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Public Health & Communities

Core20PLUS5 in Suffolk

Suffolk Annual Public Health Report 2022

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Introduction from Stuart Keeble, Director of Public Health and Communities

This year, the focus of the Director of Public Health's Annual Report for Suffolk is **Core20PLUS5.**

Stuart Keeble, Director of Public Health and Communities

Core20PLUS5 is way of improving outcomes, and reducing health inequalities –the avoidable, unfair and systematic differences in health between different groups of people. We focused on health inequalities in the 2020 Director of Public Health's Annual Report for Suffolk - but through a different lens, the voices of our community. The legacy of this work must carry on as we continue to tackle existing health inequalities and face new challenges following the COVID-19 pandemic and the emerging cost of living crisis.

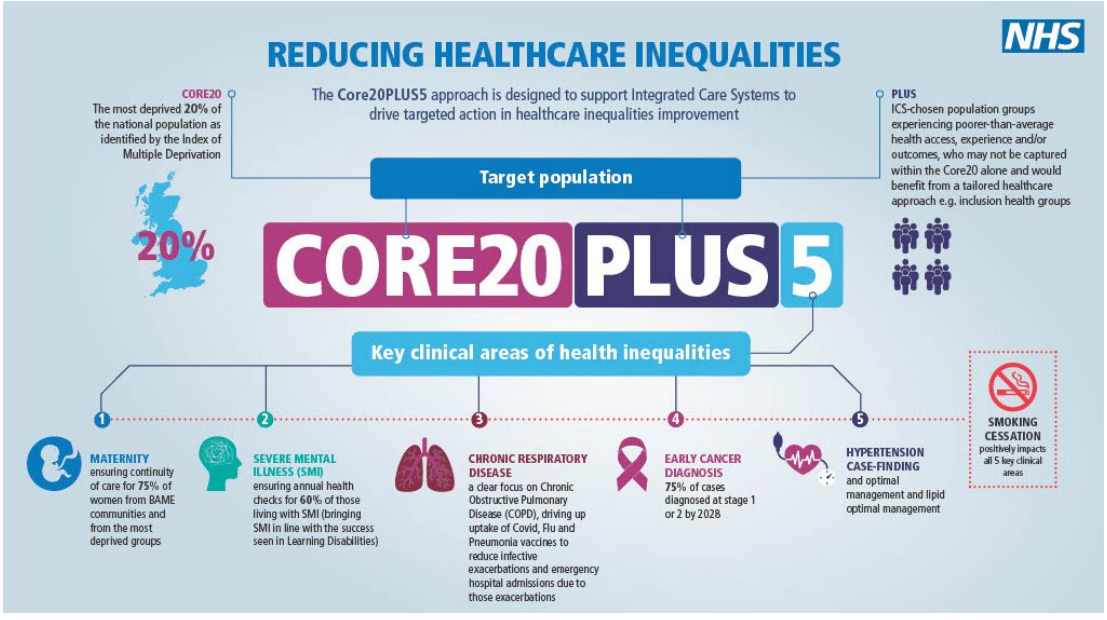
With the formal statutory establishment of ICSs across England in July 2022, and as a core member of the Integrated Care Board, **the focus is on all of us, working collaboratively as a system**, to ensure we are working to improve care, health and wellbeing of the population, whilst working with local communities. Many organisations are already working extensively to reduce inequalities – recent examples include work to address inequalities in COVID-19 vaccine access by the Suffolk and North East Essex Integrated Care Board, West Suffolk Foundation Trust and East Suffolk and North East Essex NHS Foundation Trust's work to review and manage waiting lists in light of inequalities, and the COVID-19 and subsequent Protect Now work in Norfolk and Waveney. We must continue to build on the excellent ways of collaborative working we fostered during the pandemic to address both the new threats to people's health and wellbeing we now face, and to tackle the long-standing and multiple areas of disadvantage which have blighted people's life chances and fostered inequality for too long.

Whilst it is an NHS initiative designed for use by our Integrated Care System (ICS) areas, the goals of **Core20PLUS5** mirror our own priorities within Public Health and Communities Suffolk – to improve health and wellbeing and reduce inequalities. I recognise two ICS areas cover Suffolk (encompassing the neighbouring areas of Essex and Norfolk), and the focus of my report is on the Suffolk population. However, it is for this reason, that there is an even greater need for cross-system working – to share ideas, good practice and to join up even when our geographical boundaries don't always align!

This report provides an overview of what **Core20PLUS5** is, and what we, and everyone in the wider Suffolk system of health and care, can do to continue long established work around reducing health inequalities and to tackle them using new approaches including population health management and Core20PLUS5.

It is only by working together, that we can close the health inequality gap and ensure Suffolk has: healthier people, healthier places and healthier futures.

Core20PLUS5 summary graphic:



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Recommendations

The Integrated Care Boards (ICBs) covering Suffolk should:

1. Use this Annual Public Health Report as an evidence base for tackling inequalities through **Core20PLUS5.**

2. Ensure clinical and managerial leadership and accountability for reducing health inequalities through **Core20PLUS5** are clear.

3. Agree and adopt the 'plus' populations recommended in this report for routine consideration and action across Suffolk to reduce inequalities in outcomes, access and experience – **coastal communities; rural communities; people from minority ethnic communities; and groups and individuals facing the sharpest health inequalities and worst outcomes.**

4. Ensure **Core20PLUS5** is included in all Integrated Care Board (ICB), Alliance, Integrated Neighbourhood Team (INT) and provider plans and strategies, with additional PLUS populations agreed at area and system level where appropriate, and that it drives action.

5. Ensure population health management data, tools and capacity are available to facilitate work on **Core20PLUS5** across the health and care system, enabling Alliances and front-line integrated teams to identify their own local and hyperlocal 'PLUS' populations, in order to reduce local health inequalities.

6. Recognise that there is a clear need for a renewed focus on prevention, ensuring there are clear plans of action for maximising prevention opportunities, with a particular focus on people in mid-life.

7. Ensure the current levels of performance with regard to the **Core20PLUS5** populations and clinical pathways are understood, including local data covering all the areas of **Core20PLUS5**, and monitor the data over time to provide assurance of improvement.

8. Apply the learning from the Covid vaccination programme to **Core20PLUS5** by working through community leaders, Voluntary, Community and Social Enterprise (VCSE) and District and Boroughs, who already have relationships with the communities which find our services hard to access.

Through these recommendations, and the work to progress **Core20PLUS5** more broadly, we must all ensure we don't inadvertently widen local health inequalities, and that ***all*** communities benefit from the activity undertaken, not just those who are relatively easy to reach. This may require more explicit focus, action and investment in some parts of Suffolk than others.

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What are health inequalities?

Health inequalities is the term used to describe the unfair and avoidable differences in health - found across our community, and between different groups. They exist in all areas, including unequal experiences of health services, education, work and housing opportunities, and can also be affected by the different ethnic, cultural, religious, gender or social groups with which you identify.

These are some common features about health inequalities that most people agree on:

- Health inequalities are unjust, unfair and avoidable
- They do not occur by chance. They go against the principles of social justice, and they are largely out of an individual's control.
- These socially determined circumstances disadvantage people and limit their chances of living longer, healthier lives.

Health inequalities have been documented for a long time, in fact as early as the 17th century (John Graunt's analysis of the English Bills of Mortality). The 1980 Black Report documented differences in mortality rates across social groups in Great Britain, and in 1998 the Acheson Report was published - formally titled the Independent Inquiry into Inequalities in Health Report. Again, this report highlighted the persistence of health inequalities in our population.

In 2010, Professor Sir Michael Marmot published Fair Society, Healthy Lives. The report showed that the worse off someone is socially and economically, the more likely they are to experience poor health and live a shorter life, compared to those who are better-off.

In the 10 years since the first Marmot report there has been a growing understanding that many complex and overlapping factors contribute to good health. However, outcomes have not improved. The Marmot Review: 10 Years On showed that life expectancy had stopped increasing in the UK, and for some communities it has started to fall.

The COVID-19 global pandemic has increased awareness of health inequalities because the virus had an unequal impact on different social, ethnic, and economic groups. There is also growing concern that the post-pandemic economic upheaval, including the highest inflation rates seen in the UK for 40 years, and the ongoing disruption to education, and physical and mental health services, will deepen pre-existing health inequalities, and potentially create new ones.

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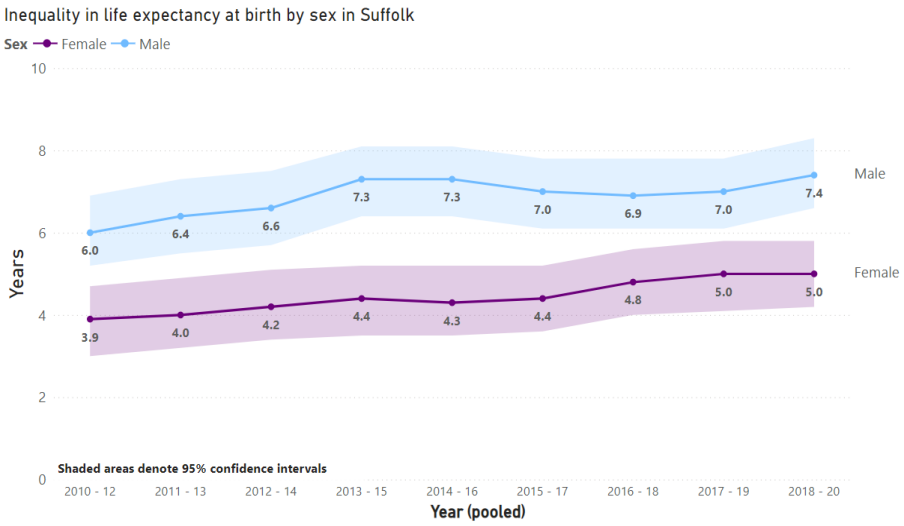
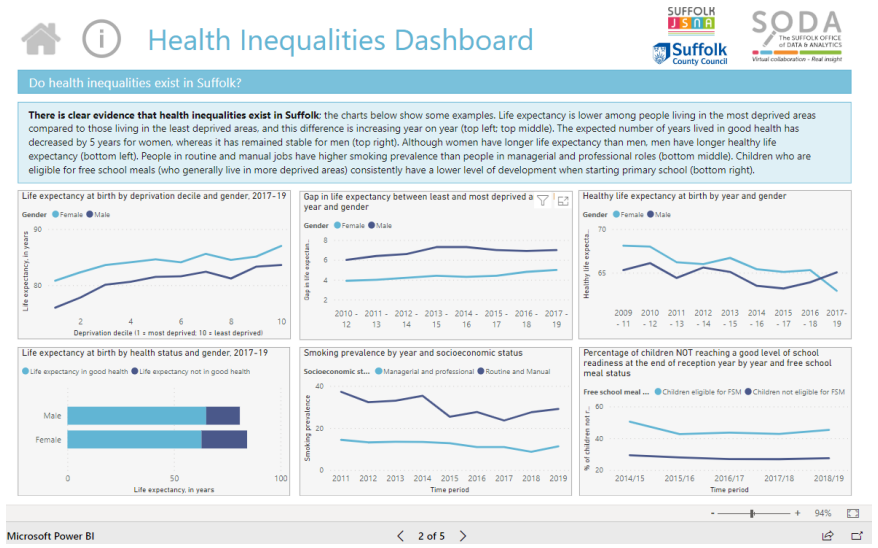
Health inequalities in Suffolk

- There is clear evidence that health inequalities are present in Suffolk.
- For **men, there is a difference of 7.4 years** in the average life expectancy between someone born in the most deprived communities in Suffolk, compared to someone born in the least deprived. **For women, the difference in average life expectancy is 5.0 years.**
- These differences in life expectancy can be described as Suffolk's ***life expectancy gap*.**
- Both values have increased over the last ten years (men from 6.0 in 2010-12, women from 3.9 years) indicating that health inequalities in Suffolk are widening.
- This data does not yet include the impact of the COVID-19 pandemic, which may have increased health inequalities still further.
- In addition, the number of years that women can expect to live in good health in Suffolk is falling, from 68.1 years in 2009-11, to 64.4 years in 2018-20. Initial data also suggests that overall life expectancy in Suffolk and more widely across the UK has at best stalled and may be starting to fall, an unprecedented occurrence in the post Second World War period



View more inequalities data via the [Health inequalities dashboard]:



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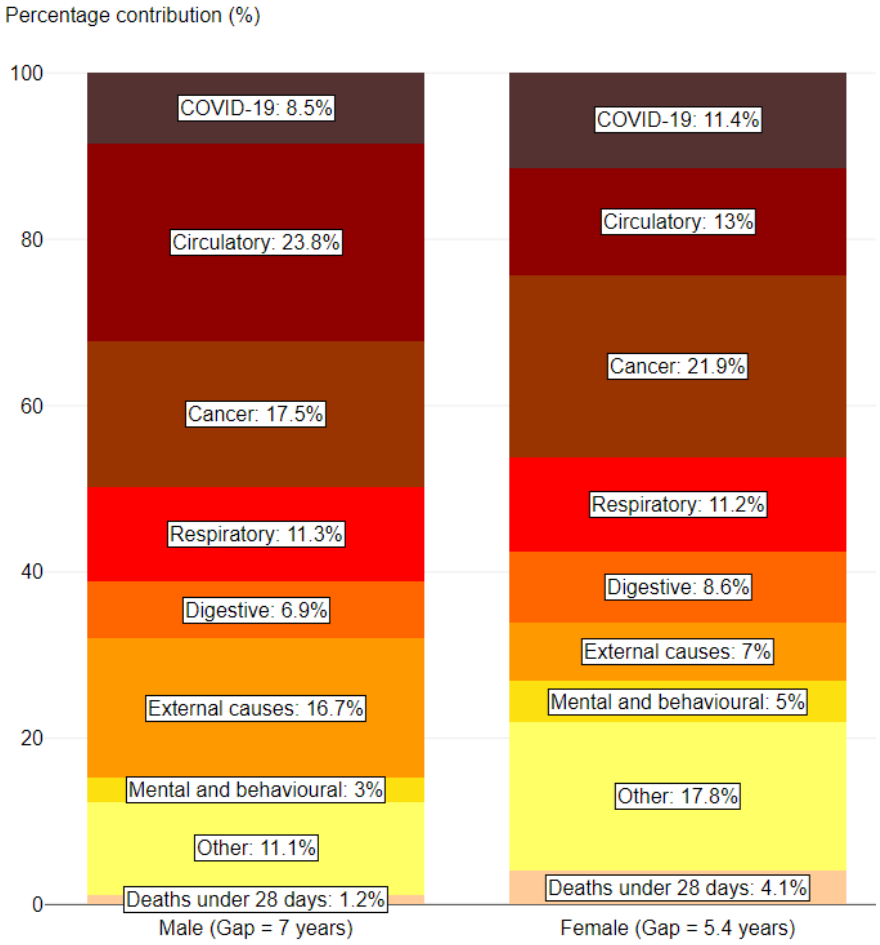
What diseases are leading to the life expectancy gap in Suffolk?



Provisional data from the Office for Health Improvement and Disparities (OHID) Segment tool for 2020-2021 shows how different causes of death contribute to the overall difference in life expectancy between the most and least deprived communities in Suffolk.

Circulatory conditions contribute the largest percentage to the life expectancy gap for males, whereas **cancers** are the largest contributor to the gap for females.

The differential impact of COVID-19 is also clear – and it may also have had an indirect effect, for example in deaths from external causes (injury, poisonings and by suicide).

While changes in data definitions over time mean it is difficult to compare trends, the impact of deaths from external causes in men, and from cancer in women, seem to be becoming more significant over time.

Tackling these causes of death will therefore contribute to reducing health inequalities, particularly if focus is explicitly given to the most deprived communities in Suffolk, and to other communities who face specific health challenges.

Source: OHID Fingertips

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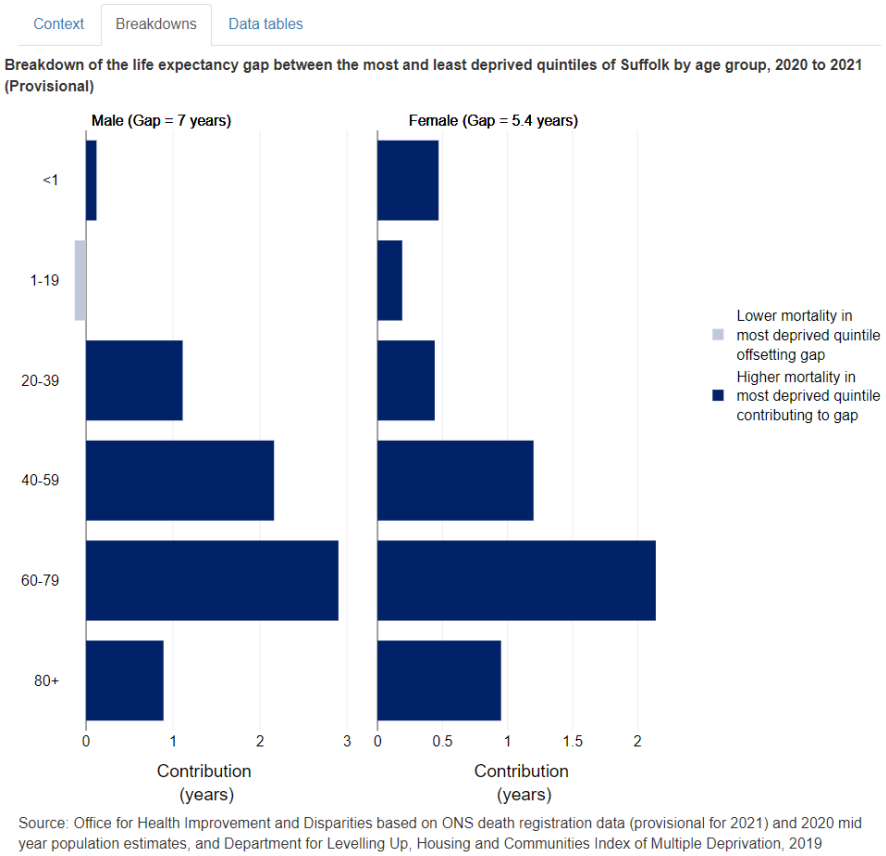
At what ages are deaths occurring which are contributing to the life expectancy gap in Suffolk?



The OHID Segment tool also allows breakdowns of the life expectancy gap between the most and least deprived areas by age group.

Almost every age group has higher mortality in the most deprived areas which contributes to the life expectancy gap. **The largest contribution is from deaths occurring in those in mid-life and entering retirement:**

	Contribution to the gap (years)	
Age	Male	Female
<1	0.1	0.5
1-19	-0.1	0.2
20-39	1.1	0.4
40-59	2.2	1.2
60-79	2.9	2.1
80+	0.9	1.0

This suggests that there are opportunities to prevent deaths occurring between 40-80 years of age, and that preventing those deaths would reduce local inequalities.

Source: OHID Fingertips

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Is reducing health inequalities all about treating disease?

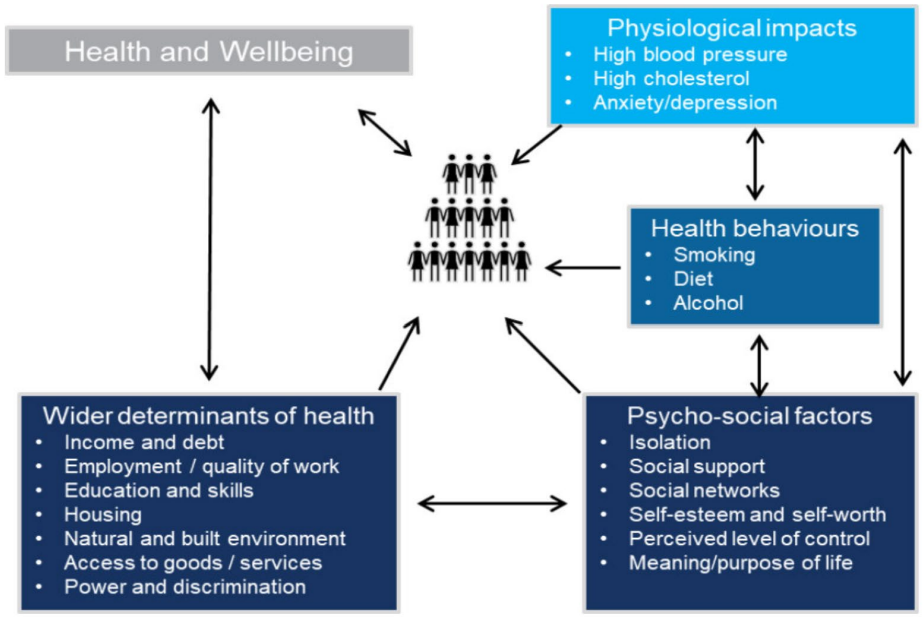

Figure 4. System map of the causes of health inequalities.

Health inequalities are complex.

Within every person there is a unique interplay between:

- their wider determinants of health (for example, poverty, housing education);
- their psycho-social status;
- how they behave in relation to their health (for example their diet, how active they are, and whether they smoke);
- and how those factors then combine to present as clinical conditions (for example, high blood pressure, mental ill-health, cancer)

People cannot always directly control all these factors – and they cannot all be prevented. But some of them can be changed if individuals have the right support, and some of them can be diagnosed and then managed, preventing an individuals' risk of ill-health from increasing further.

These risks do not occur equally across all communities in Suffolk – so prevention activity which specifically addresses these different needs and outcomes is vital. This is where population health management (PHM) and **Core20PLUS5** can help.

Source: Adapted Labonte Model, Place Based Approaches to Reducing Inequalities

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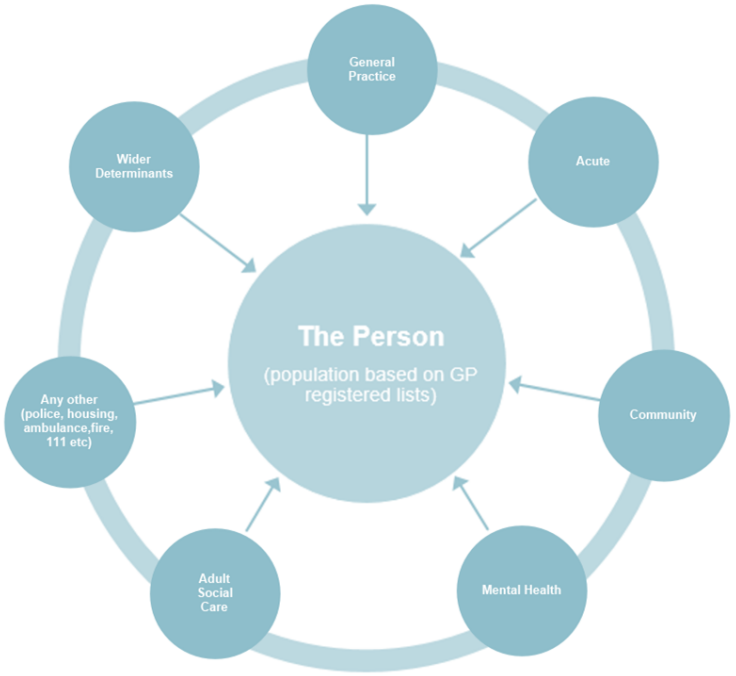
How does Population Health Management (PHM) link to all this?

- PHM uses historical and current data to understand what factors are driving poor outcomes in different population groups.
- It brings together data from services including primary and secondary care, community health, public health, adult social care and data on the wider determinants of health to build a holistic picture of the local population.
- Importantly, this data is brought together at a person level and while not perfect, this combined data will help us to understand intersectionality in our local populations and their health needs more clearly.
- This means not only can we better understand the health needs of the local population, but we can also deliver targeted interventions and design new proactive models of to reduce health inequalities and improve health and wellbeing, today and in the future.
- PHM is still being developed locally but a range of approaches have been successfully trialled, including the NHS 20 week programme.
- Whilst PHM data not robust enough to inform this Annual Public Health Report, **it will be a key enabler for delivering Core20PLUS5 over coming years**, helping to inform evidence-based interventions at ICS, Alliance and local team level, to find the individuals who could benefit from **CORE20PLUS5** approaches, and to monitor and evaluate progress and outcomes.

Data to inform our understanding: a PHM approach



Source: NHS

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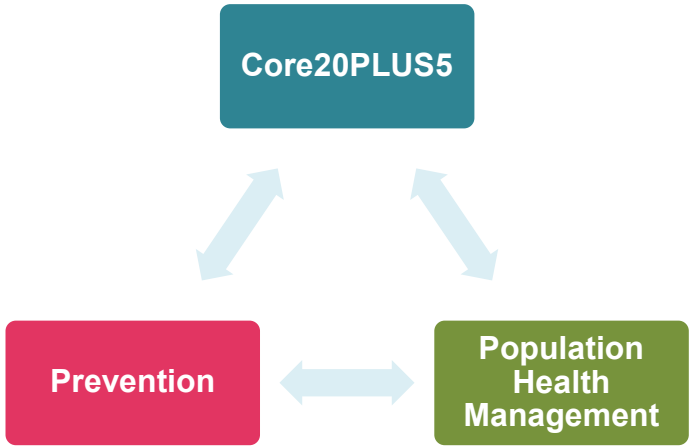
And how does prevention link to this work?

- As we have seen, there is a gap between overall life expectancy (how long someone is expected to live) and healthy life expectancy (the number of years spent in good health) of around 14 year for males and nearly 20 years for females in Suffolk. We also know that there are opportunities for prevention in Suffolk, specifically in relation to those between 40-80 years of age.

- **Continuing a strong focus on prevention is therefore vital. Prevention can help to reduce the number of years spent in declining health or lost to early death; keep people healthier for as long as possible; reduce other health inequalities; and reduce demand and cost across the wider system.**

- Suffolk's Prevention Strategy '[The Time is Now]' focused on several key action areas amenable to prevention over a 5-10 year period. Priorities within this strategy were:
  - Priority 1: improve early detection and treatment of hypertension, atrial fibrillation, chronic obstructive pulmonary disease, diabetes and frailty
  - Priority 2: improve direct and indirect support to those who wish to change their lifestyle/health behaviours
  - Priority 3: create community and personal capacity and enhance community and personal resilience

Our current data shows that there is a clear need for a renewed focus on prevention; and that the previous areas highlighted in 'The Time is Now' are still relevant. Many of these areas are now explicitly included in **Core20PLUS5.**



Core20PLUS5 therefore offers a way of reducing inequalities by **targeting prevention work** through the use of **Population Health Management data and approaches** in ways which **are responsive to the needs of the Suffolk population**. It will enable us to move from data to action, and have much greater impact than could be achieved previously.

All of these elements are needed in combination to have the maximum impact

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So what is Core20PLUS5?

Fundamentally Core20PLUS5 is an approach to reducing health inequalities

- **Core20PLUS5** is a national NHS England and NHS Improvement approach to support the reduction of health inequalities at both national and system level between 2021-2024.
- There are two Integrated Care Systems (ICSs) that cover the Suffolk County Council footprint:
  - **Suffolk and North East Essex (SNEE)**: this encompasses Ipswich and East Suffolk, and West Suffolk, with North East Essex falling within Essex County Council
  - **Norfolk and Waveney (NW):** This encompasses the Lowestoft/ Waveney area of East Suffolk, the rest aligns to Norfolk County Council

- The approach defines a target population cohort:
  - The **Core 20%** most deprived population in the area
  - **Plus** ICS chosen cohorts that experience worse than average health experiences, outcomes and/or access
  - **5** nationally defined focus clinical areas requiring accelerated improvement, with the addition of smoking cessation as a thread running through the 5 areas.
- **Core20PLUS5** is designed as the NHS contribution to a wider system effort by Local Authorities, communities and the Voluntary, Community and Social Enterprise (VCSE) sector to tackling healthcare inequalities – and aims to complement and enhance existing work in this area.
- The aim is that **Core20PLUS5** will support ICSs to effectively prioritise energy, attention and resources enabling the biggest possible impact.
- **Core20PLUS5** is not designed to be a new set of priorities but should refine existing NHS Long Term Plan commitments on tackling health inequalities into clear and focused areas which have the biggest opportunities to narrow the health inequality gap.

Source: NHS England

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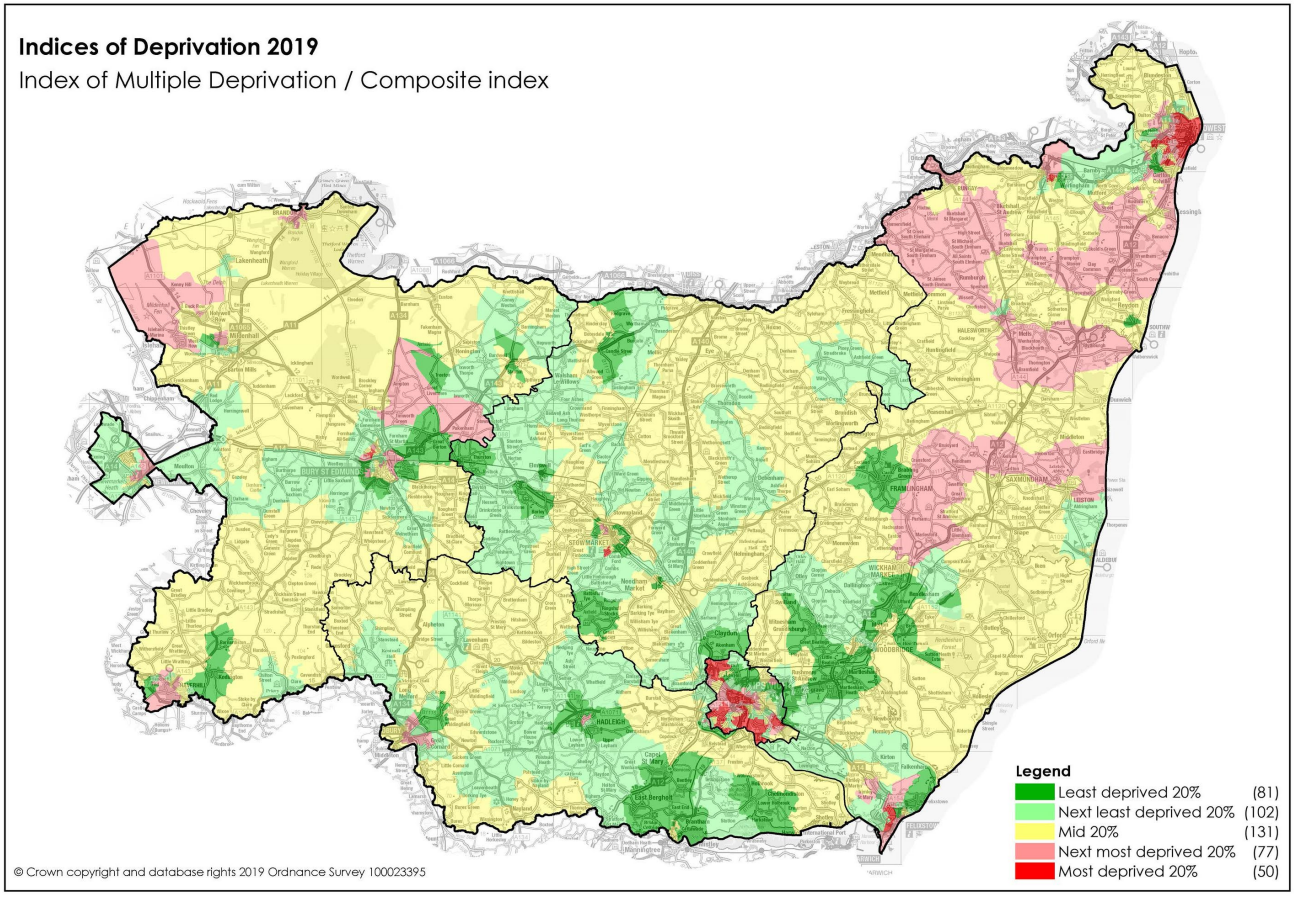
What the current data tells us about… Suffolk's CORE20:



- **80,068** people in Suffolk live in the 20% most deprived Lower Super Output Areas (LSOAs) in England.
- This is approximately **10% of Suffolk's residents**.
- Pockets of greater relative deprivation can be found in more built-up areas such as Beccles, Bury St Edmunds, Felixstowe, Ipswich, Lowestoft, and Stowmarket.
- Ipswich is the most deprived local authority in Suffolk and has **28 LSOAs that are in the 20% most deprived nationally – 1/3 of all the Ipswich LSOAs.**
- East Suffolk is the next most deprived local authority in Suffolk, the most deprived areas within East Suffolk are in the Lowestoft area. **20 LSOAs in East Suffolk are in the 20% most deprived nationally. 90% (18 of the 20) most deprived LSOAs are located in the Lowestoft and surrounding area.**

Source: 2020 mid year estimates, Indices of Deprivation 2019

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A focus on the 5:

There are five clinical areas of focus. Governance for these five focus areas sits with national programmes; national and regional teams coordinate local systems to achieve national aims.

1. **Maternity:** ensuring continuity of care for 75% of women from Black, Asian and minority ethnic communities and from the most deprived groups.

2. **Severe mental illness (SMI):** ensuring annual health checks for 60% of those living with SMI (bringing SMI in line with the success seen in learning disabilities).

3. **Chronic respiratory disease**: a clear focus on Chronic Obstructive Pulmonary Disease (COPD) driving up uptake of COVID, flu and pneumonia vaccines to reduce infective exacerbations and emergency hospital admissions due to those exacerbations.

4. **Early cancer diagnosis**: 75% of cases to be diagnosed at stage 1 or 2 by 2028.

5. **Hypertension case-finding** and optimal management and lipid optimal management: to allow for interventions to optimise blood pressure and minimise the risk of myocardial infarction and stroke.

Whilst not included in the 5, **smoking cessation** is also included at this level of **Core20PLUS5** as a cross cutting theme. This is because stopping smoking has a positive impact in all of the five clinical areas of focus.

Source: NHS England

CORE20 PLUS 5

The scale of the Suffolk challenge

CORE20:
80,000 residents in Suffolk

- 80,068 people in Suffolk live in the 20% most deprived Lower Super Output Areas (LSOAs) in England - approximately 10% of Suffolk's residents.
- Ipswich is the most deprived local authority in Suffolk and has 28 LSOAs that are in the 20% most deprived nationally – 1/3 of all the Ipswich LSOAs.
- East Suffolk is the next most deprived local authority in Suffolk. 20 LSOAs in East Suffolk are in the 20% most deprived nationally. 90% (18 of the 20) of these most deprived LSOAs are located in Lowestoft and the surrounding area.

Hypertension: 74,000 – 84,000 undiagnosed; 8,500 diagnosed but not achieving optimal hypertension control

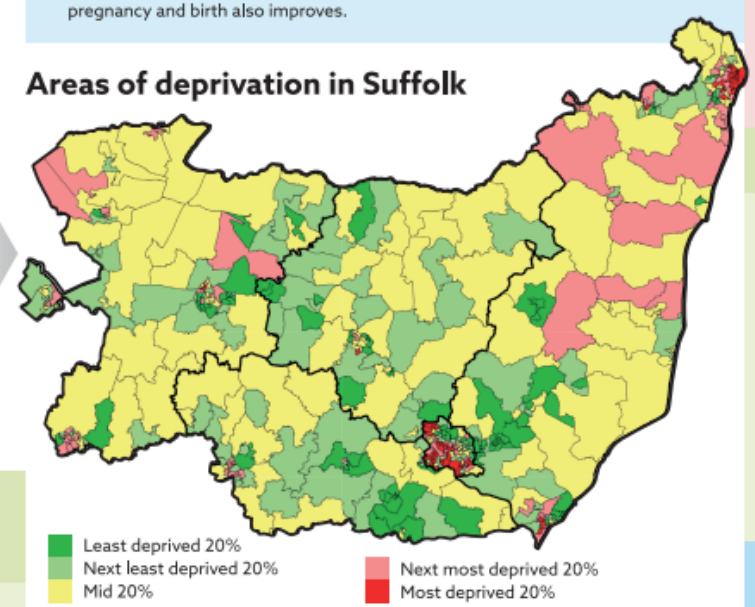
- Hypertension (high blood pressure), is a key priority within the NHS Long Term Plan and a risk factor for hospitalisation or death from heart attack or stroke.
- Although standards are in place that describe good control of hypertension, it is estimated that only four in ten adults nationally with high blood pressure are both aware of their condition and are managing it properly.
- Finding people with hypertension allows early intervention to optimise blood pressure and reduce the risk of heart attacks and stroke. It also presents an opportunity to offer preventative measures to those at risk of developing the condition.
- When increasing the numbers of people needed to meet **CORE20PLUS5** targets for lowering blood pressure, it is vital to target the most deprived / at risk populations first- otherwise we risk increasing inequalities.

Maternity

*where ethnicity was recorded

- 665 births to mothers in the 20% most deprived areas of Suffolk in 2021.
- 970 births to mothers from non-White ethic groups (in the year to April 2022). While there is likely to be some overlap between these groups, up to 1,225 women will need to receive continuity of care to meet the target.
- The NHS Long Term Plan and the **MBRRACE-UK** reports highlight the significant differences in maternal mortality between different ethnic groups and those from the most deprived areas.
- **Black and Asian mothers are more likely to die** as a result of childbirth than their white counterparts and this gap has widened since 2010.
- **Evidence suggests** that mothers who receive continuity of carer are less likely to lose their baby or experience preterm birth. Their experience of care during pregnancy and birth also improves.

Areas of deprivation in Suffolk



Cancer: 1,600 cancers NOT diagnosed early (2019), 650 cancer diagnoses need to be made at stage 1 or 2 to meet 75% target

- Cancer is one of the biggest contributors to inequalities in life expectancy. People from the **most deprived communities more likely to get cancer, be diagnosed at a late stage for certain types of cancer and to die from the disease.**
- National data indicates that 59.3% of people in the least deprived decile have their cancers diagnosed at stage 1 or 2, compared to only 53.5% of people in the most deprived decile.
- When increasing the numbers of people needed to meet **CORE20PLUS5** targets for early cancer screening, it is vital to target the most deprived / at risk populations first- otherwise we risk increasing inequalities.

Respiratory disease

- 26,000 missed flu jabs for those aged 65 and over in 2021/22
- 42,000 missed flu jabs for under 65's in at risk groups 2021/22
- 139,000 COVID-19 missed vaccines (Aug 2022/ NIMS data)
- 47,000 Pneumococcal missed vaccines in 2020/21
- Chronic respiratory disease is the third biggest cause of the life-expectancy gap between the most and least deprived groups.
- 2020 data indicates that the **rate of premature mortality due to respiratory disease** among people living in the most deprived quintile of areas was a least twice the average for England.
- Acute exacerbations of chronic obstructive pulmonary disease account for roughly **1 in 8 emergency hospital admissions** in England and **deprivation is linked with increased emergency health care use among people with COPD.**

Smoking: 83,000- 109,000 current smokers

- 2020/21 stop smoking data indicates around 1,800 Suffolk residents quit smoking 4 weeks after setting a quit date. Assuming this number of quitters yearly, no new smokers, and all smokers wanting to quit... It would take over 46 years for 83,000 people to stop smoking!
- Smoking is the biggest cause of preventable death in England, with the Global Burden of Disease study ranking tobacco as the top modifiable risk factor driving deaths and disability. 96,000 deaths were attributable to smoking in England in 2019.
- In Suffolk, smoking-related illnesses cause around 1,000 deaths every year, which equates to almost three people dying every day in the county.

Severe mental illness: 1,500 missing health checks

*Note: Ipswich and East Suffolk Integrated Care Board, and West Suffolk Integrated Care Board only, Q1 of 2022/23. We know this figure is likely to be an underestimate due to undiagnosed cases, and data for the Waveney area is not published for this indicator.

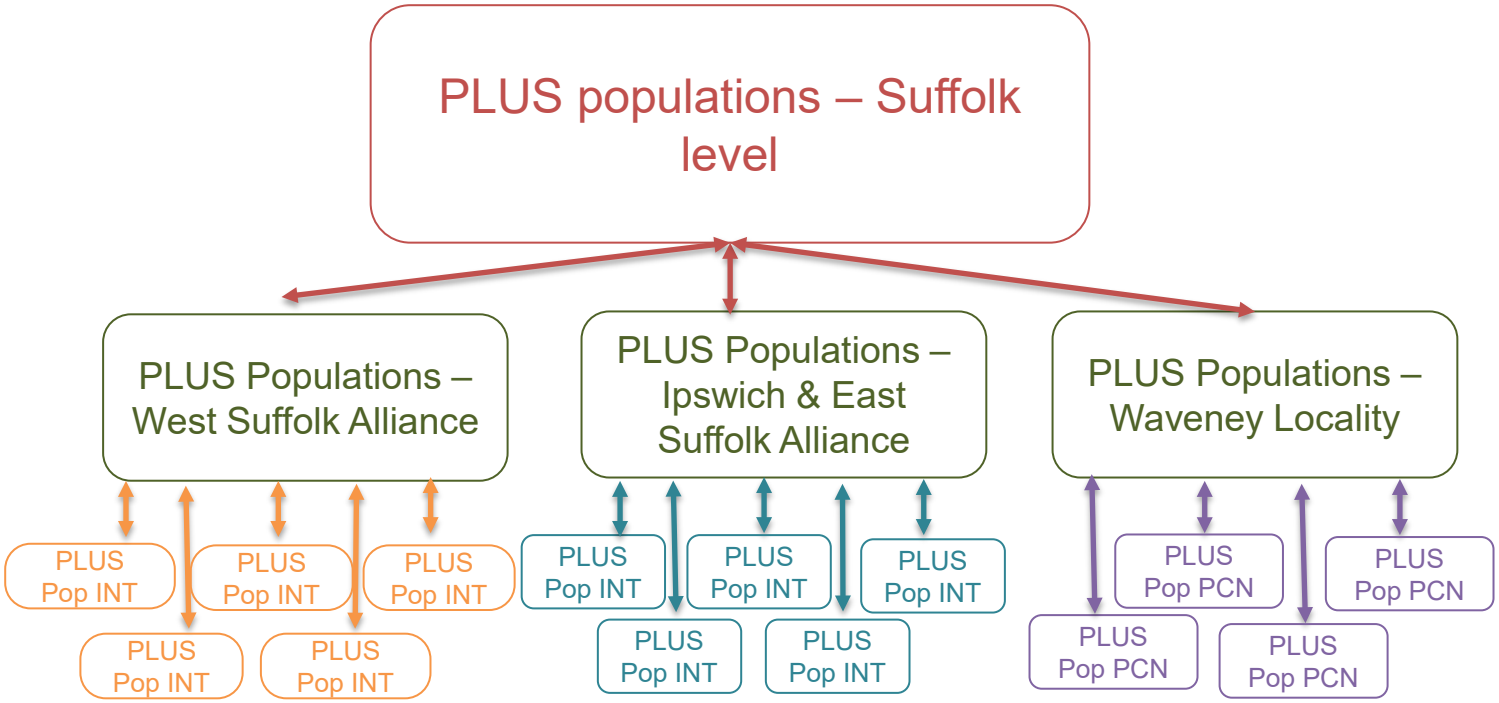
- People with a mental illness such as schizophrenia or bipolar disorder **die on average 15-20 years sooner** than the general population. The **prevalence of Severe Mental Illness (SMI) within the most deprived areas** is triple that of those living in the least deprived areas.
- Much of this reduced life expectancy is from higher rates of **physical health conditions**, such as cardiovascular disease.
- Annual health checks for people with SMI support the early detection of physical health conditions and help to improve access to evidence-based physical care, assessment and intervention.

View online at: www.healthysuffolk.org.uk/jsna/annual-public-health-report

Who are the 'PLUS' populations within CORE20PLUS5?

- We also need to consider local population groups who may be experiencing poorer than average **health access, experience and/or outcomes**, but who may not be included within the **CORE20 or 5** groups

- These groups need to be decided locally and at different levels across the health and care system. This report sets out key PLUS populations for Suffolk as a whole County, but consideration should also be given to more local PLUS groups at Alliance, Locality Level, Integrated Neighbourhood Team (INT) or Primary Care Network (PCN) level – collectively these groups form the **'PLUS' populations in the CORE20PLUS5 framework.**



Source: [Place based approaches to reducing inequalities]

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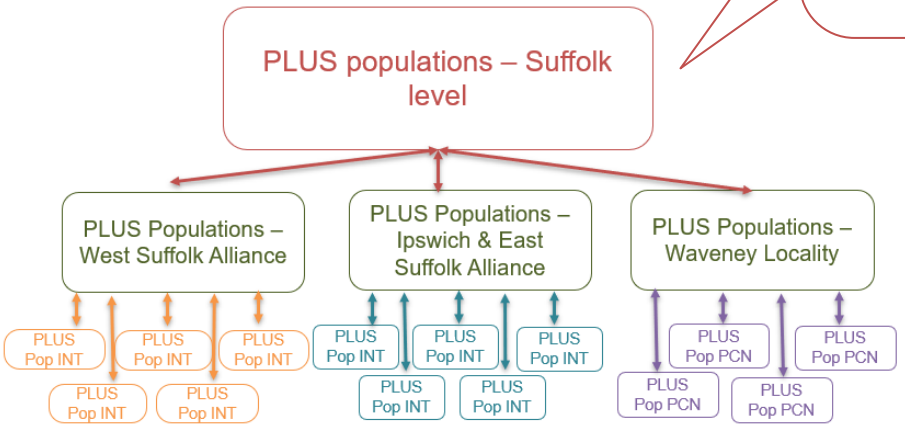
Why have different 'PLUS' populations?

Some PLUS populations are relevant across Suffolk – these are the focus of this report and commissioners and planners should take care to consider their needs and the inequalities in outcomes, access and/or experience which they face at all times



Some of these Suffolk-wide PLUS populations will also be relevant at Alliance level – but not all. Alliances should consider the Suffolk-wide populations in their planning; but also consider whether there are other groups, risks or conditions in their more local populations which they need to prioritise as well

Some Suffolk-level and Alliance-level PLUS populations will also be relevant at Integrated Neighbourhood Team or Primary Care Network level – but some will not be, and this will vary. INTs and Primary Care Networks (PCNs) should consider the Suffolk and Alliance level PLUS populations as well as the needs of their local populations when making their plans

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The 'PLUS' populations for Suffolk

- PLUS populations are those groups of people who may not be in the CORE20 population, but who face inequalities in outcomes, access to or the experience of care, and whose needs must be explicitly recognised and met in order to reduce inequalities.

At the level of Suffolk as a whole, based on data and evidence, we recommend the following as Suffolk's PLUS Populations:

- **People from minority ethnic communities**
- **Coastal communities**
- **Rural communities**
- **People and groups facing the sharpest health inequalities in Suffolk (such as groups at risk of disadvantage)**

- The following slides set out the rationale for highlighting these groups, with more detail available in the Evidence Base that accompanies this report.

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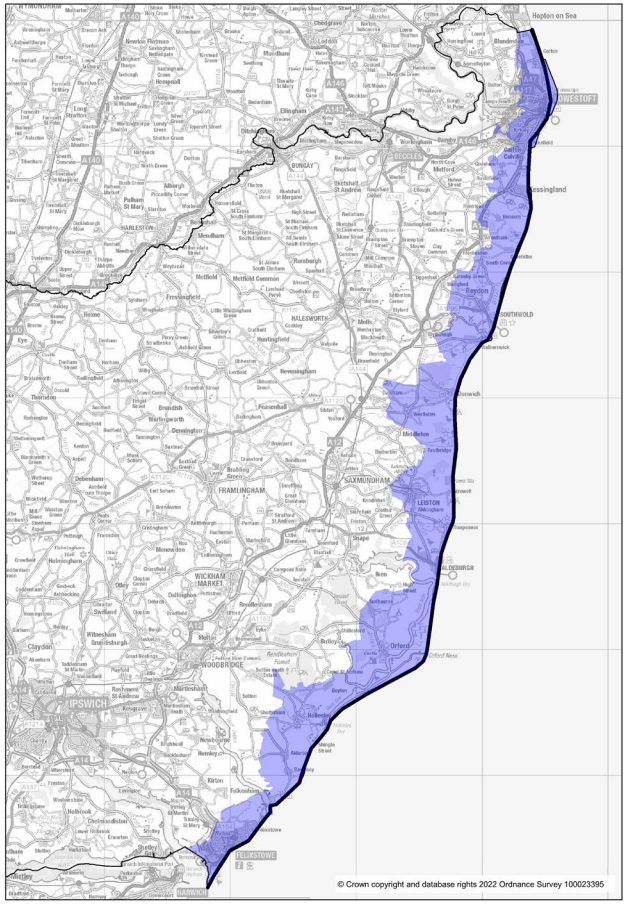
Why include coastal communities as PLUS communities in Suffolk?

The health of coastal communities is of both national and local importance, as highlighted in the Chief Medical Officer's annual report 2021:

- Coastal communities have some of the worst health outcomes in England, with low life expectancy and high rates of many major diseases.
- High levels of deprivation, driven in part by major and longstanding challenges with local economies and employment, are important reasons for these poor health outcomes
- There are known high rates of preventable illness in these areas, and if we do not tackle the health problems of coastal communities vigorously and systematically there will be a long tail of preventable ill health which will get worse as current populations age.
- There are many reasons for poor health outcomes in coastal communities. The pleasant environment attracts older, retired citizens to settle, who inevitably have more and increasing health problems. An oversupply of guest housing has led to Houses of Multiple Occupation which can concentrate deprivation and ill health. The sea is a benefit but also a barrier: attracting NHS and social care staff to peripheral areas is harder, catchment areas for health services are artificially foreshortened and transport is often limited, in turn limiting job opportunities. Many coastal communities were created around a single industry such as tourism, fishing, or port work, meaning work can often be scarce, low paid or seasonal.
- There is evidence of 'hollowing out' of some Suffolk coastal communities by second homes and holiday lets – threatening the viability of year-round services



- Office for National Statistics (ONS) analysis found that 71% of coastal towns had both slower population and employment growth than the England and Wales average over the 2009 to 2018 period; this compares with 47% of non-coastal towns.
- The same analysis found that 30% of the resident population in small seaside towns were aged over 65 years old in 2018 compared with 22% in small non-coastal towns.

Source: Chief Medical Officer's annual report 2021, Office for National Statistics (ONS)

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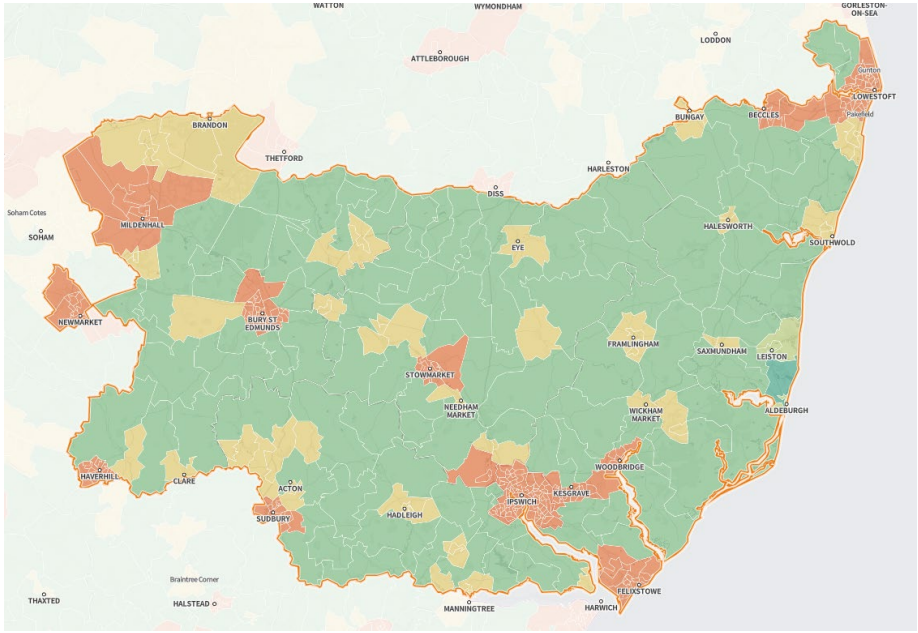
Why include rural communities as PLUS communities in Suffolk?

- Suffolk is a predominantly rural county, with approximately 305,020 people living in areas classed as rural.
- Whilst health outcomes are generally more favourable in rural areas than in urban areas broad brush indicators can mask small pockets of significant deprivation and poor health outcomes.
- Gross Disposable Household Income per head is lower in Suffolk compared to both an aggregation of rural areas nationally, and to England, suggesting rural resilience to the cost of living crisis may be limited. Many rural homes in Suffolk are off the gas grid, and are old and energy inefficient. Many rural residents rely increasingly on expensive heating oil to fuel their homes, which has now been included in the energy cap, but often has to be paid for in bulk, and in advance.
- People living in more rural areas often find transport options more limited (such as infrequent public transport, or having to rely on expensive private transport), meaning access to key services is more difficult.
- If the rural area also has poor broadband, this could also mean less ability to access core services provided online, to tap into job options, training, services and increasingly, health services. All of these could directly, or indirectly, impact on health and wellbeing.
- Although the most deprived areas in Suffolk are concentrated in towns and other urban areas, highly localised rural deprivation occurs when small pockets of deprivation are masked in the data by areas of relative affluence. Very small areas of deprivation are difficult to identify and may mean people do not receive the same levels of resource and intervention that a larger and more defined area would.



Rural/Urban Classification

Classification of Lower Super Output Areas.

Key

- Urban major conurbation
- Urban minor conurbation
- Urban city and town
- Urban city and town in a sparse setting
- Rural town and fringe
- Rural town and fringe in a sparse setting
- Rural village and dispersed
- Rural village and dispersed in a sparse setting

Data

ONS 2011 rural/urban classification

Source: State of Suffolk, Suffolk Annual Public Health Report 2020, Health and wellbeing in rural areas

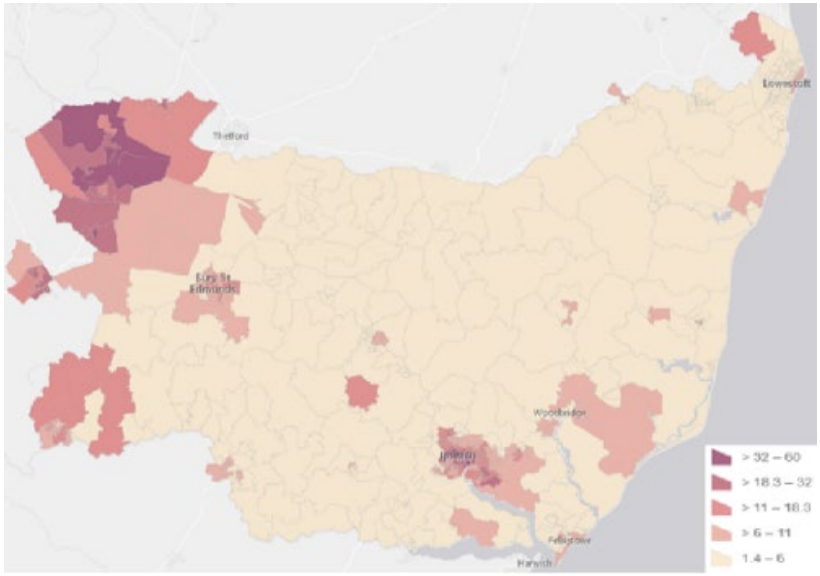
Why include people from minority ethnic communities as PLUS communities in Suffolk?

- 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%). Comparing the data to the 2001 census indicates that diversity is increasing in Suffolk. We are awaiting the 2021 census data.

- The Local Government Association notes that the pandemic has had a disproportionate impact on ethnic minority communities. They have experienced higher levels of infection and death rates. Geography, deprivation, occupation, living arrangements and health conditions have all played a role as well as genetic factors. But the report also notes:
  - These inequalities were already having an impact on the health and wellbeing of ethnic minority communities before COVID-19 hit –the pandemic has shone a light on them like nothing before.
  - People from some ethnic minority groups, especially Pakistani and Bangladeshi groups, are more likely than White British to report long-term illness and poor health. But on some measures Black Caribbean and Black African communities report better outcomes than their white peers.
  - Certain conditions, such diabetes and cardiovascular disease, are more common among South Asian and Black groups than in the white population.
  - People from ethnic minority groups are more likely to live in deprived areas.
  - Structural racism and marginalisation cannot be ignored either. Whether it is accessing health care or finding work, the way society runs can reinforce inequalities.

- There is disparity in maternal mortality between Black women and White women. Black British mothers are 5 times more likely to die in pregnancy or 6 weeks after childbirth, than White women. Women from minority ethnic groups are also at an increased risk of having a pre-term birth, stillbirth, neonatal death or a baby born with low birth weight.

Map of Suffolk showing the proportion of residents from minority ethnic groups by lower super output area, 2011:



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

A particularly high proportion of residents from minority ethnic groups were found in West Suffolk, which is likely to be associated with the United States military forces bases in the area.

Source: State of Suffolk, Local Government Association,

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Why include groups facing the very sharpest inequalities and worst outcomes as PLUS communities in Suffolk?

- Suffolk residents facing the sharpest inequalities are sometimes also referred to as 'groups at risk of disadvantage'. These are groups in society who are at high risk of experiencing health inequalities compared to the rest of the population.

- They will often be more vulnerable due to factors in their lives that make it harder to maintain good physical and mental health. For example, migrants, travellers, those who are homeless, those in prison and sex workers.

- They experience worse health and disability and may require extra help to achieve equality of health compared to others of the same age or living in the same area.

- It is often difficult to obtain robust information about people within these groups. That can be due to the way in which the data is organised or collected, but it is also the case that many people do not wish to disclose this information and may fear giving this information in case it risks arrests, fines or stigma.

- The information we have on groups at risk of disadvantage is often limited or out of date or is described as incomplete. We do collect specific data through our Suffolk based services and organisations, but the information is often not configured in a way that represents a complete picture for our residents. This needs to improve so that service planning for these groups can also improve.

- The continued focus on these groups is therefore necessary due to the persistence of inequalities in these groups, and the fact that these inequalities have not reduced. The Covid-19 pandemic further emphasised many of these inequalities and is likely to have made many of them worse, with the current cost of living crisis now compounding the challenges and risks faced by the most vulnerable in our communities still further.

Core20PLUS5 potential focus areas by INT:

- Each coloured box corresponds to an INT area.
- This summary serves as an overarching guide, and needs to be used in conjunction with local knowledge.
- Some points are descriptive: for example coastal locations. GRT sites are based on settled sites.
- Diagnosed health conditions such as blood pressure and cancer are considered 'high' when compared to the England values.
- Data sources are hyperlinked.

- Higher diversity
- Armed forces personnel
- Higher births
- High blood pressure
- High Chronic Obstructive Pulmonary Disease
- High smoking
- High cancer
- GRT sites

Source: PBNA

- Higher diversity
- High smoking
- Higher births

Source: PBNA

- Rural populations (excluding central Haverhill)
- High blood pressure
- High Chronic Obstructive Pulmonary Disease
- High smoking
- High cancer
- GRT site

Source: PBNA

- Largely rural apart from Sudbury and Gt Cornard
- High blood pressure
- High Chronic Obstructive Pulmonary Disease
- High cancer
- GRT sites

Source: PBNA

- Rural
- High blood pressure
- High Chronic Obstructive Pulmonary Disease
- High cancer
- GRT sites

Source: PBNA

- Rural
- High blood pressure
- High cancer

Source: PBNA

- 1,700 in 20% most deprived
- Higher diversity
- High blood pressure
- High cancer
- GRT site

Source: PBNA

- Rural
- High blood pressure
- High cancer

Source: PBNA

- 1,700 in 20% most deprived
- Rural
- High blood pressure
- High Chronic Obstructive Pulmonary Disease
- High cancer
- GRT site

Source: PBNA

- Urban population
- 37,800 in 20% most deprived
- Higher diversity
- GRT sites
- Higher births
- Higher homelessness
- High smoking
- High SMI

Source: PBNA

- Urban population
- 7,700 in 20% most deprived
- Higher diversity
- Higher homelessness
- High smoking

Source: PBNA

- Coastal community
- 26,400 in 20% most deprived
- High blood pressure
- High smoking
- High SMI
- High Chronic Obstructive Pulmonary Disease
- High cancer
- GRT Sites

Source: Fingertips

- Coastal community
- Rural
- 1,500 in 20% most deprived
- High cancer
- High SMI
- High blood pressure
- High Chronic Obstructive Pulmonary Disease
- GRT site

Source: Fingertips

- Coastal community
- Rural
- High blood pressure
- High cancer

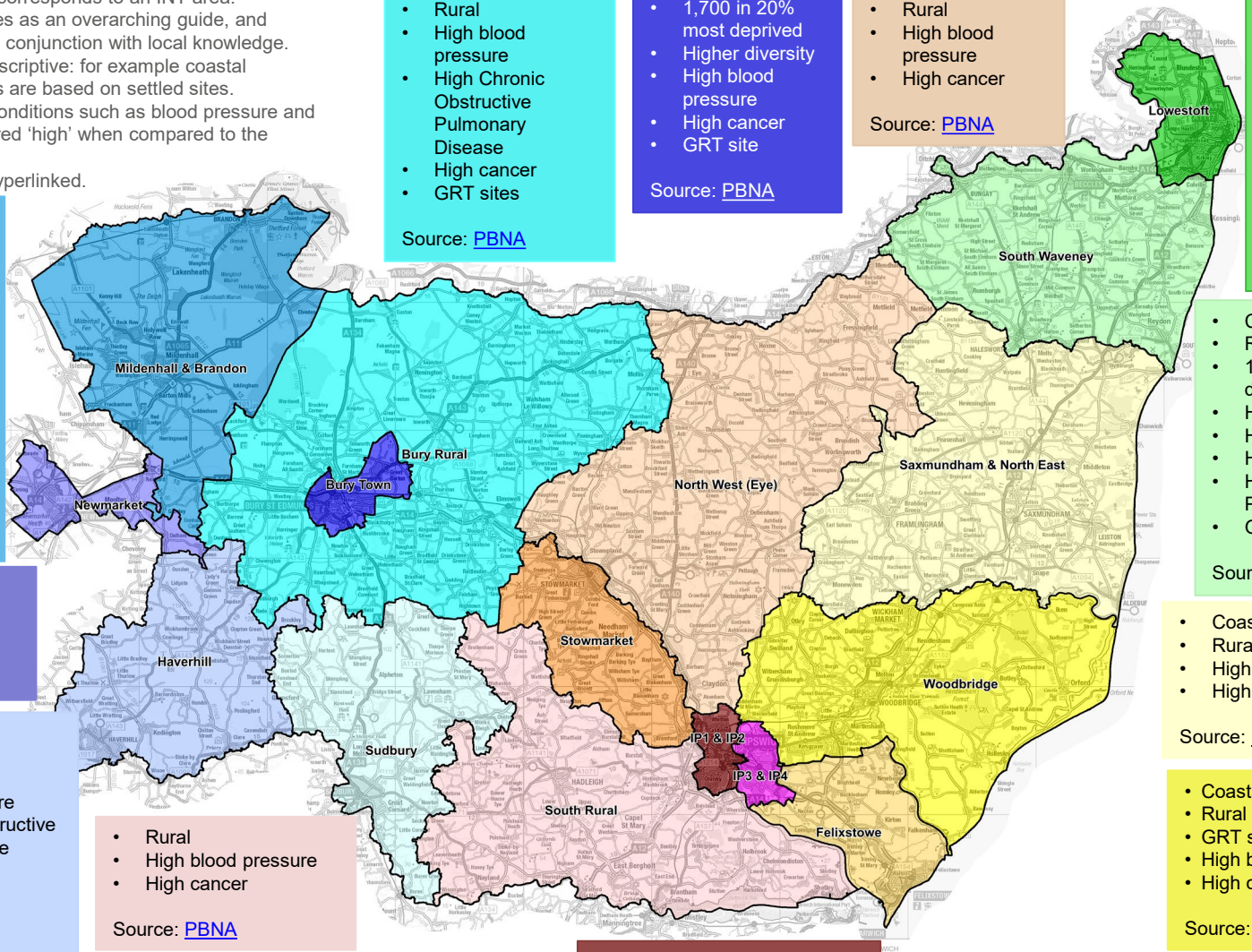
Source: PBNA and Fingertips

- Coastal community
- Rural
- GRT sites
- High blood pressure
- High cancer

Source: PBNA and Fingertips

- Coastal community
- 3,300 in 20% most deprived
- High smoking
- High blood pressure
- High Chronic Obstructive Pulmonary Disease
- High cancer

Source: PBNA



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Summary

- **Core20PLUS5** is a new approach, led by the NHS, aimed at reducing inequalities
- While some elements of it are clinical, realising the full potential of this approach will require effort and commitment by all partners in our health and care systems.
- **Core20PLUS5** highlights the need for ongoing **prevention** work; and if driven by **Population Health Management data and approaches**, this activity may be more effective than ever before
- Within Suffolk there are clear opportunities to improve the identified conditions, care pathways and health behaviours within **Core20PLUS5** which would increase the likelihood of good health outcomes for many thousands of people
- We propose that coastal communities; rural communities; people from minority ethnic communities; and populations facing the sharpest health inequalities should be our chosen PLUS populations at Suffolk level. Alliance and teams will also define their own PLUS populations over time, some of which will overlap with these larger communities, and some of which will rightly reflect very local need.

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Public Health & Communities

Recommendations

The Integrated Care Boards (ICBs) covering Suffolk should:

1. Use this Annual Public Health Report as an evidence base for tackling inequalities through **Core20PLUS5.**

2. Ensure clinical and managerial leadership and accountability for reducing health inequalities through **Core20PLUS5** are clear.

3. Agree and adopt the 'plus' populations recommended in this report for routine consideration and action across Suffolk to reduce inequalities in outcomes, access and experience – **coastal communities; rural communities; people from minority ethnic communities; and groups and individuals facing the sharpest health inequalities and worst outcomes.**

4. Ensure **Core20PLUS5** is included in all Integrated Care Boards (ICBs), Alliance, Integrated Neighbourhood Team (INT) and provider plans and strategies, with additional PLUS populations agreed at area and system level where appropriate, and that it drives action.

5. Ensure population health management data, tools and capacity are available to facilitate work on **Core20PLUS5** across the health and care system, enabling Alliances and front-line integrated teams to identify their own local and hyperlocal 'PLUS' populations, in order to reduce local health inequalities.

6. Recognise that there is a clear need for a renewed focus on prevention, ensuring there are clear plans of action for maximising prevention opportunities, with a particular focus on people in mid-life.

7. Ensure the current levels of performance with regard to the **Core20PLUS5** populations and clinical pathways are understood, including local data covering all the areas of **Core20PLUS5**, and monitor the data over time to provide assurance of improvement.

8. Apply the learning from the Covid vaccination programme to **Core20PLUS5** by working through community leaders, Voluntary, Community and Social Enterprise (VCSE) and District and Boroughs, who already have relationships with the communities which find our services hard to access.

Through these recommendations, and the work to progress **Core20PLUS5** more broadly, we must all ensure we don't inadvertently widen local health inequalities, and that ***all*** communities benefit from the activity undertaken, not just those who are relatively easy to reach. This may require more explicit focus, action and investment in some parts of Suffolk than others.