support can be accessed for all medical conditions.
- Culturally sensitive and accurate information to be produced from trusted sources.
- Develop a central Directory of Services.
- Increase publication of Dementia Action Alliance/Dementia Friendly Communities.
- Link to locally accessible food outlets with healthy alternatives for fast-food.
- Develop a fully integrated frailty service for the North of Warwickshire. This would include arrangements to case find frail elderly patients and support the management of long term or frailty related conditions, prevent A&E attendance and admission

through step up services when urgent care issues arise, establish a front door frailty service at A&E to return people home when people require emergency care at the hospital, strengthen in-hospital frailty services to reduce length of stay when frail patients require a short hospital stay and develop a true, non-hospital based Discharge to Assess service for the population in the North of Warwickshire .

- Seek to improve same day emergency care access in the community and at the hospital, aiming to deal with a defined percentage of patients requiring urgent and emergency care without recourse to hospital admission.
- Identify three Out-patient pathways which could be delivered away from the acute hospital environment and work with Primary and Community Care colleagues to move a proportion of these patients through newly designed pathways within the next two years