



Are we sitting comfortably?

A story of health in Suffolk

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English

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Kurdish

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Farsi

اگر می خواهید هر بخشی از این سند را با فورمت دیگری داشته باشید مانند ایزی رید، چاپ درشت، بریل، صوتی – و/ یا ترجمه شده به زبان فارسی داشته باشید، لطفا با شماره 01473 770014 با ما تماس بگیرید.

Introduction

Rushbrook House, NHS Suffolk headquarters



Welcome to the 2012 annual public health report for Suffolk, Are we sitting comfortably? A story of health in Suffolk, my first as Director of Public Health in Suffolk. This report has been a real team effort, initiated by Dr Amanda Jones, Deputy Director of Public Health, with contributions from the whole team. The report is written at a time of great change in the organisations, systems and structures that deliver public health in England.

The aim of an annual public health report is to provide an independent view on the health of the population of Suffolk. This report complements the 2011-14 Joint Strategic Needs Assessment, The State of Suffolk.

This report presents information from a brand new collection of data which will form the Public Health Outcomes Framework for England. The framework was published in January 2012 and sets the context and strategic direction for the new public health system, with the vision of improving and protecting health and improving the health of the poorest fastest. The intention is that this framework refocuses the whole system around achieving positive outcomes and improving health inequalities. It looks at a wider

set of data than we have used in the past to measure public health. The indicator set is not yet complete and will be further developed during the year.

My intention in this report is to introduce the outcomes framework to you. I have used the indicators we have so far, to paint a picture of health across Suffolk and to point out areas that I believe deserve special attention.

I hope you enjoy the report and find it useful.



Tessa Lindfield
Director of Public Health,
Suffolk County Council and NHS Suffolk

Looking forward

Suffolk is a largely healthy population with ongoing improvements in life expectancy. The countywide health statistics, on the whole, compare favourably with the rest of England.

But there is no reason for complacency and there are areas where we need to make further progress.

We need to give our children a better start in life. We have 20,165 children living in poverty in our county and only around half of our babies are breastfed. Half of our children are significantly behind their peers at the start of their school life and attainment at age 11 and GCSE is also lower than it should be. Suffolk ranks 121st out of 150 local authorities for educational attainment at age 16. Education and health are closely linked, poor health and wellbeing adversely affects education and without a good education it is harder to be in control of your life and lifestyle.

As well as improving life expectancy, we also need to focus on quality of life by minimising the impact of long term illnesses and disability. Disability free life expectancy provides us with an estimate of the number of years a person is likely to live free from longstanding illness or infirmity. In 2007-09, disability free life expectancy in

Suffolk was estimated to be 62.8 years for men and 64.6 years for women. This means on average, men in Suffolk are likely to develop a long term illness or disability before they reach retirement age. However if a man reaches retirement without developing a disability, he is estimated to live a further 8.5 years in good health. Women can expect 9.7 years with no longstanding illness or infirmity.

Over the past few years we have seen a lot of work nationally and locally to help people lessen the risks they take with their health. We need to accelerate the progress we are making in helping people to live healthier lifestyles, not smoking, maintaining a healthy weight and staying active. We need to build on the work of identifying assets in our community to embed healthy lifestyles for the long term in people's lives.

Enabling older people to live independently is an important area. We have a growing population of older people in Suffolk which is predicted to continue to expand. The statistics show us that adults in Suffolk are not currently as healthy as they could be, so we need to help people make long term changes to the way they live their lives now, to keep them fit and healthy well into retirement.



**Endeavour House,
Suffolk County Council
headquarters**

Looking forward

Recommendations: our focus for the future.

The system in Suffolk should address health inequalities in all commissioning decisions through the Health and Wellbeing Board and its strategy.

In particular we should focus on:

- **Giving Suffolk children a better start in life.**
- **Addressing mental ill health.**
- **Promoting independence in old age.**
- **Embedding sustained healthy changes in people's lifestyles.**

We are still seeing unacceptable variations in health between different communities in Suffolk and work to tackle these inequalities must remain a priority across all public health outcomes. These differences are not restricted to different geographic or socioeconomic groups but also for example between ethnic groups, groups of people with disabilities or between the sexes.

We know that commissioned health services are only part of the picture when it comes to the health of a population. 2012 marks the start of the development of several new organisations in the NHS and the transition year for moving public health duties and responsibilities into local government. It also marks the birth of the Health and Wellbeing Board, a group of influential leaders from organisations across the county, tasked with driving improvements in the health of Suffolk people and facilitating the integration of health with other services.

The Health and Wellbeing Board has identified mental health as one of its priority areas for development. The public health outcomes data available in time for this report is not comprehensive and there are many gaps remaining, particularly around mental health indicators. We know mental ill health is common; between 1 in 3 and 1 in 4 of the population each year will have some sort of mental health problem (180,000 - 240,000 people in Suffolk). We also know that mental illness is disabling and a key reason for lost productivity. This is an area that will need focused work moving forward.

Our public health team has been located in Suffolk County Council since September 2011, and we see this as a real opportunity. We will continue to work closely with health service commissioners, our local authority colleagues and the voluntary and independent sector, to further positively influence the wider determinants of health and address inequalities across the county.

The Public Health Outcomes Framework

For many years we have known that your health is determined by many factors, about half from the health care services you use and about half from the opportunities you have around you to lead a healthy life. These opportunities can present themselves in all sorts of ways.

You might, for example, love dance at school or try hiking with the Girl Guides and these experiences become an inspiration for physical activity throughout your whole life.

The Marmot report, Fair Society Healthy Lives (2010) set out the agenda for public health in stark terms. The report showed the differences in health between different groups in our society, according to the level of deprivation they experience and the amount of control they have over their lives.

We are no different in Suffolk from other parts of the UK. Even in this largely affluent county, we see poorer health in poorer communities. And just as we saw in the Marmot report, these differences widen throughout life. Our children are not so different in terms of their health between different communities, but by the time

they get to school, children in more affluent areas are performing better than those from the most deprived areas.

This implies that in different communities, children and their families are not universally able to seize the opportunity to be as healthy as they could be. It also implies that we should be able to do something to change the health opportunities we have on offer across the county, to lessen the differences between our communities.

Whilst much of the Marmot report wasn't a surprise, the scale and relentless predictability of the differences between communities was humbling. Time and time again we see sloping graphs of health outcomes and determinants of health, often adversely related to deprivation.

And yet the multiple influences on health haven't always been a feature of public health policy or a feature of the measures used to evaluate public health improvements.

In 2011, this changed with the publication of the Healthy Lives, Healthy People White Paper and the accompanying Public Health Outcomes Framework (PHOF).



Improving outcomes
and supporting
transparency

Part 1: A public health outcomes framework for
England, 2013-2016

The Public Health Outcomes Framework



The scope of the outcomes framework is much broader than traditional measures of public health. Determinants of good health are included, those things that influence our ability to develop in good health and stay as healthy as we can throughout our lives, as we leave school and go to work, right through until we retire.

The PHOF has four domains, with related objectives to achieve the overall goal of increased healthy life expectancy and reduced differences in life expectancy and healthy life expectancy between communities.

All the domains vary between communities and therefore have an influence on health inequalities. Domain one is improving the wider determinants of health, those factors outside health care that affect health and wellbeing. Domain two is health improvement, where people are helped to live healthy lifestyles and make healthy choices. Domain three is health protection where the population's health is protected from major incidents, outbreaks of disease and other threats. Finally domain four is healthcare public health and preventing early deaths, where the objective is to reduce the numbers of people living with preventable ill health and/or dying young.

The White Paper and the PHOF emphasise that issues such as readiness for school and first time entrants to the youth justice system, are just as much public health issues as they are the concern of children's services and the police. Public health is clearly not just an NHS issue but one firmly embedded in the issues and services provided and influenced by local government.

The PHOF also demonstrates that the reach of the role of public health extends far beyond health services, to influence organisations and services that enable people to take control of their lives. This will require public health practitioners to join together to drive change across the system. These practitioners are likely to be a diverse group including staff groups like health visitors, leisure centre workers and probation workers.

This annual public health report aims to illustrate key indicators from the PHOF from a Suffolk point of view and to highlight particular areas of importance locally. It is an independent report of the Director of Public Health and contributes to the Suffolk Joint Strategic Needs Assessment.

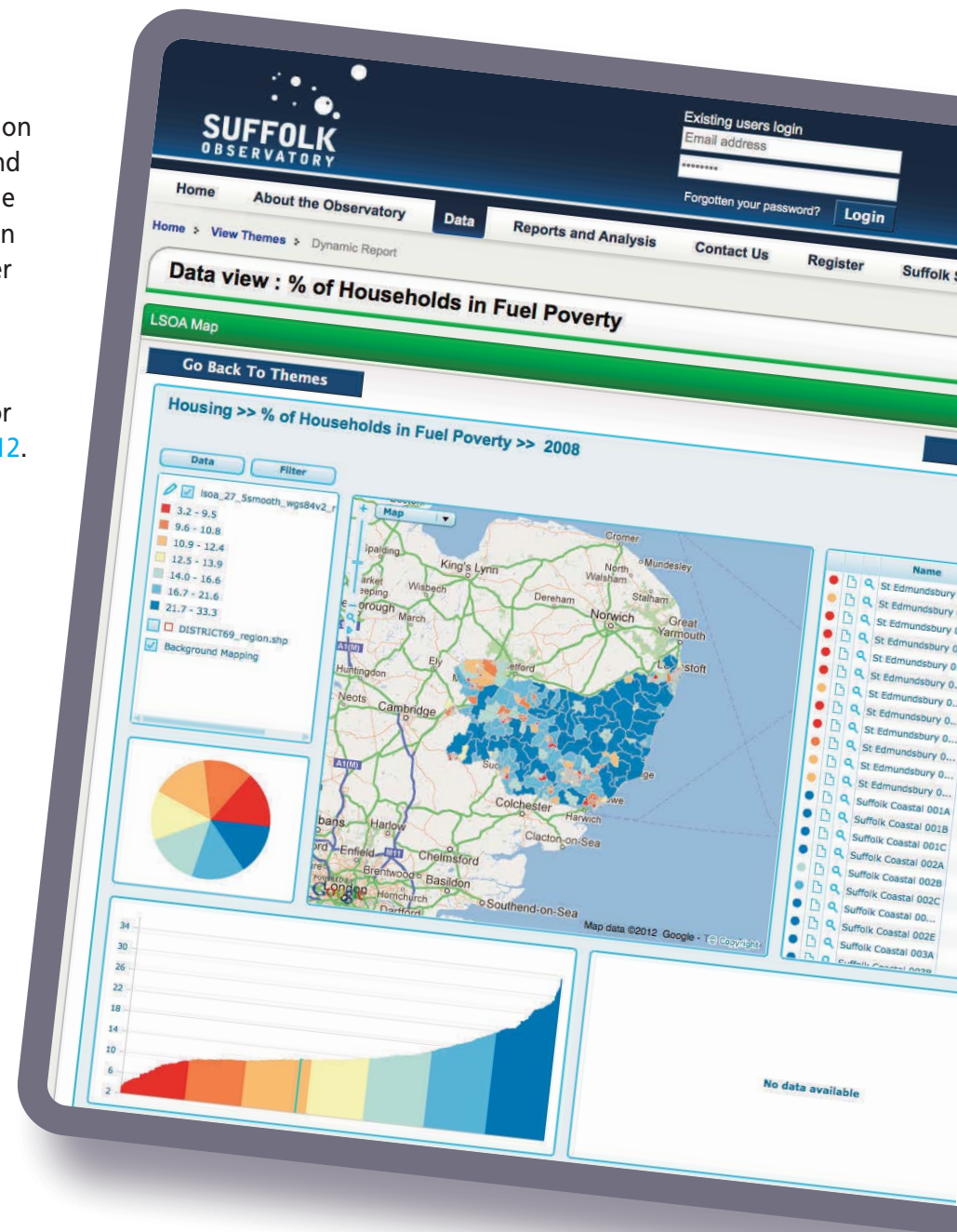
The Public Health Outcomes Framework

A key recommendation from the Marmot report was action across the life course and this report is structured in groups of indicators that range from birth through to older age.

To illustrate what these indicators might mean in everyday life, we have created a fictional family. They may seem like a caricature at times but they serve purely to try and bring the public health outcomes in the report to life. We have also included case studies of real people from across Suffolk to demonstrate some of the positive work already going on across the county.

We have made every effort to keep this report succinct and to the point. We have focused on a selection of outcomes and noted those that we need to investigate further. A summary table of results for Suffolk and how they compare to the England averages, is in Appendix one.

Each outcome has its own section which explains the indicator and what the data tells us about the situation and any inequalities in Suffolk. More details and fuller profiles for each indicator are available on the Suffolk Observatory website at www.suffolkobservatory.info or at www.suffolk.nhs.uk/aphr2012.



Introducing the Whittakers of Suffolk Street

Suffolk Street is in Ipswich. It was built in the 1970s and is made up of terraced and semi-detached houses, some of which are divided into flats.

Originally the houses were owned by the council but most of them were bought out by their owners in the 1980s. Now some people live in their own homes and some rent from private landlords or housing associations.

11
Suffolk Street

Maureen and Derek Whittaker have lived at number 11 for years and know everyone in the street. They love living there.

Maureen is a care assistant in a residential home for older people and Derek has his own business as a delivery driver. They have two young children; Jamie aged 3 and a half who goes to nursery and Hannah who is 6 and at primary school.

Derek has a 17 year old daughter, Jessica from a previous relationship, who has just left sixth form, because she has found out she's pregnant.

Maureen and Derek are both Suffolk born and bred. Maureen comes from near Bury St Edmunds which is where her parents, Elsie and Ted, still live. Maureen's brother Mike lives around the corner with a couple of friends.



Children

Derek and Maureen Whittaker have three children between them. The children are growing up fast but to Maureen and Derek it seems like yesterday that they were babies.

Maureen really wanted to breastfeed her two children because she knew it would be better for them and her own health if she did, but she didn't ever manage to get going with it. She started off OK in the hospital but was sent home soon after her babies were born, and she found it really hard to know what to do once she was on her own at home. Now her step daughter is expecting, she is keen to do everything she can to help Jessica feel confident about feeding her new baby when it arrives.

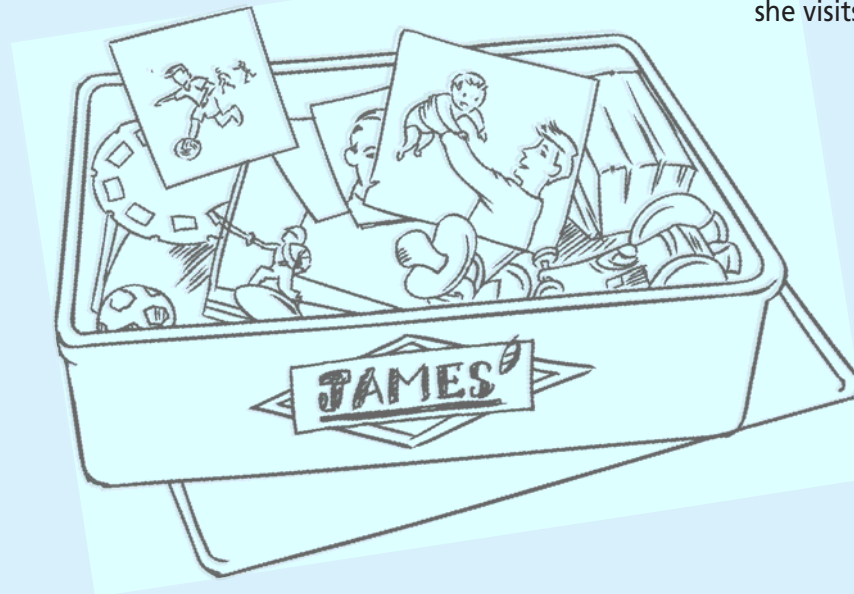
Maureen's story is all too common in Suffolk, but now new mothers are being supported by breastfeeding peer supporters while they are in hospital and at home. The peer supporters are women who have breastfed their babies themselves and offer practical advice on how to start and keep going with breastfeeding until new mothers are confident and happy to continue on their own.

Maureen worked part-time when her kids were small, she made sure she read all the information about health for the children that came her way. Her health visitor had really stressed the importance of the childhood immunisations and Maureen made sure she kept these appointments to get all the injections done. She remembered when she was little, how horrible measles and mumps were and she didn't want her children to go through the same experience.

Jamie wasn't very sociable as a youngster and his older sister hardly gave him a chance to say anything, so Maureen joined the toddler group at

her local Children's Centre. They gave her some play tips for Jamie and recommended the reading game at the local library. She was amazed at how well he came on.

Hannah has been referred to a local weight management service called Alive 'n' Kicking to help her slim down after she was weighed at school. The whole family has benefited from Alive 'n' Kicking, eating better and becoming more active. Derek is even finding his diabetes is easier to control since he has been taking regular exercise with the children. Because she doesn't drink fizzy drinks any more Hannah is really hoping she won't need another filling next time she visits the dentist.



Low birth weight of term babies

Key messages:

- Low birth weight is associated with a greatly increased risk of death in the first year of life as well as serious illness and lifelong disability.
- Low birth weight is known to be influenced by a number of factors including mother's age, inadequate maternal weight gain during pregnancy, lifestyle issues like poor nutrition, smoking, substance misuse, general wellbeing and socioeconomic factors such as low income and lack of education.

:: Definition

Low birth weight rate is calculated as a percentage of all live births at term with low birth weight less than 2,500g at birth.

:: Why is this important?

Low birth weight in children is likely to result in poorer health outcomes for the child; a healthy birth weight is key to promoting a good start in life. This indicator is therefore in line with the Government's direction for public health on starting well through early intervention and prevention.

:: What does the data tell us about Suffolk?

Between 2006 and 2010, 6.4% of babies born in Suffolk were of low birth weight. This means that about one out of every 15 babies

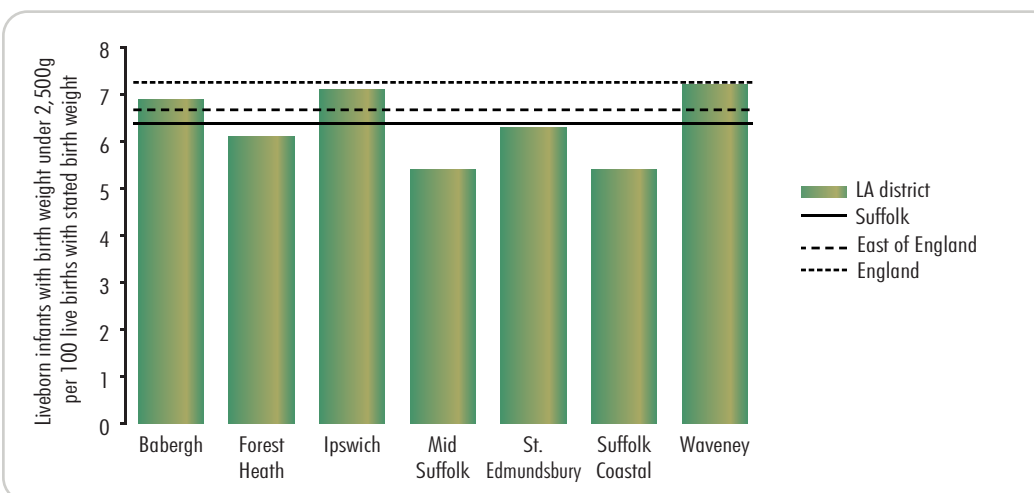
born alive weighed less than 2,500g. This was lower than the regional (6.7%) and the national average (7.2%). Ipswich and Waveney had higher rates compared to other districts in Suffolk.

:: Inequalities

Nationally there is a high degree of inequality in low birth weight according to social class, area deprivation and lone mother status:

- Disadvantaged families are more likely to have low birth weight babies.
- Unemployed parents are twice as likely to have low birth weight babies compared to those with higher professional status.
- Teenage and unmarried mothers have a significantly increased risk of having a low birth weight baby.

Low birth weight rates for live births: live births to residents of local authority districts in Suffolk, pooled data from 2006-10.
Source: Office of National Statistics



Infant mortality

:: Definition

The infant mortality rate is defined as the number of deaths under the age of one year per 1,000 live births.

:: Why is this important?

This indicator reinforces the Government's direction for public health on starting well and early intervention. Infant mortality is an indication of the overall health of infants and a reflection of the population's access to health services and the influence of the wider determinants of health.

:: What does the data tell us about Suffolk?

The rolling 3 year average mortality rates in Suffolk have been well below the England average between 2002-2010. Compared with the regional rate, Suffolk rates have fluctuated during this period, but over the 9 years have been stable.

As infant deaths involve such small numbers it is expected that there will be some fluctuation; none of the differences on the chart below are statistically significant so no real inference should be drawn from it.

In 2008 -10 the infant mortality rate in Suffolk was 4 deaths per 1,000 live births, which is similar to the regional (4.0) and national (4.6) averages. This is equivalent to approximately 32 deaths each year.

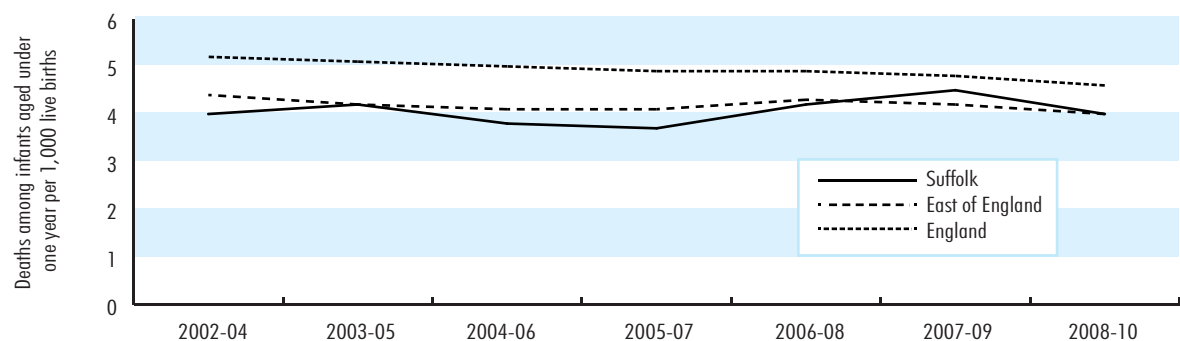
:: Inequalities

District level data does not show a clear relationship between deprivation and the rate of infant mortality in Suffolk. However, evidence suggests babies of mothers born in Pakistan, the Caribbean, aged under 20 years and who were the sole registrant of their baby's birth, have a higher risk of infant mortality.

Key messages:

The evidence suggests that these measures are important to tackle the main causes of infant mortality:

- Preventing immaturity related conditions and preterm births where possible, including effective screening during the antenatal and neonatal period.
- Preventing sudden unexpected deaths in infancy.
- Reducing the number of teenage pregnancies and giving support to teenage mothers.



Trend in infant mortality rate in Suffolk: deaths among infants under one year per 1,000 live births

Source: Office for National Statistics

Breastfeeding

case study

Breastfeeding Network Peer Support Programme in Suffolk

The Breastfeeding Network (BfN) Peer Support Programme in Suffolk began in September 2007. The Primary Care Trust has continued to fund the registration, co-ordination and supervision of BfN peers since 2011 and individual Children's Centres have funded the training of helpers.

The BfN programme is accredited through the Open College Network; helpers abide by a Code of Conduct and attend regular supervision to maintain quality and their registration.

Currently there are 80 peers in Suffolk. They run 31 groups in west and south Suffolk, largely in Children's Centres. Peers volunteer in a number of settings; at antenatal clinics, health visitor weighing clinics, breastfeeding workshops and antenatal workshops, as well as breastfeeding drop ins. In addition, since October last year, volunteers visit both Ipswich and West Suffolk hospitals on a daily basis to support mums on the postnatal wards and, where appropriate, the special care baby unit and the antenatal ward.

As well as helpers, 19 breastfeeding supporters have completed additional training, including a written portfolio which is externally assessed. Once qualified, supporters can volunteer on the national breastfeeding helpline and can visit mums at home to give extra help.



:: Case Study Laura Cresswell

Laura says "Peer support helped to empower me to make my own decision about continuing to breastfeed my baby when there was lots of pressure to introduce formula with both my babies. This contact has changed my life as I now have much more confidence in myself and have trained as a BfN breastfeeding helper to help other mums like they helped me... "

Laura with Amelia & Imogen

Breastfeeding

:: Definition

- Number of women who initiate breastfeeding in the first 48 hours after delivery.
- Number of infants who are totally or partially breastfed at 6-8 week check.

:: Why is this important?

Increases in breastfeeding initiation and prevalence are expected to reduce illness in young children which will in turn reduce hospital admissions for infants aged under one year. In the longer term infants who are not breastfed are more likely to become obese in later childhood, develop type 2 diabetes and tend to have slightly higher levels of blood pressure and blood cholesterol in adulthood.

:: What does the data tell us about Suffolk?

In 2009-10, 72.1% of mothers in Suffolk initiated breastfeeding, which was lower than the East of England (73.8%) and the overall England figure (73.6%). Breastfeeding initiation is similar across all local authority districts, except Waveney, which has a much lower level of 62.8%.

Data on breastfeeding prevalence at the 6-8 week check shows that in the first quarter of 2011-12, little over half (52%) of all infants in Suffolk were (totally or partially) breastfed. This prevalence was higher than the regional (47.7%) and the national figure of 49.1%.

:: Inequalities

There is no data available to determine any inequalities in breastfeeding initiation at local level. Evidence shows that in the UK, 76% of women start breastfeeding, but for mothers under age 20, it is just 51%. Socioeconomic inequalities in breastfeeding also exist; mothers classified in higher occupations are much more likely to breastfeed than mothers classified in lower occupations and in lower socioeconomic groups.



Key messages:

- A decision to breastfeed, especially for the first six months of a baby's life, can have a very positive impact on the baby's health and development.
- Breastfeeding is important also in the longer term, conferring health benefits during childhood and into adulthood. Infants who are not breastfed are more likely to become obese in later childhood, develop type 2 diabetes and have slightly higher levels of blood pressure and blood cholesterol in adulthood.
- Breastfeeding provides health benefits for mothers too. It can reduce the risk of ovarian cancer, breast cancer and weak bones later in life.

Population vaccination coverage

Key messages:

- Measles Mumps and Rubella (German Measles) used to be common diseases in the UK causing death and disability on a significant scale. The introduction of vaccination led to a significant decline in both deaths and disability, but these diseases could return if vaccination rates fall too far.
- Following the MMR scare in the late 1990s, uptake rates for both the first MMR and second MMR vaccinations fell markedly. This was particularly true for the second vaccination, which is given when the child is about 3 years 4 months of age. In 2007-08 uptake for this vaccination was just 71% but, as confidence in the vaccine has returned, the number of children being vaccinated has increased and uptake for the second vaccination reached 87.3% in the year to 31 March 2012.

:: Definition

This indicator has several parts and includes data on coverage of the vaccines given as part of the national immunisation programme in England.

:: Why is this important?

Vaccination coverage is the best indicator of the level of protection a population will have against vaccine preventable communicable diseases. Coverage is closely correlated with levels of disease. Monitoring coverage identifies possible drops in immunity before levels of disease rise.

Measles, Mumps and Rubella (MMR) vaccination coverage

:: What does the data tell us about Suffolk?

Children receive two doses of MMR vaccine – the first when they are about 12-13 months old and the second at about 3 years and 4 months.

There has been a steady increase over the last few years in the proportion of children receiving both doses of the MMR vaccination.

Some 93.4% of children received the first dose in the year ending 31 March 2012. This is the highest percentage ever recorded in Suffolk, but still a little short of the 95% uptake level recommended by the World Health Organisation (WHO).

Uptake for the second dose has also been increasing steadily, but at 87.3% in the year to 31 March 2012, is still some way short of WHO's 95% target.

:: Inequalities

There is no significant difference between the proportion of children receiving these vaccinations in the different Suffolk districts/boroughs, nor is there a significant relationship between the proportion of children receiving the vaccine and the level of deprivation.

Population vaccination coverage

Diphtheria, Tetanus, Pertussis and Polio (DTPP) vaccination coverage

Children receive three doses of vaccination against Diphtheria, whooping cough (Pertussis), Polio and Tetanus in the first year of life. These are known as the primary vaccinations. At about age 3 years 4 months they receive an additional booster dose of vaccination against all four diseases.

:: What does the data tell us about Suffolk?

Uptake for the primary course of vaccinations has risen in recent years and is now above the WHO recommended level of 95% when measured at both one and two years of age.

Uptake for the booster dose (given at 3 years 4 months and measured at age 5) has also risen steadily, but in the year to 31 March 2012 was 88.5%, still short of the WHO target of 95%.

:: Inequalities

There is no significant difference between the proportion of children receiving these vaccinations in the different Suffolk districts/boroughs, nor is there a significant relationship between the proportion of children receiving the vaccine and the level of deprivation.



Key messages:

- Diphtheria, Tetanus, Polio and Pertussis (whooping cough) used to be common diseases causing significant levels of both death and disability. For example, up to 8,000 cases a year of paralytic polio were reported in the UK in the early 1950s, prior to the introduction of the polio vaccine.
- Three primary doses of the DTPP vaccine are given in the first 6 months of life and over 95% of babies born in Suffolk now receive these vaccinations by the time they are a year old. This level of uptake exceeds the 95% level set by the World Health Organisation as being necessary to avoid outbreaks of the diseases.
- Uptake for the booster dose of the vaccination – given at 3 years 4 months and measured at 5 years of age – is lower than the WHO 95% target but at 88.5% in the year to 31 March 2012, was the highest it has ever been.

School Readiness: foundation stage 1

Key messages:

- Only 52% of five year olds in Suffolk are assessed as achieving a good level of development by the end of Reception Year, often described as being school ready, meaning that half of children are significantly behind their peers and start school life with more ground to make up.
- Supporting positive social and emotional development of babies and infants through access to high-quality early learning, childcare and play opportunities also lays the foundation for developing essential communication skills which underpin learning. Children's Centres need to make a clear evidenced contribution to improving school readiness and in the early identification and intervention of additional needs including behavioural problems, especially for children vulnerable to poor attainment as a consequence of their socioeconomic circumstances and/or poorer parenting skills.

:: Definition

The definition for this indicator is still to be confirmed but will be based on the new Early Years Foundation Stage Profile (EYFSP) being developed for the academic year 2012-13.

A good level of development is defined as pupils scoring six points or more across all seven assessment scales of Personal, Social and Emotional Development and Communication,

Language and Literacy areas of learning in the EYFSP and scoring 78 or more points across all scales of the EYFSP (Neighbourhood Statistics 2012).

:: Why is this important?

Development in the early years is important for children to get the most from their education.

:: What does the data tell us about Suffolk?

Early Years Foundation Stage Profile: Pupils achieving a good level of development (residents of local authority districts in Suffolk: academic year 2010-11). Source: Neighbourhood Statistics 2012

Area	Pupils eligible for EYFSP assessment	Percentage of pupils achieving a good level of development	95% confidence interval		Compared to Suffolk percentage	Compared to East of England percentage	Compared to England percentage
			Lower limit	Upper limit			
Babergh	835	59%	56%	62%	Higher	Higher	Similar
Forest Heath	566	59%	56%	62%	Higher	Higher	Similar
Ipswich	1,647	43%	41%	45%	Lower	Lower	Lower
Mid Suffolk	974	58%	55%	61%	Higher	Similar	Similar
St. Edmundsbury	1,118	55%	52%	58%	Higher	Similar	Lower
Suffolk Coastal	1,206	52%	49%	55%	Similar	Lower	Lower
Waveney	1,115	48%	45%	51%	Lower	Lower	Lower
Suffolk	7,461	52%	49%	55%	–	Lower	Lower
East of England	65,331	56%	56%	56%	–	–	–
England	596,794	59%	59%	59%	–	–	–

School Readiness: foundation stage 1

In the academic year 2010-11 Babergh, Forest Heath and Mid Suffolk districts had higher percentages of pupils achieving a good level of development than the county as a whole. Ipswich had a lower percentage and the other districts had similar percentages to the county as a whole. However, in comparison to England, apart from Babergh and Forest Heath, all districts

had a lower level of pupils achieving a good level of development, with Ipswich significantly lower than Suffolk, the East of England and England.

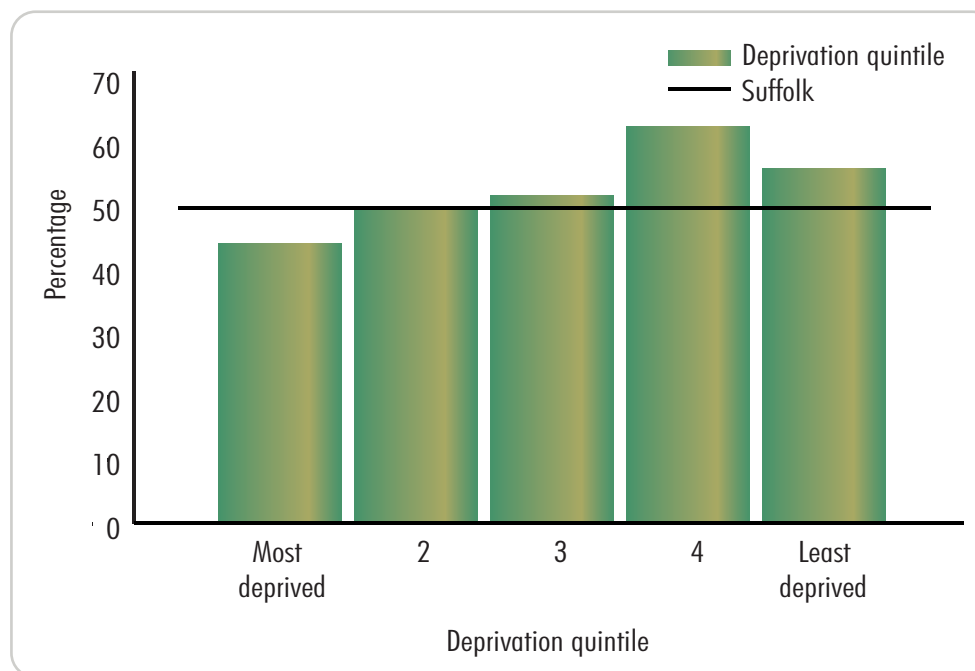
There are also gender differences. In the academic year 2010-11 a total of 61% of girls in Suffolk achieved a good level of development compared to only 44% of boys.

Key messages (cont):

- Good quality childcare for pre-school children promotes social, emotional and mental development as well as providing support for working parents. All three and four year olds, and some economically disadvantaged two year olds, are entitled to 15 hours early learning and childcare paid for by the government. This will be offered to all eligible two year olds from September 2013.

Proportion of pupils achieving a good level of development in Suffolk at age 5 by deprivation (Index of Multiple Deprivation 2010): Early Years Foundation Stage Profile (2009-10)

Source:
Neighbourhood Statistics



:: Inequalities

The proportion of children achieving a good level of development in Suffolk at age 5 is higher in more affluent areas compared to the most deprived.



Children in poverty

case study

Children's Centres

All services offered from Suffolk's 48 Children's Centres are free to families. Children's Centres provide family support to vulnerable families, including those in, or at risk of, poverty.

Side-by-side funding is available from Children's Centres to support families through short-term crises. It is most often used to purchase childcare or to provide transport to Children's Centre activities, meetings with professionals or hospital appointments. A number of Children's Centres commission Financial Inclusion Officers (FIO), all of whom are registered Money Advisers. Where FIOs are not commissioned, Children's Centre staff access Suffolk County Council's Welfare Rights service.

Children's Centres also provide adult learning opportunities, which prepare people for employment. Locally, Children's Centres have developed partnerships with the voluntary and community sector, enabling them to be conduits for families to access food parcels and other means of support.



Children in poverty

:: Definition

At a national level this indicator is defined as the percentage of children in relative poverty (living in households where income is less than 60% of median household income before housing costs).

For local authority level data, the definition is slightly different, providing an approximation of the relative child poverty measure: the percentage of children living in families in receipt of out of work benefits or tax credits where their reported income is less than 60% of median income.

:: Why is this important?

Child poverty is an important public health issue. There is evidence that child poverty leads to premature mortality and poorer health later in life. In the long term, reducing child poverty should improve adult health outcomes and increase healthy life expectancy.

:: What does the data tell us about Suffolk?

The proportion of children in Suffolk living in poverty (2009) was estimated to be 15.4% or 22,165 children. Although this was lower than the East of England (16.9%) and England (21.3%) average, this means that there are 1 in 6 children in Suffolk living in poverty. In both Waveney (21.7%) and Ipswich (22.1%), the proportion of children experiencing poverty was higher than in Suffolk, the East of England and England.

:: Inequalities

Compared to children in more affluent areas, children from the most deprived areas are:

- 4.5 times more likely to be absent from their lessons.
- More likely to be in the lowest 20% achievers at the end of the Early Years Foundation Stage.
- Performing 70% lower at GCSE level (at age 16).
- A third more likely to be obese.
- Three times more likely to be a teenage parent.

Number and proportion of children in Suffolk living in relative poverty (2009).

Source: Neighbourhood Statistics 2012

Key messages:

- Adverse outcomes arising from living in poverty can include higher rates of fatal accidents, poor dental health, child mortality, low educational attainment, low birth weight, childhood obesity, school exclusions, infant mortality, teenage pregnancy, substance misuse, and mental ill health.
- Although child poverty is a different concept to wellbeing, poverty influences each aspect of wellbeing and is a major impediment to delivering better wellbeing.

Area	No. of children living in poverty	% of children living in poverty	Compared to Suffolk average	Compared to EOE average	Compared to England average
Babergh	2,350	13.0%	Lower	Lower	Lower
Forest Heath	1,455	15.4%	Similar	Lower	Lower
Ipswich	6,285	22.1%	Higher	Higher	Higher
Mid Suffolk	2,040	10.2%	Lower	Lower	Lower
St Edmundsbury	2,580	11.6%	Lower	Lower	Lower
Suffolk Coastal	2,755	11.2%	Lower	Lower	Lower
Waveney	5,150	21.7%	Higher	Higher	Similar
Suffolk	22,615	15.4%	–	Lower	Lower
East of England	212,645	16.9%	–	–	–
England	2,429,305	21.3%	–	–	–

Excess weight in 4-5 and 10-11 year olds

Key messages:

- Obesity is preventable and reversible. Continued action is necessary to reduce the number of children and their families carrying excess weight in Suffolk.
- Obesity is a common condition, which is a risk factor for chronic diseases such as diabetes, coronary heart disease, stroke, hypertension, osteoarthritis and certain forms of cancer. Childhood obesity is a particular concern and it is widely accepted that there is a link between childhood obesity and illness and early death in later life.
- Children from more deprived areas are more likely to carry excess weight and are therefore more prone to the accompanying health risks.

Prevalence of overweight or obese children by age and deprivation (Index of Multiple Deprivation 2010) in Suffolk: children in reception year and year 6 measured between 2007-08 and 2009-10

Source: National Child Measurement Programme

:: Definition

This indicator tells us the number of primary school age children in Reception (aged 4-5) and in Year 6 (aged 10-11) with valid height and weight recorded (in a particular school) who are classified as overweight or obese.

:: Why is this important?

Excess weight in childhood often leads to excess weight in adulthood and this is recognised as a major determinant of premature mortality and avoidable ill health.

:: What does the data tell us about Suffolk?

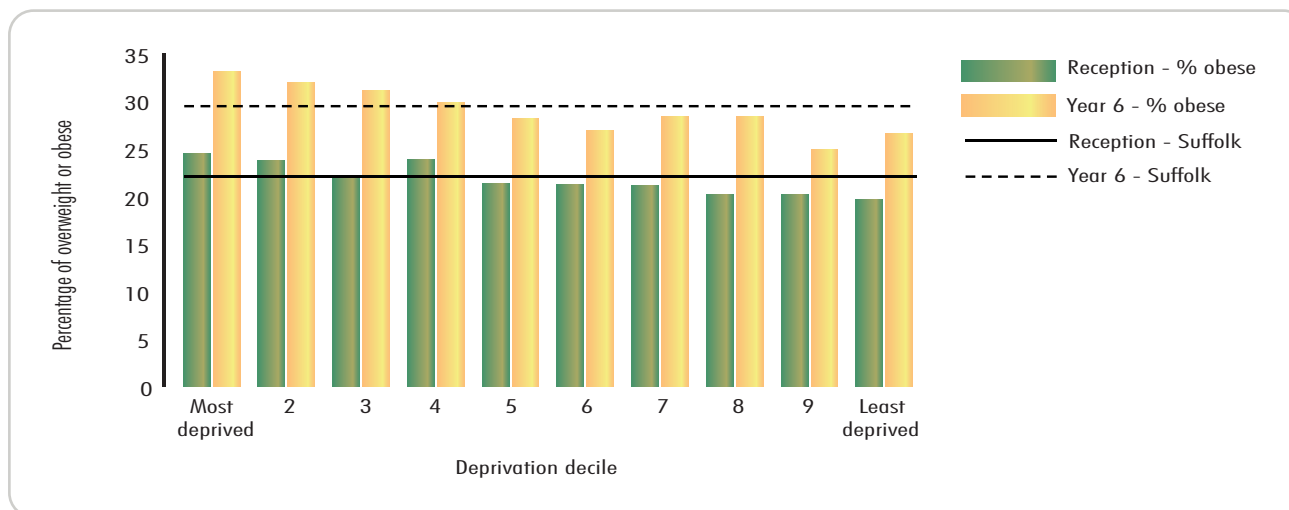
Over the last five years the prevalence of overweight and obese 5 to 6 year olds in Suffolk fell from 23.5% to 22.1%, whereas a slight

increase was observed for the older age group during the same period, from 29.7% to 31.7%. This increase reflects the East of England and England rate.

:: Inequalities

Those children living in the most deprived parts of Suffolk were more likely to be overweight or obese compared with those living in the least deprived areas. This difference is more marked in the year 6 children than the younger age group.

National evidence suggests that children who have a limiting illness are more likely to be obese or overweight, particularly if they also have a learning disability.



Excess weight in 4-5 and 10-11 year olds

Alive 'n' Kicking



Becky and Toni, a mother and daughter team, completed an Alive 'n' Kicking 12 week programme and have both seen changes in their weight and Body Mass Index. They have had some giggles along the way, reduced their portion sizes and the amount of snacks available and kick started their own activity levels in the session and at home. Both of them are feeling more energetic and more positive about life in general and mum has lost a tremendous 10 kgs in 12 weeks. Becky says "I feel a lot more confident and since losing the weight I have a lot more energy."

Hannah, like many other young people, was on the receiving end of some bullying in school and had found comfort in food for some time. Hannah gained support and motivation from the Alive 'n' Kicking team, other group members and of course her family. Hannah has seen improvements in her weight, she has improved her choices around food, she has completed the Sportivate six week gym programme and she is now looking amazing and feeling much better about herself. She is a real role model for other young people who have experienced negativity from others.

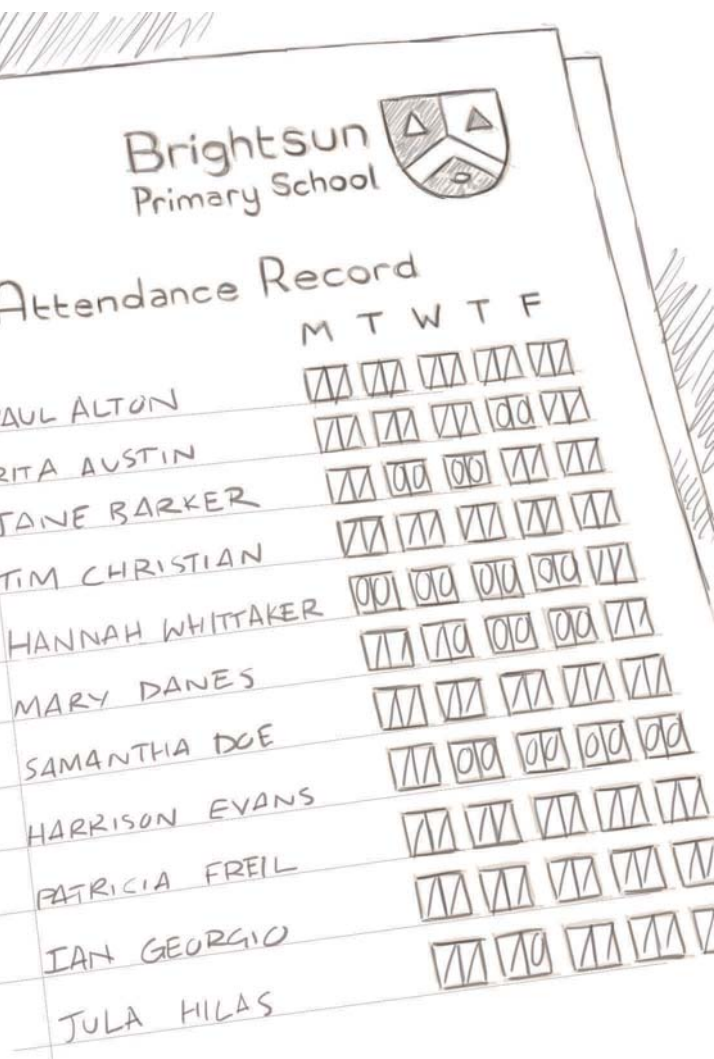


Sarah, mum of Jacob, a 6 year old boy, approached the Alive 'n' Kicking team for help after being advised by the school nurse that he was overweight and needed to kick start a more healthy future, and that is exactly what they have done.

All credit to mum who has stuck to the goals she set with the team. Although she says "It hasn't been easy, it was important to keep Jacob motivated and excited throughout the programme and not to overwhelm him." She has supported and guided Jacob and he has lost 1 st and 2 lbs (and reduced his BMI by 5). He has gone from being classed as very overweight to being in the healthy range within 24 weeks, which is outstanding.

case studies

Pupil absence



:: Definition

Percentage of half days missed by pupils due to overall absence (including authorised and unauthorised absence). Based on state funded primary and secondary schools (including maintained primary and secondary schools, city technical colleges and academies) and special schools.

:: Why is this important?

Improving pupil absence is seen as a crucial action to help every child reach their potential

and increase social mobility. Poor attendance is closely correlated with young people not in education, employment or training at age 16-18 years (NEET).

:: What does the data tell us about Suffolk?

In 2009-10 both the authorised and unauthorised rate of absence from Suffolk schools was 5.8%. This was lower than the East of England (5.9%) and England (6.0%) rate.

Number and proportion of children in Suffolk with authorised and unauthorised absence from school (2009-10).

Area	Overall absence Possible	Pupil sessions in all schools	% of overall absence	Compared to Suffolk average	Compared to EOE average	Compared to England average
Babergh	163,731	3,049,000	5.4%	Lower	Lower	Lower
Forest Heath	97,437	1,564,000	6.2%	Higher	Higher	Higher
Ipswich	290,904	4,692,000	6.2%	Higher	Higher	Higher
Mid Suffolk	185,308	3,438,000	5.4%	Lower	Lower	Lower
St Edmundsbury	212,816	3,760,000	5.7%	Lower	Lower	Lower
Suffolk Coastal	232,651	4,261,000	5.5%	Lower	Lower	Lower
Waveney	265,752	4,133,000	6.4%	Higher	Higher	Higher
Suffolk	1,448,599	24,897,000	5.8%	–	Lower	Lower
East of England	12,448,635	210,281,000	5.9%	–	–	–
England	114,025,113	1,887,833,000	6.0%	–	–	–

Source: Neighbourhood Statistics 2012

Pupil absence

The level of absence in Suffolk varied by local authority district and borough with a higher proportion of absent children in Forest Heath (6.2%), Ipswich (6.2%) and Waveney (6.4%) compared to Suffolk, the East of England and England. The rates of absence in Babergh, Mid Suffolk, Suffolk Coastal and St Edmundsbury

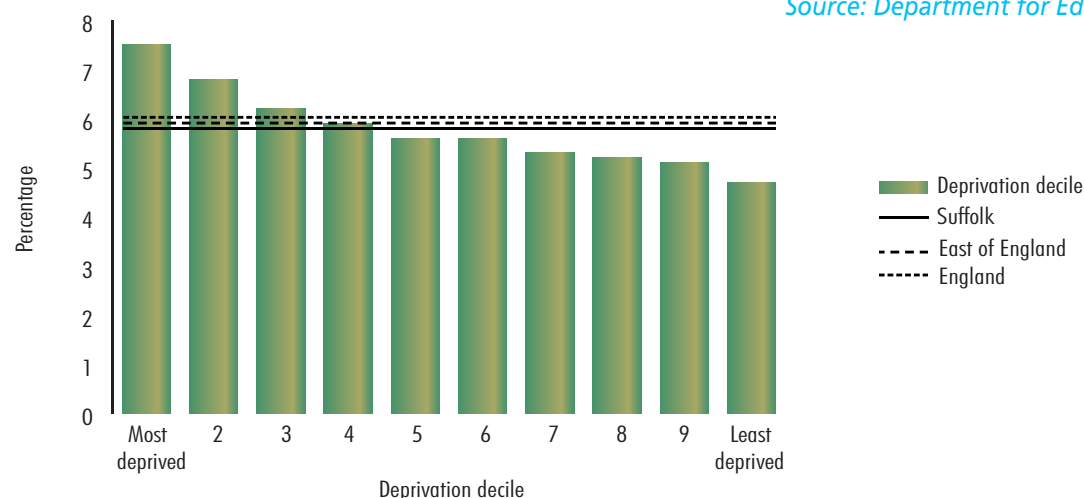
were lower than the Suffolk, the East of England and England rate.

:: Inequalities

There were clear inequalities in the rate of absence between deprivation groups in Suffolk.

Percentage of half days missed by pupils due to absence (including authorised and unauthorised absence) in Suffolk schools by deprivation decile (IMD 2010): absences during 2009-10.

Source: Department for Education



Those living in the most deprived areas experienced higher levels of absence compared to Suffolk, the East of England and England. The majority of areas (two thirds of the county)

experienced lower levels of absence compared to Suffolk, the East of England and England. There is a 60% difference in the absence rate between the most and least deprived areas.

Key messages:

- Poor attendance at school can be a cause or an effect of poor health and early identification and intervention are important for the individual, as is a whole school strategy.
- There are clear links between poor school attendance and children living in poverty, educational attainment, and later becoming NEET (16 to 18 year olds not in education, employment or training).
- Young carers are a particular group who can struggle with school attendance and may also suffer poorer health and social outcomes than their peers, as a consequence of their caring role and/or poor school attendance.

Pupil absence

case study

“Team around the child”

Keiran is a year 10 pupil at a Lowestoft High School who resides with his widowed mum and elder sister. An assessment was completed with Keiran because of his poor school attendance, uncovering difficulties with his behaviour at home and concerns over his possible cannabis use.

A “Team around the Child” with Keiran, mum, the school and an Education Welfare Officer was formed. The “Team Around the Child” meetings enabled Keiran and his mum to really talk about the issues.

Keiran was able to talk about the fact he missed having a male in the family and acknowledge that his cannabis use was daily and getting heavier. He also was able to talk about particular subjects that he was finding difficult. We were able to talk about how his behaviour was being affected by his drug use, lack of sleep, mum’s struggle to set boundaries and how all of this was impacting on his school attendance.

Mum described how, due to a low income, she needed to obtain work. However as Keiran often wasn’t attending school she felt she couldn’t work as she couldn’t trust him going into school.

As a result Keiran was referred to the Boys2Men project to provide him with a male mentor. He was referred to the Matthew Project, a young people’s substance misuse service commissioned by the Drug and Alcohol Action Team (DAAT), to tackle his cannabis use and the school has assisted in sorting out Keiran’s education concerns.

Keiran is now attending school every day. School is working with Keiran to maintain his attendance and to improve his attainment levels. Keiran has reduced his cannabis use, thus improving his sleeping pattern and behaviour. He knows how he can get support from youth services should he need it again in the future. Keiran attending school has given mum the confidence to go and get a part-time job thus relieving some money worries and letting her have her own time.



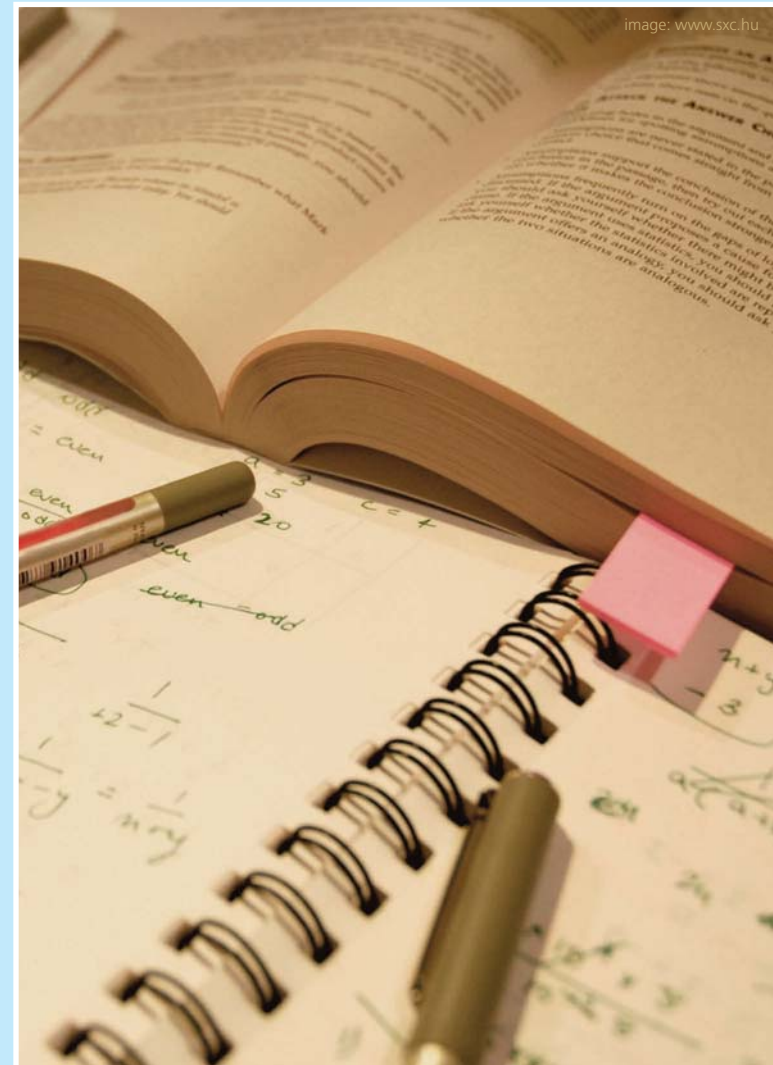
Raising the bar

Nationally, Suffolk is ranked 121st out of 150 local authorities for educational attainment at age 16. The county is in the bottom quartile when compared with our statistical neighbours, and performs comparatively amongst the lowest at age 11.

Given that Suffolk is relatively affluent, these results are unacceptable. Raising the Bar is a joined-up response to tackle this issue – it is about raising attainment and aspiration across the whole age range from early years to further education in Suffolk. It is also about linking the jobs on offer in Suffolk with the skills needed by improving connections between employers and schools and colleges in Suffolk. It was launched at a conference attended by education, business and community leaders at Trinity Park on Thursday 14 June 2012.

Work under the 'Raising the Bar' banner will focus in four areas:

1. The further development of a new relationship between all schools - maintained, academies or free schools – and Suffolk County Council;
2. The completion of the Schools Organisation Review programme that is moving to a two-tier school system across Suffolk;
3. For attainment and the achievement of children and young people to become a real, lived priority for Suffolk. We will be looking for members of the Suffolk community to become champions for attainment in Suffolk schools as Governors and mentors.
4. To raise aspiration across Suffolk, increasing collaboration between employers and the wider educational community.



feature

Tooth decay in children aged five

Key messages:

- Oral health, general health and wellbeing are causes and effects of each other.
- Dental decay is a preventable disease, however there is evidence that dental disease levels nationally may be increasing amongst 5 year olds.
- Good oral hygiene and healthy dietary habits should be established as early as infancy and continued throughout life. Fluoride varnish is recommended by the Department of Health as a safe and effective form of protection against tooth decay for all children that is very simple to apply. This treatment is provided on the NHS completely free of charge and is applied a few times a year.

:: Definition

Rate of tooth decay in children aged five years (based on the mean number of teeth per child sampled which were either actively decayed, missing, had been filled or extracted – dmft).

:: Why is this important?

Tooth decay is usually preventable but significant levels remain (31% of children in England) resulting in pain, the need for treatment, and in some cases, general anaesthetic. Oral health initiatives can be very effective in reducing tooth decay.

:: What does the data tell us about Suffolk?

- The measure of the extent of tooth decay

that has entered into the second layer (dentine) of the tooth – the first layer being the enamel – is known as d3mft. This is a measure of dentinally decayed, missing or filled teeth.

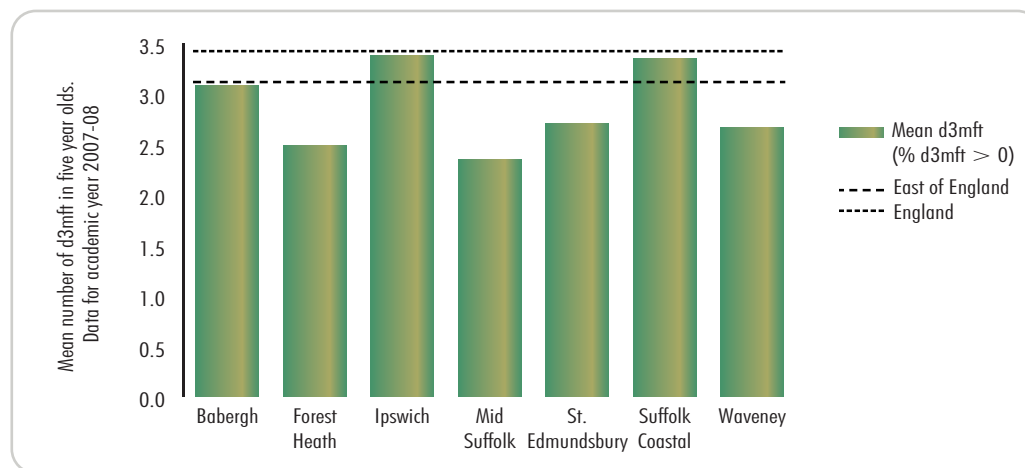
- The national picture shows an average of 3.45 teeth affected per 5 year old child.
- The picture in Suffolk is largely similar to the England average except in Forest Heath and Mid Suffolk, where children have less dental decay.

:: Inequalities

Evidence from across the country shows that children in more deprived areas use dental services less and have more decay.

Average number of 5 years olds with teeth that were decayed, missing or had been filled or extracted

*Source:
The NHS Dental Epidemiology Programme for England*



Hospital admissions caused by unintentional and deliberate injuries in under 18s

:: Definition

Crude rate of hospital emergency admissions caused by unintentional and deliberate injuries in age 0-17 years, per 10,000 resident population.

:: Why is this important?

Injuries are a leading cause of hospitalisation and represent a major cause of premature mortality for children and young people.

:: What does the data tell us about Suffolk?

The injury rate in Suffolk has reduced by 43% between 2004-5 and 2008-9 and it compares favourably with national and regional levels. Local authorities vary considerably in their relative injury incidence. Forest Heath has the lowest rates, while Waveney performed poorly. St Edmundsbury had a particularly high rate of

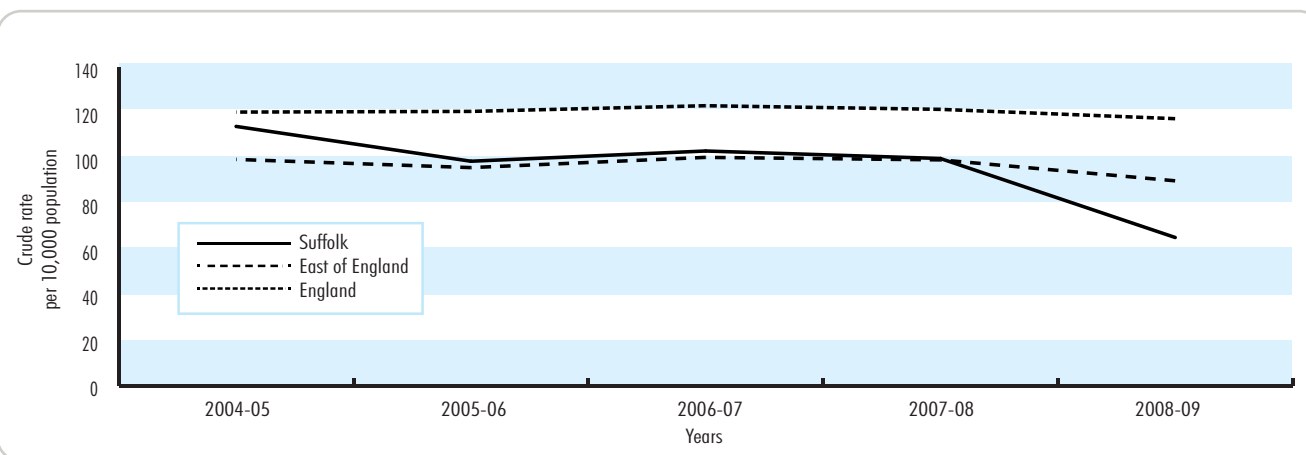
injury leading to hospital admission. The top five causes of hospital admission in Suffolk in 2010 and 2011 were falls, intentional self harm and overdosing, striking against or struck by other objects and persons, pedal cycling, and accidental poisoning. They accounted for 75% of hospital admissions for unintentional and deliberate injuries in 0-17 year olds.

:: Inequalities

Inequalities in child injury continue to exist by age, sex and socioeconomic status. Children living in the second most deprived area are significantly more likely to be injured. Male and ethnic minority children have significantly higher rates of injury, as do children in the 0-4 and 15-17 year age bands.

Key messages:

- Childhood injuries result in a large loss of potential life years, and a huge burden of illness which presents an enormous cost to the individuals, their families, and wider society.
- Most of these injuries are preventable and joint working with partner agencies can make positive improvements in safeguarding children and young people.



Hospital emergency admissions due to injury among children aged 0-17 years
 Source: South West Public Health Observatory

16-18 year olds not in education, employment or training

:: Definition

The percentage of 16-18 year olds not in education, employment or training (NEET). The indicator will use an average proportion of 16-18 year olds NEET between November and January each year.

:: Why is this important?

Young people who are not engaged in education, employment or training have a higher risk of poor physical and mental health and early parenthood.

Young people not in employment, education or training (NEET) Residents of Suffolk, East of England and England November 2011-January 2012, aged 16-19 years

Area	NEETs as % persons aged 16-19 years	95% confidence interval		Compared to East of England percentage	Compared to England percentage
		Lower limit	Upper limit		
Suffolk	6.4%	6.2%	6.6%	Higher	Higher
East of England	6.0%	6.0%	6.1%	–	Lower
England	6.1%	6.1%	6.2%	–	–

Source: Department for Education

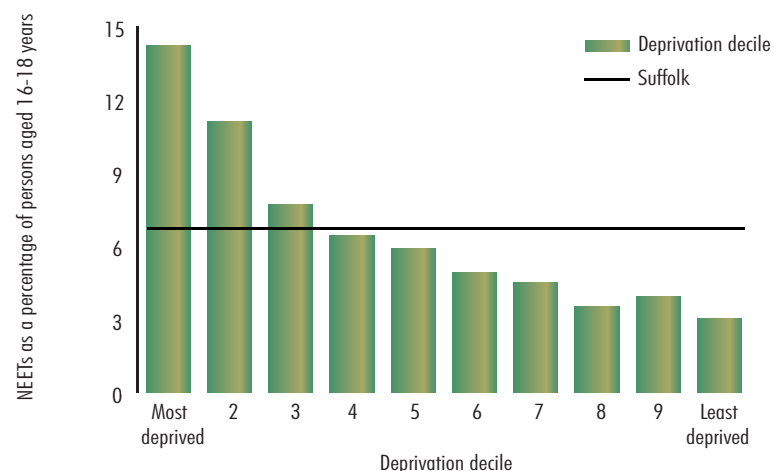
:: What does the data tell us about Suffolk?

The table shows that in November 2011 – January 2012 the percentage of young people NEET was higher in Suffolk than in the East of England and England as a whole.



16-18 year olds not in education, employment or training

Young people NEET: residents of deprivation deciles in Suffolk, December 2010-January 2011, aged 16-18 years



:: Inequalities

The chart shows that the percentage of young people NEET increases significantly with increasing levels of deprivation, highlighting the existence of inequalities in Suffolk, with the percentage of young people NEET in the most deprived group almost five times higher than in the most affluent group.

Key messages:

- There is a need for a more person-centred approach to ensuring young people get the most appropriate advice and support during this critical period. This approach is needed across the range of socioeconomic groups.
- The causes of youth unemployment and disengagement with education are wide-ranging, and associated with parental occupation and prior educational attainment. The ongoing consequences impact, not only on the individual, but also on the state. Young people who are NEET are more likely to suffer health problems and are five times more likely to enter the criminal justice system, with the life-time cost to the state of each young person who is NEET currently standing at £97,000.



16-18 year olds not in education, employment or training

case study

NEET Case Study

M had ceased to attend school in Year 9 because of serious anxiety issues and received five hours a week home tuition up to the end of Year 11. She studied for GCSEs in English and maths but did not take the exams as she did not consider she had done enough work to do well in them. M decided that she would like to work with children in the future and would like to take a relevant distance learning qualification. M was not able to contemplate going to college and in fact rarely left her house.



Her Youth Support Worker (YSW) worked with her in summer 2010 to complete an application for funding for a three day a week programme which would have combined distance learning for a childcare qualification and relevant work experience. Her application was turned down as it was considered that a three day a week programme would be too much for her to cope with after only five hours a week of study for the previous two years. It was felt that she would benefit from gaining some experience of childcare to establish if this would be the best career for her.

M was able to access a specialised project funded through the European Social Fund which offered her intensive flexible support. All meetings had to take place at M's home because of her anxiety about going out. A work placement at a local nursery was set up which she managed to attend for one day a week. She received a very positive report from the nursery. M had a 1:1 mentor who worked with her to develop her confidence, but was unable to access any of the other group work sessions provided through the project. The YSW encouraged M to apply for a distance learning Employability Programme but she did not complete it. This helped M to recognise that she needed ongoing 1:1 support and that she was unable to sustain distance learning. A fresh application was made for funding and this time it was successful, due to the progress that M had made in the work placement and her developing understanding of her support needs. M has started her new programme which includes work experience and a 1:1 mentor to help with the study and is doing well.



Under 18 conceptions

:: Definition

The under 18 conception rate estimates the number of pregnancies (resulting in live births, stillbirths, and abortions) per 1,000 females aged 15-17.

:: Why is this important?

Reducing under 18 conceptions has important benefits for the health of the parents and the baby in the short and long term. Young parents have higher rates of postnatal depression, and mental health issues in the following three years. They are more likely than older parents to have low educational attainment, be unemployed and living in poverty at age 30. Their children have higher rates of infant mortality and low birth weight and higher attendance at accident and emergency departments as a result of accidents. They also have a much higher risk of being born into poverty.

:: What does the data tell us about Suffolk?

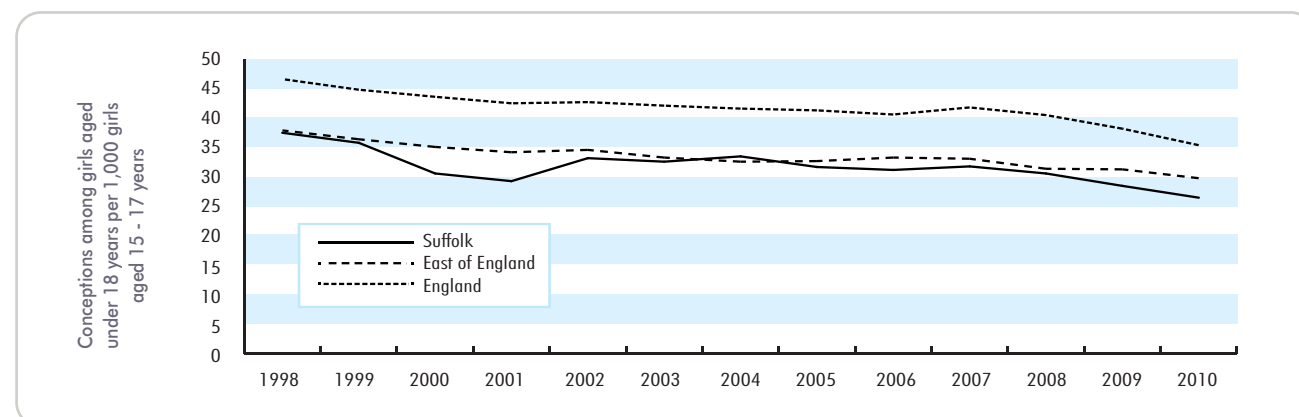
A steady decline has been observed in the under 18 conception rate since 1998. In 2010 this rate was 26.6 which was lower than the national (35.4) and the regional average (29.8).

:: Inequalities

- Higher rates of teenage pregnancy occur in areas with higher levels of deprivation. Half of all under 18 conceptions occur in the 20% most deprived wards (in Suffolk these wards are in Lowestoft and Ipswich).
- Over one third of teenage mothers have no qualifications and only 33% are in education, employment and training, compared to 90% of all 16-19 year olds.

Key messages:

- Babies of teenage mothers have a 60% higher risk of dying in the first year of life and have a significantly increased risk of living in poverty, achieving less at school and being unemployed in later life.
- Evidence shows that strong joined-up work, sex and relationships education of high quality and open-access, young people friendly contraceptive and sexual health services, targeted youth support and aspiration building programmes are the interventions which have the biggest impact on reducing teenage conception rates.



Annual teenage conception rates: conceptions among girls aged under 18 years, residents of Suffolk, East of England and England as a whole, 1998-2010

Source: Office for National Statistics



Adults

Lifestyle and preventing ill health

Derek runs his own delivery business and employs a couple of other guys part-time. Since his youngest daughter Hannah was referred to Alive 'n' Kicking he has become interested in getting his employees fitter too.

In July he went to a conference at Trinity Park that was part of an EU project called PROGRESS, where he met other employers locally. He was shocked to find out how bad it was for you to do no physical activity at all, and resolved to change the way he lived his life. He knew he could do it, after all he has been off the cigarettes now for 12 months, which wasn't anywhere near as hard as he thought it would be. He even got his daughter Jessica to quit now she is expecting, and she hasn't had a cigarette for weeks.

Derek is still worried about Jessica though. She is on the waiting list for a flat because there isn't really room for her at home now, never mind with a new baby. He is worried that she doesn't realise how expensive it is to run a home and has been finding out about insulating his house to keep his own heating bills down.

Elsie and Ted, his in-laws, put him on to it after they were able to get some advice from the Warm Front scheme.



Proportion of physically active and inactive adults

case studies

Live Well Suffolk's Community Health Coaches



Dawn's children were accessing Live Well Suffolk's child weight management programme and she decided she also wanted to get fit and lose some weight. She wasn't doing anything active before so she sought the help of one of Live Well Suffolk's Community Health Coaches.

She joined a free group zumba programme and has made some other changes and she is now walking to work. She particularly valued the healthy eating advice she has received: "I have really learnt something," Dawn said, "now I fully understand what changes I need to make and why I need to make them. My Community Health Coach Richard's motivation is fantastic, if only you could bottle his motivation!"



Maria's life has completely changed since accessing Live Well Suffolk's Community Health Coach service. Maria said "I had got in a rut. I wasn't doing anything active and I was drinking fairly heavily.

It has been an inspiration, I've tried things before but didn't keep it up. This time it's stuck, my shopping takes longer as I've been looking at all the labels, I've gone from drinking heavily to hardly at all, I'm more active and more alert."



Yvonne's children were accessing a child weight management course when she heard about Live Well Suffolk's programmes.

She has MS and wanted to get more active and lose some weight. She went to a taster session and enjoyed it and then signed up to a programme with a Community Health Coach. On finishing the programme she intends to look for a permanent zumba course to keep her active on an ongoing basis.

Proportion of physically active and inactive adults

:: Definition

- Proportion of adults (aged 16+) achieving at least 150 minutes of physical activity per week (moderate intensity in bouts of 10 minutes or more) in accordance with the national guidance from the Chief Medical Officers in the UK.
- Proportion of adults (aged 16+) classified as 'inactive' (less than 30 minutes of moderate intensity physical activity per week in bouts of 10 minutes or more).

:: Why is this important?

Being physically inactive is one of the top risk factors for dying early and physical activity has health benefits throughout life.

:: What does the data tell us about Suffolk?

- 22.6% of adults in Suffolk participated in physical activity: this is slightly above the national participation levels of 20.6%.
- Highest participation rates were in Forest Heath (28.5%) and lowest in Waveney (18.2%).

There were also 26.6% of adults in Suffolk who did not participate in any physical activity at all.

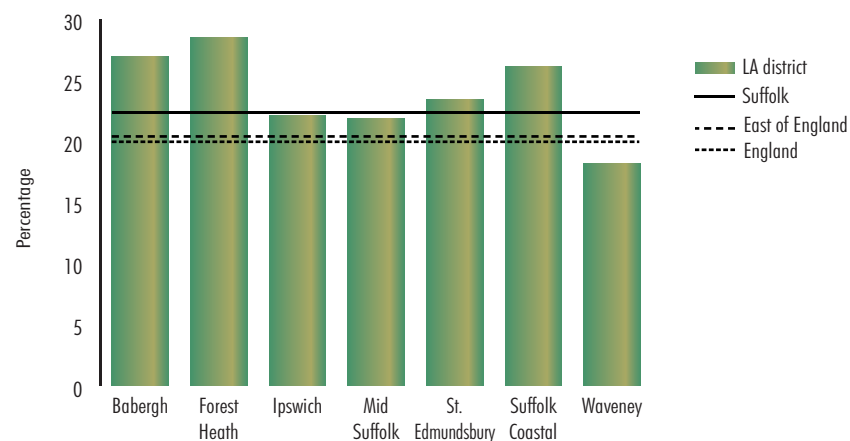
:: Inequalities

Physical activity has a role in reducing health inequalities and social exclusion. In the UK there are significant inequalities in levels of physical activity in relation to age, gender, ethnicity, socioeconomic groups and disability with corresponding inequalities in health.

Key messages:

- Low levels of physical activity costs the NHS over £1 billion per year (£6.5 billion per year to the wider economy) and is one of the top risk factors for premature mortality.
- Physical activity has comprehensive health benefits across the lifespan: it promotes healthy growth and development in children and young people, helps to prevent unhealthy mid-life weight gain, and is important for healthy ageing, improving and maintaining quality of life and independence in older adults.
- Participation in sport and active recreation during youth and early adulthood can lay the foundation for lifelong participation in health-enhancing sport and wider physical activity.

Proportion of adults participating in 5 x 30 minutes physical activity each week in Suffolk: April 2010 to April 2011. Source: Active People Survey and National Obesity Observatory



Proportion of physically active and inactive adults

case study

Live Well Suffolk's Fit Fans

David, 38, signed up for Live Well Suffolk's Fit Fans programme because he knew he needed to lose weight, but lacked the guidance and knowledge to achieve this successfully. As an Ipswich Town fan he liked the idea of the camaraderie that you find within a group of football fans!

David said: "I've really enjoyed the course and I'm definitely going to continue, even though I've already lost a considerable amount of weight. I can see a huge change and I feel much healthier. It was great fun being with the rest of the group and I loved the 'terrace ethic' which helped when things got hard."

David would recommend the programme to any other men who know they need to lose weight but don't want to go down the traditional route of gyms or team sports. He added: "The course leader wasn't preachy and didn't make you feel uncomfortable or embarrassed. He encouraged us and laughed with us – it's a great way to get in shape!"



PROGRESS

Ageing is the most critical issue facing public services today. In Suffolk we are leading a two year European funded programme to support active, dignified ageing and demonstrate the benefits of tackling ill health before old age.

By engaging the business community we held a transnational conference in July 2012 involving 100 people from a range of sectors to raise awareness, highlight the inequality between different groups of older people, and demonstrate how the extension of our working lives and how the physiological and social experience of ageing can be transformed with new approaches.

PROGRESS towards healthy ageing in Europe involves five EU Member nations and will inform EU and national policy makers how we can foster local conditions to make it possible for more EU citizens to lead healthy, active and independent lives while ageing. The programme will work in partnership with people to co-create innovative products and services and tools for employees and employers which will improve our understanding of the interests and motivations of people within the age group of 45-68.

For further information please go to <http://www.progresshealthyageing.eu/>



feature

Smoking prevalence in adults (over 18)

Key messages:

- Smoking is the primary cause of preventable morbidity and premature death.
- Smoking is also one of the biggest contributors to inequalities in life expectancy especially in relation to cardiovascular disease, coronary heart disease, respiratory disease and cancer.
- The costs of tobacco use are much greater than just costs to the NHS, with the overall economic burden of tobacco use to society estimated at £13.74 billion a year. The cost to Suffolk is estimated at £177.9 million.
- The national ambition (Tobacco Control Plan) is to reduce adult (over 18 years) smoking prevalence in England to 18.5% or less by the end of 2015.

:: Definition

- Prevalence of adult smokers as self reported in the Integrated Household Survey.

:: Why is this important?

Smoking is the primary cause of preventable illness and premature death, accounting for 18% of deaths in adults over 35 years of age. The national goal is to reduce smoking prevalence across England to 18.5% or less by 2015.

:: What does the data tell us about Suffolk?

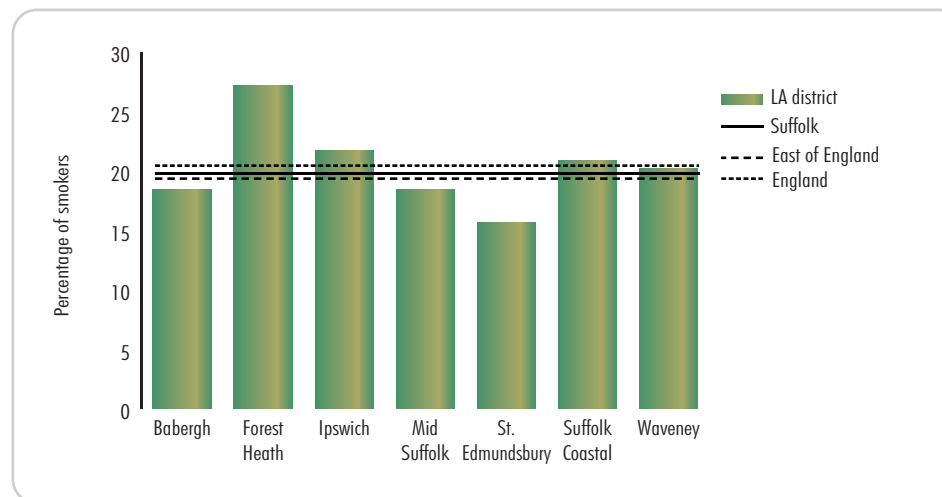
- Forest Heath has the highest prevalence of smokers, significantly above the national average.

- The prevalence of smokers in Babergh, Mid Suffolk and St Edmundsbury is below the national average.

:: Inequalities

Inequalities exist in the prevalence of smoking in Suffolk. In 2008, 23.4% of adults living in the most deprived areas were smokers compared to 16% in the rest of the population. There are also differences in smoking prevalence by occupation, with 27.8% of routine and manual workers smoking in Suffolk in 2009-10 compared to 20.1% of the population as a whole.

Smoking prevalence among adults (18+ years) by district in Suffolk, April 2010 to March 2011
 Source: Integrated Household Survey, Office of National Statistics (experimental statistics)



Smoking prevalence in adults (over 18)

Stop smoking support



Phil was smoking around 20 roll-ups a day and had been smoking for 34 years. He did a lot of driving for work so would find himself smoking 'a lot in the car'. During the breaks at work he used to 'power smoke' and smoke as many cigarettes as he could before his break was over. He was starting to find smoking 'anti-social' because of the smoking ban.

Phil attended one of Live Well Suffolk's stop smoking groups on a Tuesday evening in Ipswich, he was apprehensive at first because he "couldn't ever see himself in a group and worried it would be corny or cheesy." However after his first visit he said he was "instantly put at ease by the advisor who talked like he has known you for years." He decided to use Champix to quit and had no side effects and found the treatment "excellent." Phil said "I received practical ideas from other quitters and had a bit of banter with new friends. The experience was absolutely brilliant, helpful and uplifting and I would recommend it to others."

He has noticed the positives, his sense of smell is drastically better and his sense of taste has improved. He also feels he has his "breath back" and doesn't get out of breath as easily. He put on a kilo of weight in the first few weeks, but had returned to his normal weight a few weeks later.

case study

Statutory homelessness

:: Definition

The definition consists of two elements:

- Homelessness acceptances – Number of households who are eligible, unintentionally homeless and in priority need, for which the local authority accepts responsibility for securing accommodation under part VII of the Housing Act 1996 or part III of the Housing Act 1985.
- Households in temporary accommodation – Number of households in “temporary accommodation” as arranged by local housing

authorities. It is not possible to calculate this rate currently.

:: Why is this important?

Homelessness is an important public health problem; people in unsettled accommodation have higher health needs than their peers.

:: What does the data tell us about Suffolk?

In 2009-10 the rate of statutory homelessness in Suffolk was 1 per 1,000 households or 300

households (see table opposite). This rate was lower than the East of England (1.5) and England (1.9) average. The highest rate of statutory homelessness in Suffolk was in Ipswich (1.9 per 1,000 households or 101 households) and the lowest rate in Suffolk Coastal (0.2 per 1,000 households or 11 households). With the exception of Ipswich all districts and boroughs in Suffolk experienced lower levels of statutory homelessness compared to the East of England and England.

case study

Housing & Support Service

The Suffolk 2010-11 Adult Substance Misuse Needs Assessment clearly identified a positive link between stable accommodation and successful exits from treatment for drug misuse, 25% of people in treatment who had no housing problem during 2009-10 left treatment successfully, compared to 12% of those who had no fixed abode.

Data for 2008-09 suggests that between a quarter and a third of clients that

were discharged from drug treatment re-presented to Suffolk’s services, with particular groups more likely than others to re-enter the treatment system, e.g. Opiate and/or Crack Cocaine Users (OCUs). Detailed information on the characteristics of clients re-presenting to the treatment system is currently only available for 2005-06. Almost two thirds of all OCUs treated in this year re-presented to treatment, with more than three quarters of those using opiates and crack cocaine coming back into treatment at some point over the following three years.

To address this need, Suffolk DAAT funded a pilot Housing and Support Service to provide individually tailored, intensive support and accommodation; allowing clients to make demonstrable steps along the journey to recovery from substance misuse and ultimately achieve abstinence, and gain the skills required to live independently.

Following the success of the pilot, during 2012-13, Suffolk DAAT will be commissioning a similar housing support service for the next three years.

Statutory homelessness

Number of statutory homeless households and crude rate per 1,000 estimated households, all ages, all persons (2009-10) Source: APHO

Area	Rate of statutory homeless households	Number of statutory homeless households	Compared to Suffolk average	Compared to EOE average	Compared to England average
Babergh	1.0	37	Similar	Lower	Lower
Forest Heath	1.3	33	Similar	Lower	Lower
Ipswich	1.9	101	Higher	Similar	Similar
Mid Suffolk	0.7	25	Similar	Lower	Lower
St Edmundsbury	0.8	36	Similar	Lower	Lower
Suffolk Coastal	0.2	11	Lower	Lower	Lower
Waveney	1.0	54	Similar	Lower	Lower
Suffolk	1.0	300	–	Lower	Lower
East of England	1.54	3,660	–	–	–
England	1.86	40,020	–	–	–

:: Inequalities

- Statutory homeless figures only measure the incidence of official homelessness. They do not measure the number of households who are homeless but do not make applications to the local authority and are therefore not considered under Housing Act legislation. They do not include those who are rough sleepers; households that have become unintentionally homeless but are not considered to be in priority need or households that have become intentionally homeless. Those who do not show up in official figures are the hidden homeless and can be individuals and families

who become homeless but find a temporary solution by staying with family members or friends, or squatters. They are often referred to as 'sofa surfers' or 'concealed households'.

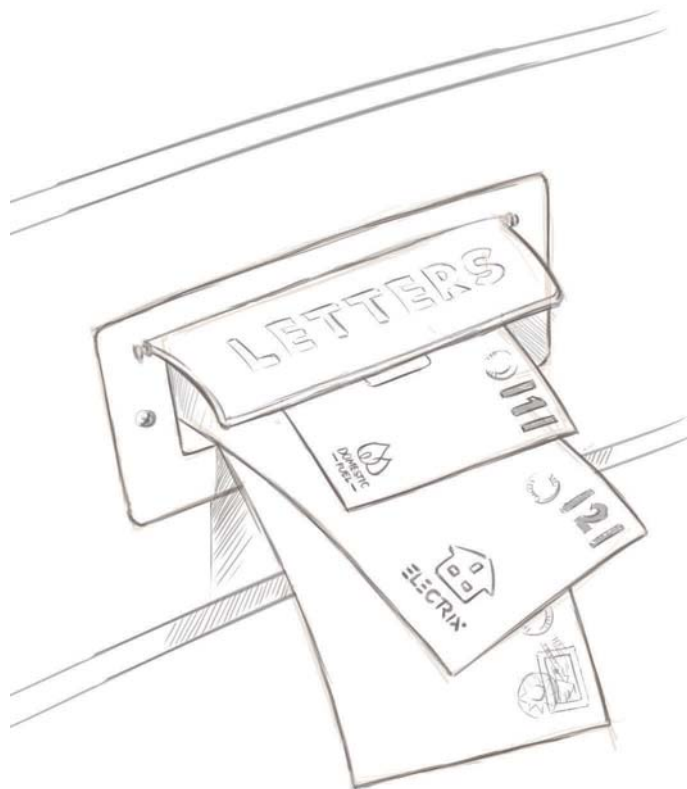
- Homelessness is associated with severe poverty, adverse health, education and social outcomes, particularly for children, and is a social determinant of health.

As such, statutorily homeless households contain some of the most vulnerable and needy members of our communities.

Key messages:

- The statutory homelessness measure is a significant underestimate of the extent of homelessness, both of those populations who would qualify for assistance and for the larger number of people who fall outside of the legislation.
- A recent report identified that institutional care, street culture activities and substance misuse and alcohol are key pathways into homelessness and that individuals interact with a variety of public services before they become homeless at significant cost to the public purse.
- Drug and alcohol services, schools and the Criminal Justice System are crucial potential intervention points to minimise homelessness.

Fuel poverty



:: Definition

A household is classified as fuel poor when it would need to spend more than 10% of its income on energy in order to maintain an adequate level of warmth.

:: Why is this important?

There is compelling evidence that the drivers of fuel poverty – low income, expensive fuel and poor energy efficiency, are strongly linked to living at low temperatures. Living in low temperatures adversely affects health. The number of excess winter deaths is conservatively estimated at 2,700 people per year, higher than

the toll of road deaths. Children living in cold homes are more likely to have asthma and bronchitis.

:: What does the data tell us about Suffolk?

As a whole Suffolk has a similar level of fuel poverty to the whole of England (18.4%) but has an overall rate that is higher than the East of England average (16.2%). The highest levels of fuel poverty are seen in Mid Suffolk (20.4%) and Waveney districts (20%) compared to Suffolk, with lower levels in Forest Heath, Ipswich and St Edmundsbury.

*Number of fuel poor households in Suffolk by local authority district and borough (IMD 2010)
Modelled estimates of fuel poverty in 2009. Source: Department of Energy and Climate Change.*

Area	Number of Fuel poor households	Total number of households	% fuel poor households
Babergh	6,932	36,930	18.8%
Forest Heath	3,785	25,212	15.0%
Ipswich	9,684	55,085	17.6%
Mid Suffolk	7,949	38,887	20.4%
St. Edmundsbury	7,094	43,949	16.1%
Suffolk Coastal	10,018	53,256	18.8%
Waveney	10,124	50,741	20.0%
Suffolk	55,586	304,060	18.3%
East of England	387,672	2,388,522	16.2%
England	3,963,923	21,535,414	18.4%

Fuel poverty

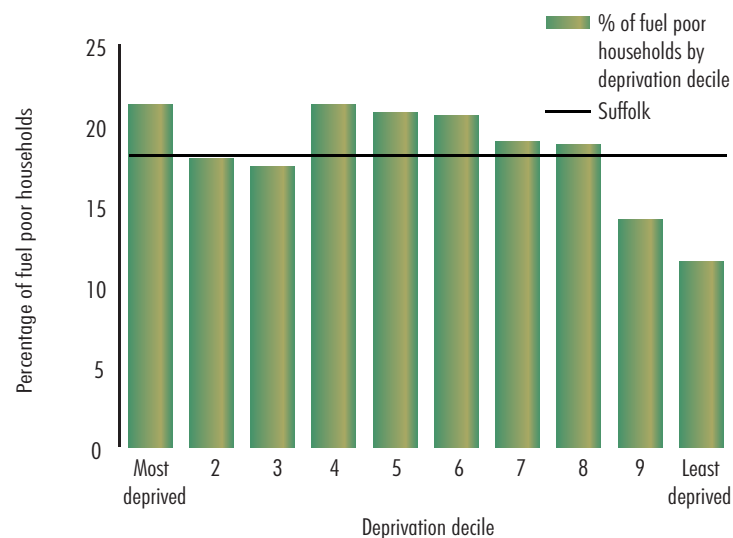
:: Inequalities

- Those living in the most deprived areas experience the highest levels of fuel poverty (21.3%) in Suffolk whilst those living in the least deprived areas experience the lowest (11.5%).
- However fuel poverty does not follow the normal pattern associated with inequalities. As can be seen in the graph below those living

in areas of average levels of deprivation also experienced higher levels of fuel poverty compared to the Suffolk average. This may be explained by the types of houses and population living in these areas. For instance older people who may be relatively asset rich (living in larger houses) may not have the necessary income to effectively insulate or heat their home.

Fuel poor households in Suffolk by deprivation: modelled estimates of fuel poverty in 2009.

Source: Department of Energy and Climate Change



Key messages:

- The estimates currently available are now three years out of date and do not take into account the increase in energy prices seen since 2009. The figures therefore are likely to be an underestimate of the number of households in fuel poverty in 2012.
- Tackling fuel poverty has multiple benefits; better living standards and conditions for people with low incomes; an improved and more energy efficient housing stock; fewer winter deaths and reduced costs for the NHS.
- The numerous schemes available to offset fuel poverty create a complexity that prevents some households from accessing the support they are eligible for.

Fuel poverty

case study

Suffolk Warm Homes, Healthy People Project

Simon

"Simon's in his late 60s. His poor health keeps him in a wheelchair in his living room all day every day. His social worker telephoned the Warm Homes helpline to say that Simon had no heating because he had run out of oil and could we help.

Andy from the Suffolk Warm Homes, Healthy People Project went out to Simon to see what could be done. Andy found that Simon's house was leaking heat with no loft insulation and draughts blowing in through curtain-less windows. Simon was freezing.

Andy took with him a plug-in oil filled heater to get Simon's living room warmer. He organised an emergency oil delivery and a heating engineer to get the boiler going. Andy also sorted out someone to measure up for loft insulation and fit heavy duty curtains.

Simon got these jobs paid for through the Suffolk Warm Homes, Healthy People Project. Simon is warmer now.

Jane

Jane is a widow whose life had been relatively comfortable up until the death of her husband, just before retirement. Payment of debts forced her to sell her home and move into privately rented accommodation.

To the outside world Jane appears to be a well-to-do pensioner but the reality is she is keeping up appearances. Jane's home is electrically heated and her bills this winter were huge, leaving her in debt to her energy supplier for hundreds of pounds. She turned off one storage heater, wrapped herself in two duvets and put on microwaveable slippers every evening and was still cold.

A Warm Homes, Healthy People card dropped through her door brought her to our attention and we were able to get free loft insulation installed, pay off some of her fuel debts and give her the confidence to heat more effectively. She is being assessed for benefits and is feeling more confident about next winter.

Successful completion of drug treatment

:: Definition

Number of drug users that left drug treatment successfully (free of drug(s) of dependence) who do not then re-present to treatment again within six months as a proportion of the total number in treatment.

:: Why is this important?

Individuals achieving a successful outcome gain significant improvements in health and wellbeing, which benefits both the individual and society.

:: What does the data tell us about Suffolk?

There is estimated to be 2,872 Opiate and/or Crack Cocaine users (OCU) in Suffolk (2009-10 estimate, National Treatment Agency). In 2010-11 there were 1,209 OCUs in drug treatment, a figure which rises to 1,403 when all other drugs (excluding alcohol) are included.

Research tells us it often takes a person several years to succeed through drug treatment, and they may have more than one period in treatment. Successful completions from treatment in a specific time period do not, therefore, give a full picture of recovery in a community.

:: Inequalities

Drug treatment services in Suffolk are located in the three main towns in the county - Bury St Edmunds, Ipswich and Lowestoft – with satellite services provided in other parts of the county.

There is a perception that drug use is likely to be more prevalent in areas of significant deprivation. Whilst the Index of Deprivation 2007 shows concentrations of deprived wards in the main towns in Suffolk (where a majority of people in treatment are resident), drug use is not restricted to these locations and those in treatment live right across Suffolk, including rural areas traditionally less associated with problematic drug use.

Sources: National Drug Treatment Monitoring System; National Treatment Agency

Key messages:

There are a number of potential influences on successful completions from treatment, but three key factors are:

- Treatment services must be responsive to each individual's needs and apply appropriate treatment to deal with the substances being used.
- Individuals need to be prescribed appropriately, which may involve aims around stabilisation initially, but which should move towards long term abstinence from drug use during the client's treatment journey.
- A crucial element of long term recovery is engagement with mutual aid groups, for example Narcotics Anonymous and Alcoholics Anonymous.

Cancer screening coverage

Current cancer screening programmes

Screening Programme	Eligible population	Frequency of screening
Cervical Screening	Women aged 25–64 years	Every 3 years for women aged 25–50. Every 5 years for women aged 50–64.
Bowel Cancer Screening	Men and women aged 60–75 years	Every 2 years
Breast Cancer Screening	Women aged 47–70 years	Every 3 years for women aged 47–70. Women older than 70 can self refer.

:: Definition

Percentage of women in a population eligible for breast and cervical screening at a given point in time who were screened adequately within the specified period.

Data for this indicator is only readily available at GP practice and Primary Care Trust (PCT) level. The PCT does not cover all of Suffolk therefore district/borough and county values were estimated for cervical screening by assigning each practice to the local authority district and

borough in which the main surgery was based. This was not possible for breast screening data, and therefore PCT values have been used.

:: Why is this important?

Breast screening is important to identify cancers early so they can be more effectively treated. Cervical cancer screening identifies signs that may become cancer so they can be treated early, preventing cancer from developing.

:: What does the data tell us about Suffolk?

Number and proportion of females aged 25 to 64 screened for cervical cancer in the last 42 to 66 months (2010-11)

Area	Females aged 25-64 screened for cervical cancer in last 42-66 months	Females aged 25-64	Proportion of females screened adequately in the previous 42 months (if aged 24-49) or 66 months (if aged 50-64)	Compared to Suffolk average	Compared to England average
Babergh	16,129	20,133	80.1	Higher	Higher
Forest Heath	12,117	16,022	75.6	Lower	Similar
Ipswich	30,111	39,817	75.6	Lower	Similar
Mid Suffolk	17,274	21,572	80.1	Higher	Higher
St Edmundsbury	21,927	27,864	78.7	Similar	Higher
Suffolk Coastal	19,508	24,324	80.2	Higher	Higher
Waveney	22,433	28,903	77.6	Similar	Higher
Suffolk	139,499	178,635	78.1	–	Higher
England	10,150,949	13,427,745	75.6	–	–

Cancer screening coverage

Number and proportion of females aged 50 to 64 screened for breast cancer in the last 3 years.

Primary Care Trust	Number of women aged 50-64 screened in last 3 years	% uptake of breast screening
Bedfordshire	34,322	80.1%
Cambridgeshire	48,050	78.7%
Great Yarmouth & Waveney	21,993	80.1%
Hertfordshire	84,200	77.5%
Luton	11,201	75.6%
Mid Essex	33,233	82.3%
Norfolk	72,215	81.8%
North East Essex	29,574	81.4%
Peterborough	11,139	75.8%
South East Essex	28,696	74.0%
South West Essex	30,284	74.5%
Suffolk	57,240	81.8%

:: Inequalities

- Those practices covering the most deprived areas of Suffolk had lower levels of cervical screening coverage compared to the rest of Suffolk and England.
- Women living in the catchments of the most affluent practices experienced higher levels of cervical screening coverage compared to both Suffolk and England.
- There is an association between affluence and breast screening uptake. The less socioeconomically deprived an individual is the more likely they will respond to and access

breast screening.

- A recent health equity audit produced by NHS Suffolk identified social factors (ethnicity, educational attainment etc.), and psychological factors (fear, anxiety, cancer fatalism) as being associated with a lack of participation in breast screening.

Nationally people from black and minority ethnic backgrounds are less likely to attend screening appointments than their peers.

Key messages:

- When invited for cervical screening it is important women attend for the smear appointment – early detection is strongly linked to better outcomes from treatment.
- When invited for breast screening it is important that women attend for the mammography appointment – early detection of problems is strongly linked to better outcomes.
- Whilst both breast and cervical screening coverage in Suffolk is good in comparison to other PCTs in the region, there must be no let up in the general message that screening saves lives and with cancer screening specifically, early detection is vital.
- Public health initiatives are vital in ensuring whole eligible population coverage is high – and should include specific campaigns in areas of deprivation and other groups with known low uptake of screening.

Adults

Ill health



Derek and Maureen both work and they are very busy people. Not only do they have the children to care for, they also keep a close eye on Maureen's parents, Ted and Elsie and Maureen's brother Mike, who has Down's syndrome.

Elsie has been in the wars of late; she likes a tippie and is finding it harder to manage alcohol now she is getting older. She doesn't do much exercise and her balance isn't what it was.

A few months back she took a tumble on the way back from dinner in the pub and broke her hip. She did really well with her rehabilitation but still needs some help with shopping.

Maureen really loves her mum and wants to care for her, but finds it really gets her down being at the beck and call of her mum, her children and her brother. She gets fed up as she doesn't seem to get any time just for her. She envies her sister Sandra, who can afford a housekeeper and doesn't have to work. Sandra always has time to cook meals from scratch and go to the gym.

Derek does his best for Maureen and is taking much better care of himself since she laid down the law and said she couldn't look after him as well as everyone else. He has been learning more and more about his diabetes through the Expert Patient Programme and recently had a health check with his GP which spurred him on to exercise more and lose a bit of weight.

The Expert Patient Programme

The Expert Patient Programme in Suffolk provides patients with information, knowledge and techniques to enable them to self manage their long term conditions more effectively. It also helps improve communication and understanding between patients and health care professionals to improve patient experience, outcomes and quality of life. Patient education promotes independence and assists people to take control and manage their condition better.



Health checks

Melissa, a 43 year old woman, had a health check at work through the outreach programme. The check identified that she had dangerously high blood pressure and was overweight, and as a result she was referred on to her GP. She had extensive tests on her heart, which revealed nothing wrong, but she was advised to lose weight, stop smoking and stop drinking.

Melissa has followed all of the advice she was given, feels and looks much better and her blood pressure is now back to normal.



Recorded diabetes (age 17 years and over)



:: Definition

Number of Quality and Outcomes Framework-recorded cases of diabetes per 100 patients registered with GP practices (17 years and over). This indicator definition needs further development to consider the most appropriate way to produce local authority level data. District/borough and county values have been estimated by assigning each practice to the local authority district and borough in which the main surgery was based.

:: Why is this important?

Diabetic complications, which include cardiovascular, kidney, eye and foot diseases,

result in considerable illness and disability.

Type 2 diabetes, which accounts for 90% of cases, is partially preventable. It can be prevented or delayed by lifestyle changes, eating well, exercising and maintaining a healthy weight.

:: What does the data tell us about Suffolk?

The recorded prevalence of diabetes (2010-11) in Suffolk was 5.3% or 32,361 people. This was similar to the East of England rate (5.4%) and lower than the England rate (5.5%). Waveney experiences a higher prevalence (6.1%) compared to Suffolk, the East of England and England, with other districts and boroughs experiencing a similar or lower rate.

Prevalence of diabetes among adults (aged 17+ years) in Suffolk by deprivation.

Source: The Health and Social Care Information Centre

Area	Diabetes Mellitus (Diabetes) Register (ages 17+)	Population 17+	Diabetes Mellitus (Diabetes) Prevalence	Compared to Suffolk average	Compared to EOE average	Compared to England average
Babergh	3,642	69,748	5.2	Similar	Similar	Lower
Forest Heath	2,807	52,145	5.4	Similar	Similar	Similar
Ipswich	6,566	129,808	5.1	Lower	Lower	Lower
Mid Suffolk	3,760	71,436	5.3	Similar	Similar	Lower
St Edmundsbury	4,690	91,653	5.1	Lower	Lower	Lower
Suffolk Coastal	4,417	86,614	5.1	Lower	Lower	Lower
Waveney	6,479	106,562	6.1	Higher	Higher	Higher
Suffolk	32,361	607,967	5.3	–	Similar	Lower
East of England	257,835	4,804,410	5.4	–	–	–
England	2,455,937	44,291,915	5.5	–	–	–

Recorded diabetes (age 17 years and over)

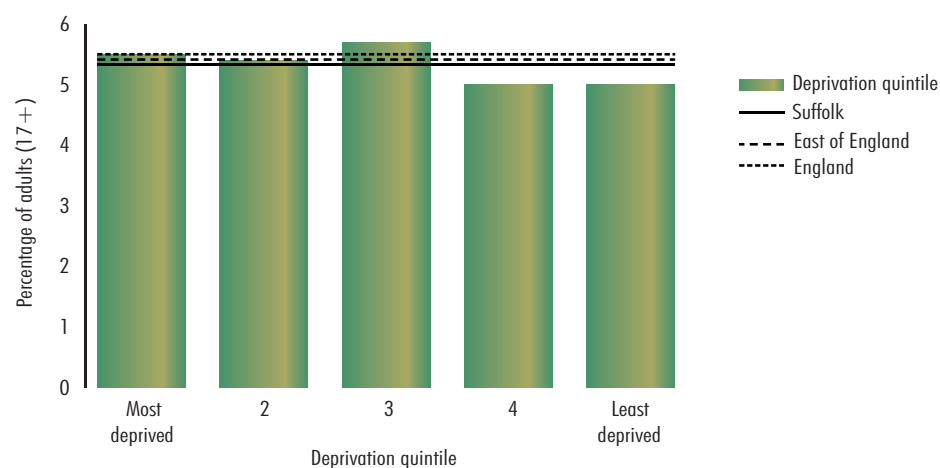
:: Inequalities

The graph below shows that there is not a clear gradient of inequality for diabetes. It should be noted that the requirement to use practice level data could mask inequalities related to deprivation, as some practices, especially in Ipswich, have a mixture of both deprived and

non-deprived patients. Deprivation is strongly associated with factors linked to the risk of diabetes, eg obesity and low levels of physical activity. Evidence shows that people from South Asian and Black Caribbean ethnic groups are more likely to have diabetes and develop the condition at younger ages.

Prevalence of diabetes among adults (aged 17+) in Suffolk by deprivation.

Source: The Health and Social Care Information Centre



Key messages:

- The number of people with diabetes is increasing due to a range of factors, increasing prevalence of obesity and physical inactivity as well as a growing and aging population in Suffolk.
- It is important to prevent the disease where possible, in particular by reducing obesity. Exercise combined with diet reduces the risk of developing the disease by between 38% and 58%.
- It is also important to control diabetes closely to minimise complications of diabetes such as foot ulcers and blindness.
- Data from the Department of Health shows that, compared to other areas, Suffolk spends a disproportionately high amount of money on hospital-based diabetes care and a disproportionately low amount of money on community-based care. The local NHS is working in partnership with local specialists in diabetes to see how patients might be supported closer to where they live.

Alcohol related admissions to hospital



:: Definition

The official indicator definition is under development, therefore as a proxy, we have used data on hospital admissions in Suffolk where alcohol was a contributory factor.

:: Why is this important?

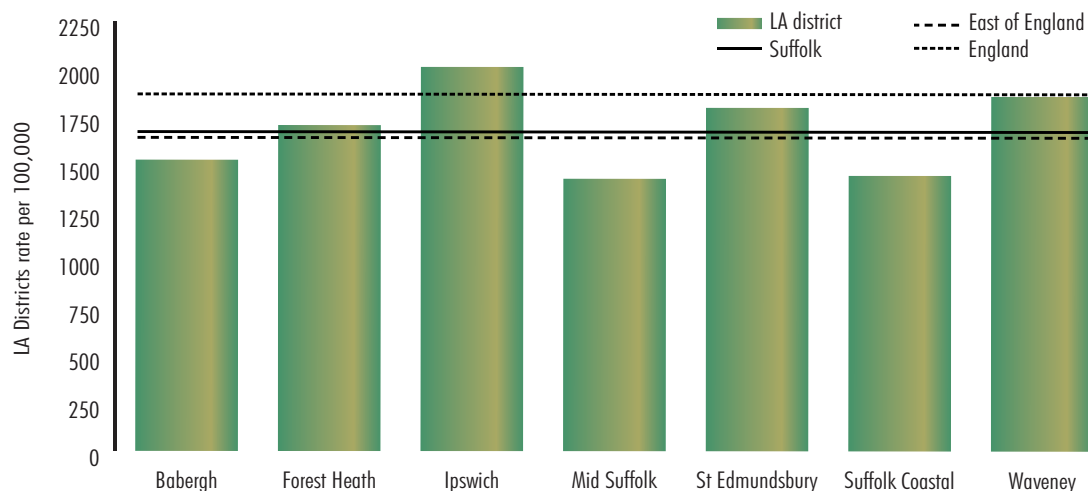
Alcohol misuse is the third greatest overall contributor to ill health after smoking and high blood pressure. In 2009-10 over one million hospital admissions in England were related to alcohol.

:: What does the data tell us about Suffolk?

In 2010-11 the rate of alcohol-related hospital admissions in Suffolk varied between districts:

- Ipswich was above the national, regional and local averages.
- St. Edmundsbury and Waveney were below the national average but above the regional and local averages.
- Babergh, Mid Suffolk and Suffolk Coastal were below the national, regional and local averages.

Rate of alcohol-related hospital admissions in Suffolk 2010-11: directly age standardised rate per 100,000 population. *Source: North West Public Health Observatory.*



Alcohol related admissions to hospital

:: Inequalities

Socioeconomic differences in drinking patterns are complex: unemployed people and those on higher incomes are most likely to drink above recommended levels and to binge drink. These factors, together with the concentration of

licensed premises, lead to complex geographic inequalities in binge drinking. Rates of alcohol-related deaths in England and Wales has increased significantly in recent years, and are substantially greater for men aged 25-49 from more disadvantaged socioeconomic groups.

The Suffolk Alcohol Treatment Service

The Suffolk Alcohol Treatment Service (SATS) was commissioned in 2009 to provide support to people with alcohol related issues. In 2011-12 the service saw 1,078 people which will have a significant effect on reducing the number of hospital admissions related to alcohol.



Key messages:

- Alcohol causes hospital admissions for a diverse range of conditions from falls to liver disease. The rates are a cause for concern; they are high across England and preventable.
- The harm from alcohol is not limited to the drinker but also adversely affects the health of friends and family members.
- This indicator is one of the key contributions by the Government to promote measurable, evidence-based prevention activities at a local level, together with a national ambition to reduce alcohol-related hospital admissions.

Fall injuries and hip fractures in the over 65s

Definitions

- Fall injuries - The definition for the falls indicator in the Public Health Outcomes Framework is not yet finalised. The following is therefore based on directly age-sex standardised rates of inpatient admissions for unintentional falls per 100,000 resident population aged 65 years and over.
- Hip fractures - Age-sex standardised rate of emergency admissions for fractured neck of femur in persons aged 65 and over per 100,000 population.

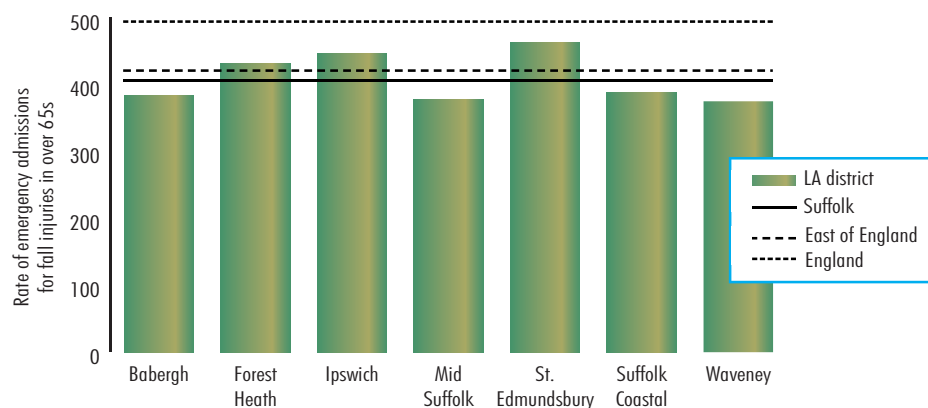
Why is this important?

Hip fracture is debilitating, only one person in three gets back former levels of independence after breaking a hip. They are almost as common and costly as strokes to the health and care system and they are becoming more common. There is evidence for interventions to prevent falls and prevent fractures in people at risk.

What does the data tell us about Suffolk?

Emergency hospital admissions due to fall injuries in the over 65s in Suffolk

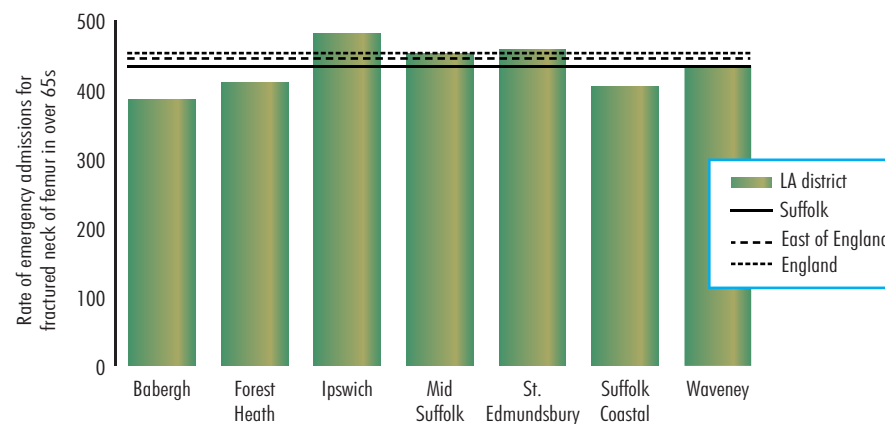
Source: Injury profiles, Public Health Observatories of England.



- The rate of emergency hospital admissions for fall injuries in the over 65s in Suffolk was 404 admissions per 100,000 population or 4,550 admissions. This was lower than the East of England (425) and England (500) rates.
- St Edmundsbury experienced a higher rate of admissions (463) compared to Suffolk and the East of England. All other districts and boroughs in Suffolk experienced lower rates of hospital admissions compared to England.

Emergency admissions for fractured neck of femur in over 65s in Suffolk

Source: Injury profiles, Public Health Observatories of England.



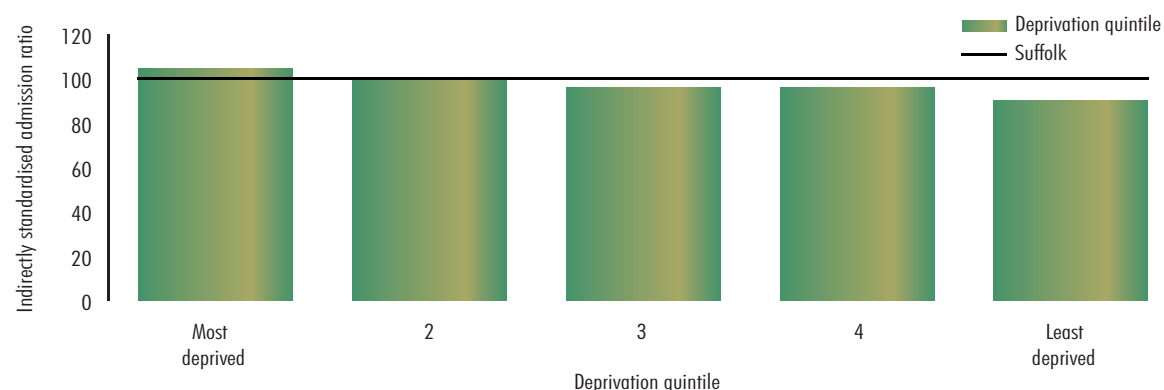
- The rate of emergency hospital admissions due to fractured neck of femur among 65s and over in Suffolk was 432 admissions per 100,000 population or 886 admissions. This was similar to the rate for the East of England (444) and England (452) averages.
- Within Suffolk admission rates did not differ significantly by local authority district/borough with all areas experiencing similar admissions rates to Suffolk, the East of England and England.

Fall injuries and hip fractures in the over 65s

:: Inequalities

- In Suffolk there is a slight inequality gradient for emergency hospital admissions due to fractured neck of femur.
- Those living in the least deprived parts of Suffolk experienced a significantly lower rate of admissions for fractured neck of femur than was expected.

Indirectly standardised hospital admission ratios due to fractured neck of femur by deprivation quintiles in Suffolk (2006-2011). *Source: Association of Public Health Observatories*



Key messages:

- Falls are a leading cause of ill health and death in older people. Most falls do not result in serious injury, but have psychological consequences (e.g. fear of falling, loss of confidence) resulting in loss of mobility and subsequent social isolation, depression, disability and loss of independence.
- A hip fracture is the most common serious injury that can occur following a fall. About 30% of older people die within a year of sustaining the injury. Close to half of previously independent older people become partly dependent and a third become totally dependent following a hip fracture.
- There is evidence of effective and cost effective multi-factorial interventions to prevent falls and fractures in older people. Successful implementation however requires coordinated multi-agency action by partner organisations across health, social care and in the community.
- Actions to prevent falls in later life need to start early. Keeping active and strong in adulthood is important.

Adults

Mental health



Maureen has been really down recently because of all her responsibilities and her doctor has referred her for some talking therapy which she is finding really helpful.

Her brother Mike has also had problems with depression and is on medication. Living in his own home has made a huge difference for him and he is really getting involved with his local community now he knows he is settled somewhere for the long term.

Maureen was very worried about Mike for a while there; she was really concerned he would do something to himself like Jessica's friend Ruth. Ruth was a sensitive but happy girl, but hit a hard time when she was bullied at school then broke up with her boyfriend. She went from being OK to suicidal so quickly. Maureen knows Jessica still hasn't got over it and blames herself for not making sure her friend got help when she needed it.

Hospital admissions as a result of self-harm

:: Definition

Age-sex standardised rate of emergency hospital admissions for intentional self-harm per 100,000 population. Self-harm is when somebody physically damages or injures themselves on purpose, with a non-fatal outcome. Self-harm is not usually an attempt at suicide but a way of expressing deep emotional distress. A history of self harm is associated with later suicide.

:: Why is this important?

Intentional self-harm results in about 150,000 attendances at accident and emergency departments each year. It is one of the top five causes of acute medical admission.

:: What does the data tell us about Suffolk?

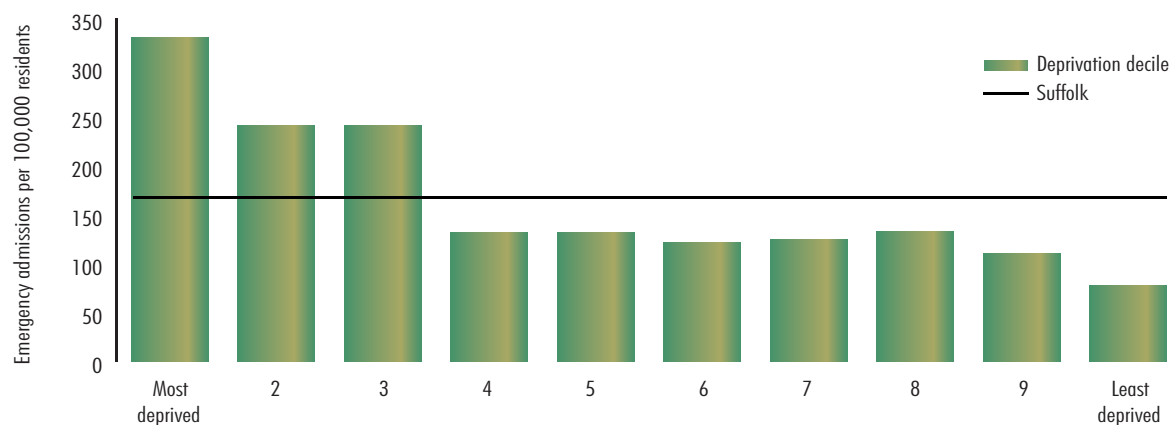
The England rate for admissions for intentional self-harm was 198.3 per 100,000 population in 2009-10. The rate for Suffolk was lower at 182.5.

:: Inequalities

The chart shows that emergency admission rates for self harm increase with deprivation, with four times as many admissions in the most deprived area compared to the least. There are also differences between men and women, with the emergency admission for self-harm rate for women (208.1 per 100,000 residents) significantly higher than that for men (123.3 per 100,000 residents).

Key messages:

- Rates of self-harm in the UK have increased over the past decade and are amongst the highest in Europe. Rates are much higher among groups with high levels of poverty and in adolescents and younger adults.
- Those who have self-harmed are 100 times more likely than the general population to die by suicide in the subsequent year. One half of the people who die by suicide each year will have self-harmed at some time in the past.



Age-sex standardised hospital admission rates: emergency admissions for self-harm. Residents of deprivation deciles in Suffolk: financial years 2009-10 – 2010-11, all ages.
 Source: NHS Suffolk

People with mental illness or disability in settled accommodation

case study

A few years ago Carol, (fictional name) was diagnosed with bowel cancer at the age of 80. Her mental health deteriorated rapidly from mild anxiety linked to her ill health to a serious deep depression requiring hospitalisation for four months and treatment via electroconvulsive therapy (ECT) and drug therapy.

After a slow steady recovery over the following six months and then fortunately two 'good' years maintaining her independence, social and family life with friends and grandchildren, Carol experienced a further rapid deterioration in her physical health leading to a reoccurrence of her severe anxiety and depression, and an emergency admission to a mental health unit where Carol remained for 10 weeks.

This situation placed a huge strain on her daughter, who, with a family of her own, needed to support the ward to plan her mother's discharge. The only viable option was to have her mother back to live with her, to pack up and sell her mother's house, and gradually help to build up her mother's confidence and health to enable her to move into supported accommodation in the longer term.

Carol has now moved into a warden supported bungalow, three minutes

away from her daughter's house and has gradually started to settle and rebuild new social networks in the town where her daughter and family live.

For Elizabeth, Carol's daughter, life has been extremely difficult, balancing full time work with a young family and caring for her elderly mother. The strain of the last few months has taken its toll on family relationships and her personal health and wellbeing.

"Sometimes, I didn't know whether to laugh or weep, and many days I just had to function robotically to get through the tasks of the day, remembering to put fuel in the car, food in the fridge and a meal on the table" said Elizabeth. "Although it felt like running a marathon at times, I knew we would get there in the end and that my mother was not going to be 'written off' by people. We fought to make people understand that mum has a treatable, mental health condition, and could regain a degree of independence again."

"The most aggravating moments were when you felt you needed to do your bit as well as think for everyone else. Mum's physical and mental health were equally important and needed close attention, but there were many examples of oversight and neglect of mum's needs by health professionals, which made life extremely demanding."

People with mental illness or disability in settled accommodation

:: Definition

This indicator is in two parts. The percentage of adults with learning disability known to social services who were assessed or reviewed during the year and were in settled accommodation at the time of their latest assessment, and the percentage of adults receiving secondary mental health services known to be in settled accommodation at the time of their most recent assessment, formal review or care planning meeting.

:: Why is this important?

Living in settled accommodation improves safety and reduces risk of social exclusion for adults with mental health problems. It promotes personalisation and quality of life and helps

prevent the need for admission to hospital. For people with a learning disability accommodation has a strong impact on their safety and overall quality of life.

:: What does the data tell us about Suffolk?

Data for people in Suffolk with severe mental illness and learning disability is shown below. Suffolk performs very well, with high levels of people in settled accommodation compared to the East of England or England.

:: Inequalities

Data relating to the indicator for people with mental illness and / or disability in settled accommodation are not available at different levels of deprivation.

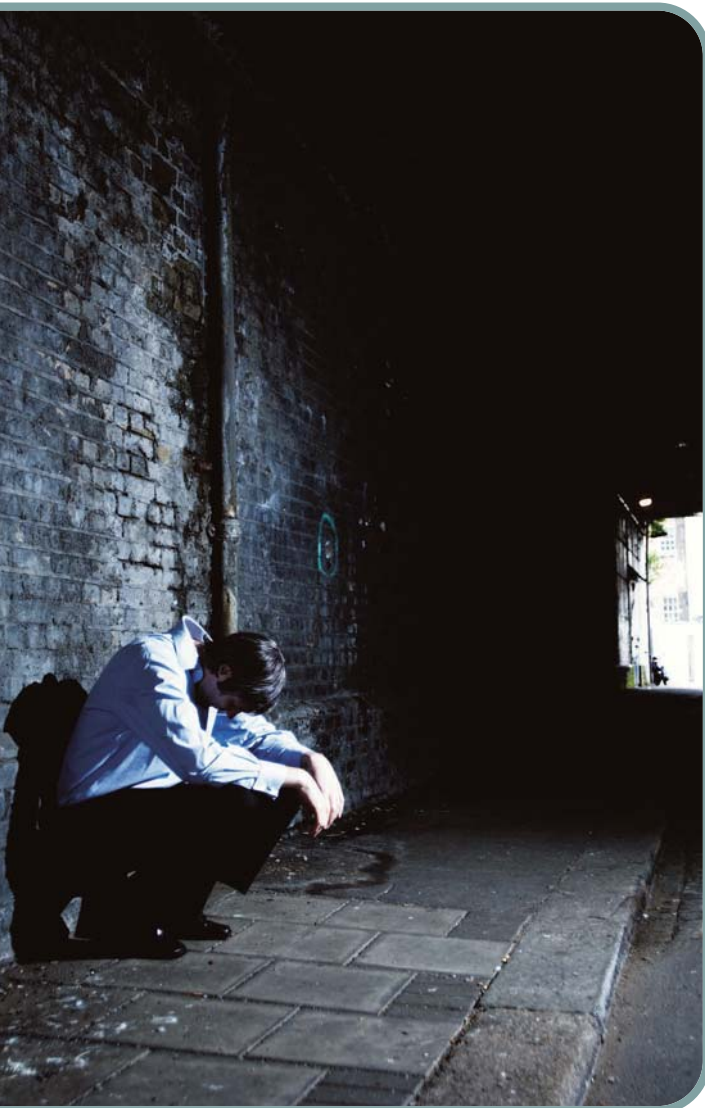
Key messages:

- This is an important issue as stable, settled accommodation linked to supportive social care may improve outcomes for adults with mental health problems by:
 - Improving their safety, as they may be at increased risk of accidents, assault and self-harm.
 - Reducing their risk of social exclusion.
 - Promoting a normal life and better quality of life.
 - Preventing the need to readmit people into hospital or more costly residential care.
 - Ensuring closer links with social care.
- There is also evidence that settled accommodation can improve outcomes for adults with learning disabilities. The nature of accommodation for people with learning disabilities has a strong impact on their safety and overall quality of life and reducing social exclusion.

Percentage of people with mental illness and/or disability in settled accommodation: numbers and percentages: residents of Suffolk, East of England and England, financial year 2010-11, persons aged 18-69 years

Area	Numerator	Indicator	95% confidence interval of indicator		Compared to East of England	Compared to England
			Lower limit	Upper limit		
Suffolk	880	75.2%	72.7%	77.7%	Higher	Higher
East of England	11,930	63.5%	63.5%	64.9%	–	Lower
England	138,695	66.8%	66.6%	67.0%	–	–

Suicide



:: Definition

Age standardised mortality rate from suicide and injury of undetermined intent per 100,000 population.

:: Why is this important?

Suicide is frequently preventable and preceded by sudden and treatable mental ill health.

Suicide is a key cause of years of life lost.

:: What does the data tell us about Suffolk?

The table shows that rates of death from self-harm across the county are similar to regional and national averages, with only Forest Heath having a rate that is higher.

Deaths from self-harm and event of undetermined intent: numbers and rates: local authority districts in Suffolk, pooled data for 2008-10, persons of all ages.

Area	Number of deaths	Mortality rate	95% confidence interval of indicator		Compared to Suffolk rate	Compared to East of England rate	Compared to England rate
			Lower limit	Upper limit			
Babergh	21	7.4	3.8	11.0	Similar	Similar	Similar
Forest Heath	29	14.3	9.0	19.6	Similar	Higher	Higher
Ipswich	40	10.6	7.3	13.9	Similar	Similar	Similar
Mid Suffolk	28	8.5	5.2	11.8	Similar	Similar	Similar
St. Edmundsbury	28	8.6	5.3	11.9	Similar	Similar	Similar
Suffolk Coastal	27	7.5	4.5	10.5	Similar	Similar	Similar
Waveney	32	8.9	5.6	12.1	Similar	Similar	Similar
Suffolk	205	9.3	8.0	10.6	–	Higher	Similar
East of England	1,358	7.4	7.0	7.8	–	–	Similar
England	12,889	7.9	7.8	8.1	–	–	–

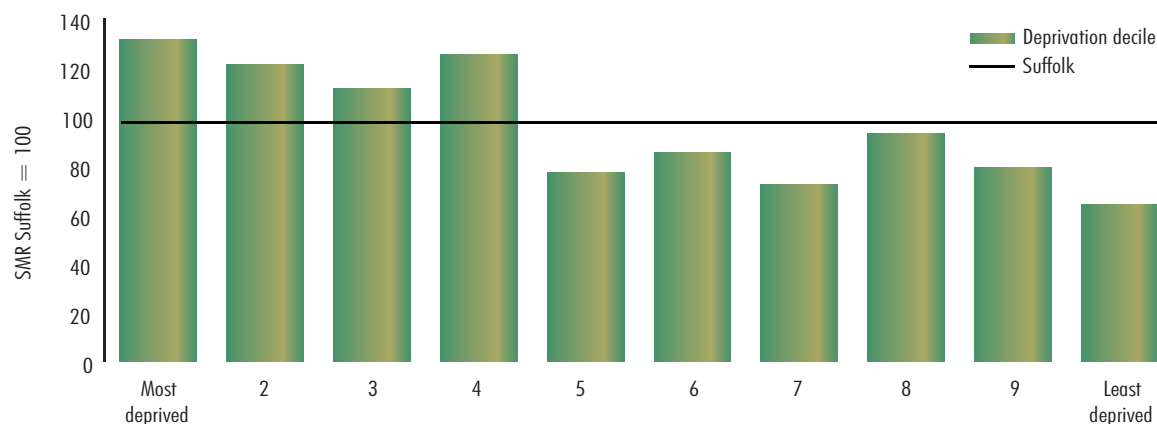
:: Inequalities

The chart below clearly shows the link between deprivation and mortality rates for self-harm, with rates in the most deprived areas significantly higher than those in more affluent areas.

Nationally suicide affects young people and older people disproportionately. Men are more likely to kill themselves than women.

Standardised mortality rates (SMRs). Deaths from self-harm and event of undetermined intent: numbers and rates: local authority districts in Suffolk, pooled data for 2008-10, persons of all ages.

Source: *Compendium of Population Health Indicators*



Key messages:

- The evidence shows that the main risk factors for suicide are being male, living alone, unemployment, drug or alcohol misuse and a history of mental illness.
- The evidence shows that effective approaches to suicide prevention include population based restriction of access to methods to complete suicide such as firearms, toxic medicines, access to hot spot locations such as bridges, and training staff to detect the risk of suicide so that they can give help and treatment.
- Intervention in high risk groups include: secondary prevention after episodes of self-harm; risk assessment in review of patients with mental health problems; and identification and treatment of depression in individuals with long term conditions or who are informal carers.

Early death



Maureen and Derek know that the community they live in is largely healthy compared to other places in England, but the health authorities say that things can always be better and that the main issue is the variations in health between different communities in the county. Derek was surprised to learn that babies born in Chantry, Ipswich can expect to live until they are around 77, but in Southwold, where Sandra and Tom live, life expectancy is 83.

Derek is really trying to look after himself now, his diagnosis of diabetes really shocked him into action and he doesn't want to end up like his dad, who passed away in his late 50s of a heart attack.

Derek has become a bit of a healthy living convert since he has been seeing the health

coach at Live Well. Derek is always nagging Maureen about going to her breast and cervical cancer screening appointments and recently Elsie and Ted have done their bowel screening tests at home and had their flu and pneumococcal vaccines. Derek knows that catching his diabetes early has helped in getting it under control and that the same applies to successfully treating cancer. He was particularly shocked to find out how much weight he needed to lose. When he started calorie counting he was amazed at how many calories there were in beer and wine.

Some of the other men he has met since he has been exercising are in even worse shape than him, and he is glad he quit smoking before his chest got too bad, and fixed his diet and alcohol intake before he did any permanent damage to his liver. It made him realise how much damage his lifestyle had been doing to his health over the years.

Mortality from all cardiovascular diseases (including heart disease and stroke)

:: Definition

The age standardised rate of mortality from all cardiovascular diseases (including heart disease and stroke) in persons less than 75 years of age per 100,000 population.

:: Why is this important?

Heart disease and stroke are key causes of premature death in England. There have been significant gains over the last decade but there is still much more to be done.

:: What does the data tell us about Suffolk?

Premature mortality from cardiovascular disease (CVD) has fallen by more than 50% in the last 15 years mirroring the national and regional trend. Death rates locally have been consistently below both national and regional levels. However there are some indications that the rate of decline is beginning to slow in Suffolk.

CVD is a major cause of premature death (accounting for approximately 25% of all premature deaths) and is the leading cause of health inequalities in Suffolk.

:: Inequalities

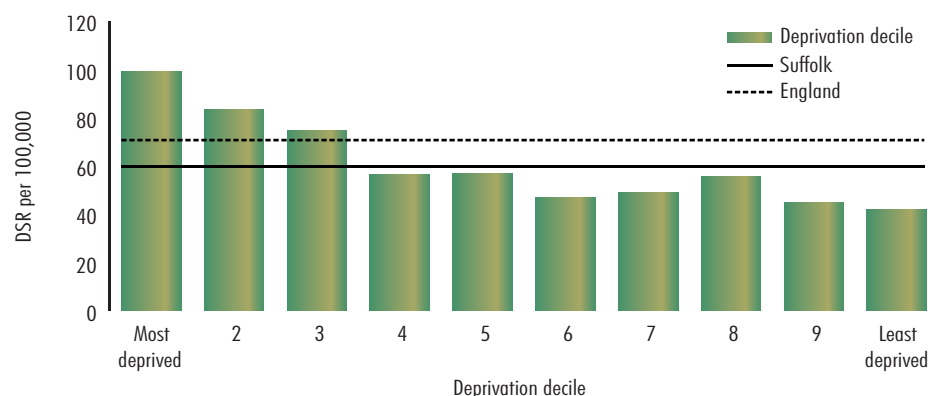
There are particularly marked health inequalities in Suffolk between people living in the most deprived areas compared with others. In 2008-10 both men and women aged under 75 living in the most deprived areas of Suffolk had a 65% higher risk of dying prematurely from CVD compared with the rest of the population. In NHS Suffolk, the health inequality between the most deprived areas and the rest of the population for coronary heart disease, which accounts for approximately half of all CVD deaths, had widened between 1994-98 and 2004-08.

Key messages:

- Too many people (about 500 a year) die early from CVD in Suffolk.
- There is good evidence that much of the disease is preventable (15-25% of CVD deaths are linked to smoking).
- Tackling the substantial and widening excess burden of death and ill health due to CVD in disadvantaged communities is a major challenge in Suffolk.
- Social gradients in the major lifestyle risk factors can explain approximately three-quarters of this excess – smoking alone can explain more than half.
- Action is required to continue to maximise population coverage of effective treatments and to target initiatives to reduce lifestyle risk factors towards the most deprived communities in Suffolk.

Mortality from CVD by deprivation area in Suffolk. Directly age-standardised rates (DSR).

Source: ONS Annual District Death Extract and mid year population estimates



Mortality from cancer



:: Definition

This indicator has two parts and is likely to be developed further.

- Age-standardised mortality rate from all cancers for persons aged under 75 per 100,000 population.
- Age-standardised rate of mortality that is considered preventable from all cancers in persons less than 75 years of age per 100,000 population.

:: Why is this important?

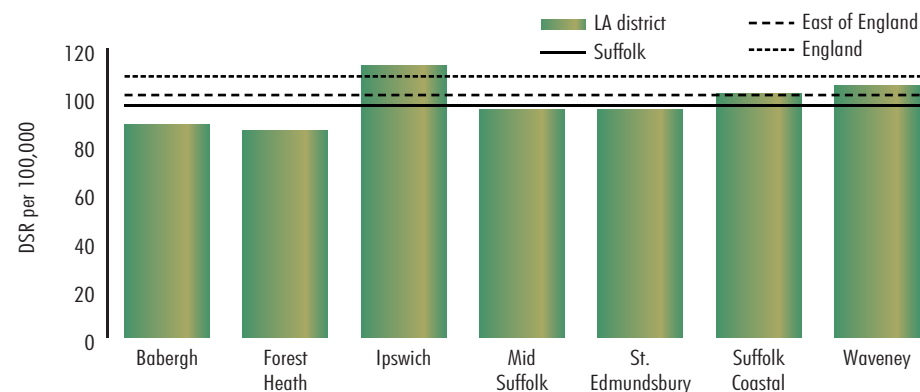
Cancer is the highest cause of death in England in under 75s. Early death from cancer is improving

but there is still much more to do to prevent and effectively treat cancers.

:: What does the data tell us about Suffolk?

- No districts or boroughs differed significantly from the all Suffolk rate for premature deaths due to cancer.
- The rates in Babergh and Forest Heath were lower than the East of England rate. All districts except Suffolk Coastal, Waveney and Ipswich borough had significantly lower rates compared to England.

Premature mortality from cancer by local authority in Suffolk: directly age-standardised rates per 100,000: persons less than 75 years of age.
 Source: NHS Information Centre for Health and Social Care



Mortality from cancer

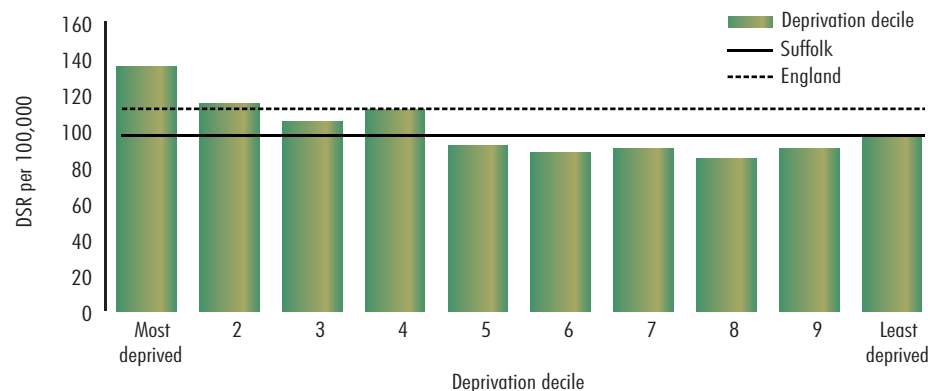
:: Inequalities

- Although Suffolk generally compares well to the whole of England, those living in the 10% most deprived areas in Suffolk experience higher levels of mortality compared to England.
- People living in the 20% most deprived parts of Suffolk experience significantly higher

mortality rates compared to Suffolk overall. The difference between the most and least deprived areas is considerable, with those living in the most deprived parts of Suffolk experiencing a mortality rate 40% higher than those living in the least deprived areas.

Premature mortality from cancer by deprivation in Suffolk: directly age-standardised rates per 100,000, persons less than 75 years of age.

Source: Office of National Statistics



- Cancer contributes to the difference in life expectancy between the most deprived and least deprived areas accounting for 19% of the difference in males and 9% of the difference in females.
- A cancer awareness survey across Suffolk also highlighted lower levels of awareness of cancer signs and symptoms in more deprived groups and in black and minority ethnic groups.

Key messages:

- Cancer is the leading cause of premature deaths in Suffolk, accounting for about 42% of premature deaths in males and 51% in females. There are on average nearly 900 premature deaths from cancer each year in Suffolk. The rate of premature mortality due to cancer has fallen by 25% over the last 15 years, but there are some indications that the rate of decline is beginning to slow.
- Late diagnosis is a recognised key factor contributing to poorer outcomes from cancer and is more common amongst lower socioeconomic groups and in some ethnic minority groups. About half of all cancers could also be prevented by lifestyle changes. Lifestyle factors account for most of the variance in cancer incidence between the most and least deprived population groups.
- Concerted and coordinated action by all organisations and communities in improving prevention, public awareness, early diagnosis and treatment is required in order to ensure that premature mortality from cancer continues to fall.

Mortality from cancer

case study

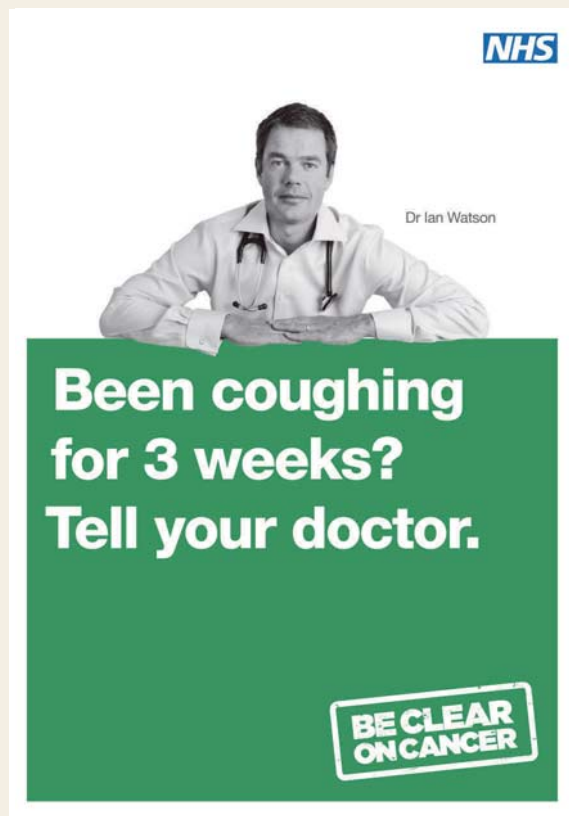
Early diagnosis

David Brinkley, 66, lives with his wife Trisha in Bucklesham in Suffolk. He was diagnosed with cancer of the gullet (oesophagus) in November 2009 and although he had heard of this cancer before (because a friend had died from it) he wasn't aware of the symptoms.

In fact it was a visit to the doctor to ask about something completely different that led by chance to the cancer diagnosis.

David says: "I went to see the doctor about my hearing after my wife had been nagging me about turning the TV up too loud. When the doctor said my hearing was OK, I said: 'Oh and while I am here...' I told him about the swallowing problems and the partial restriction I had been feeling in my throat, although there wasn't any consistency in the types of food this would happen with. He sent me for immediate tests."

The day after his first test at Ipswich Hospital, David was relaxing on his boat at



Felixstowe Ferry when his doctor phoned. He says: "I knew at that point it must be serious and from then on it was a roller coaster."

David was diagnosed with cancer of the gullet, the long food pipe which connects

the throat to the stomach. After extensive further tests and chemotherapy at Ipswich Hospital to shrink the tumour he was given a chance to recover and rebuild his strength for his operation. He then had surgery to remove the infected part of his oesophagus and part of his stomach at Broomfield Hospital in Chelmsford in March 2010.

He continues: "The support you get from the medical teams in Ipswich and Chelmsford and the way in which the two hospitals work together is fantastic. You never feel alone and the specialist nurses are always available to speak to."

After a spell of ten days in hospital, David went home and with the support of Trisha and many friends made a fairly quick recovery. He says: "I was in good shape before I went in for the operation. I didn't smoke or drink a lot and my wellbeing was key to a faster recovery."

After a further course of chemotherapy as a preventive measure David returned to a normal life and by August 2010 he was at the gym getting his fitness back. Already retired David then began to

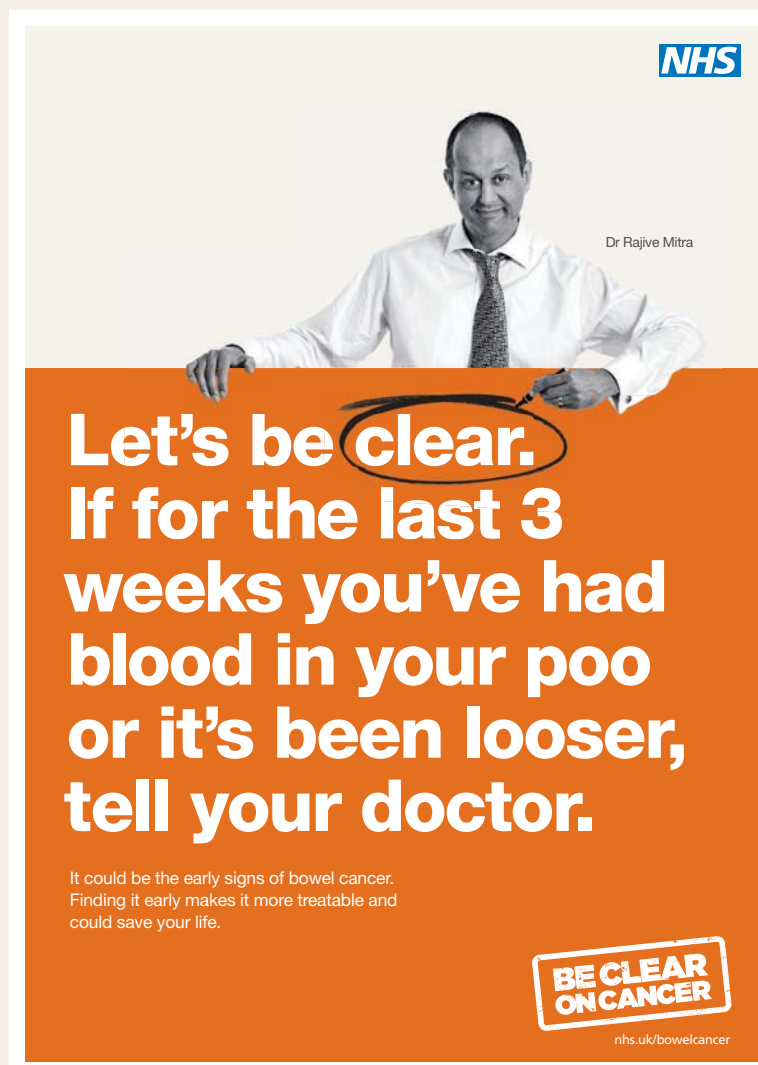
Mortality from cancer

He's also become closely involved with cancer charity MacMillan and has been trained to deliver (in tandem with a medical professional) a cancer survivorship course for people who have finished their treatment and are taking their next step to get their lives back on track.

The first seven week course he's helping to deliver (giving his time voluntarily for 2 ½ hours each week) he says is 'brilliant'.

'give something back' to help other cancer patients.

He says: "My working life was all cut and thrust business and it wasn't until I got myself into this environment that I understood there were so many kind, passionate people around who could support you as they did. I said that when I got through it I would put something back into the system." David became an active member of Ipswich Hospital Cancer Services User Group who he helps by promoting awareness.



NHS

Dr Rajive Mitra

Let's be clear.
If for the last 3 weeks you've had blood in your poo or it's been looser, tell your doctor.

It could be the early signs of bowel cancer. Finding it early makes it more treatable and could save your life.

BE CLEAR ON CANCER

nhs.uk/bowelcancer

case study

Mortality from liver disease

:: Definition

Age standardised mortality rate from liver disease for persons aged under 75 per 100,000 population. This indicator definition is still being developed.

:: Why is this important?

Liver disease is an important public health issue because not only is it a top cause of early death but the situation is worsening with people dying from liver disease at earlier ages than previously. Most liver disease can be prevented.

:: What does the data tell us about Suffolk?

Liver disease is one of the leading causes of premature mortality in Suffolk causing approximately 85 early deaths each year. The death rate from liver disease is increasing unlike other major causes of death, such as CVD and cancer that are declining. The rate of premature mortality from liver disease in Suffolk has increased by nearly 8% since 2005-07 mirroring both the regional and national trend.

case study

Hepatitis B and C

Suffolk DAAT has a range of initiatives in place to reduce the transmission of hepatitis and other blood borne viruses. Routine Hepatitis C screening is in place for prisoners in Suffolk and educational campaigns focused on prisoners and intra-venous drug users are commencing. Needle exchange programmes, which have been shown to prevent Hepatitis B and C infections, are operating across the county. However, reducing the frequency of needle sharing remains a significant challenge in Suffolk.

Hepatitis B: In 2010-11, 591 adults that started treatment were offered a course of Hepatitis B vaccinations (98% of all people

starting treatment). 32% of these individuals (number = 189) accepted the offer. People may not agree to or need a course of vaccinations for a number of reasons, including because they may be immunised already or they have acquired immunity.

Hepatitis C: In 2010-11, 314 adults that started treatment and who were current or previous injectors of drugs were offered a test for Hepatitis C. 32% of these individuals (number = 99) accepted the offer.

At the end of 2010-11 there were 931 current or previous injectors in treatment, of which 515 (55%) had received a Hepatitis C test.

*Source for Hepatitis B/Hepatitis C figures:
National Drug Treatment Monitoring System*

Mortality from liver disease

Compared to Suffolk and the East of England, Ipswich borough experienced a higher rate of premature mortality from liver disease. The rate in all other local authorities was similar to

the regional average but the rates in Babergh, Mid Suffolk, St Edmundsbury, Suffolk Coastal and Waveney were lower than the England average.

Directly age-standardised mortality rate for liver disease among persons aged under 75 years in Suffolk (2006-10).

Area	DSR	No of deaths	Compared to Suffolk average	Compared to EOE average	Compared to England average
Babergh	7.5	21	Similar	Similar	Lower
Forest Heath	9.5	17	Similar	Similar	Similar
Ipswich	16.8	59	Higher	Higher	Similar
Mid Suffolk	8.2	29	Similar	Similar	Lower
St Edmundsbury	7.2	25	Similar	Similar	Lower
Suffolk Coastal	8.4	40	Similar	Similar	Lower
Waveney	10.5	44	Similar	Similar	Lower
Suffolk	9.8	235	–	Similar	Lower
East of England	10.5	1,937	–	–	–
England	14.6	23,189	–	–	–

:: Inequalities

The premature mortality rate from liver disease in the most deprived parts of Suffolk is nearly three times higher than in the least deprived areas. The relationship between alcohol and socioeconomic status is complex but people in lower socioeconomic groups are more

likely to have problem drinking and experience the harmful effects of alcohol. The link between drug use and socioeconomic status is also well recognised. High risk groups for viral hepatitis infections include prisoners and injecting drug users.

Key messages:

- The key factors driving the increasing numbers of deaths from liver disease are all preventable such as alcohol, obesity and hepatitis. The increase in death rate is primarily attributable to alcohol with alcoholic liver disease accounting for more than a third of liver disease deaths.
- Priority actions include targeted activities to achieve lifestyle risk factor change in people living in the most deprived areas of Suffolk. Brief, evidence-based interventions for reducing alcohol consumption have been commissioned in Suffolk. These are targeted opportunistically in primary care and for those admitted to hospital via accident and emergency for alcohol-related causes.

Mortality from respiratory diseases

Key messages:

- Smoking is the main cause of COPD, which is one of the major respiratory diseases causing a high number of deaths.
- Premature mortality from COPD and pneumonia is potentially avoidable either through reduction of known risk factors (such as smoking for COPD) or preventative treatment (such as seasonal flu and other vaccinations for those at risk).
- Sustained targeted action is required to reduce smoking prevalence in the most deprived communities in Suffolk and to increase the uptake of seasonal flu and pneumococcal vaccination in at risk people.

:: Definition

Age standardised mortality rate from respiratory diseases for persons aged under 75 per 100,000 population. This indicator definition is still being developed.

:: Why is this important?

Respiratory disease is a top cause of premature death and disability. Smoking is a key cause.

:: What does the data tell us about Suffolk?

Respiratory disease is the third most frequent cause of death in Suffolk and is a major cause of both premature mortality and health inequalities. The rate of premature mortality due to respiratory disease in Suffolk has stayed relatively stable since 2005-07, mirroring regional

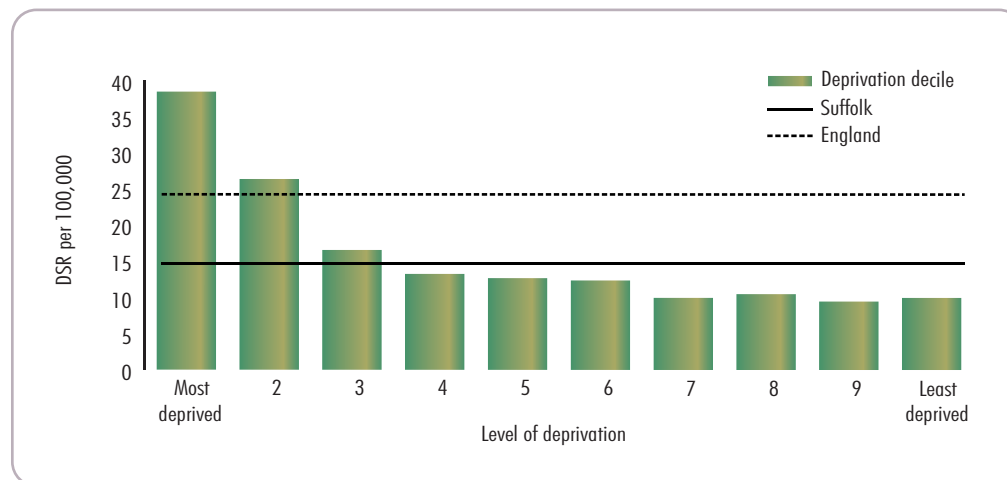
and national trends, and has been consistently below both the national and regional rate. Approximately 135 people die prematurely each year from respiratory disease – 7% of all premature deaths. The respiratory conditions with the highest impact on mortality are chronic obstructive pulmonary disease (COPD) and pneumonia.

:: Inequalities

There are marked inequalities in the rates of premature mortality from respiratory disease in Suffolk between people living in the most deprived areas compared with the rest. Premature mortality rates in the most deprived parts of Suffolk are nearly four times that of people living in the least deprived areas.

Mortality from respiratory disease by deprivation in Suffolk 2006-10. Directly age-standardised rates (DSR).

Source: ONS Annual District Death Extract and mid year population estimates



Excess winter deaths

:: Definition

Excess winter deaths index: the ratio of extra deaths from all causes that occur in the winter months compared to the expected number of deaths, based on the average of the number of non-winter deaths.

:: Why is this important?

Excess deaths in winter are more common in older people and those on low incomes. It is thought that many could be prevented.

:: What does the data tell us about Suffolk?

There were on average 409 excess winter deaths in Suffolk each year between 2006 and 2009. The Excess Winter Death Index for Suffolk in this period was 18.7% which is similar to the England average (18.1%). There was no significant difference in the rate of excess winter deaths between districts and boroughs in Suffolk. Suffolk rates are also comparable to the rates in the East of England and England overall. The key issues identified by further analysis of the Suffolk data for the period 2002–2009 are:

- Persons under 65: the rate of excess winter deaths for under 65s in Waveney district was higher than the England rate, with an average of 13 excess winter deaths per year.
- Persons 85+: the rate of excess winter deaths for over 85s in Babergh district was higher

than the England rate with an average of 37 excess winter deaths per year.

- All respiratory disease: the rate of excess winter deaths due to respiratory disease in Babergh district was higher than the England rate with an average of 25 excess winter deaths per year.
- Influenza and pneumonia: the rate of excess winter deaths due to influenza and pneumonia in Babergh district was higher than the England rate with an average of 14 excess winter deaths per year.
- Circulatory disease, coronary heart disease and stroke: for these conditions there was no difference in the rate between districts and boroughs in Suffolk and the England average.

:: Inequalities

Although excess winter deaths affect people of all ages they tend to increase with age, with the most vulnerable being those over 75, especially those living on their own and those with chronic illnesses. Mortality in winter increases more in England compared to other European countries with colder climates, suggesting that it is more than just lower temperatures that are responsible. Part of the explanation may lie in the quality of our housing stock, which is less thermally efficient than that in most other north European countries and hence may afford less protection against the cold. People living in older

Key messages:

- Excess winter deaths can be attributed to nearly all the main causes of death, however certain conditions are known to be exacerbated during winter months. Respiratory and circulatory diseases together account for three quarters of the excess winter deaths in Suffolk.
- Key measures to reduce the impact of cold weather include effective falls prevention programmes, increasing the uptake of flu vaccinations and better management of long term conditions. Broader measures include increasing the uptake of benefits to improve homes and reduce fuel poverty.

properties which are more difficult to heat have a greater excess of winter deaths. This phenomenon is seen across all socioeconomic groups with no evidence of a social gradient in excess winter deaths.

Appendix 1 – Overview of outcomes and indicators

Vision: To improve and protect the nation's health and wellbeing, and improve the health of the poorest fastest.

Outcome measures:

Outcome 1: Increased healthy life expectancy, ie taking account of the health quality as well as the length of life.

Outcome 2: Reduced differences in life expectancy and healthy life expectancy between communities (through greater improvements in more disadvantaged communities).

1. Improving the wider determinants of health

Objective:

Improvements against wider factors that affect health and wellbeing and health inequalities.

Indicators:

- Children in poverty
- *School readiness (Placeholder)*
- Pupil absence
- First time entrants to the youth justice system
- 16-18 year olds not in education, employment or training
- People with mental illness or disability in settled accommodation
- *People in prison who have a mental illness or significant mental illness (Placeholder)*
- Employment for those with a long-term health condition, including those with a learning difficulty/disability or mental illness
- Sickness absence rate
- Killed or seriously injured casualties on England's roads
- *Domestic abuse (Placeholder)*
- *Violent crime (including sexual violence) (Placeholder)*
- Re-offending
- *The percentage of the population affected by noise (Placeholder)*
- Statutory homelessness
- Utilisation of green space for exercise / health reasons
- Fuel poverty
- *Social connectedness (Placeholder)*
- *Older people's perception of community safety (Placeholder)*

2. Health improvement

Objective:

People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities.

Indicators:

- Low birth weight of term babies
- Breastfeeding
- Smoking status at time of delivery
- Under 18 conceptions
- *Child development at 2-2.5 years (Placeholder)*
- Excess weight in 4-5 and 10-11 year olds
- Hospital admissions caused by unintentional and deliberate injuries in under 18s
- *Emotional wellbeing of looked-after children (Placeholder)*
- *Smoking prevalence – 15 year olds (Placeholder)*
- Hospital admissions as a result of self-harm
- *Diet (Placeholder)*
- Excess weight in adults
- Proportion of physically active and inactive adults
- Smoking prevalence – adults (over 18s)
- Successful completion of drug treatment
- People entering prison with substance dependence issues who are previously not known to community treatment
- Recorded diabetes
- Alcohol-related admissions to hospital
- *Cancer diagnosed at stage 1 and 2 (Placeholder)*
- Cancer screening coverage
- Access to non-cancer screening programmes
- Take up of the NHS Health Check Programme – by those eligible
- Self-reported wellbeing
- Falls and injuries in the over 65s

3. Health protection

Objective:

The population's health is protected from major incidents and other threats, while reducing health inequalities.

Indicators:

- Air pollution
- Chlamydia diagnoses (15-24 year olds)
- Population vaccination coverage
- People presenting with HIV at a late stage of infection
- Treatment completion for tuberculosis
- Public sector organisations with board-approved sustainable development management plans
- *Comprehensive, agreed inter-agency plans for responding to public health incidents (Placeholder)*

4. Healthcare public health and preventing premature mortality

Objective:

Reduced numbers of people living with preventable ill health and people dying prematurely, while reducing the gap between communities.

Indicators:

- Infant mortality
- Tooth decay in children aged five
- Mortality from causes considered preventable
- Mortality from all cardiovascular diseases (including heart disease and stroke)
- Mortality from cancer
- Mortality from liver disease
- Mortality from respiratory diseases
- *Mortality from communicable diseases (Placeholder)*
- *Excess under 75 mortality in adults with serious mental illness (Placeholder)*
- Suicide
- *Emergency readmissions within 30 days of discharge from hospital (Placeholder)*
- Preventable sight loss
- *Health-related quality of life for older people (Placeholder)*
- Hip fractures in the over 65s
- Excess winter deaths
- *Dementia and its impacts (Placeholder)*

Overview of outcomes and indicators

Outcome	Description	Time period	Geographical area	Area value	England	Compared to England
1 Improving the wider determinants of health						
Children in poverty	Percentage of children in relative poverty (living in households where income is less than 60% of median household income before housing costs)	2009	Suffolk County	15.4%	21.3%	Lower
School readiness	Percentage of pupils scoring six points or more across all seven assessment scales of Personal, Social and Emotional Development and Communication, Language and Literacy areas of learning in the Early Years Foundation Stage Profile (EYFSP) and scoring 78 or more points across all scales of EYFSP	2010-11	Suffolk County	52%	59%	Lower
Pupil absence	% of half days missed by pupils due to overall absence (including authorised and unauthorised absence)	2009-10	Suffolk County	5.8%	6%	Lower
First time entrants to the youth justice system	Rate of young people aged 10-17 receiving their first reprimand, warning or conviction per 100,000 population aged 10-17 years	2010	Suffolk County	719	921	Lower
16-18 year olds not in education, employment or training	Percentage of young people aged 16-18 years not in employment, education or training	November 2011 – January 2012	Suffolk County	6.4%	6.1%	Higher
People receiving secondary mental health services in settled accommodation	People with mental illness and/or disability in settled accommodation: percentage of adults aged 18-69 years receiving secondary mental health services known to be in settled accommodation at the time of their most recent assessment, formal review or multi-disciplinary care planning meeting	2010-11	Suffolk County	72.7%	66.8%	Higher

Overview of outcomes and indicators

Not all of the indicators can currently be measured and are identified in the PHOF as "placeholders". For some of these indicators the data is not available, and for others the definition requires further clarification. The Department of Health intends to improve this range of information over the coming year.

Outcome	Description	Time period	Geographical area	Area value	England	Compared to England
People in prison who have a mental illness or significant mental illness (Placeholder)						
Employment for those with a long-term health condition including those with a learning difficulty/disability						
Sickness absence rate						
Killed or seriously injured casualties on England's roads	People killed or seriously injured on the roads of the area, crude rate per 100,000 resident population, all ages	2008-10	Suffolk County	48.3	44.3	Higher
Domestic abuse (Placeholder)						
Violent crime (including sexual violence) (Placeholder)						
Re-offending	Proportion of proven re-offences among all offenders. Proven re-offence is defined as any offence committed in a one year follow-up period and receiving a court conviction, caution, reprimand or warning in the one year follow up or a further six months waiting period	2009-10	Suffolk County	25.4%	26.4%	Similar
The percentage of the population affected by noise (Placeholder)						
Statutory homelessness	Crude rate of statutory homeless households per 1,000 estimated total households	2009-10	Suffolk County	1	1.86	Lower
	Crude rate of statutory homeless in temporary accommodation per 1,000 estimated total households					

Overview of outcomes and indicators

Outcome	Description	Time period	Geographical area	Area value	England	Compared to England
Utilisation of green space for exercise/health reasons						
Fuel poverty	Percentage of households needing to spend more than 10 per cent of income on all fuel use to heat the home to an adequate standard of warmth	2009	Suffolk County	18.3%	18.4%	Similar
Social connectedness (Placeholder)						
Older people's perception of community safety (Placeholder)						
2 Health improvement						
Low birth weight of term babies	Live and stillborn infants with birth weight under 2,500 grams per 100 live and still births with a stated birth weight	2006-10	Suffolk County	6.7	7.5	Lower
Breastfeeding	Percentage of mothers initiating breastfeeding	2009-10	Suffolk County	72.1%	73.6%	Lower
Smoking status at time of delivery	Percentage of mothers smoking at time of delivery	2009-10	Suffolk County	16.6%	14.0%	Higher
Under 18 conceptions	Conceptions among girls aged under 18 years per 1,000 girls aged 15-17 years	2008-10	Suffolk County	28.6	38.1	Lower
Child development at 2-2.5 years (Placeholder)						

Overview of outcomes and indicators

Outcome	Description	Time period	Geographical area	Area value	England	Compared to England
Excess weight in 4-5 and 10-11 year olds	Percentage of children with valid height and weight measurements in Reception Year that are classified as overweight or obese	2010-11	Suffolk County	22.1%	22.6%	Similar
	Percentage of children with valid height and weight measurements in Year 6 that are classified as overweight or obese	2010-11	Suffolk County	31.7%	33.4%	Lower
Hospital admissions caused by unintentional and deliberate injuries in under 18s	Crude rate of emergency hospital admissions due to injury in persons aged 0-17 per 10,000 resident population	2010-11	Suffolk County	105.6	124.3	Lower
Emotional wellbeing of looked-after children (Placeholder)						
Smoking prevalence – 15 year olds (Placeholder)						
Hospital admissions as a result of self-harm	Directly age and sex standardised emergency admission rate per 100,000 population for self-harm and injury undetermined, all ages	2009-10	Suffolk County	182.5	198.3	Lower
Diet (Placeholder)						
Excess weight in adults						
Proportion of physically active and inactive adults	Proportion of adults (aged 16 and over) participating in no sessions of sport or physical activity at moderate intensity in the previous 28 days (0 x 30 minutes)	2010-11	Suffolk County	26.3%	29.5%	Lower
	Proportion of adults (aged 16 and over) participating in sport and/or undertaking some form of physical activity at moderate intensity on 20 occasions in the previous 28 days (5 x 30 minutes per week)	2010-11	Suffolk County	22.6%	20.6%	Higher

Overview of outcomes and indicators

Outcome	Description	Time period	Geographical area	Area value	England	Compared to England
Smoking prevalence – adult (over 18s)	Smoking prevalence in the adult (aged 18+) population from the Integrated Household Survey	2010-11	Suffolk County	20.1%	20.7%	Similar
Successful completion of drug treatment	Number of drug users that left drug treatment successfully (free of drug(s) of dependence) who do not then re-present to treatment again within six months as a proportion of the total number in treatment					
People entering prison with substance dependence issues who are previously not known to community treatment	% of people assessed for substance dependence issues when entering prison					
Recorded diabetes	The percentage of patients aged 17 years and over with diabetes mellitus, as recorded on practice disease registers (based on aggregating values for GP practices located in Suffolk County)	2010-11	Suffolk County	5.3%	5.5%	Lower
Alcohol-related admissions to hospital	Directly age and sex standardised hospital admissions for alcohol-related harm at all ages, per 100,000 resident population	2010-11	Suffolk County	1681	1891	N/A
Cancer diagnosed at stage 1 and 2 (Placeholder)	Patients with cancer diagnosed at stage 1 and 2 as a proportion of cancers diagnosed					
Cancer screening coverage	The % of women aged 53-70 eligible for breast screening at a given point in time who were adequately screened within the last three years	2009-10	NHS Suffolk	81.8%	76.9%	Higher
	The % of women 26-64 in a population eligible for cervical screening at a given point in time who were adequately screened within the last five years	2005-06 – 2010-12	Suffolk County	78.1%	75.6%	Higher

Overview of outcomes and indicators

Outcome	Description	Time period	Geographical area	Area value	England	Compared to England
Access to non-cancer screening programmes	HIV coverage: The % of pregnant women eligible for infectious disease screening who are tested for HIV, leading to a conclusive result					
	Syphilis, hepatitis B and susceptibility to rubella uptake: the % of women booked for antenatal care, as reported by maternity services, who have a screening test for syphilis, hepatitis B and susceptibility to rubella					
	The % of pregnant women eligible for antenatal sickle cell and thalassaemia screening for whom a conclusive screening result is available at the day of report					
	The % of babies registered within the area both at birth and at the time of report who are eligible for newborn blood spot screening and have a conclusive result recorded on the Child Health Information System within an effective timeframe					
	The % of babies eligible for newborn hearing screening for whom the screening process is complete within four weeks corrected age or five weeks correct age	2009-10	NHS Suffolk	84.9%	92.3%	Lower
	The % of babies eligible for newborn physical examination who were tested within 72 hours of birth					
	The % of those offered screening for diabetic retinopathy who attend a digital screening event					
Take up of the NHS Health Check Programme – by those eligible	% of eligible people who receive an NHS Health check	2010-11	NHS Suffolk	20.8%	13.9%	Higher
Self-reported wellbeing						

Overview of outcomes and indicators

Outcome	Description	Time period	Geographical area	Area value	England	Compared to England
Falls and injuries in the over 65s	The definition is not yet finalised. The following is therefore based on directly age-sex standardised rate of inpatient admissions for unintentional falls per 100,000 resident population aged 65 years and over	2010-11	Suffolk County	404.4	498.3	Lower
3 Health protection						
Air pollution	The mortality effect of anthropogenic particulate air pollution per 100,000 population					
Chlamydia diagnoses (15-24 year olds)	Rate of chlamydia diagnosis per 100,000 resident population aged 15-24 years. Population from ONS mid-year estimates	2010	NHS Suffolk	2219	2259	Similar
Population vaccination coverage	Hepatitis B vaccination coverage (one and two year olds)					
	BCG vaccination coverage (1-16 year olds)					
	DTaP/IPV/Hib vaccination coverage (one year olds)	2008-09 – 2011-12	Suffolk County	94.5%	94.2%	Similar
	DTaP/IPV/Hib vaccination coverage (two year olds)	2008-09 – 2011-12	Suffolk County	95.4%	96.0%	Similar
	DTaP/IPV vaccination coverage (five year olds)	2008-09 – 2011-12	Suffolk County	87.4%	85.9%	Higher
	MenC vaccination coverage (one, two and five year olds)					
	PCV vaccination coverage (one year)					
	PCV vaccination coverage (two years)	2010-11	NHS Suffolk	89.8%	89.3%	Similar
	PCV vaccination coverage (five years)					

Overview of outcomes and indicators

Outcome	Description	Time period	Geographical area	Area value	England	Compared to England
Population vaccination coverage (continued)	Hib/MenC booster vaccination coverage (2 year olds)	2010-11	NHS Suffolk	92.9%	91.6%	Higher
	Hib/MenC booster vaccination coverage (5 year olds)					
	PCV booster vaccination coverage (2 and 5 year olds)					
	MMR vaccination coverage for one dose (2 year olds)	2008-09 – 2011-12	Suffolk County	89.1%	89.1%	Similar
	MMR vaccination coverage for one dose (5 year olds)					
	MMR vaccination coverage for two doses (5 year olds)	2008-09 – 2011/12	Suffolk County	83.5%	84.2%	Similar
	Td/IPV booster vaccination coverage (13-18 year olds)					
	HPV vaccination coverage (females 12-17 year olds)					
	PPV vaccination coverage (over 65s)					
	Flu vaccination coverage (over 65s)	2010-11	NHS Suffolk	73.4%	72.8%	Higher
	Flu vaccination coverage (at risk individuals aged over 6 months)	2010-11	NHS Suffolk	48.8%	50.4%	Lower
People presenting with HIV at a late stage of infection	Percentage HIV diagnoses aged 15+ with CD4 cell count <350 at time of diagnosis	2009	NHS Suffolk	56.3%	51.3%	Similar
Treatment completion for tuberculosis	The proportion of all tuberculosis patients with treatment outcome reported who have completed treatment	2006-2008	NHS Suffolk	72%	Unknown	N/A
Public sector organisations with board-approved sustainable development management plans	% of NHS organisations with board-approved sustainable development management plans					

Overview of outcomes and indicators

Overview of outcomes and indicators

Outcome	Description	Time period	Geographical area	Area value	England	Compared to England
Comprehensive, agreed inter-agency plans for responding to public health incidents (Placeholder)						
4 Healthcare public health and preventing premature mortality						
Infant mortality	Crude mortality rate of infants aged under 1 year per 1,000 live births	2008-10	Suffolk County	4	4.6	Similar
Tooth decay in children aged five	Mean number of teeth per child sampled which were either actively decayed, missing or filled (dmft)	2007-08	Suffolk County	0.63	1.1	Lower
Mortality from causes considered preventable						
Mortality from all cardiovascular diseases (including heart disease and stroke)	Directly standardised mortality rate per 100,000 population for circulatory diseases, aged <75	2008-10	Suffolk County	57.8	67.3	Lower
Mortality from cancer	Directly standardised mortality rate per 100,000 population for cancer, aged <75	2008-10	Suffolk County	98.5	110.1	Lower
Mortality from liver disease	Directly standardised mortality rate per 100,000 population for liver disease, aged <75	2008-10	Suffolk County	9.9	14.6	Lower
Mortality from respiratory diseases	Directly standardised mortality rate per 100,000 population for respiratory disease, aged <75	2008-10	Suffolk County	19.9	24.4	Lower
Mortality from communicable diseases (Placeholder)						
Excess under 75 mortality in adults with serious mental illness (Placeholder)						
Suicide (all ages)	Directly standardised mortality rate per 100,000 population for self-harm and injury undetermined	2008-10	Suffolk County	9.3	7.9	Similar

Overview of outcomes and indicators

Outcome	Description	Time period	Geographical area	Area value	England	Compared to England
Emergency readmissions within 30 days of discharge from hospital (Placeholder)						
Preventable sight loss						
Health-related quality of life for older people (Placeholder)						
Hip fractures in over 65s	Directly standardised rate of emergency hospital admissions for fractured neck of femur, per 100,000 population age 65+	2010-11	Suffolk County	431.6	451.9	Similar
Excess winter deaths	The ratio of extra deaths from all causes that occur in the winter months compared to the average of the number of non-winter deaths of the same period	2006-09	Suffolk County	18.7%	18.1%	Similar
Dementia and its impacts (Placeholder)						

Update on recommendations from 2011

:: Recommendation 1

Locality and community wellbeing is becoming a major priority for the forthcoming multi-agency Health and Wellbeing Board. It is recommended that the information in this report is used as a basis for discussions by the Board which will set local priorities in 2011-12. The Board needs to recognise that there are numerous factors influencing wellbeing and that commercial and voluntary/third sector bodies can work alongside communities as well as the public sector.

The Suffolk Health and Wellbeing Board was established in shadow form in April 2012 and has a committed membership from partners including local authorities, the NHS and the voluntary sector.

The potential of the Board to impact on the wide range of factors that improve people's wellbeing has been recognised and the Board has set itself the challenge of tackling difficult issues, improving joint work between agencies and "unblocking" barriers. Prevention and early intervention, as well as ensuring a locality perspective, are priorities of the Board. A pilot to build a detailed community based asset profile has started in Mid Suffolk and Babergh and will help develop the way the public health teams work with districts and boroughs in the future.

:: Recommendation 2

A validated information source which defines assets and vulnerabilities can be very useful for communities in informing their priorities. It is recommended that the data in this report and additional profiles on the Suffolk Observatory website are made widely available to community leaders, elected members, voluntary bodies, local government officers and NHS staff working with communities, to complement their existing knowledge.

An asset based profile for every ward in Suffolk has been developed and added to the Suffolk Observatory website www.suffolkobservatory.info. The 2011 Annual Public Health Report was widely circulated to partners in Suffolk County Council, the NHS, district and borough councils, the voluntary sector and placed in public libraries in the county. It is also freely available on the internet at www.suffolkpct.nhs.uk/aphr2011. The report is also part of the suite of resources that make up the Suffolk Joint Strategic Needs Assessment (JSNA) and has been available to the Health and Wellbeing Board to help inform their decision making.

:: Recommendation 3

Many communities have commented that public data needs to offer a consistent picture and be easy to understand. Most particularly that information is needed for small geographic areas to inform local decisions. It is recommended that the information in this report is fully incorporated in the Joint Strategic Needs Assessment, and that more small area data is developed in 2011-12, and we ask for feedback from communities on how accurate and useful the information has been.

The Suffolk Observatory contains Suffolk's vital statistics. It is the one-stop shop for data, statistics and reports all about Suffolk, provided by a variety of partner organisations. Through data, reports and analysis, the Suffolk Observatory provides a comprehensive picture of the county and is an accessible source for useful facts and figures to help inform local decision making. All areas of the county are covered, including information at district, ward and parish level, easily accessible in a variety of formats. Data available for small geographic areas includes population estimates, life expectancy, deprivation, mortality rates, physical activity, childhood obesity, GCSE attainment, unemployment, benefit claimants and crime data which, along with the asset based ward profiles, can help communities garner a comprehensive picture of their area.

Update on recommendations from 2011

:: Recommendation 4

As part of the NHS reforms, the four current Clinical Commissioning Groups (CCGs) in Suffolk will gradually take over many of the existing Primary Care Trust (PCT) commissioning responsibilities in the next couple of years. It is recommended that health profiles along CCG boundaries are developed as soon as possible.

Work on developing profiles was started before the geographical coverage of CCGs was confirmed and was therefore based on the original three General Practice Commissioning Consortia within NHS Suffolk. The three NHS Suffolk profiles are complete and NHS Great Yarmouth and Waveney are developing a health profile for Health East, the clinical commissioning group based in Waveney. Any future public health profiles will be produced based on the populations of the CCGs. Each completed profile includes information on geography, demography, deprivation, all cause mortality, life expectancy, and on three diseases: CVD, cancer and respiratory disease. This focus was chosen because the three diseases collectively account for over three quarters of deaths and are major causes of both premature mortality and health inequalities in Suffolk. In addition, the recently published Public Health Outcomes Framework (Department of Health, 2012) includes indicators for premature mortality from cardiovascular disease, cancer and respiratory disease, and progress against these will be measured to see if real improvements are being made. Other information of interest to CCGs is available on the Suffolk Observatory website.

:: Recommendation 5

Heart disease is still the commonest cause of health inequalities, and cancer is the commonest cause of early deaths in Suffolk. It is recommended that the Director of Public Health continues to support the contributions from Healthy Ambitions Suffolk, Clinical Commissioning Groups, PCTs, county council and district and borough councils in their collective efforts to address these areas as part of a wider strategy to make Suffolk the healthiest county by 2028. Part of this work needs to identify and implement measures which will have the greatest positive impact on the health of the county. See the following box for high impact changes.

- Support people in their lifestyle choices, especially:
 - Stop smoking initiatives
 - Increase physical activity eg walking, cycling
- Support the work of Healthy Ambitions Suffolk improving “heart health”
- Improve screening uptake
- Expand current programmes for health in workplaces by working with the Suffolk Chamber of Commerce
- Expand current programmes for health in schools
- Increase public awareness of the signs and symptoms of cancer
- Improve NHS service provision by:
 - Improving the management of people with heart failure
 - Increasing access to cardiac rehabilitation
 - Reducing delays in diagnosis of cancer
 - Improving the management of cancer patients

The Suffolk Health and Wellbeing Board has been informed of the considerable progress that has already been made in reducing early deaths and health inequalities from heart disease and cancer. The commencement of new prevention services such as the Healthy Lifestyle Service (Live Well Suffolk), and the roll out of NHS Health Checks in 2011 (with targeted interventions for the most deprived communities), have improved the quality and range of prevention services aimed at decreasing heart disease and cancer. Healthy lifestyle advice and treatment are offered by Live Well Suffolk who have helped more smokers than ever quit in 2011, and have offered new opportunities such as healthy cooking sessions, spinning classes and zumba. Obese adults have, for the first time, access to a 12 week course of diet and exercise, and the summer of 2010 saw a skin cancer awareness campaign run across the county. Further developments of the healthy lifestyle service are planned for 2012.

Substantial NHS service improvements in the last year for heart disease include a two-fold increase in the number of cardiac rehabilitation courses available and a number of GP-led projects to improve the management of heart failure in primary and community care.

Over the last year, a number of high profile campaigns have been held across Suffolk to raise public awareness of early signs and symptoms of cancer.

Update on recommendations from 2011



We are now working with local organisations and community groups/champions to sustain this activity. We are also working with local GPs and cancer specialists on a number of initiatives aimed at reducing delays in diagnosis of cancer. Local cancer services continue to improve with ongoing achievement of cancer targets and the implementation of national guidance on service standards.

:: Recommendation 6

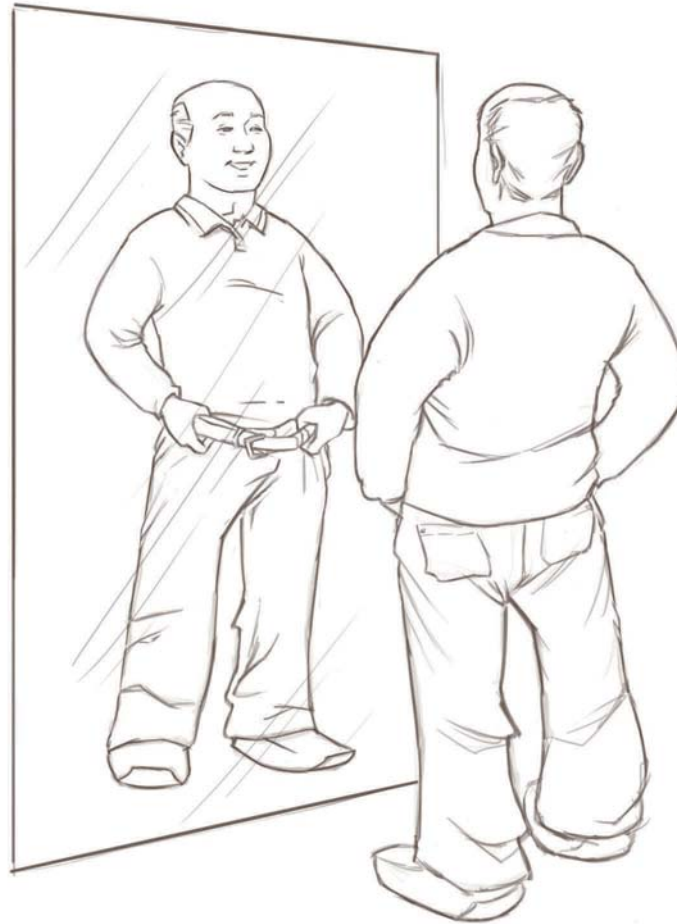
The annual public health report in 2010 reported on the growing importance of taking a life course approach to improving health and wellbeing, based on the well regarded review published by Sir Michael Marmot, which is currently informing future public health policy. It is recommended that the Health and Wellbeing Board adopts a life course approach and considers future areas of focus for each age group. Topics of interest could include; prevention and services for the frail elderly, early years development, mental health promotion, areas of low skills and employment or the impact of employment on health.

The Suffolk Joint Strategic Needs Assessment (JSNA) has been refreshed, and the published report The State of Suffolk, looks at priorities in Suffolk across the life course and has been used to inform the Suffolk Health and Wellbeing Board. In accordance with the priorities identified in the State of Suffolk report and the Marmot recommendation of taking a life course approach to improving health and wellbeing, the Suffolk Health and Wellbeing Board has considered ageing well, and children and young people in families living in poverty. During 2012 the Board will also consider a paper on physical activity, aimed at making Suffolk the most active county. The Board is able to create solutions for change that require a whole Suffolk system approach, which has not been possible from a single organisation perspective.

:: Recommendation 7

Some groups have difficulty accessing initiatives to improve wellbeing, because of their financial or social status, their sexual orientation, their cultural or religious belief, or they do not have English as their first language. Where individuals or groups experience multiple problems they are particularly at risk and this is a major cause of health inequality. The case studies of good practice in this report can be used by all agencies to address the needs of the most vulnerable. However it is suggested that the Health and Wellbeing Board adopts a strategic role in systematically reducing health inequalities and regularly monitoring progress over the next few years.

To improve health inequalities, action beyond the reach of the NHS is required, for example housing and the environment are key factors influencing the health and wellbeing of an individual. The Health and Wellbeing Board will need to focus on health inequalities and ensure high quality, consistent and comprehensive health and wellbeing services are commissioned and delivered in Suffolk. The Board will receive information from equity profiles in the JSNA, and data from the 2011 Census, to facilitate their decision making so that progress is made in decreasing the health inequalities of the communities of Suffolk.



This report contributes to the Joint Strategic Needs Assessment (JSNA) for Suffolk