

Health Behaviours in Suffolk

Health Needs Assessment: introductory summary

June 2022



Contents

Acknowledgements.....	4
Word accessibility	4
COVID-19 and data limitations	5
Introduction	6
Understanding Suffolk’s population	7
What is the local picture?	8
Population by ethnicity	8
Population by sex.....	10
Population by sexual identity.....	10
<i>Population by religion</i>	11
How is the population changing?	11
Suffolk Indices of Deprivation	13
Understanding the impact of health behaviours.....	16
Health behaviours.....	16
What is the Global Burden of Disease?	17
Understanding risks associated with death and disability adjusted life years (DALYs)	17
A closer look at health behaviours in Suffolk.....	21
Conditions linked to health behaviours.....	22
Executive summary	25
Understanding health behaviours	25
Alcohol	25
Tobacco.....	26
Child weight management.....	27
Adult weight management	27
Physical activity.....	28
NHS Health Checks.....	28
Re-imagining Healthy Living Survey: service user engagement	30
Demographics	30
Age profile.....	30
Gender profile.....	30
Ethnicity	31
Locality	31
Findings	33
Motivation to access services	33
Barriers to accessing services	35

Delivering Healthy Behaviour Services	37
Service user feedback	42
Recommendations	48
References	54

Acknowledgements

There have been wide ranging stakeholder contributions to this Health Needs Assessment (HNA). Contributions have been through several consultation events to discuss the scope of this report, a stakeholder survey codesigned with stakeholders and service users across Suffolk, and continued service user interviews that go beyond the scope of this report. The development and ongoing workstreams associated with this HNA have been overseen by a Steering Group that have stakeholder representation.

A special thank you to all organisations that have made – and continue to make - this work possible.

Word accessibility

Please contact the Knowledge, Intelligence and Evidence Team at Public Health Suffolk if you require a word version of this Health Needs Assessment.

Email: knowledgeandintelligence@suffolk.gov.uk

COVID-19 and data limitations

The data within this report mostly cites 2019/20 data sets and therefore does not examine the impact of COVID-19 on service provision, health behaviours or outcomes. Rather, the impact of COVID-19 is currently being explored through interviews with stakeholders and service users throughout Suffolk, which are not included in this report.

Please note that report was written in October 2021 and published in May 2022. At the time of publication, 2020/21 data has been published. Therefore, future work streams related to health behaviour services will reflect new data sources.

Smoking prevalence data

The Annual Population Survey (APS) is designated as a National Statistic and has provided a consistent time series of data for smoking prevalence. However, in 2020 due to the impact of the COVID-19 pandemic the mode of the APS changed from face-to-face interview to telephone only from Quarter 2 2020. Prior to publication, Office for National Statistics (ONS) have investigated whether there was a relationship between the smoking prevalence estimate and the change in data collection. The conclusion was that the estimates have indeed been impacted by the change in survey mode from face-to-face interview to telephone, and that selection bias will have also influenced the final prevalence figures. The final prevalence figures as published are lower than would have been expected if data collection had stayed the same for 2020.

Therefore, this report refers to 2019/20 smoking prevalence data so that it is possible to provide time series and comparable reflection.

Quality and Outcome Framework data

The adult weight management data and smoking prevalence data relate to Quality and Outcomes Framework (QOF) data provided by GP practices. 2020/21 QOF data is now available on the Office for Health Improvement and Disparities (OHID) [Fingertips](#) website. As this report was written in 2021 and published in 2022, the QOF data within this report refers to 2019/20.

National Childhood Measurement Programme (NCMP)

COVID-19 affected NCMP data collection for the 2019/20 reporting period. Firstly, the Reception Year total for number children measured was 4,155 compared to the previous year total of 7,489, a 22.2% reduction. While Year 6 data collection was not significantly affected due to the majority of measurements completed by December 2019 (7,387 in 2018/19 compared to 7,250 in 2019/20 – a reduction of 4.2%).

Introduction

The average life expectancy in the world has increased substantially in the past few decades¹. Although people live longer, older individuals often live with disabilities and chronic diseases². With aging populations comes a higher prevalence of chronic diseases such as diabetes, cardiovascular disease, and cancer. People with chronic diseases including cancer, cardiovascular disease, and diabetes have a shorter life expectancy than their peers without these chronic conditions³. Estimates of the loss in life years due to these chronic conditions range from 7.5 to 20 years, depending on the methods used and the characteristics of the study population¹.

Modifiable health behaviours including smoking, physical activity, alcohol intake, body weight, and diet quality affect both total life expectancy and incidence of chronic diseases⁴. Studies have shown that smoking, inactivity, poor diet quality, and heavy alcohol consumption contribute up to 60% of premature deaths and 7.4-17.9 years loss in life expectancy¹.

As a result of COVID-19, there is a renewed urgency to understand and effectively manage entrenched inequalities relating to health behaviours. There is existing cross system activity on health behaviour inequalities but it is clear that more needs to be done.

This Health Needs Assessment provides a snapshot of Suffolk's key modifiable health behaviour risk factors, addressing geographical variation in health outcomes where possible. This report, alongside ongoing national and local work such as the NHS Long Term Plan, local Transformation Plans, and the Suffolk and North East Essex Integrated Care System, provides a firm commitment to a more concerted and systematic approach to reducing health behaviour inequalities and addressing unwarranted variation in care.

This summary document provides an overview of key modifiable behavioural risk factors in Suffolk in line with the research from the [Global Burden of Disease](#) followed an executive summary of findings for alcohol, tobacco, weight management, physical activity, and NHS Health Checks. An analysis of service user feedback is then presented followed by the recommendations.

More detailed reports on the health behaviours reviewed in this summary are available on the [Healthy Suffolk](#) website.

Understanding Suffolk's population

The health and health care needs of a population cannot be measured or met without knowledge of its size and characteristics. The main population influences on health service needs are:

- size
- age structure
- ethnicity
- migration
- inequalities and deprivation

One individual may belong to more than one demographic "group". Not everyone within the same demographic group will experience the same challenges.

Understanding how a population has changed in the past can help project how a population may appear in the future, whether by complex calculations or simple facts. For example, the "baby boomers" born in the 1960s will be in "older age" by 2041. These projections can inform future health and care planning.

Some life stages require higher levels of health care, such as:

- neonatal period (first 4 weeks of life) and infancy
- fertile years for women (support for pregnancy and childbirth)
- old age (when multimorbidity increases, healing may be slower, and treatments may be palliative rather than curative)

Further impacts of longer life include:

- increased need for social care. One in five people aged 75 to 84 have at least some difficulty washing or dressing, and this is even higher for people aged 85 and over
- difficulty accessing services, as older people often live in more rural areas and may find it difficult to travel

In Suffolk (and England as a whole) the population aged 65 and over is growing more rapidly than the working age population, and faster than the retirement age is increasing.

Population data should be used to improve access to services and reduce inequalities. The Equality Act 2010 prohibits unlawful discrimination in the provision of services on the grounds of age, disability (physical or mental, including long-term conditions), gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation (these are known collectively as "protected characteristics"). Clinical Commissioning Groups are legally required to reduce inequalities in access to and outcomes of health services. Therefore, organisations need to know about our communities and their needs.

NHS England uses the term "inclusion health" to define groups of people who are socially excluded and often experience poor health outcomes, such as:

- people who are homeless and rough sleepers
- the Traveller community (including Gypsies and Roma)
- vulnerable migrants (refugees and asylum seekers)
- sex workers
- those undergoing or surviving Female Genital Mutilation (FGM)

- those undergoing or surviving human trafficking
- those who define themselves as being part of the recover mental ill health
- the trans / non-binary community

What is the local picture?

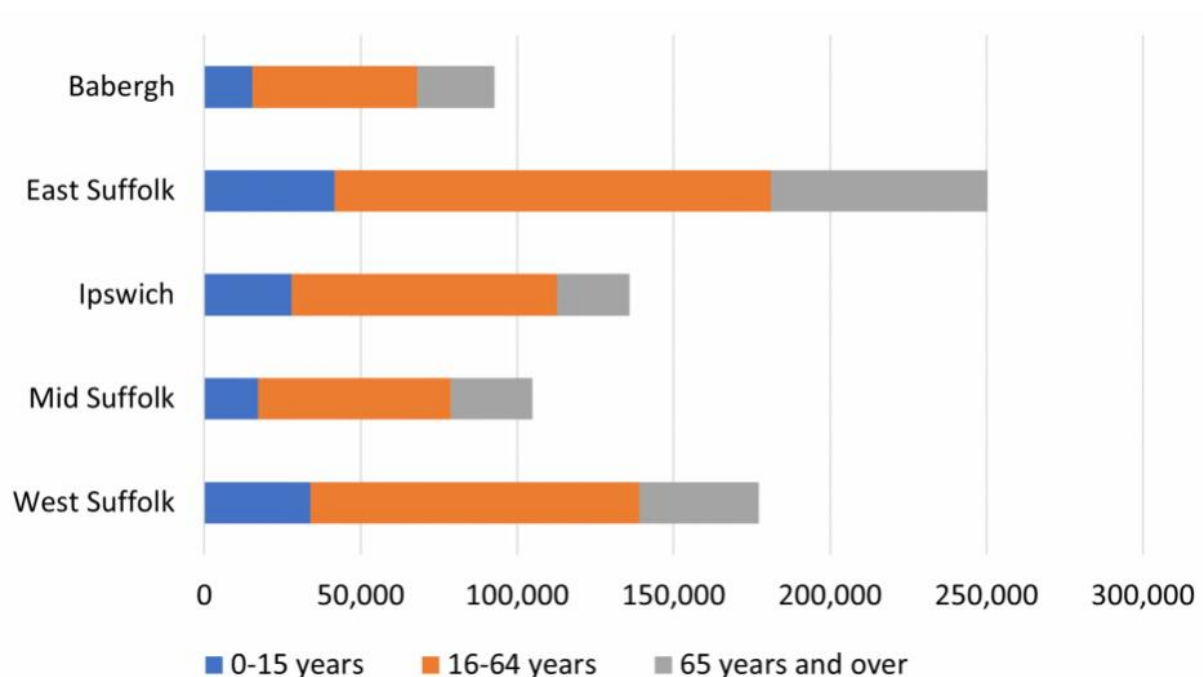
Suffolk has a higher percentage of its population aged 65 and over than England (23.8% compared to 18.5%), and a lower proportion of working age people (58.3% compared to 62.3%).

Ipswich (20.5%) is the only area in Suffolk where the percentage of children (aged under 16) is above the average for England (19.2%). (Figure 1)

East Suffolk (27.7%) and Babergh (26.5%) have the highest proportion of people aged over 65. Other than Ipswich, all areas in Suffolk have a higher proportion of people aged 65 compared to England (18.5%).

Ipswich is the only borough or district to have a higher proportion of working age adults than England (Ipswich 62.5%, England 62.3%).

Figure 1: Suffolk population by broad age band and district/borough, 2020

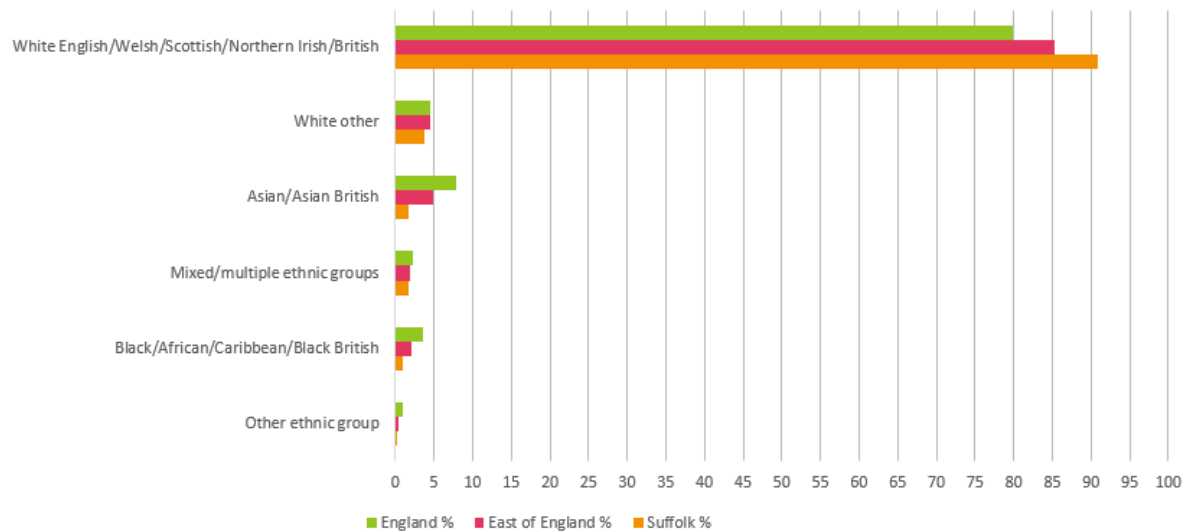


Source: Office for National Statistics. "Mid-Year Population Estimates, UK, June 2020", 2021.

Population by ethnicity

At the time of the 2011 Census, 90.8% of Suffolk's population was White British, compared to 79.8% for England. After White British, the most common ethnicities were Other White (4.4%), Asian (1.8%) and Mixed heritage (1.7%) (Figure 2). The results of the 2021 Census should be available in 2022.

Figure 2: Ethnic groups in Suffolk, region and country, 2011



Source: Office for National Statistics. Census 2011 Ethnic group - NOMIS table KS201EW. (2011)

In 2011, the proportion of residents who did not identify as White British was higher in urban areas compared to rural areas. Proportions were higher in the north west of the county, where United States military forces and support staff are stationed with their families (Figure 3).

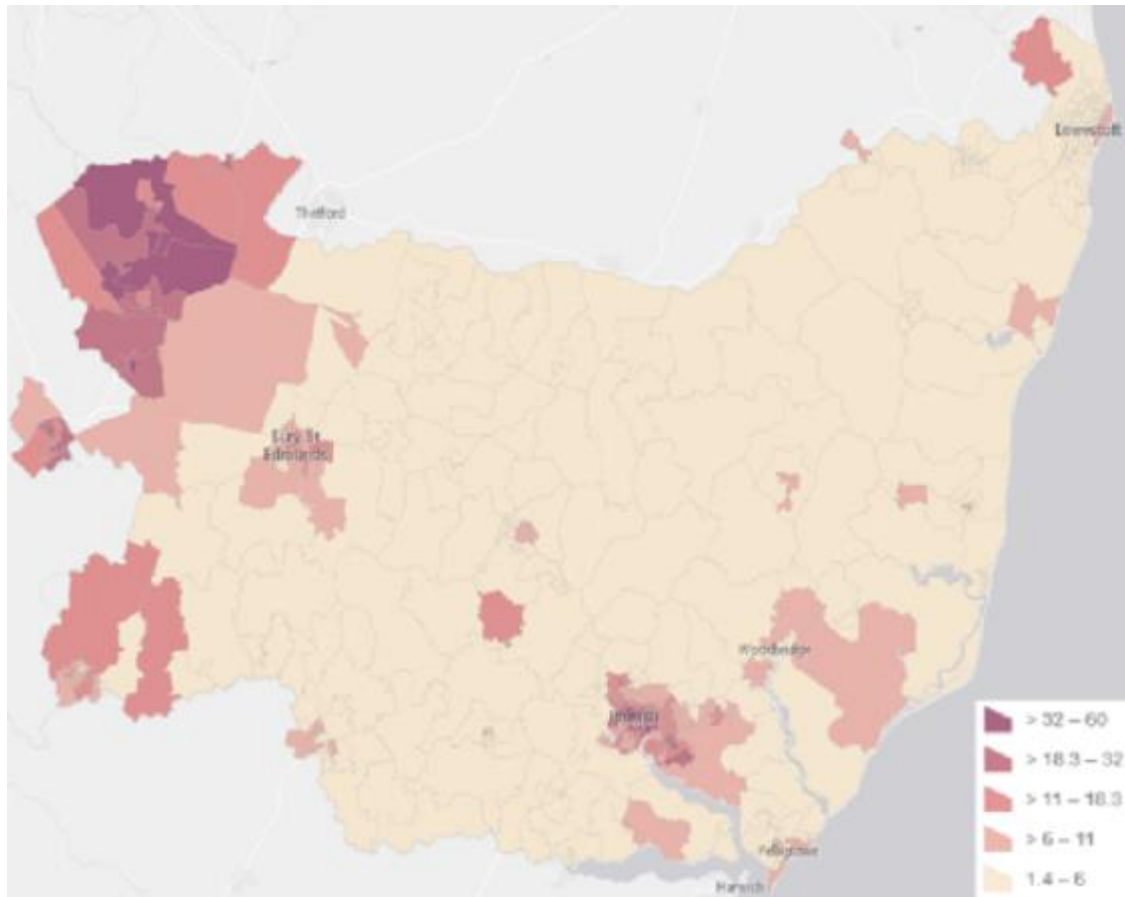
In 2020, 92.4% of the Suffolk population were UK nationals, which is higher than for England (90.3%). People who were not UK nationals were most likely to be nationals of:

1. European Union 5.2% (England 5.5%)
2. Rest of the World 1.6% (England 1.9%)
3. Sub-Saharan African 0.7% (England 0.8%)
4. North American 0.7% (England 0.4%)

In 2020, 90.3% of Suffolk residents were born in the UK, compared to 84.4% in England. People living in Suffolk who weren't born in the UK were most likely to have been born in:

1. European Union 6.1% (England 5.6%)
2. Rest of the World 2.3% (England 4.6%)
3. Sub-Saharan Africa 1.1% (England 2.4%)
4. North American 0.9% (England 0.6%)

Figure 3: Map of Suffolk showing the proportion of residents from a Black, Asian or minority ethnic group by lower super output area, 2011



Source: Office for National Statistics. Census 2011 Ethnic group - NOMIS table KS201EW. (2011)

Population by sex

A higher proportion of the population are female in England, and in Suffolk. ONS estimates and projections by sex and broad age band show there are more males than females among children (0-15), a difference that is less pronounced among the working age population (16 to 64). Better life expectancy rates for women mean there are more older women (65 and over) than men.

The gap between the number of males and females aged 65 and over is reducing. By 2041, 47.0% of people aged 65 and over in Suffolk will be male, compared to 44.8% in 2008 (46.6% in 2041 and 43.7% in 2008 for England).

There are estimated to be 2,630-7,610 transgender people in Suffolk, that is people whose gender identity is different from the sex assigned at birth. This estimate is based on a population prevalence of 0.35%-1.0% as used by the Government Equalities Office. This Figure does not include people who identify as non-binary⁵.

Population by sexual identity

Estimates of sexual identity can be calculated using results from the Annual Population Survey. By applying estimates for the East of England region to the Suffolk population, there may be between

10,600 and 23,100 Suffolk residents aged 16 and over who identify as lesbian, gay, bisexual or other (Table 1). Estimates at a lower geography are unreliable and not available for Suffolk.

Older people (65 and older) are more likely to identify as heterosexual or straight (UK 95.8%, CI +/- 0.2%) than younger people (16 - 24) (UK 88.5%, CI +/- 1.1%). As Suffolk has a higher percentage of older people, the estimate is likely to be slightly lower than shown.

Table 1: Sexual identity in England, and estimated Suffolk Figures, 16 years old and over, 2019

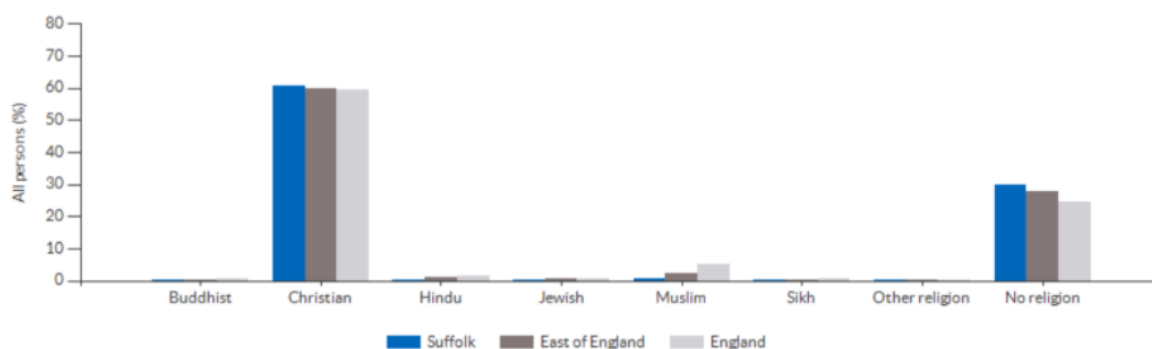
Sexual identity	East of England		Suffolk	
	%	Confidence interval (CI) +/-	Low est.	High est.
Heterosexual or straight	95.5%	0.7	592,100	600,800
Gay or lesbian	1.2%	0.4	5,000	10,000
Bisexual	1.0%	0.3	4,400	8,100
Other	0.5%	0.3	1,200	5,000
Don't know or refuse	1.8%	0.4	8,700	13,700

Source: Office for National Statistics. Sexual orientation, UK: 2019

Population by religion

3 in 5 (443,632) Suffolk residents identified as Christian in the 2011 Census (60.9%, 59.4% England). The next largest group was people who had “no religion” (29.7%, 24.7% England). The next largest religious group was Muslim, at 0.8% (5.0% England), or fewer than 6,000 people (Figure 4).

Figure 4: Population by religion, Suffolk 2011



Source: Suffolk Observatory / Census

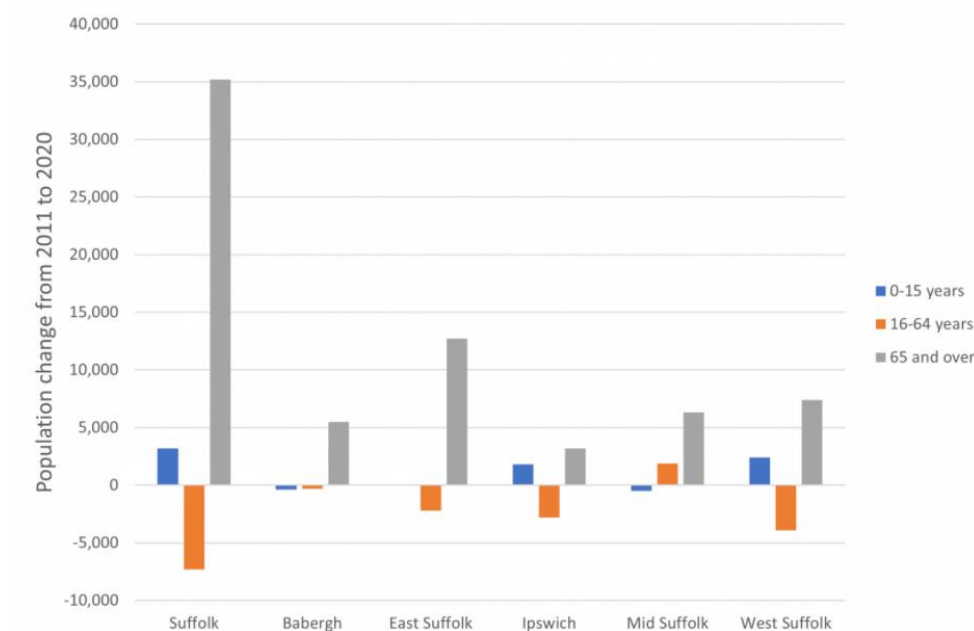
How is the population changing?

The population of Suffolk grew by 4.3% from 2011 to 2020, which is lower than the growth rate for England (6.5%). This overall growth rate conceals larger changes within age groups. Suffolk’s over 65 population has seen dramatic growth compared to those aged 0 – 15. Those aged 16 – 64 decreased from 2011 to 2020.

The number of people aged 65 and over in Suffolk is projected to grow by 20.8% between mid-2020 and mid-2030 (20.9% England). Growth will be seen in all districts and boroughs. The older population will increase at the lowest rate in Ipswich (16.4%), and the highest in Mid Suffolk (23.7%).

In mid-2020, two districts in Suffolk had a population where at least one-quarter of people were estimated to be aged 65 and over (East Suffolk 27.7%, Babergh 26.5%). By 2030, only Ipswich (20.0%) and West Suffolk (24.5%) will have populations where less than a quarter of people are estimated to be 65 and over. In East Suffolk (32.2%) and Babergh (30.6%), people aged 65 and over will comprise nearly a third of the resident population.

Figure 5: Population change from 2011 to 2020 by broad age group for Suffolk local authorities

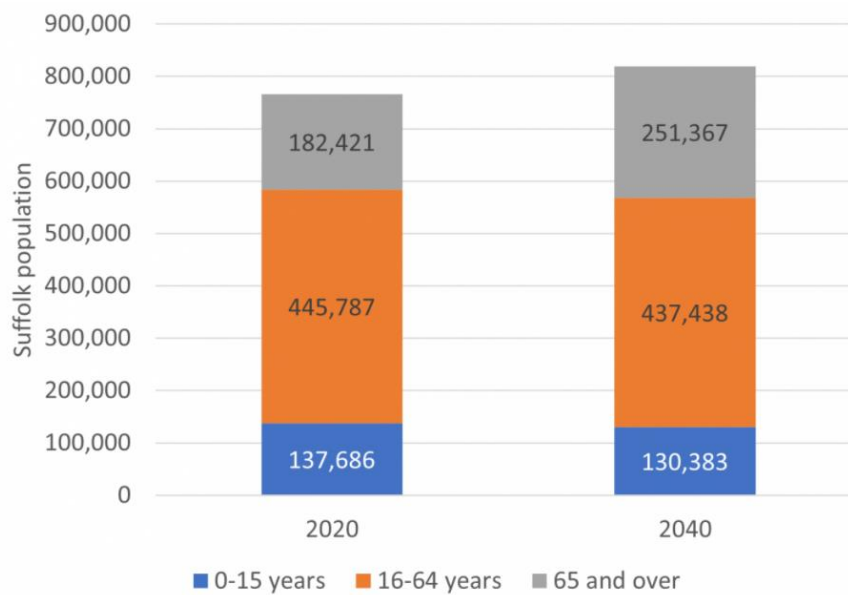


Source: Office for National Statistics. Population estimates - local authority based by five-year age band.

In 2020, an estimated 23.8% of Suffolk's population was aged 65 and over (compared to 18.5% for England). By 2040, the population of residents aged 65 and over will increase by over 37.8% (in line with England 38.3%), while the Suffolk population under 65 will fall by 2.7%, compared to growth in England of 1.0%.

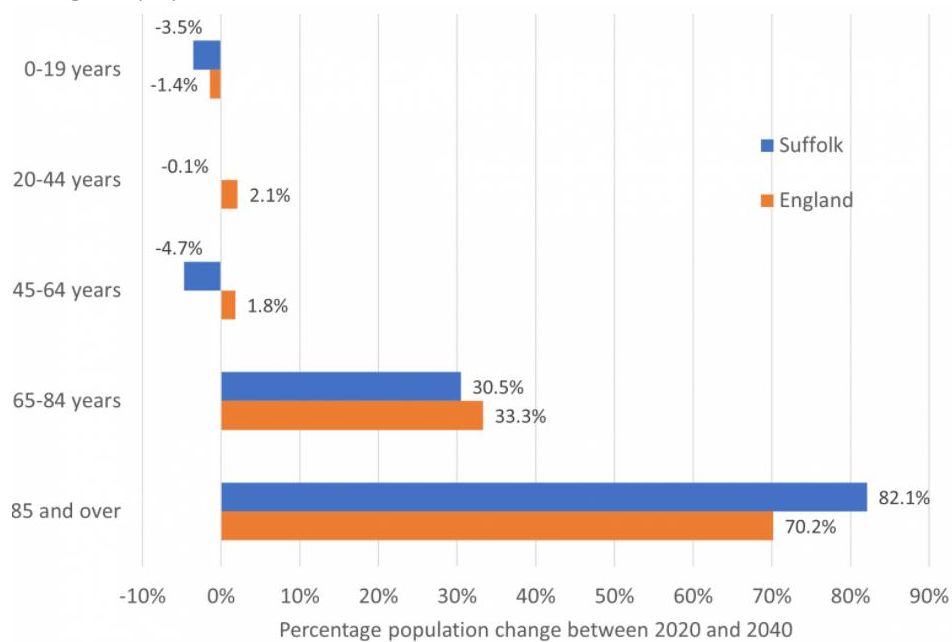
In 20 years, it is forecast that 1 in 3 Suffolk's residents will be aged 65 or over, compared to 1 in 4 for England. The number of people aged 85 or over in Suffolk is expected to increase from 25,900 to 47,200.

Figure 6: Suffolk population change 2020 - 2040, based on 2018-based projections (ONS)



Source: Office for National Statistics. Subnational Population Projections for England: 2018-Based (Report). 2020

Figure 7: Change in population 2020 to 2040



Source: Office for National Statistics. Subnational Population Projections for England: 2018-Based (Report). 2020

Suffolk Indices of Deprivation

The Index of Multiple Deprivation, commonly known as the IMD, domain indices and the supplementary indices, together with the higher area summaries, are collectively referred to as the Indices of Deprivation (IoD) 2019.

The IMD is the official measure of relative deprivation for small areas in England. It is the most widely used of the Indices of Deprivation (IoD). It ranks every small area (Lower Super Output Area or LSOA) in England from 1 (most deprived area) to 32,844 (least deprived area).

The Indices of Deprivation measure deprivation on a relative rather than an absolute scale, so a neighbourhood ranked 100th is more deprived than a neighbourhood ranked 200th, but this does not mean it is twice as deprived⁶.

Changes to boundaries

Changes in boundaries have had a large impact on the indices of deprivation for Suffolk. East Suffolk Council was formed on April 1st 2019, covering the former districts of Suffolk Coastal District Council and Waveney District Council. On the same day, Forest Heath District Council and St Edmundsbury Borough Council were replaced by a single district council called West Suffolk Council.

The impact of these changes means that pockets of deprivation that were once identifiable at local authority level are no longer observable, for example the differing levels of deprivation experienced between Waveney and Suffolk Coastal. Therefore, LSOA level analysis is vital for place-based assessment of deprivation.

This also impacts data for West Suffolk, which contains the former Forest Heath authority area. Additionally, the challenges associated with estimating the characteristics of this area, due to the inclusion or exclusion of the United States Visiting Forces (USVF) population in different indicators, mean that it is difficult to establish whether the changes in relative deprivation in Forest Heath are 'real'.

Deprivation in Suffolk

The dramatic decline in relative deprivation seen in Suffolk between 2010 and 2015 has not been repeated, but neither has there been much of a recovery in Suffolk's relative position.

Suffolk continues to experience below average levels of deprivation, but it has experienced a slight increase in rank of average rank among other Upper Tier Local Authorities, from 101st in 2015 to 99th in 2019, indicating increased relative deprivation. Also note that the number of council areas has decreased from 152 to 151. This change has also resulted in an increase in deprivation relative to Suffolk's 15 nearest statistical neighbours.

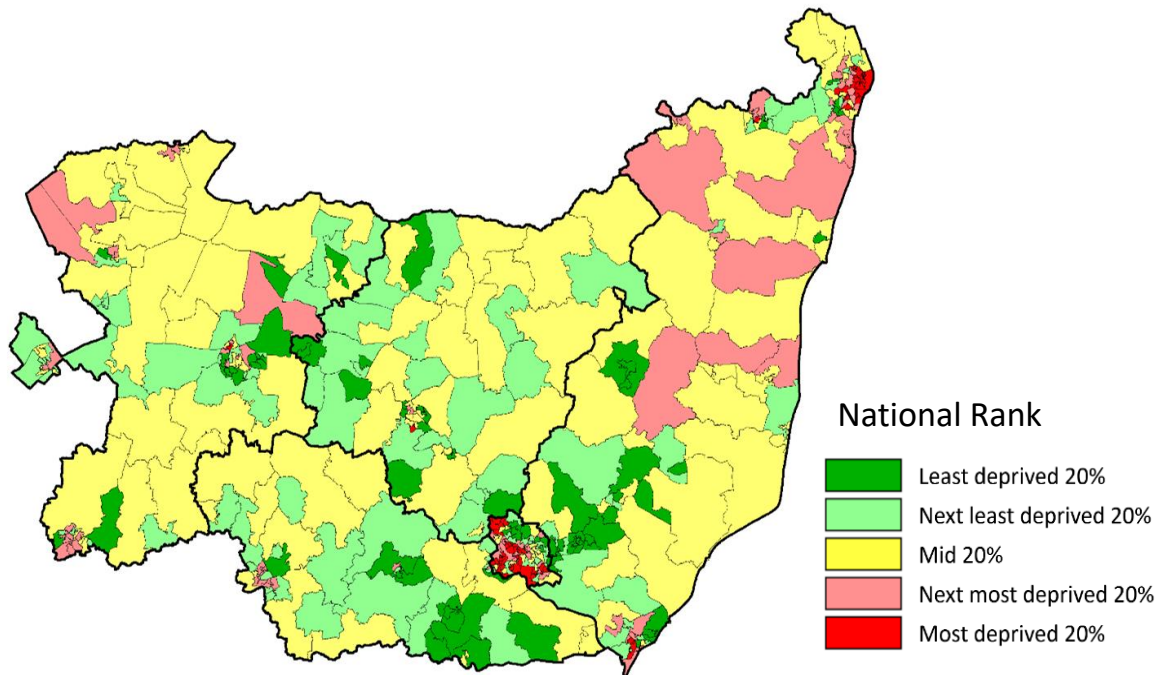
90% of the LSOAs in Suffolk that were in the most deprived 20% nationally in 2015 were still in the most deprived 20% nationally in 2019.

11.3% of Suffolk's LSOAs are in the 20% most deprived in England (50 LSOAs in Total). 96% of the 20% most deprived LSOAs in Suffolk are in either East Suffolk (20 LSOAs) or Ipswich (28 LSOAs).

Ipswich has the highest number and proportion of LSOAs in the 20% most deprived areas nationally, when compared to other local authorities in Suffolk. Ipswich is now the most deprived area in Suffolk, as changes to council configuration have led to a loss of granular detail particularly affecting Waveney.

Mid Suffolk remains the least deprived area, while West Suffolk and Babergh have seen small improvements in relative deprivation between 2015 and 2019; all other areas have declined, albeit by small amounts.

Figure 8: Indices of Multiple Deprivation quintile by LSOA in Suffolk, 2019



Source: Suffolk Public Health and Communities

Understanding the impact of health behaviours

Health behaviours

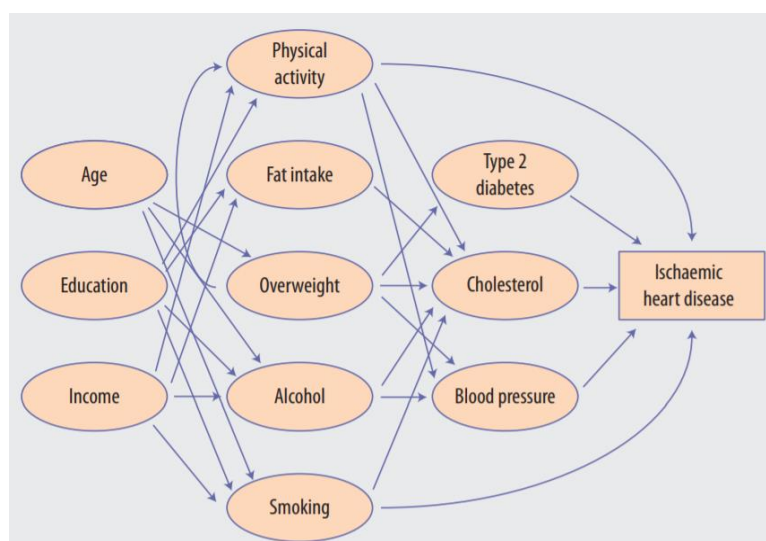
Health behaviours, sometimes called health-related behaviours, are actions taken by individuals that affect health or mortality. These actions may be intentional or unintentional and can promote or detract from the health of the actor or others. Actions that can be classified as health behaviours are many; examples include smoking, substance use, diet, physical activity, sleep, risky sexual activities, health care seeking behaviours, and adherence to prescribed medical treatments. Health behaviours are frequently discussed as individual-level behaviours, but they can be measured and summarised for individuals, groups, or populations. Health behaviours are dynamic, varying over the lifespan, across cohorts, across settings, and over time.

To prevent disease and injury, it is necessary to identify and deal with their causes – the health risks that underlie them. Each risk has its own causes too, and many have their roots in a complex chain of events over time, consisting of socioeconomic factors, environmental and community conditions (often referred to as ‘wider determinants’), and individual behaviour. The causal chain offers many entry points for intervention.

As can be seen from the example of ischaemic heart disease (figure 9), some elements in the chain, such as high blood pressure or cholesterol, act as a relatively direct cause of the disease. Some risks located further back in the causal chain act indirectly through intermediary factors. These risks include health behaviours such as physical inactivity, alcohol, smoking or fat intake. For the most distal risk factors, such as education and income, less causal certainty can be attributed to each risk.

A concise and robust tool for understanding the impact of health behaviours on local populations is the Global Burden of Disease (GBD). This chapter outlines behavioural risks regarding deaths and disability adjusted life years (DALYs) through the lens of the GBD framework. The main behavioural risks seen in the GBD data for Suffolk are then broadened into the chapters within this report: smoking, weight management, physical activity, alcohol use, and health seeking behaviours seen through NHS Health Checks.

Figure 9: The causal chain: linking wider determinants and health behaviours to health outcomes



Please note: arrows indicate some (not all) of the pathways by which causes interact

Source: World Health Organisation, Global Health Risks

What is the Global Burden of Disease?

The Global Burden of Disease (GBD) provides a tool to quantify health loss from hundreds of diseases, injuries, and risk factors, so that health systems can be improved, and disparities can be eliminated.

Collected and analysed by a consortium of more than 7,000 researchers in more than 156 countries and territories, the data capture premature death and disability from more than 350 diseases and injuries in 195 countries, by age and sex, from 1990 to the present, allowing comparisons over time, across age groups, and among populations.

Understanding risks associated with death and disability adjusted life years (DALYs)

A description of diseases and injuries - and the risk factors that cause them - is vital for health decision making and planning. Data on the health of populations and the risks they face are often fragmentary and sometimes inconsistent. A comprehensive framework such as GBD helps health systems to pull together information and facilitate comparisons of the relative importance of health risks across different populations nationally and locally.

Most scientific and health resources go towards treatment. However, understanding the risks to health is key to preventing disease and injuries. A particular disease or injury is often caused by more than one risk factor, which means that multiple interventions are available to target each of these risks. For example, the infectious agent mycobacterium tuberculosis is the direct cause of tuberculosis; however, crowded housing and poor nutrition also increase the risk, which presents multiple paths for preventing the disease. In turn, most risk factors are associated with more than one disease and targeting those factors can reduce multiple causes of disease. For example, reducing smoking will result in fewer deaths and less disease from lung cancer, heart disease, stroke, chronic respiratory disease, and other conditions. By quantifying the impact of risk factors on diseases, evidence-based choices can be made about the most effective interventions to improve a population's health.

Risks associated with death

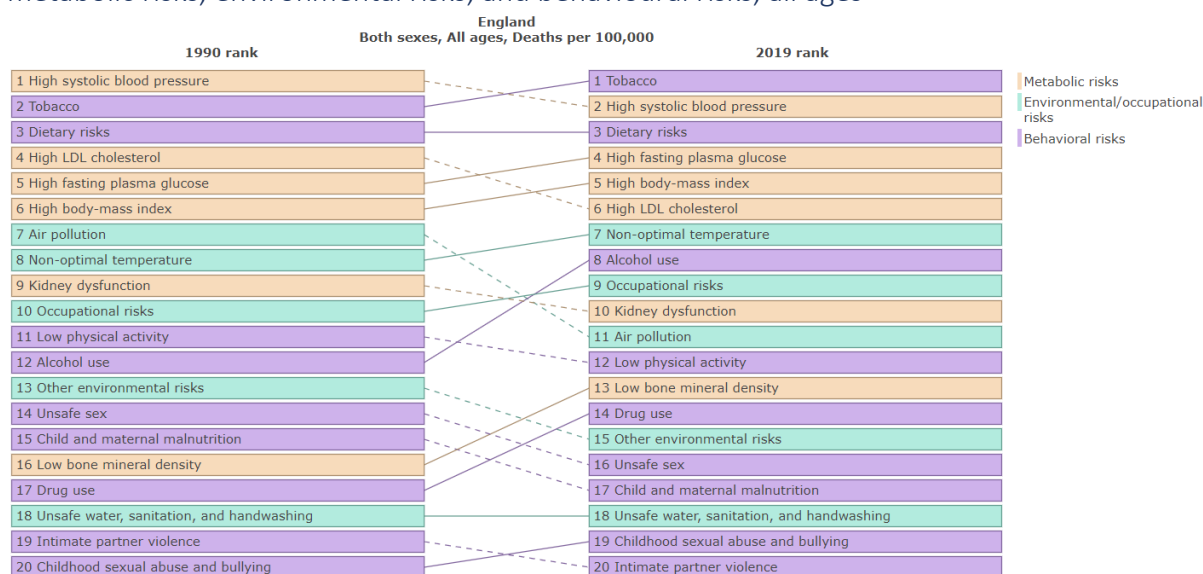
The GBD classifies risks into three categories: 1) metabolic risk, 2) environmental/occupational risk, and 3) behavioural risk. As the focus of this report is 'health behaviours', the following sections will focus on behavioural risks only.

England

Although many of the same risks associated with death are seen in 1990 and 2019, three of the top ten risk factors are now directly linked to behavioural risks compared to just two in 1990 (see figure 10). For example, tobacco is now the primary risk factor linked to death for England. Alcohol use has also moved up the risk register, from 12th in 1990 to 8th in 2019, and dietary risk remains in 3rd.

Many of the metabolic risks can also be linked to health behaviours, such as high fasting plasma glucose (5th to 4th), high body mass index (6th to 5th), and high LDL cholesterol (4th to 6th) (see figure 10).

Figure 10: Risks associated with death, England, 1990 compared to 2019, classified as metabolic risks, environmental risks, and behavioural risks, all ages



Source: GBD Compare

Suffolk

Suffolk present a similar picture to England from 1990 to 2019. The only change to the ranking is that alcohol use is less prominent in Suffolk compared to England in 2019 (10th place compared to 8th place, respectively) (see figure 11).

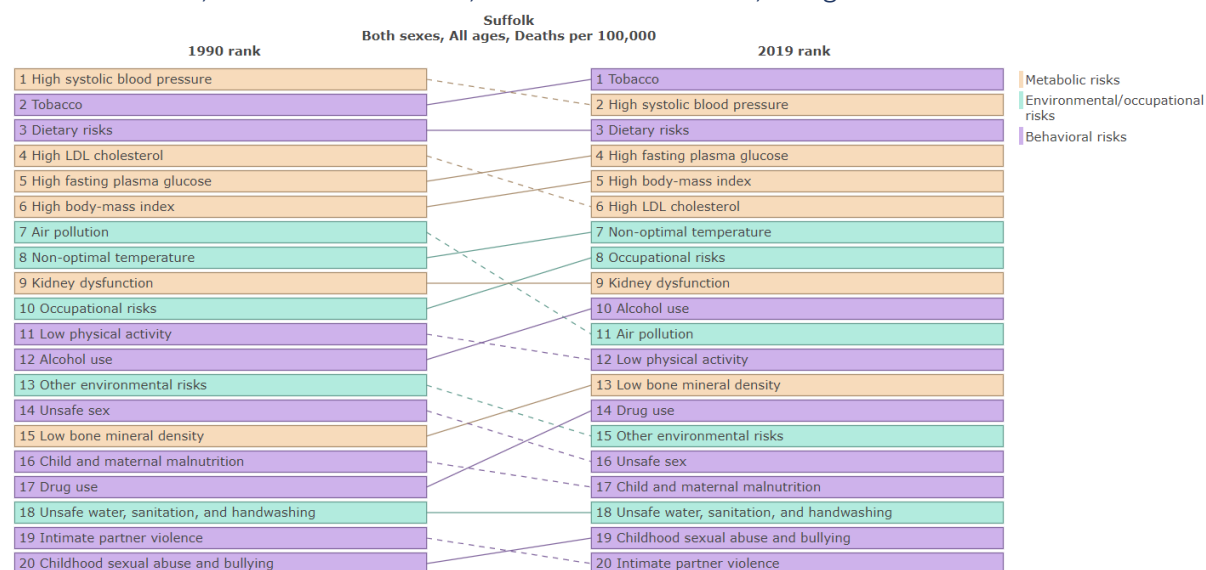
Below is a summary of the key behavioural risks that appear in the top 10 risks associated with deaths in Suffolk for in 2019:

Tobacco: Although there are 33% less death from tobacco in 2019 (193 per 100,000) compared to 1990 (289 per 100,000), tobacco is now the highest ranked risk in terms of deaths per 100,000 in Suffolk.

Dietary risks: dietary risks remain unchanged at 3rd highest risk from 1990 to 2019. However, it is evident that substantial progress has been made in this area as there are 42% less death from dietary risks in 2019 (136 per 100,000) compared to 1990 (233 per 100,000).

Alcohol use: deaths relating to alcohol use have seen a significant increase from 13 per 100,000 in 1990 to 34 per 100,000 in 2019. This is a change of 173% and has caused alcohol use to move from 12th in 1990 to 10th in 2019.

Figure 11: Risks associated with death, Suffolk, 1990 compared to 2019, classified as metabolic risks, environmental risks, and behavioural risks, all ages



Source: GBD Compare

Risks associated with disability adjusted life years (DALYs)

The disability-adjusted life year is a measure of overall disease burden, expressed as the number of years lost due to ill-health, disability or early death. It was developed in the 1990s as a way of comparing the overall health and life expectancy of different countries.

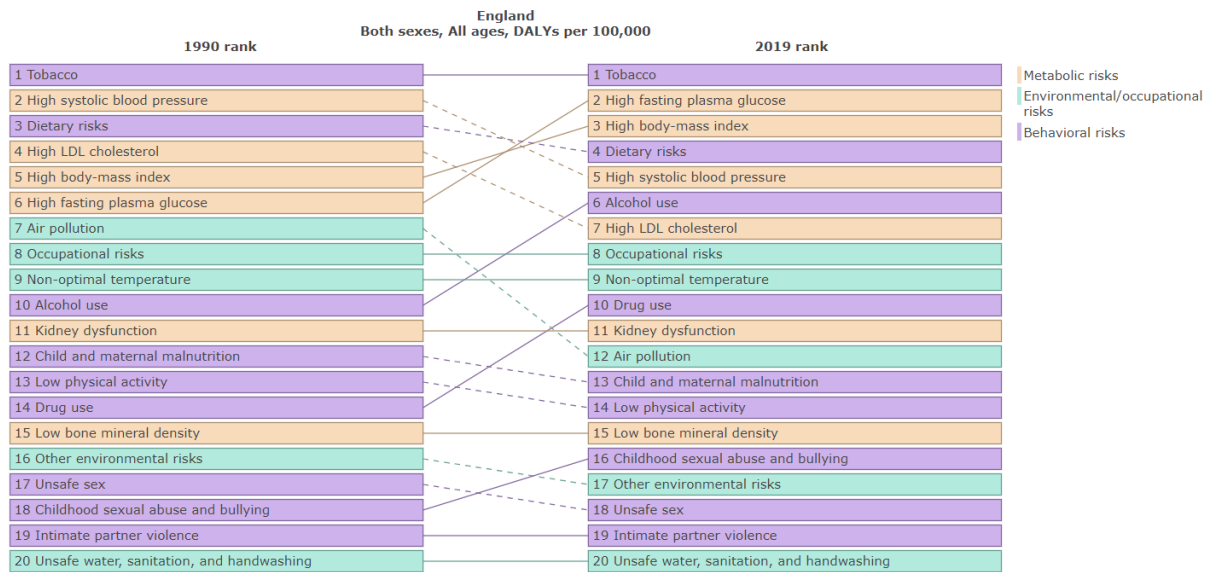
One DALY can be thought of as one lost year of “healthy” life, and the burden of disease can be thought of as a measurement of the gap between current health status and an ideal situation where everyone lives into old age, free of disease and disability.

England

Tobacco, dietary risks, and alcohol use also appear in DALYs for England from 1990 to 2019. However, alcohol use increased in the ranking from 10th in 1990 to 6th in 2019. This could be in part to more alcohol consumption in England⁷ but also improved interventions for metabolic and environmental risks, such as high blood pressure, high LDL cholesterol, and air pollution⁸.

Drug use has also seen an increase contribution to DALYs from 1990 to 2019, moving from 14th to 10th.

Figure 12: Risks associated with DALYs, England, 1990 compared to 2019, classified as metabolic risks, environmental risks, and behavioural risks, all ages



Source: GBD Compare

Suffolk

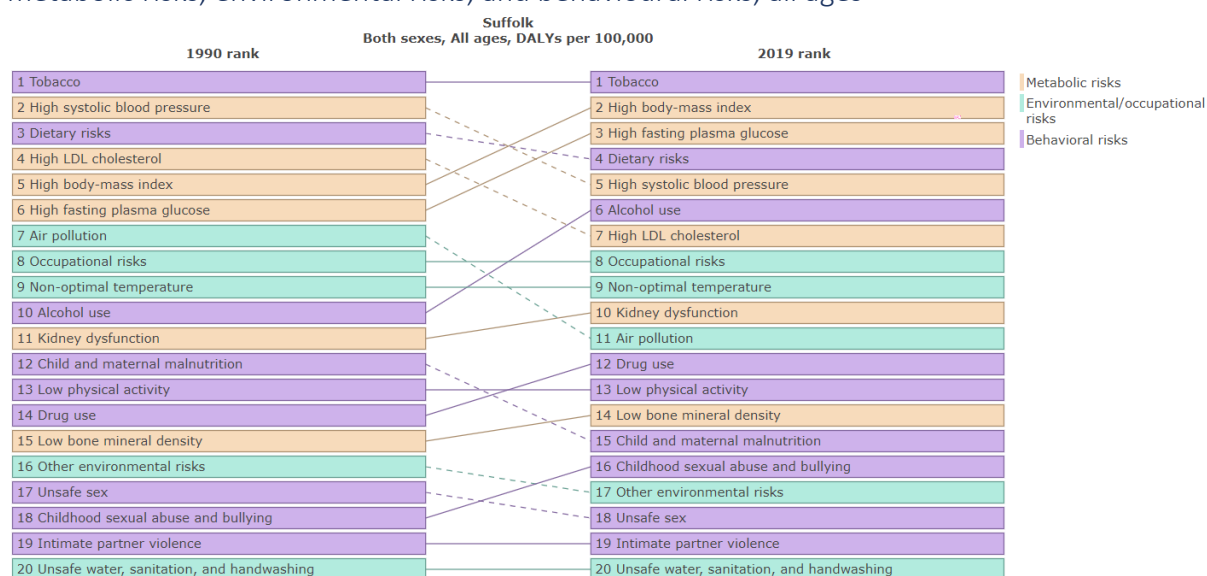
Below is a summary of the key behavioural risks that appear in the top 10 risks associated with DALYs in Suffolk for in 2019:

Tobacco: Tobacco remains the highest contributor to DALYs in Suffolk; 6,434 per 100,000 in 1990 and 1,497 per 100,000 in 2019.

Dietary risks: Although a lot of positive work has been done around dietary risks over the last 30 years, it still appears in the top 5 for Suffolk. Dietary risks were 3rd in 1990 at 4,153 DALYs per 100,000, and although they've seen a 44% drop, they are the 4th highest risk in 2019 at 2,316 DALYs per 100,000.

Alcohol use: Alcohol use has seen the largest change in DALYs from 1990 to 2019. In 1990, alcohol use was the 10th highest risk with 858 DALYs per 100,000. This had risen by 46% in 2019; alcohol use is now ranked 6th and contributes to 1,255 DALYs per 100,000.

Figure 13: Risks associated with DALYs, Suffolk, 1990 compared to 2019, classified as metabolic risks, environmental risks, and behavioural risks, all ages



Source: GBD Compare

A closer look at health behaviours in Suffolk

As discussed, the top 5 behavioural risks associated with deaths and DALYs in Suffolk are the same: tobacco, dietary risks, alcohol use, low physical activity, and drug use (see Table 2). Looking at these health behaviours in isolation shows that, for example, deaths from tobacco in Suffolk are eight times as great as deaths from low physical activity (193.4 deaths per 100,000 compared to 24.2 death per 100,000, respectively). However, it is important to note that many health behaviours do not happen in isolation. Often, health behaviours are cumulative and can impact on one another.

Health behaviours are also worsened by deprivation and societal inequalities. For example, people in the most deprived areas in England are more than twice as likely to be admitted to hospital for obesity-related health problems⁹, report statistically significantly lower levels of physical activity than those in the least deprived areas¹⁰, and are more than four times more likely to smoke than those living in the least deprived areas¹¹.

Table 2: Top 5 behavioural risks associated with deaths and DALYs, Suffolk, 2019, all ages

Rank	Deaths	DALYs
1	Tobacco (193.4 deaths per 100,000 / 18.1% of total deaths)	Tobacco (4,196.6 DALYs per 100,000 / 13.7% of DALYs)
2	Dietary risks (135.7 deaths per 100,000 / 12.7% of total deaths)	Dietary risks (2,316.2 DALYs per 100,000 / 7.6% of DALYs)
3	Alcohol use (34.3 deaths per 100,000 / 3.2% of total deaths)	Alcohol use (1,254.6 DALYs per 100,000 / 4.1% of DALYs)
4	Low physical activity (24.2 deaths per 100,000 / 2.3% of deaths)	Drug use (491.8 DALYs per 100,000 / 1.6% of DALYs)

Rank	Deaths	DALYs
5	Drug use (6.0 deaths per 100,000 / 0.6% of deaths)	Low physical activity (382.6 DALYs per 100,000 / 1.3% of DALYs)

Source: GBD Compare

Conditions linked to health behaviours

Health behaviours are linked to a wide range of diseases and disorders. The tables below show that the four behavioural risks examined in this report are directly linked to nine different causes of death and eleven causes of DALYs in Suffolk (Table 3 and Table 4). Many of these causes span all four of the health behaviours; for example, neoplasms are directly linked to causes of death for tobacco (97.8 deaths per 100,000), dietary disease (21.4 deaths per 100,000), alcohol use (18.4 per 100,000), and low physical activity (4.8 deaths per 100,000). Therefore, continuing to understand and tackle these four health behaviours will have wide-reaching impact on Suffolk's health and social care system in the years to come.

Table 3: behavioural risks relating to deaths in Suffolk, including cause of death linked to behavioural risks, both sexes, 2019

Behavioural risk	Cause of death linked to behavioural risk
Tobacco	Respiratory infections and tuberculosis (97.85 deaths / 12.5 deaths per 100,000)
	Neoplasms (685.6 deaths / 97.8 deaths per 100,000)
	Cardiovascular disease (350.6 deaths / 44.9 deaths per 100,000)
	Chronic respiratory disease (279.4 deaths / 35.8 per 100,000)
	Digestive disease (10.8 deaths / 1.4 deaths per 100,000)
	Neurological disorders (70.8 deaths / 9.1 deaths per 100,000)
	Diabetes and kidney disease (11.0 deaths / 1.4 deaths per 100,000)
Dietary risks	Neoplasms (166.8 deaths / 21.4 deaths per 100,000)
	Cardiovascular disease (853.5 deaths / 109.3 deaths per 100,000)
	Diabetes and kidney disease (39.1 deaths / 5.0 deaths per 100,000)
Alcohol use	Respiratory infections and tuberculosis (31.1 deaths / 4.0 deaths per 100,000)
	Neoplasms (144.0 deaths / 18.4 per 100,000)
	Digestive disease (71.0 deaths / 9.1 deaths per 100,000)
	Neurological disorders (14.0 deaths / 1.8 deaths per 100,000)

Behavioural risk	Cause of death linked to behavioural risk
	Transport injuries (8.9 deaths / 1.1 deaths per 100,000)
	Self-harm and interpersonal violence (15.1 deaths / 1.9 deaths per 100,000)
Low physical activity	Neoplasms (37.2 deaths / 4.8 deaths per 100,000)
	Cardiovascular disease (137.9 deaths / 17.7 deaths per 100,000)
	Diabetes and kidney disease (13.8 deaths / 1.8 deaths per 100,000)

Source: GBD Compare

Table 4: behavioural risks relating to DALYs in Suffolk, including cause of death linked to behavioural risks, both sexes, 2019

Behavioural risk	Cause of DALYs linked to behavioural risk
Tobacco	Respiratory infections and tuberculosis (1,256 DALYs / 161 DALYs per 100,000)
	Neoplasms (12,425 DALYs / 1,591 DALYs per 100,000)
	Cardiovascular disease (6,961 DALYs / 891 DALYs per 100,000)
	Chronic respiratory disease (6,349 DALYs / 813 DALYs per 100,000)
	Digestive disease (326 DALYs / 42 DALYs per 100,000)
	Neurological disorders (1,137 DALYs / 146 DALYs per 100,000)
	Diabetes and kidney disease (1,143 DALYs / 146 DALYs per 100,000)
	Musculoskeletal disorders (2,941 DALYs / 377 DALYs per 100,000)
	Unintentional injuries (156 DALYs / 20 DALYs per 100,000)
Dietary risks	Neoplasms (2,866 DALYs / 367 DALYs per 100,000)
	Cardiovascular disease (12,537 DALYs / 1,605 DALYs per 100,000)
	Diabetes and kidney disease (2,685 DALYs / 344 DALYs per 100,000)
Alcohol use	Respiratory infections and tuberculosis (396 DALYs / 51 DALYs per 100,000)
	Neoplasms (2,911 DALYs / 373 DALYs per 100,000)
	Cardiovascular disease (178 DALYs / 23 DALYs per 100,000)

Behavioural risk	Cause of DALYs linked to behavioural risk
	Digestive disease (1,935 DALYs / 248 DALYs per 100,000)
	Neurological disorders (239 DALYs / 31 DALYs per 100,000)
	Substance use disorders (2,790 DALYs / 357 DALYs per 100,000)
	Transport injuries (251 DALYs / 32 DALYs per 100,000)
	Unintentional injuries (683 DALYs / 87 DALYs per 100,000)
	Self-harm and interpersonal violence (688 DALYs / 88 DALYs per 100,000)
Low physical activity	Neoplasms (562 DALYs / 72 DALYs per 100,000)
	Cardiovascular disease (1,614 DALYs / 207 DALYs per 100,000)
	Diabetes and kidney disease (811 DALYs / 104 DALYs per 100,000)

Source: GBD Compare

Executive summary

As a result of COVID-19, there is a renewed urgency to understand and effectively manage entrenched inequalities relating to health behaviours. There is existing cross system activity on health behaviour inequalities but it is clear that more needs to be done.

This Health Needs Assessment provides a snapshot of Suffolk's key modifiable health behaviour risk factors, addressing geographical variation in health outcomes where possible. This report, alongside ongoing national and local work such as the NHS Long Term Plan, Local Transformation Plans, and the Suffolk and North East Essex Integrated Care System (SNEE ICS), provides a firm commitment to a more concerted and systematic approach to reducing health behaviour inequalities and addressing unwarranted variation in care.

Understanding health behaviours

- Health behaviours, sometimes called health-related behaviours, are actions taken by individuals that affect health or mortality. These actions may be intentional or unintentional and can promote or detract from the health of the actor or others. Actions that can be classified as health behaviours are many; examples include smoking, substance use, diet, physical activity, sleep, risky sexual activities, health care seeking behaviours, and adherence to prescribed medical treatments. Health behaviours are frequently discussed as individual-level behaviours, but they can be measured and summarised for individuals, groups, or populations. Health behaviours are dynamic, varying over the lifespan, across cohorts, across settings, and over time.
- This report focuses on alcohol, tobacco, weight management, physical activity, and health seeking behaviours seen through NHS Health Checks.

Alcohol

- Suffolk has a statistically significantly lower rate of alcohol-specific deaths (7.9 per 100,000) compared to England (10.9 per 100,000). Regarding Suffolk's Lower-Tier Local Authorities (LTLAs), East Suffolk has the highest rate of alcohol-specific deaths (9.8, statistically similar to England), while Mid Suffolk has the lowest rate (3.4, statistically significantly lower than England).
- Suffolk has a statistically significantly lower rate of deaths from chronic liver disease (8.7 per 100,000) compared to England (12.2 per 100,000). Regarding Suffolk's LTLAs, Ipswich has the highest rate of deaths from chronic liver disease (10.9 per 100,000, statistically similar to England), while Mid Suffolk had the lowest rate (4.9 per 100,000, statistically significantly lower than England).
- Ipswich is the only LTLA in Suffolk that presents a statistically significantly higher hospital admission rate for alcohol-related conditions compared to England, both for males and females. Although Ipswich was statistically similar to England in 2018/19, there has been a statistically significantly higher rate of hospital admissions for alcohol-related conditions in

2019/20 (600 per 100,000) compared to England (519 per 100,000) and the East of England (484 per 100,000).

Tobacco

- Suffolk had the fourth highest prevalence of smoking in adults (16.1%) out of the eleven local authorities in the East of England. Smoking prevalence in Suffolk was statistically similar to England (13.9%) and the East of England (13.7%).
- Ipswich was the only LTLA to present a statistically significantly higher smoking prevalence (20.7%) compared to England (13.9%) and the East of England (13.7%). Ipswich was ranked 3rd highest for smoking prevalence out of the 45 districts and boroughs in the East of England.
- In 2019/20, there were 54,822 (15.6%) recorded tobacco users in the Ipswich and East Suffolk Clinical Commissioning Group (IESCCG), 35,351 (16.3%) in the West Suffolk Clinical Commissioning Group (WSCCG), and 39,247 (19.7%) in Great Yarmouth and Waveney Clinical Commissioning Group (GYWCCG)¹. Please note that GYWCCG is now Norfolk and Waveney Clinical Commissioning Group (NWCCG).
- IESCCG had ten GP practices with a statistically significantly higher smoking prevalence compared to England (ranging from 19.2% to 25.7%), WSCCG had eight GP practices with a statistically significantly higher smoking prevalence compared to England (ranging from 18.3% to 24.1%), and GYWCCG had five Suffolk-based GP practices with a statistically significantly higher smoking prevalence compared to England (ranging from 20.6% to 31.2%).
- Although the number of smokers recruited into smoking cessation services and setting a quit date is statistically significantly better than England (4,253 per 100,000 compared to 3,512 per 100,000 respectively), Suffolk has the second lowest recruitment rate across services in the East of England (4,672 per 100,000). In 2019/20, only 4.4% of estimated current smokers had set a quit date in Suffolk.
- Proportionally, Ipswich presents a statistically significantly higher smoking prevalence among those working in routine and manual occupations (42.5%) compared to England (23.2%) and the East of England (25.1%). Babergh was the only district in Suffolk to present a statistically significantly lower smoking prevalence among those working in routine and manual occupations (3.5%).
- GYWCCG continues to have a statistically significantly higher prevalence of smoking at time of delivery (19.2%) compared to England (10.6%) for the fifth consecutive year.

¹ Based on Suffolk-based GP populations only. Please note that GYWCCG is now Norfolk and Waveney Clinical Commissioning Group (NWCCG)

Child weight management

- Results from the 2019/20 academic year indicate that prevalence of overweight and obese Reception Year children (aged 4 to 5) is lower in Suffolk (21.6%) than England (23.0%) and similar to the East of England (21.8%).
- Similarly, the prevalence of overweight and obese Year 6 children (aged 10 to 11) is lower in Suffolk (31.7%) than England (35.2%) and similar to the East of England (32.7%).
- Despite performing better than England, it is important to note that nearly 1 in 3 (31.7%) Year 6 students in Suffolk are above the recommended healthy weight.
- There is a strong association between deprivation and obesity in children. In 2019/20, the prevalence of obesity in children Reception Year class (aged 4 to 5) was almost twice as high in the most deprived areas of Suffolk (16.2%) compared to the least deprived areas of Suffolk (8.7%).
- Similarly, the prevalence of obesity in Year 6 children (aged 10 to 11) was more than twice as high in the most deprived areas (35.3%) of Suffolk compared to the least deprived areas of Suffolk (17.3%)

Adult weight management

- Suffolk has seen an increase in the proportion of adults (aged 18 years and over) registered to a GP practice recorded as clinically obese over the last three years, rising from 10.4% in 2017/18 to 11.5% in 2019/20. A similar trend can be seen across England, where the prevalence of obesity has gone from 9.8% in 2017/18 to 10.5% in 2019/20.
- Based on the 2019/20 Quality and Outcomes Framework data (QOF), there were 38,464 patients across IESCCG aged 18 and over with a Body Mass Index (BMI) greater than or equal to 30 in the previous 12 months. 13 GP practices in IESCCG presented a higher proportion of patients aged 18 and over with a BMI greater than or equal to 30 in the previous 12 months compared to England (10.5%) and IESCCG (11.6%).
- There were 22,494 patients across WSCCG aged 18 and over with a BMI greater than or equal to 30 in the previous 12 months. 9 GP practices in WSCCG presented a higher proportion of patients aged 18 and over with a BMI greater than or equal to 30 in the previous 12 months compared to England (10.5%) and WSCCG (10.8%).
- There were 12,912 patients across Suffolk-based NWCCG GP practices aged 18 and over with a BMI greater than or equal to 30 in the previous 12 months. 5 GP practices in NWCCG presented a higher proportion of patients aged 18 and over with a BMI greater than or equal to 30 in the previous 12 months compared to England (10.5%) and NWCCG (10.8%).

Physical activity

- Over half (58.1%) of children and young people in Suffolk do not meet the guidelines of 60+ minutes of exercise per day across the week. This equates to an estimated 52,400 children and young people. 2 in 5 (42.0%) children and young people aged 5–16 years meet the Chief Medical Officer (CMO) guidelines for physical activity. This is comparable to the levels of active 5-16 year-olds in England (45.0%) and the East of England (46.1%).
- Activity levels for children and young people in Suffolk increased from the 2019/20 academic year to the 2020/21 academic year. Those reporting an average activity level of 60+ minutes per day increased from 36.9% in 2019/20 to 42.0% in 2020/21, while inactivity (less than 30 minutes per day) went down from 36.9% to 31.2%.
- East Suffolk had the highest proportion of active adults (65.0%). The highest proportion of inactive adults were found in Ipswich where 29.2% of adults (n=31,800) were inactive. Over a quarter of adults in Babergh, Ipswich, and West Suffolk were categorised as inactive, partaking in less than 30 minutes of exercise per week.
- The most recent Active Lives Survey data presents physical activity levels for May 2020. This captures the end of phase 1 COVID-19 restrictions when England was in full lockdown. Over a quarter (28.4%, n=177,200) of adults in Suffolk reported being inactive in May 2021. Of these, nearly two-thirds (62.2%, n=110,218) reported no activity in the last 28 days. Inactivity in adults went up from 26.0% pre-pandemic (November 2019) to 28.4% in May 2020. This is an estimated increase of 15,400 reporting inactivity.
- Ipswich presented the largest increase in inactivity, from 29.2% in November 2019 to 38.5% in May 2020. There was minimal change in inactivity for the other LTLAs in Suffolk.

NHS Health Checks

- While Suffolk has historically performed well against England and East of England neighbours regarding NHS Health Check invites, NHS Health Checks were severely disrupted due to the pandemic. This has continued into 2021/22.
- Although uptake of Health Checks after invite has historically been statistically significantly higher in Suffolk compared to England, Suffolk has performed statistically significantly worse than England from 2018/19 to 2020/21. This is primarily due to the COVID-19 pandemic, which has seen Suffolk report statistically significantly lower uptake after invite compared to England in the last three quarterly reporting periods.
- Although the delivery of Health Checks has been reduced nationally and locally due to the COVID-19 pandemic, Suffolk continues to deliver a statistically significantly higher proportion of Health Checks to the eligible population.

- The average uptake based on GP practice targets for 2018/19 was 79%. However, there was a large range in uptake across Suffolk, ranging from 0% to 166%. A similar distribution can be seen in 2019/20: although the average uptake across GP practices was better (81%), uptake ranged from 0% to 155%.
- In Suffolk, health check uptake is statistically significantly higher in older people and women. However, unlike England, more deprived populations have a statistically significantly lower attendance rate compared to less deprived areas. Key insights for Health Check non-attendance in Suffolk:
 - Statistically significantly higher non-attendance in the 40% most deprived population.
 - Statistically significantly higher non-attendance in 40–54-year age bandings.
 - Statistically significantly higher non-attendance among males.

Re-imagining Healthy Living Survey: service user engagement

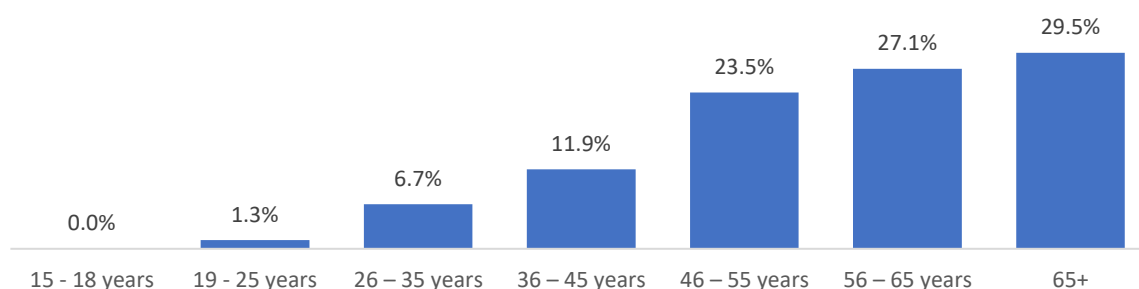
A healthy living survey was disseminated online by Public Health and Communities Suffolk from [INSERT DATE] to February 21st, 2022. It was directed at adults who had previously used the OneLife Suffolk service. The survey received 556 responses.

Demographics

Age profile

The majority of respondents (80%) were over 46 years old. This age profile reflects the service users that use OneLife Suffolk. 1 in 5 respondents (20%) were 19 to 45 years old.

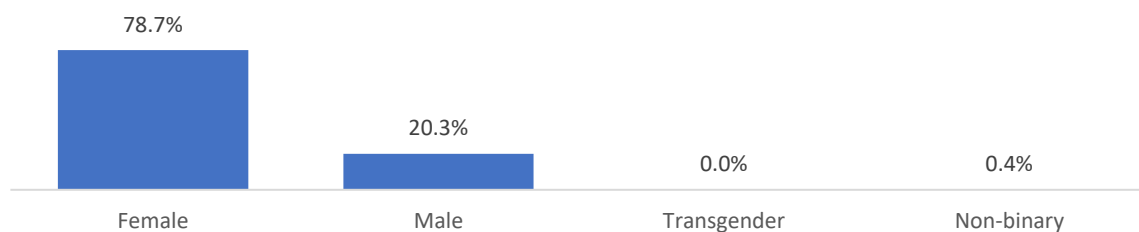
Figure 94: Age profile of respondents (n=536)



Gender profile

The majority of respondents (78.7%) were female, while 1 in 5 (20.3%) were male. No respondents reported being transgender and 0.4% reported being non-binary.

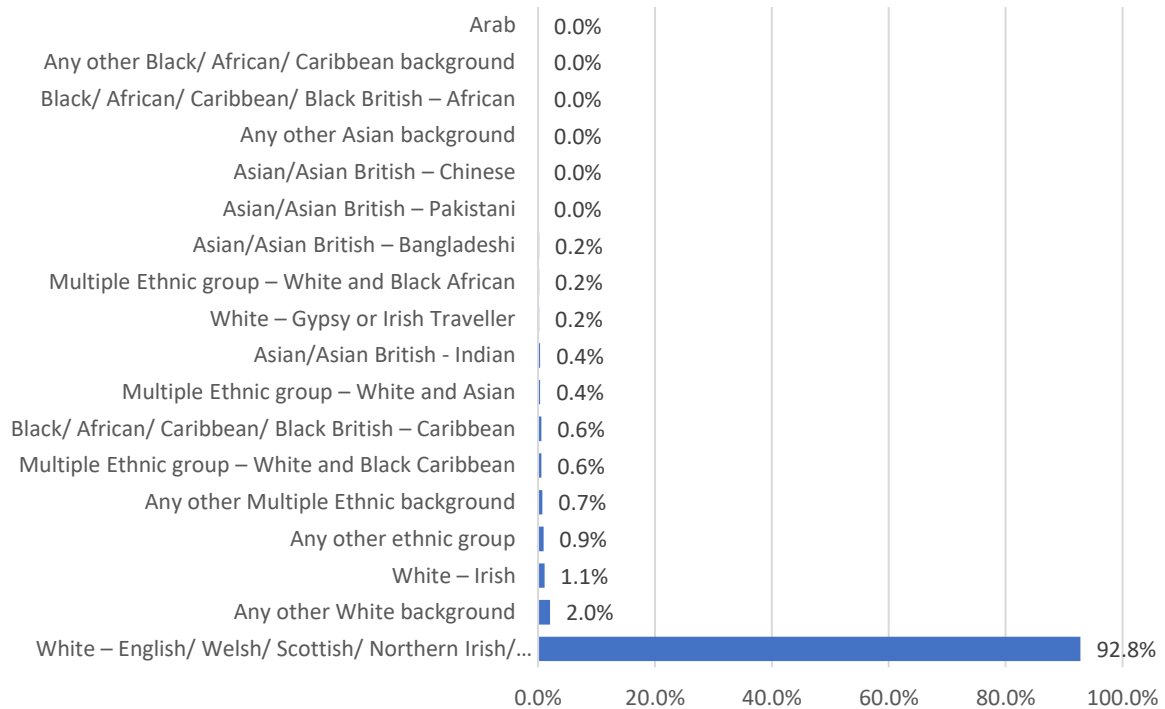
Figure 95: gender profile of respondents (n=553)



Ethnicity

The majority of respondents (92.8%) were white. Under 1 in 10 respondents (7.2%) were from ethnic minorities, with the largest proportions describing their ethnicity as ‘other white background’ (2.0%) and ‘white – Irish’ (1.1%).

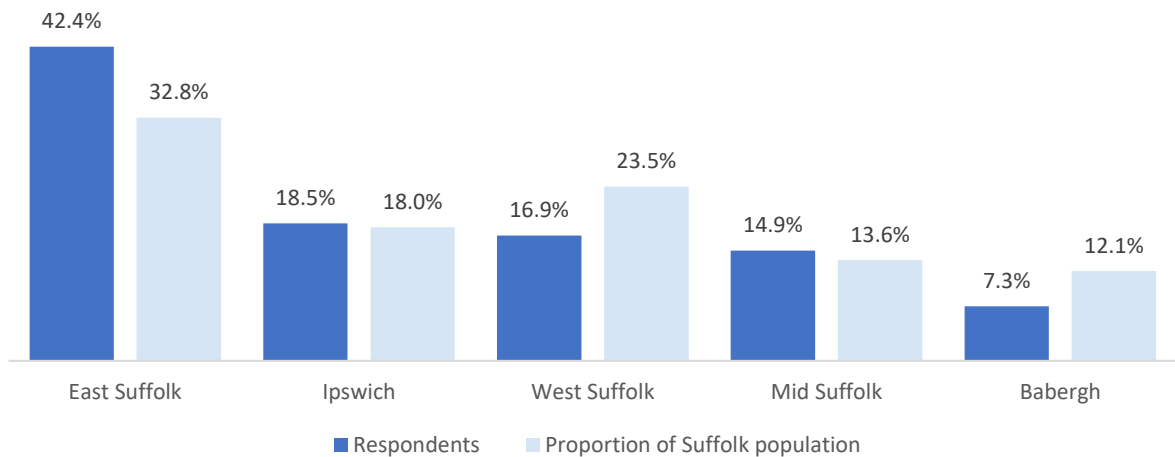
Figure 96: gender profile of respondents (n=541)



Locality

The breakdown of where respondents live largely reflects the composition of Suffolk. The highest proportion of respondents live in East Suffolk (42.4%). Similar proportions were from Ipswich (18.5%), West Suffolk (16.9%), and Mid Suffolk (14.9%). Under 1 in 10 respondents (7.3%) lived in Babergh.

Figure 97: Respondents’ locality within Suffolk compared to proportion of Suffolk population living within each lower tier local authority (n=545)



Health and disability

While half of respondents (49.5%) reported having no health problems or a disability, almost half (48.4%) reported that their ill health or disability limited them a little (28.5%) or a lot (19.8%) (see Figure 98).

Of those respondents who said that they had ill health or disability, almost 2 out of 3 (64.5%) had mobility issues, 1 in 3 (33.7%) had stamina or breathing difficulties, and just under 1 in 3 (29.3%) reported poor mental health (see Figure 99).

Figure 98: Are your day-to-day activities limited because of a health problem or disability which has lasted, or is expected to last, at least 12 months (include any problems related to old age)? (n=550)

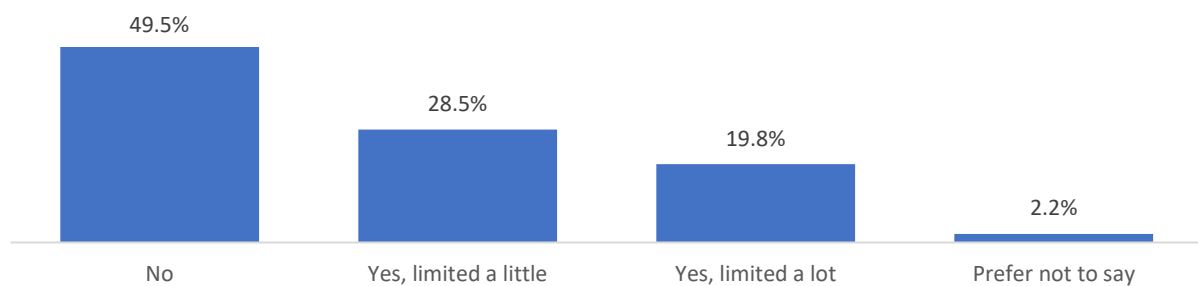
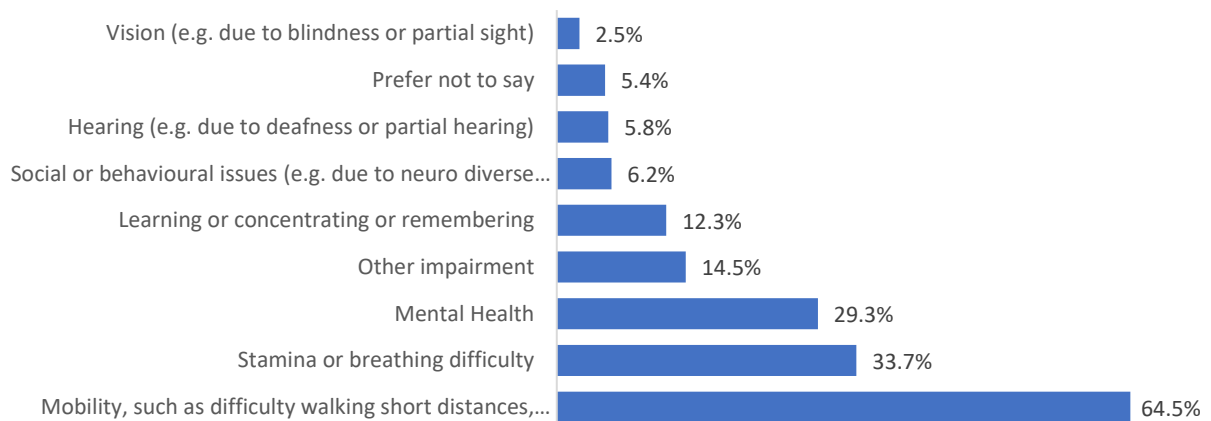


Figure 99: Disability by the proportion of respondents reporting ill health or disability (n=276)



Findings

Motivation to access services

What do you think might motivate you to attend a healthy living service or group?

Sometimes life events might encourage a person to get healthier. Respondents were asked what would motivate them to attend a healthy living service or group.

522 respondents answered this question. Once sifted for nonresponses, this was reduced to 436. Please note that Figure 100 below only shows themes relating to 3 or more comments.

Illness / health needs

Over 1 in 3 respondents (37.6%) said that illness or poor health would motivate them to seek out healthy living services. Many of these were described as 'near miss' incidents and/or related to re-evaluating life due to aging and comorbidities.

'A health scare - of myself or of a close family member (If talking about hereditary or linked condition)'

Weight loss

Just over 1 in 10 (12.6%) said that the need to lose weight would motivate them to seek out healthy living services. A proportion of these comments also related to 1) wanting to lose weight so that they could play with / be around for their children and 2) gaining weight and inactivity in older age. Many respondents noted that they had accessed the Slimming World vouchers provided by OneLife Suffolk.

'I recently heard of a 12-week Slimming World course funded by OneLife Suffolk. Due to a low income, it wasn't financially possible for me to attend the group to start losing weight, which I really needed to, so the funding voucher has made it possible to assist me on my weight loss journey which I otherwise wouldn't have afforded'

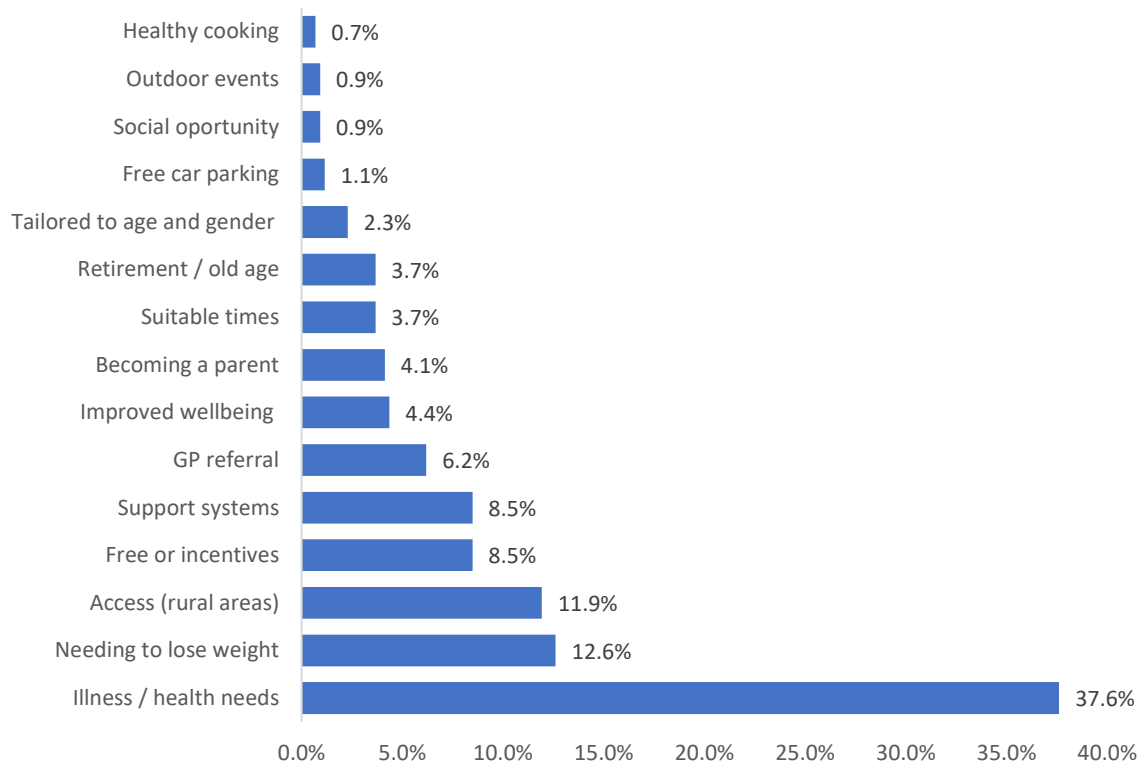
Access (rural areas)

Just over 1 in 10 respondents (11.9%) noted that accessibility would motivate them to attend a healthy living service. "Accessibility" is a very broad term, but often respondents wanted services that were local to them, with some respondents mentioning that existing services were often located in Suffolk's main towns such as Ipswich. The time that services run was also mentioned in conjunction with the location of the service, with some respondents noting that work and parental commitments provided them with limited times to access services.

'It being at a time and place that is convenient for me; that it is local to where I live; that it is easy to join and clear it is welcoming for people at the beginning of a getting healthier journey.'

'Local, both outdoors and indoors but most of all guarantees that you will be included as most groups become clicky and if you don't gel well with others you can feel more lonely in a group that on your own. So a guarantee of companionship even if it only comes from the staff as isolation and loneliness is often unrecognised within groups.'

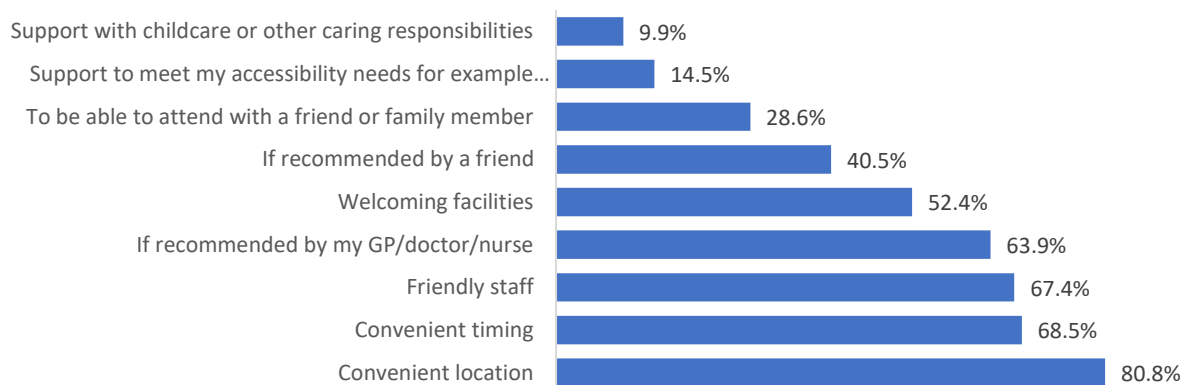
Figure 100: Sometimes life events might encourage a person to get healthier. What do you think might motivate you to attend a healthy living service or group? (n=436)



If you felt that healthy living services or groups might be useful to you, what might help you decide to use them?

Regarding approaches to delivering a healthy living service, location (80.8%) and convenient timing (68.5%) were seen as the most important deciding factors when getting respondents to access services. Recommendations by GPs (63.9%) and friends (40.5%) were also ranked highly. The atmosphere of the services was also considered important by respondents, with over 2 out of 3 respondents (67.4%) selecting 'friendly staff' and over half (52.4%) selecting 'welcoming facilities'.

Figure 101: If you felt that healthy living services or groups might be useful to you, what might help you decide to use them? (n=546)



Barriers to accessing services

Words and phrases that become barriers to access

It has been noted in previous research that certain words or phrases can put people off accessing health and social care services. Public Health and Communities Suffolk sought to identify trigger words that may be seen as a barrier to accessing healthy living services in Suffolk.

425 respondents answered this question. Once sifted for nonresponses, this was reduced to 272. Please note that Figure 102 below only shows themes relating to 4 or more comments.

Weight / weigh in

Many of the respondents had previously used Slimming World and therefore had comments regarding the weekly weigh-in and methods of weight management that are used in the group sessions. Just over 1 in 10 (13.6%) mentioned weight reviews / weigh-ins as a barrier to accessing services. A sub-section of these respondents were not keen on the public monitoring of weight in large groups and a minority mentioned that clapping was off-putting.

'When you go to a weight loss group and everyone in the group knows you have gained weight that week like at slimming world [...] so horrific'

Diet

Just over 1 in 10 (12.1%) said that the word 'diet' put them off joining a service or group. Respondents noted that dieting can be seen as 'a regime', making some foods 'forbidden', and would prefer it to be labelled as a 'lifestyle change'.

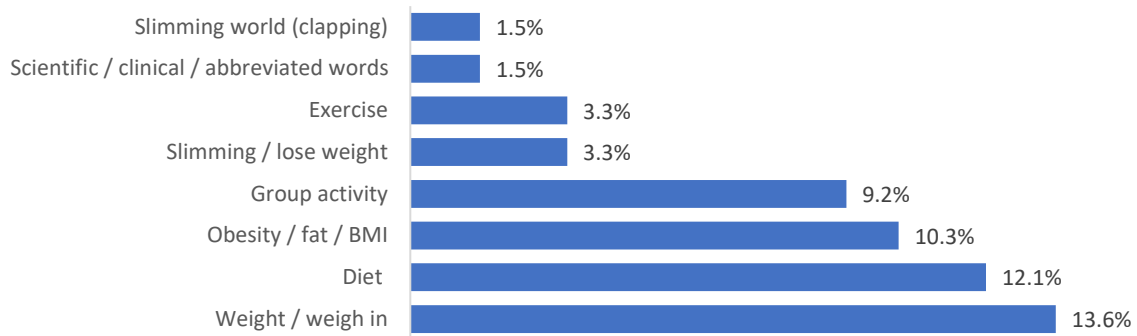
'Diet. Constant talking about food and what meals you have. Shaming if you have not lost that week'

Obesity / fat / BMI

1 in 10 (10.3%) respondents said that words such as 'obesity', 'fat', and 'BMI' would put them off accessing a service. Many of these comments were coupled with respondents saying that clinical, scientific and/or abbreviated words were hard to follow and detracted from the service's offer (1.5%).

'Any fatphobic use of language - there is still a lot of discrimination around weight in the health world. Any language which does not recognise other health conditions being the reason for things such as gaining weight, anything that makes it seem as if it is that person's fault'

Figure 102: Are there certain words or phrases about healthy living that might put you off going to a service or group? (n=272)



Reasons for not accessing services

Not knowing services are there

For those respondents who had not used a healthy living service, 2 out of 5 (41.1%) said that they had not used a service previously as they did not know about them.

Relevance and convenience

Almost 1 in 3 (29.8%) said that the services were not relevant to them, while 1 in 5 (18.4%) said that the services were not convenient for them. The comments showed that “convenience” often related to respondent’s working hours or childcare commitments.

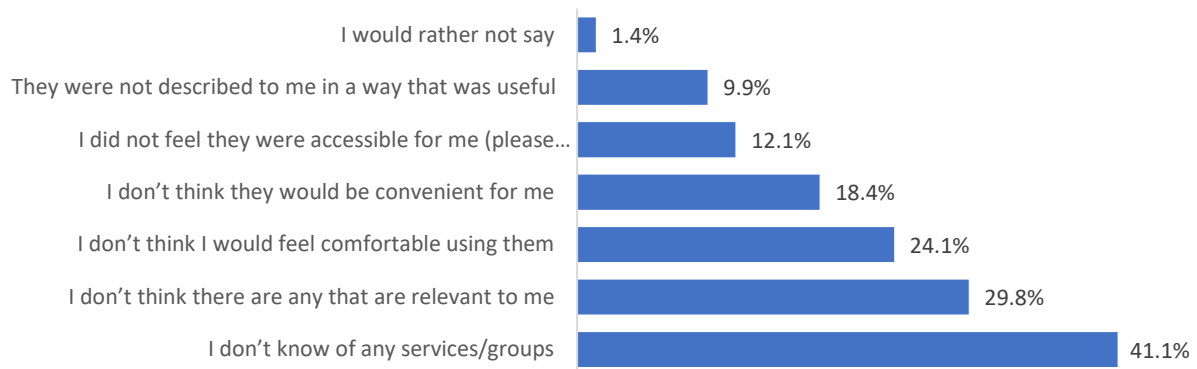
‘Because life is very hectic with family issues and being tied to particular times was hard. I felt I knew what I should be doing and therefore felt I didn't need external input’

Feeling uncomfortable

A quarter of respondents (24.1%) hadn’t accessed services as they would not feel comfortable using them. This was echoed in some of the comments where respondents cited being ‘uncomfortable’, ‘anxiety’ or ‘anxiousness’ when attending group services.

‘My husband tried the weight loss programme but was uncomfortable as it was most ladies!’
‘I felt uncomfortable I could not understand or hear what was said and when confronted with a question felt unable to cope’

Figure 103: If you have not used a service or group before, why not? (n=141)



Delivering Healthy Behaviour Services

Information prior to accessing services

Providing accurate and timely information to the public through good marketing and advertisement can ensure that healthy living services are reaching the right people. Public Health and Communities Suffolk sought to identify what information people would like to see before accessing healthy living services in Suffolk.

491 respondents answered this question. Once sifted for nonresponses, this was reduced to 418. Please note that Figure 104 below only shows themes relating to 5 or more comments.

Timing and location

Almost half of all respondents (47.6%) wanted to know the time, duration, and frequency of the services (24.6%) on offer and where the service was located (23.0%). Location was often mentioned in conjunction with travel time.

'Time Frequency - short or long term - and what the long-term expectation is/are'

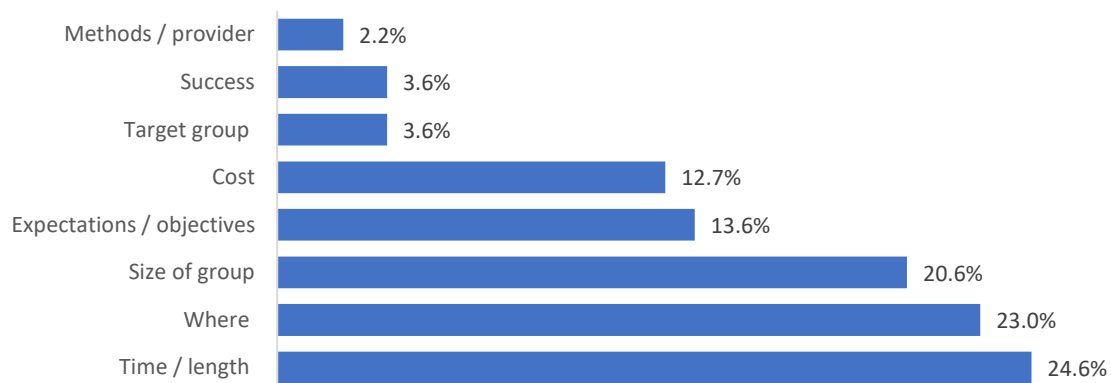
Size of group and target cohort

1 in 5 respondents (20.6%) wanted to know the size of the group they would be attending, while 3.6% wanted to know who the target demographic was for the service. Both were predicated on social anxiety for many respondents, mentioning 'large groups' or being the 'odd one out' regarding the age or gender of attendees.

'How many people would be there. What's involved, all info upfront on what to expect to help ease social anxiety'

'Whether it was for my age group or all ages? I wouldn't want to be the old one in the group'

Figure 104: If you were thinking about attending a service/group, what would you like to know about it before you went? (n=418)



Practical methods for aiding access to services

Information on behavioural change

Over two thirds of respondents (69.5%) said that information on behavioural change, such as health eating, would help them to use a healthy living service or group. A proportion of the respondents who commented noted that there should be less emphasis on reducing smoking, caloric intake or low physical activity, and more emphasis on changing behaviours first.

'Recognition that it is the psychology and behaviour that create change - and one to one help could be helpful. I think there is an assumption that the problem exists because of a lack of knowledge, when it is also likely to be about a behaviour issue - so educating me about calories might be interesting but is unlikely to change my behaviour. on the other hand, learning how to change behaviours and break habits can change things for ever'

Peer support

Almost two thirds of respondents (63.9%) said that peer support would help them to use a healthy living service or group. This was most strongly felt in comments left by people who had gone through weight management programmes; having someone lead by lived experience was pivotal for some respondents.

'Needs to enable others to freely share their stories at the same time not allowing one person to take over. Longer time frame to facilitate people meeting and sharing etc. Most people need ongoing support for longer than 12 months to achieve their goals and maintain them it will also help friendships to develop whereby they can learn to move away from group successfully. Most people know why they have developed bad habits, so need for more group sharing and less technical lectures. Also, group leaders who have had same difficulties would help. Tea and coffee help to break down barriers, small payment needed obviously'

Fun activities

Over half of respondents (58.9%) said that fun activities performed in groups would help them to use a healthy living service or group. However, there were a subsection of respondents acknowledging that large groups are sometime detrimental to successful, personal outcomes and/or socially off-putting.

'Outside activities as long as they are not too crazy are good. I do attend a walking yoga group every other week which I love because it is stretching and walking both of which I can do'

Financial incentives

Although not provided as an option as a survey response, many comments were made regarding financial incentives such as low cost or free access to services, particularly for individuals with children, those in low pain employment, and those who are retired.

'I am keen to do more exercise and think it would be good for my mental health, but these are sometimes very expensive, I am a pensioner, I like yoga, tai chi, things for my ability'

Figure 105: If you felt you needed/wanted to use a healthy living service or group, do you have any ideas about what might help you? (n=538)



Preferred methods of accessing services

Many public services moved to online and telephone methods of engagement during the COVID-19 pandemic. For some this has worked well and for others it has not. Looking towards future ways of working, Public Health and Communities Suffolk sought to identify what type of engagement respondents preferred.

550 respondents answered this question. The survey asked respondents to choose a method of delivery for 1) stop smoking services, 2) weight loss, 3) physical activity, and 4) alcohol consumption. There was no significant difference between options chosen and type of service, so the responses have been aggregated.

Meeting at regular intervals

1 in 5 respondents (18.2%) wanted to meet at regular intervals, such as weekly. This was echoed in comments relating to other questions in the survey, as respondents often wanted to be held accountable, have consistency, and feel that they are working towards a goal.

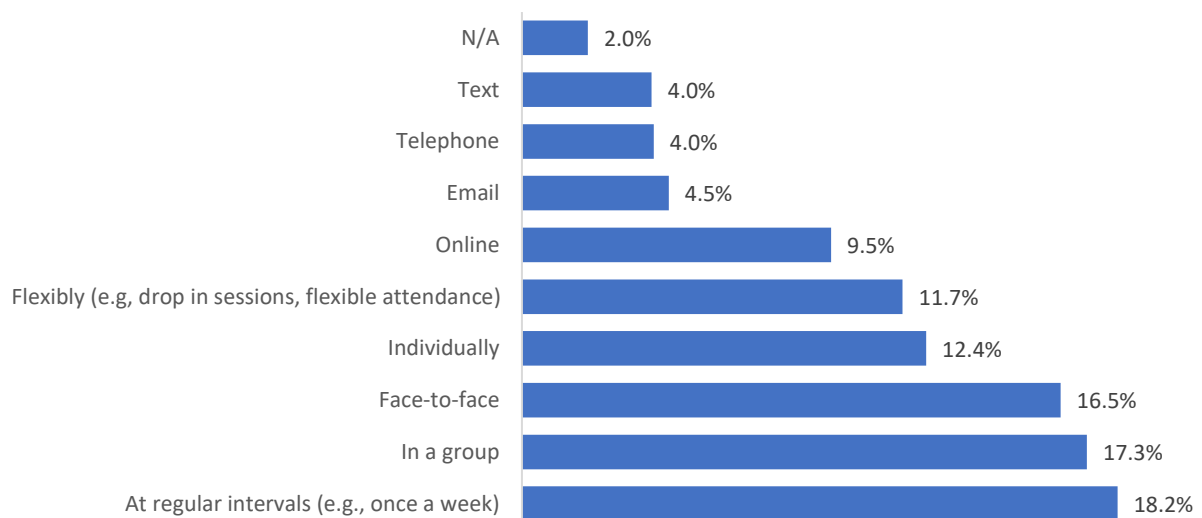
Group activity

17.3% of respondents wanted to access services via group activities. However, many comments throughout the survey noted that smaller groups were preferable in regards to making new friendships and have more time with the instructor or service leader.

Face-to-face

16.5% of respondents wanted face-to-face services. This is mirrored by lower needs attributed to text (4.0%), telephone (4.0%), and email (4.5%). There were, however, still a sizable proportion that wanted online services (9.5%).

Figure 106: Different kinds of services/groups can take place in different ways. For example, services/groups can happen online or over the telephone; in a group or one to one. We'd like to know what ways you'd be happy to use services or groups if you felt you wanted/needed to. (n=550)



Preferred methods of service delivery

Respondents were asked if they had further suggestions for methods of delivering support services. 242 respondents answered this question. This was reduced to 129 once sifted for nonresponses. Please note that Figure 107 below only shows themes relating to 5 or more comments.

Small groups / face-to-face delivery

1 in 5 respondents (20.2%) said that small groups and/or face-to-face was their preferred means of service delivery. Although the reasons for this were wide ranging, many comments touched on feeling inclusive, heard, and connected when meeting in small groups and/or face-to-face.

'Groups should be comfortably small in size so that individuals don't get over shadowed'

'Face to face is the best way to obtain commitment and attention from an attendee'

Flexibility

Almost 1 in 5 (18.6%) mentioned flexibility in varying guises. Flexibility often referred to being flexible with attendees pre-existing commitments, such as employment or childcare. They also referred to flexibility in regard to the way that attendees learn, engage, and consume information and services.

'You need the structure, a social/peer dynamic, but also some flexibility i.e. if you can't attend one week, it is complimented by good online support, so that you don't miss out'

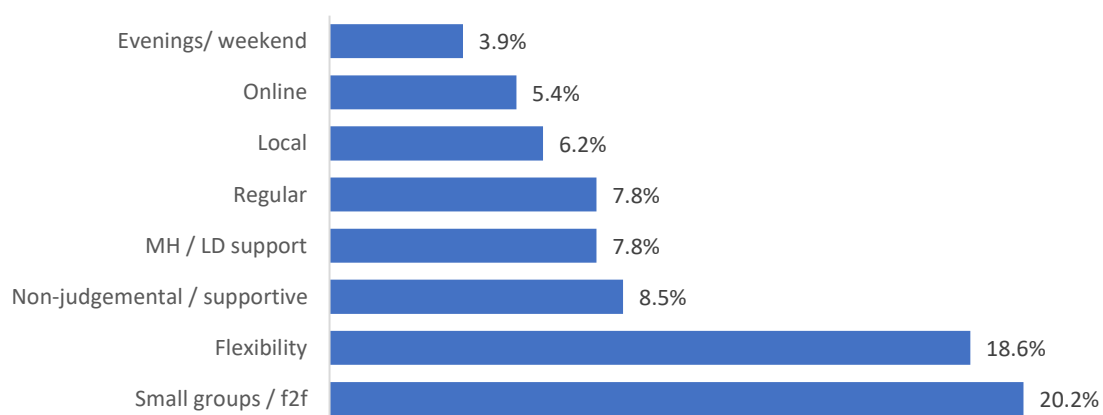
Mental Health and Learning Disability support

Almost 1 in 10 (7.8%) mentioned mental health or learning disability support. Many of these responses referred to a need for services to adopt a personalised approach to delivering activities, acknowledging that individuals who need mental health and/or learning disability adjustments find it difficult to access mainstream service provision due to many, varying reasons.

'I think there needs to be individual options, not all group based. I have multiple health issues and am not able to keep up with group activities. I also have social anxiety (I am autistic) and struggle with group situations. A lot of people, especially people with weight-based body issues, feel embarrassed in group exercise, so avoid it, so individual options could encourage more people'

'Have visual PowerPoints presentations each week to cover the topic. As a dyslexic I find having visual prompts really are helpful for my understanding'

Figure 107: Do you have any other thoughts on how you'd like support to be delivered? (n=129)



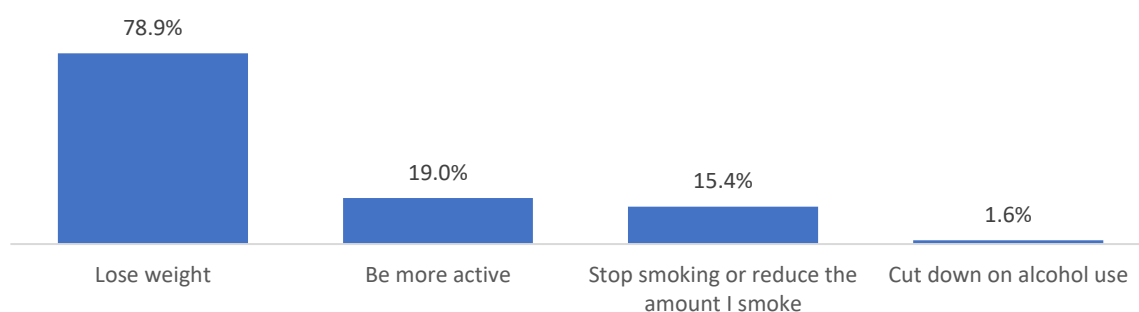
Service user feedback

Understanding respondents healthy living service use

Two thirds of respondents (66.7%) said that they had used healthy living services in Suffolk. The 371 respondents who identified that they had used healthy living services in Suffolk when then asked what type of services that had used.

Almost 8 out of 10 respondents (78.9%) reported using weight loss services, while 1 in 5 (19.0%) reported using physical activity services. Smaller proportions reported using smoking reduction services (15.4%) and alcohol reduction services (1.6%).

Figure 108: What kinds of services or groups have you used? (n=369)



Aspects of the service and/or group that made service users attend

Please note that the following section and question has been broken down by service type. Themes have been created if there were a sufficient number of comments.

Q: What was it about the service/group (or services/groups) that helped you decide to use it/them?

Alcohol services

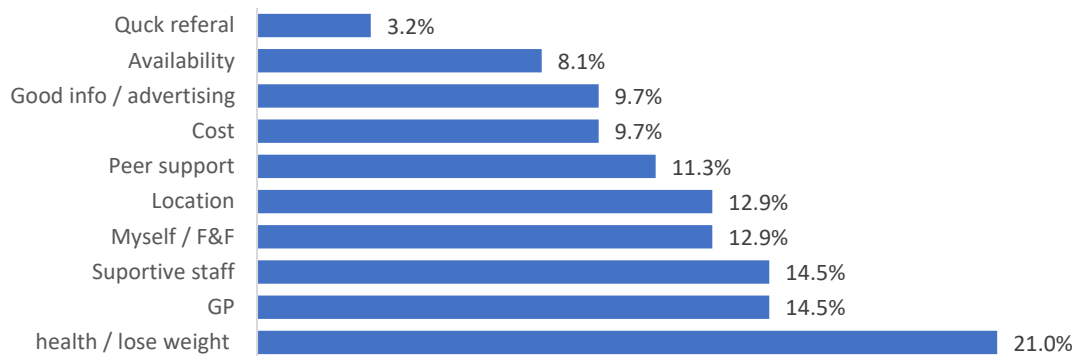
There were only 5 comments relating to alcohol services. 1 individual cited health as a reason for accessing services, while others said that peers and GP referrals were to reason for accessing services.

Physical activity services

1 in 5 respondents (21.0%) joined the physical activity service for health reasons and/or weight loss, while 14.5% of respondents joined the service via a GP referral or because the service's staff were friendly and supportive.

'friendly leader who was supportive, but firm and valued all of us in wanting us to feel better about ourselves. she was very honest about her own temptations and always made us feel that where we slipped up it wasn't the end of the world!'

Figure 109: What was it about the service/group (or services/groups) that helped you decide to use it/them? Physical activity service users only (n=64)



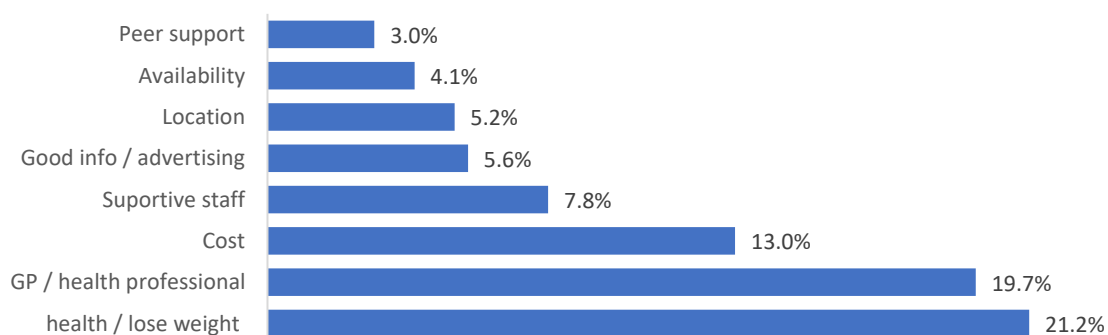
Weight management services

As with respondents accessing physical activity services, 1 in 5 respondents (21.2%) accessing weight management service did so for positive health benefits and/or weight loss. 1 in 5 (19.7%) were referred by a GP or health professional.

Almost 1 in 10 (7.8%) referred to the low cost of access. Many of these were referring to the Slimming World vouchers.

'Slimming world in Leiston has helped me lose 5 stone 4 lb to date. Julie is brilliant cant praise her enough. That you one life for giving me the first free 12 sessions. Slimming world helped me realise how much alcohol can change your life for the worse'

Figure 110: What was it about the service/group (or services/groups) that helped you decide to use it/them? Weight management service users only (n=269)



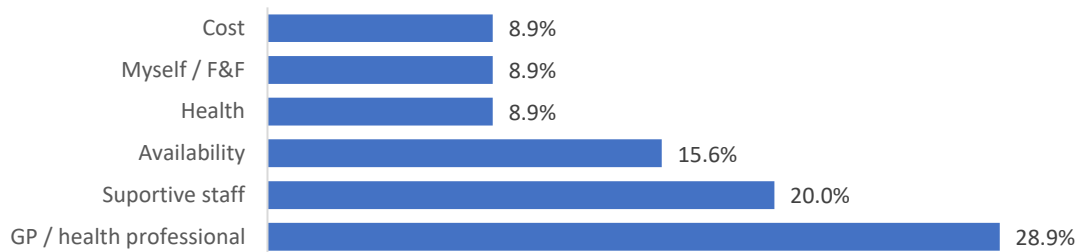
Smoking cessation services

The largest proportion of smoking cessation service users said that they decided to access services after a referral from a GP or health professional (28.9%). This was followed by 1 in 5 respondents (20.0%) saying that staff were supportive and friendly, and 15.6% saying that the availability of the service was a reason for opting on to the smoking cessation programmes offered.

'Initially I went to the stop smoking sessions because they supplied free nicotine substitute products, but their advice and support was very helpful'

'The relaxation group was recommended by my cardiac rehab team'

Figure 111: What was it about the service/group (or services/groups) that helped you decide to use it/them? Smoking cessation service users only (n=45)



Aspects of the services that service users like

Please note that the following section and question has been broken down by service type. Themes have been created if there were a sufficient number of comments.

Q: What did you like about services/groups you have used?

Alcohol services

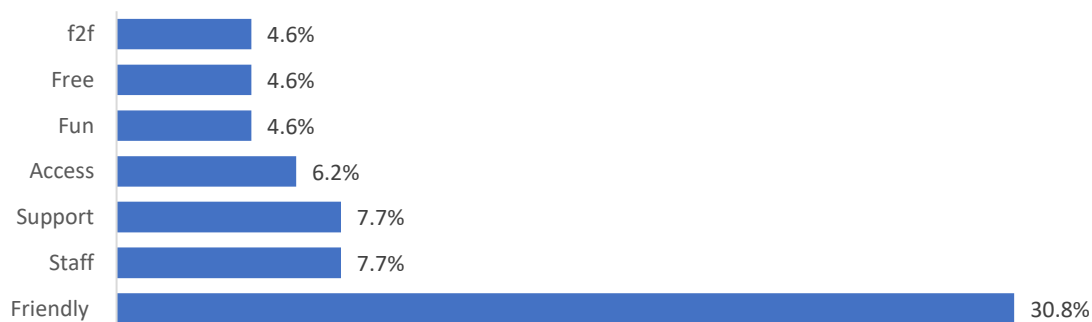
There were only 4 comments relating to alcohol reduction services. All of them were positive, stating that the groups or sessions were facilitated by friendly staff and included like-minded clients with the same aims.

Physical activity services

Almost a third of respondents (30.8%) who used physical activity services said that the groups were friendly, creating an atmosphere where service users felt comfortable and wanted to return. Just under 1 in 10 (7.7%) said that they liked the staff, including the staff's knowledge and expertise, and that the groups and staff were supportive when service users were trying to reach their goals.

'The FREE service meant that I was able to participate without any financial worries. The course leaders were very friendly and supportive. I particularly enjoyed the practical exercise element of the fitness class'

Figure 112: What did you like about services/groups you have used? Physical activity service users only (n=65)

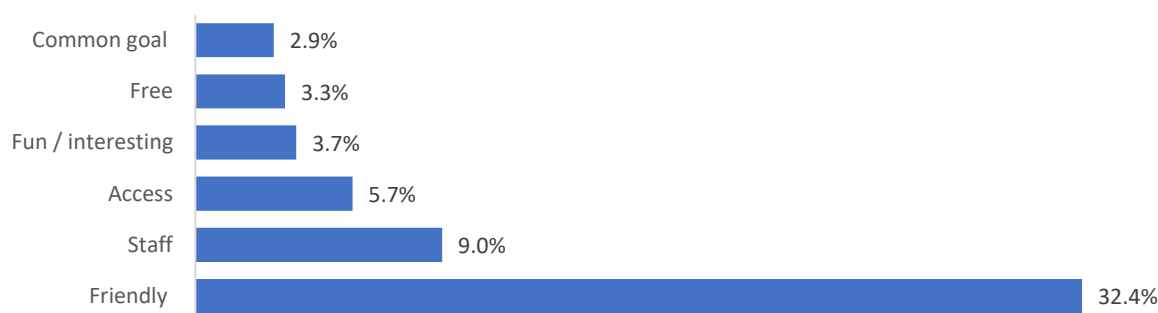


Weight management services

As seen in the physical activity service user responses, a third of weight management service users (32.4%) said that the groups were friendly, creating an atmosphere where service users felt comfortable and wanted to return. 1 in 10 (9.0%) said that they liked the staff, often saying they were supportive in helping service users stay on track and reach their goals. 1 in 20 (5.7%) said that accessing the services was easy as they were at convenient times and locations.

'The location and time was convenient. The leader was very good, friendly, and very well informed. The materials and course helped me set goals, monitor my progress and for the first time ever, really reflect upon and understand and control my overeating. I could also see that I had gradually become too sedentary and was able to make changes here too by setting small, manageable targets'

Figure 113: What did you like about services/groups you have used? Weight management service users only (n=244)

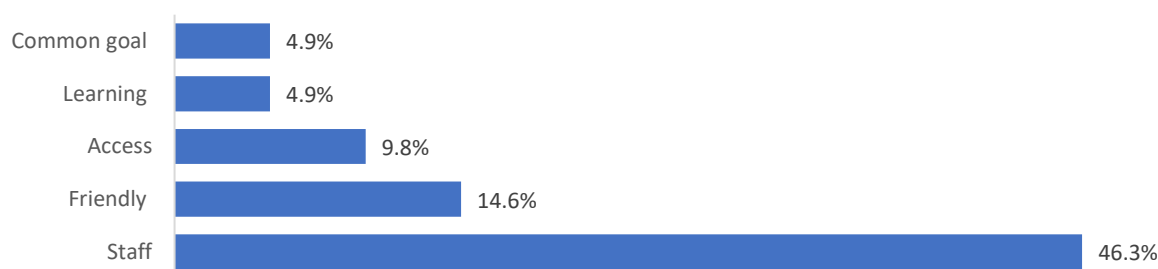


Smoking cessation services

Smoking cessation service users put more of an emphasis on staff (46.3%), with many saying that having a staff member or counsellor who is an ex-smoker was pivotal in their cessation journey as they had 'lived experience'.

'Weekly voice contact with my counsellor, this was so helpful to me and played a massive part in my giving up, it is more than a year now, and my counsellor was an ex-smoker himself which put me at ease'

Figure 114: What did you like about services/groups you have used? Smoking cessation service users only (n=41)



Aspects of the services that service users did not like

Please note that the following section and question has been broken down by service type. Themes have been created if there were a sufficient number of comments.

Q: What didn't you like about the services/groups you have used?

Alcohol services

There were only 3 comments relating to alcohol services. 1 individual stated that the 'aftercare was sporadic', while the other respondents stated 'nothing'.

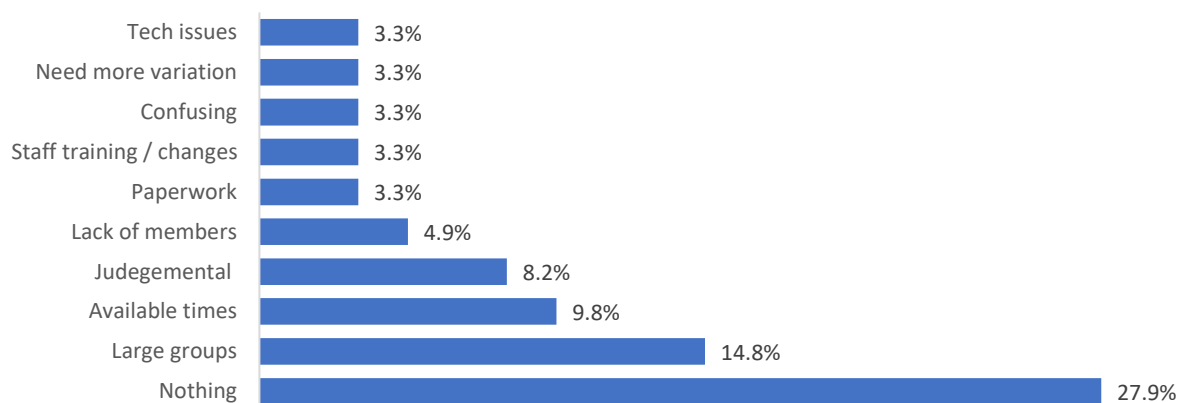
Physical activity services

Over a quarter of respondents (27.9%) didn't have anything negative to say about the physical activity services. 14.8% said that the groups were too large, while 1 in 10 (9.8%) said that the availability of the service did not always suit their lifestyle. Just under 1 in 10 (8.9%) said that some of the other attendees were judgemental.

'When they stopped, my unhealthy eating habits due to stress and emotional problems were still with me, but there was nothing I could do, no one to discuss this with. So nothing really changed'

'There is a lot of repetition across the programs, so that if participants have joined more than one course, they may find it a bit boring. Eg, the sleep hygiene, eat well plate, stress reduction modules were almost identical across the 2 courses I joined'

Figure 115: What didn't you like about services/groups you have used? Physical activity service users only (n=61)



Weight management services

1 in 5 respondents (19.3%) didn't dislike anything about the weight management services they attended. Around 1 in 10 said that the groups were often too large (9.9%), and that the information covered in the group sessions were too simplistic (9.0%). Simplistic information was often coupled with respondents feeling patronised in the weight management sessions (6.1%). A smaller proportion of the respondents noted that some staff may need further training as there wasn't always consistent

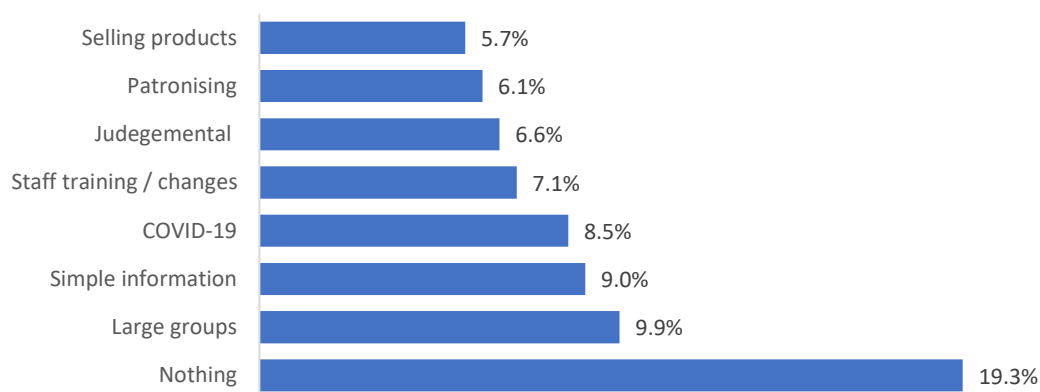
delivery of services or standards. 1 in 20 respondents (5.7%) said that the Slimming World programme focused too much on trying to sell products rather than promoting healthy weight change.

‘Sometimes the things were obvious. A little patronising. Most overweight people have dieted for years and we probably know more about food and calories than anybody!’

‘Too much technical information, hard to understand in short periods of time. The first time I met the staff member he was enthusiastic and had so much energy and it was kept easy and simple to follow along. This time around the same member of staff didn't have the same enthusiasm and was not very interactive with the information and seemed over stretched with delivering the new curriculum’

‘Sometimes what puts me off is to be taught by a person who all her/ his life never had weight problems or any other form of addictive behaviour. These are people that often do not understand what the issue with addictive behaviour might be and think that it's all about will power. Addiction it's not necessarily about making the decision to change, it's about self-image and other issues that have deep roots and cannot easily be changed’

Figure 116: What didn't you like about services/groups you have used? Weight management service users only (n=212)



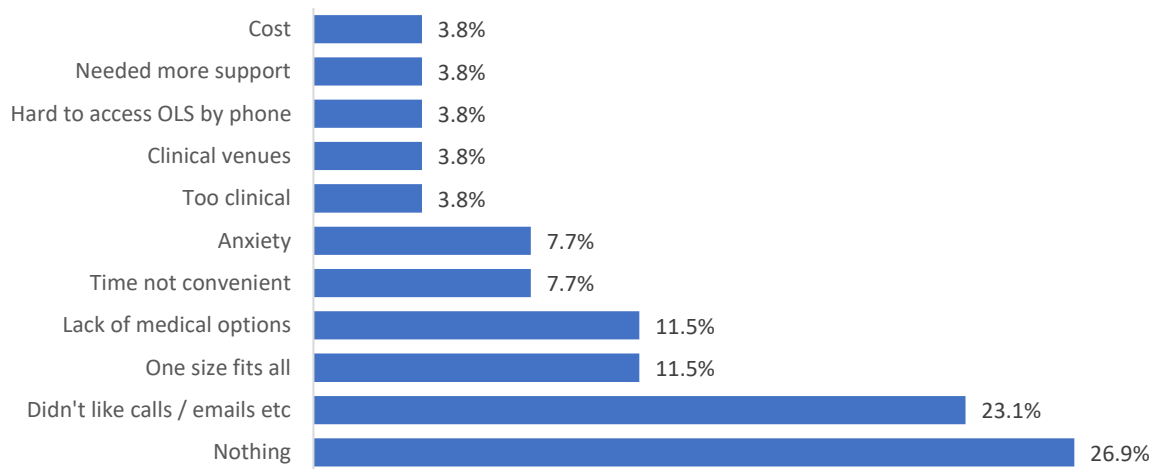
Smoking cessation services

Almost a quarter of respondents (23.1%) said that they did not like accessing the smoking cessation services via telephone calls or emails. Rather, they would prefer face-to-face services. Just over 1 in 10 (11.5%) referred to the service as a 'one size fits all' service that doesn't work for everyone. The same proportion of respondents (11.5%) said that there was a lack of medical option offered for smoking cessation and that the current offer did not suit their needs.

‘Getting in touch with one life suffolk is very tedious by call. The line drops and when you do get through if you miss an appointment the receptionist isn't very helpful. Easiest way is to fill out a form so far. This needs to change or to be notified’

‘Always in very clinical venues such as doctors health clinics. Or hard to reach places’

Figure 117: What didn't you like about services/groups you have used? Smoking cessation service users only (n=26)



Recommendations

Overarching recommendations

<p>Recommendation: Reducing health inequalities associated to health behaviours</p>	<p>Rationale: Public Health and Communities Suffolk will continue to work with health and social care, Voluntary, Community, and Social Enterprise (VCSE), and community partners to understand and combat inequalities associated with risky health behaviours.</p>
<p>Recommendation: Communities, place-based approaches, and inclusion health and equalities to inform health behaviours</p>	<p>Rationale: Public Health and Communities Suffolk’s work to reduce health inequalities linked to health behaviours for vulnerable groups and communities recognises that these residents have very high needs and require targeted responses. Therefore, Public Health and Communities Suffolk will continue to work in partnership with the Suffolk and North East Essex Integrated Care System, and place-based systems such as the Primary Care Networks (PCNs) and grass-roots Voluntary Charity and Social Enterprise (VCSE) organisations, to ensure that communities and their voices are at the forefront of changing health behaviours in Suffolk.</p>
<p>Recommendation: Community engagement and co-production</p>	<p>Rationale: Public Health and Communities Suffolk will continue to promote and embody the ethos of co-production when developing the ongoing ‘re-imagining health behaviours’ workstream and implementation of future services. Public Health and Communities Suffolk will also promote co-production in relation to health behaviours through the Engaged Communities Group, promotion of Healthwatch Suffolk’s ‘A Recipe for Co-production’, Integrated Care System (ICS) engagement through ‘Let’s Talk SNEE’, and ongoing collaboration with the Norfolk and Waveney Health and Care Partnership.</p>
<p>Recommendation: Informing decisions with data</p>	<p>Rationale: Public Health and Communities Suffolk will continue to broaden its data intelligence function to inform health behaviours in Suffolk. A crucial part of this will be the implementation of Population Health Management in April 2023.</p>
<p>Alcohol</p>	
<p>Recommendation: Review admission profile of people admitted to Ipswich Hospital for alcohol-related conditions to inform harm reduction approaches</p>	<p>Rationale: Those aged 40 to 64 in Ipswich, both male and female, were the only age banding across all of Suffolk’s LTLAs to show a statistically significantly higher rate of admission for alcohol-related conditions compared to England. Public Health and Communities Suffolk and system partners should make a concerted effort to tackle problematic drinking in Ipswich residents aged 40 to 64.</p>

<p>Recommendation: Review options for funding interventions beyond commissioned specialist alcohol treatment providers, optimising opportunities to align resources across the wider Suffolk system</p>	<p>Rationale: There was a consensus across all stakeholders that there is a need for brief and extended interventions beyond traditional commissioned services, in areas where they are most effective and have the greatest cost benefits. For example, interventions at a population level through PCNs or GP Practices and preventative programmes through specialist nurses in acute hospitals when service users present with substance use issues.</p> <p>Also, this is very important for young people who frequently will not engage with specialist treatment but can be picked up by Children and Young People (CYP) services, e.g., youth justice, county lines.</p>
Tobacco	
<p>Recommendation: Continue the commissioning of Local Stop Smoking Services (LSSS) in Suffolk</p>	<p>Rationale: There is strong evidence for the effectiveness of LSSS both nationally and locally. This suggests that investment in local stop smoking services would be an effective use of resource moving forwards. Further work can be done to improve the reach and accessibility of services to populations at higher risk of smoking related harm.</p>
<p>Recommendation: Targeted engagement with populations at higher risk of smoking-related harm</p>	<p>Rationale: Behavioural science approaches can be used to target engagement to those population groups with the highest level of risk to harms of smoking. Specific work to understand the needs and motivations of those in routine and manual occupations (including pregnant routine and manual workers) in Ipswich, and Black and minority ethnic populations, can be used to inform targeting and health promotion messaging.</p>
<p>Recommendation: Work in collaboration to target geographical and population-based smoking cessation interventions</p>	<p>Rationale: Using high relative deprivation, high smoking prevalence, and low smoking support as a proxy for enhanced targeted support, GP patients lists can be used to inform the targeting of priority intervention groups. collaborative working between partners who work to support primary care will support the development of local actions and support in each of the priority categories.</p>
<p>Recommendation: Work in collaboration to develop, monitor and evaluate local pathways for pregnant smokers and smokers</p>	<p>Rationale: Using the partnerships that have been created across SNEE and Norfolk and Waveney (N&W) tobacco dependency steering groups.</p>

with mental-ill health as part of the NHS Long Term Plan	
Recommendation: Improve data collection and monitoring of longitudinal data around quits to gain a better understanding of long-term impact of LSSS	Rationale: Consider local engagement with smokers and ex-smokers, and the use of technology to support and maintain contact with previous smokers.
Recommendation: Continue to develop and deliver support and training options for primary care and wider statutory and voluntary sectors organisations	Rationale: Using local engagement conversations to identify reasons for low offers of support to inform approaches to training and support. Continued promotion of Making Every Contact Count and behaviour change approaches will be beneficial.
Adult Weight management	
Recommendation: Continue to develop and implement the system-wide strategy for reducing overweight and obesity in adults, building upon the 2021 publication of 'Tackling Obesity in Suffolk'.	Rationale: This strategy should acknowledge the importance of place, and utilise local understanding of prevalence, deprivation, and the wider social and environmental influences on weight to inform universal and place-based approaches to weight management.
Recommendation: Conduct targeted engagement with Suffolk residents to inform the development of adult weight management services, with a focus on broadening the options for support.	Rationale: Activity and outcome data from current weight management services show good outcomes for those completing programmes, however a large proportion of people are non-completers. Alternative programmes of support will be needed to meet the diverse needs of different population groups.
Recommendation: Continue to commission enhanced weight management services for target population groups.	Rationale: Data shows that for those that complete enhanced weight management programmes, they achieve good outcomes. However, many participants drop-out early. Further analysis is required to understand who within the population these enhanced programmes work for, to better inform effective targeting of resources to these groups.
Recommendation: Deliver a programme of training and support to the primary care workforce, targeting GP practices highlighted to be in priority areas.	Rationale: Partnership working should be prioritised to ensure alignment between ICS workforce development plans and priorities within local structures such as PCNs and Integrated Neighbourhood Teams (INTs).

Child weight management	
Recommendation: Build on the Whole System Approach to childhood obesity using learning from the two Suffolk pilot areas.	Rationale: Ensure the recommendations included in the Suffolk Childhood Obesity Strategy are considered and review progress in 2023.
Recommendation: Focus on families in need of extra support and areas of higher deprivation	Rationale: Use data from the National Child Measurement Programme (NCMP) to target schools and early year settings based on their prevalence of obesity and deprivation level.
Recommendation: Deliver targeted engagement and co-production activities with local families to inform the future design and delivery of support around child weight management	Rationale: Completion rates for current child weight management programmes are low. Engagement activities should aim to understand the barriers to healthy lifestyles, and work with families to identify how support can be delivered to reduce these barriers and improve access to support within local communities.
Recommendation: Support community and voluntary services established in Suffolk to increase their capacity in supporting families who are already engaged in their service.	Rationale: Maximising the potential of the existing relationships local organisations have with Suffolk families can help to improve the support for those children and families that find it difficult to engage in more formalised weight management services.
Recommendation: Ensure future models of support can adapt to the needs of families' and include provision around diet, physical activity, and behaviour change.	Rationale: Consideration should be made as to how we can build upon and the work of current services rather than duplicating current options for families of support.
Physical activity	
Recommendation: Physical activity interventions should continue to be targeted at groups disproportionately impacted by low levels of physical activity	Rationale: This includes individuals who have disabilities, those living in areas of high-deprivation, women and girls, and all ethnic minorities inclusive of non-white British communities.
Recommendation: Collaborative working across statutory and voluntary sector will be required to respond to high levels on inactivity in Suffolk which have been exacerbated by the COVID-19 pandemic	Rationale: The data presented in this report represented pre-pandemic activity levels. More recent data has shown that inactivity and physical activity levels have decreased throughout the pandemic, so concerted effort across local organisations will be required to support positive changes in activity levels across the county.

Recommendation: Targeted engagement should be undertaken to better understand the barriers to, and drivers of, physical activity within populations experiencing physical activity inequalities	Rationale: Work should be undertaken to understand the assets and strengths within local communities, as well as the social networks and relationships that can be built upon to increase the accessibility of initiatives to get more people active at a local level. Particular attention should be paid to the drop off in activity at key points in the life-course such as between childhood and adolescence or during pregnancy to support with future targeting of interventions.
NHS Health Checks	
Recommendation: Deliver NHS Health Check invites based on deprivation	Rationale: Public Health and Communities Suffolk to work with Provide (invite distribution company) to weight invites towards GP populations in the 40% most deprived areas relative to England. Public Health and Communities Suffolk should also increase the use of innovative invitation methods, including texting, analysing invite methods, undertaking service user engagement, and working with the Behavioural Insights Team to improve uptake from invites
Recommendation: Creating local solution to NHS Health Check coverage	Public Health and Communities Suffolk should develop local solutions to increase coverage and close the gap in non-attendance between men and women as well as least and most deprived populations. Public Health can pilot the use of community assets such as Primary Care Networks and Integrated Neighbourhood Teams to follow up non-attendances, as well as evaluating prototypes such as the Healthy Heart Fund and increasing non-health care settings such as Leisure Providers to assess impact. Additionally, Public Health and Communities Suffolk will explore the potential to increase the invite frequency for at-risk audiences, reducing the invite frequency for those less at risk of CVD through population health management.
Recommendation: Improving systems for evaluation and monitoring	Rationale: Public Health and Communities Suffolk will agree a standardised approach to collecting NHS Health Check data across Suffolk which will allow for robust insight and planning.

	<p>Working with those administering NHS Health Checks, Public Health and Communities Suffolk will enable appropriate auditing to identify GP practice level gaps in uptake among high-risk communities as well as other outcomes from the Health Check. There is also a need to tackle the lack of recorded ethnicity data relating to completed NHS Health Checks. Improving data capture systems will begin to highlight health behaviour inequalities by area and ethnicity.</p>
<p>Recommendation: Investment in training</p>	<p>Rationale: Public Health and Communities Suffolk will work with the Behavioural Insights Team and other partners to identify suitable behaviour change and motivational interview training to upskill Health Care Assistants where required.</p>
<p>Recommendation: Continued collaboration</p>	<p>Rationale: Public Health and Communities Suffolk will work with CVD Prevention and Primary Care ICS colleagues to:</p> <ul style="list-style-type: none"> - Identify suitable PCNs or Practices who may want to engage in specific targeted work. - Learn from GP practices with high numbers of patients living in areas of deprivation and achieve high levels of uptake - Explore what support Practices with very little Health Check delivery activity need

References

1. Micheal Cross. Healthy lifestyle and life expectancy free of cancer, cardiovascular disease, and type 2 diabetes: prospective cohort

- study <https://www.gov.uk/government/statistics/english-indices-of-deprivation-2019>.
Published online 2020:342:d3938. <http://www.bmj.com/content/346/bmj.f869.abstract>
2. British Heart Foundation. Economic costs of physical inactivity. *BHF Natl Cent Phys Act + Heal*. Published online 2013:8.
<http://www.ssehsactive.org.uk/userfiles/Documents/economiccosts.pdf> <http://www.ssehsactive.org.uk/userfiles/Documents/economiccosts.pdf> <http://www.bhfactive.org.uk/userfiles/Documents/economiccosts.pdf>
 3. Health effects of dietary risks in 195 countries, 1990-2017: a systematic analysis for the Global Burden of Disease Study 2017. <https://pubmed.ncbi.nlm.nih.gov/30954305/>
 4. Robson J, Dostal I, Madurasinghe V, et al. NHS Health Check comorbidity and management: An observational matched study in primary care. *Br J Gen Pract*. 2017;67(655):e86-e93. doi:10.3399/bjgp16X688837
 5. Public Health Suffolk. sos19-who-we-are @ www.healthysuffolk.org.uk. Published online 2022. <https://www.healthysuffolk.org.uk/jsna/state-of-suffolk-report/sos19-who-we-are>
 6. english-indices-of-deprivation-2019 @ www.gov.uk.
<https://www.gov.uk/government/statistics/english-indices-of-deprivation-2019>
 7. Department of Health. UK Chief Medical Officers' Low Risk Drinking Guidelines. *Dep Heal Engl*. 2016;(August):1-11. <https://www.gov.uk/>
 8. Health matters: harmful drinking and alcohol dependence.
<https://www.gov.uk/government/publications/health-matters-harmful-drinking-and-alcohol-dependence/health-matters-harmful-drinking-and-alcohol-dependence>
 9. Kings Fund. New analysis reveals stark inequalities in obesity rates across England. Published online 2021. <https://www.kingsfund.org.uk/press/press-releases/new-analysis-stark-inequalities-obesity-england#:~:text=People in the most deprived,for obesity-related health problems.&text=Childhood obesity rates follow a,%2F7 and 2019%2F20>.
 10. Public Health England. Understanding and addressing inequalities in physical activity Evidence-based guidance for commissioners. *Public Heal Engl*. Published online 2021.
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1011833/PHE_inequalities_in_physical_activity_August_update_Final.pdf
 11. ONS. Likelihood of smoking four times higher in England's most deprived areas than least deprived.
<https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/drugusealcoholandsmoking/articles/likelihoodofsmokingfourtimeshigherinenglandsmostdeprivedareasthanleastdeprived/2018-03-14>