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Note: Figures are correct at the time of publication and may be subject to change. Some sums may not total due to rounding.
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Introduction

Scope and approach

The State of Suffolk provides a high level report on health and wellbeing in Suffolk, which will inform the 2015 refresh of the Joint Health and Wellbeing Strategy for Suffolk 2012 – 2022. This is a key document within the Suffolk Joint Strategic Needs Assessment (JSNA), which is a joint responsibility of Suffolk County Council (SCC) and the Clinical Commissioning Groups (CCGs).

The report examines the current picture in Suffolk from a life course perspective; being born, growing up, being an adult and growing old. It looks at where Suffolk residents live and how they live as it is a combination of these factors that contribute to the overall health and wellbeing of residents. It highlights potential opportunities for improving healthy life expectancy, and reducing health inequalities across Suffolk, with evidence of ‘what works’ in terms of interventions, as well as our combined partnership efforts towards developing stronger and more resilient communities. It identifies issues that the Health and Wellbeing Board may wish to consider when refreshing the Joint Health and Wellbeing Strategy, including inequalities, opportunities for prevention and gaps in current service provision. This will ensure that the Suffolk Health and Wellbeing Board have robust information on which to focus their local priorities for the next three years.

Background

The Health and Social Care Act 2012 heralded the biggest change to the National Health Service (NHS) and social care system in a generation, with the abolition of Primary Care Trusts (PCTs) and Strategic Health Authorities (SHAs), and the inception of CCGs as decision-making bodies led by GPs to determine the commissioning arrangements for their local area. In addition, upper tier local authorities became the lead authority for health and wellbeing with public health becoming an integrated part of local government for the first time since 1974, increasing the potential to maximise opportunities to benefit Suffolk communities working with health, housing, leisure and other partnerships.

Suffolk Health and Wellbeing Board was set up in April 2013 as part of the new national arrangements. It brings together a range of partners with an interest in, or responsibility for, improving health in Suffolk. The Board has a duty to ‘encourage integrated working’ and is responsible for producing the Joint Strategic Needs Assessment and the Joint Health and Wellbeing Strategy.
Suffolk’s first JSNA was published in 2008, with the 2011 State of Suffolk report being the first major update. This 2015 report has been rewritten to ensure it provides a strategic overview of the challenges for health and wellbeing in the county. The Suffolk JSNA is not a single document but a suite of dynamic resources to inform commissioning of health and social care and provide strategic direction (see figure 1).

The purpose of the document is to provide the evidence to enable the Suffolk Health and Wellbeing Board to identify and refresh the priorities of the Joint Health and Wellbeing Strategy 2012-2022.

What’s happened in Suffolk since 2011?

The economic climate and the financial pressure on all public sector organisations has provided an opportunity for transformation and innovation both in Suffolk and across the country.

Drivers for change include the need for a radical change in the way health and care is delivered across the county, with a shift from focusing on urgent care to one of prevention and self-care. Announced by the Government in 2013, the Better Care Fund was introduced to facilitate transformation in health and social care. People are living longer, often with multiple long-term conditions and increasingly complex needs, which do not fit neatly into the way health or social care are organised, and cannot be addressed in isolation. Integration will enable people to

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**All inform:**

- Annual Public Health Report (yearly)
- The State of Suffolk Report (approx. every 3 years)
- Informative documents (Needs assessment, rolling programme)
- Other indicators (Engagement, Census, Additional reports and analysis, Data and indicators)

Source: Suffolk County Council 2015
receive the information, advice and support to help them live independently for as long as possible regardless of their health diagnosis. Services will be delivered at local level so that people will receive seamless, co-ordinated care and integrated services, which are not duplicated or leave gaps. This means that resources are used more effectively, and by taking early action will prevent long-term costs in the future.

Although Suffolk can be perceived as an affluent county, there are pockets of deprivation equivalent to some inner city areas. Addressing health inequalities and improving healthy life expectancy are the two long-term outcomes for the Health and Wellbeing Board.

There is recognition within the Health and Wellbeing Board that the causes of ill health, health inequalities and criminality have much in common. Improving the business of the health, justice and community safety agenda also requires a collaborative approach, and work is in progress to reduce duplication and improve outcomes for people in Suffolk, taking into account hidden harm, prevention, community cohesion and emerging themes such as ending youth and gang violence.

In addition, there are a number of strategic countywide programmes which rely on creating a culture of change using a collaborative approach to garner influence and gain leverage across the wider system to achieve our strategic aspirations and goals.

Strategic programmes in Suffolk include:

- **Creating the Greenest County:** An aspiration that involves the whole county in enhancing the natural and historic environment, and responding to climate change.

- **Health and Care Integration and The Better Care Fund:** Helping people to be healthier and more independent for longer wherever possible, reducing the costs of health and social care, and creating a system that is rewarding to work in.

- **Local Response:** Ensuring Suffolk’s public services are designed and delivered in a way that reflects and responds to the varying needs, priorities and opportunities within our communities and in different places.

- **Lowestoft Rising:** Aims to create a new and innovative way of delivering the services that Lowestoft needs, joining up public services to reduce demand, and improve outcomes for the people of the town.

- **Making Every Intervention Count (MEIC):** Aims to change the way children’s services are delivered to reduce duplication and enable families to be connected to their local networks and community based services, as well as enabling families to create sustainable change for themselves.

- **Most Active County:** Aims to inspire everyone in Suffolk to be more active in their daily lives, so that Suffolk can become the most active county.

- **Raising the Bar:** Launched in 2013 to ensure every child reaches their potential, attends a good or outstanding school, and that every child is given the best preparation for life before and beyond school.

- **Supporting Lives; Connecting Communities:** Promoting independence and recovery, local solutions in supportive
communities, working in partnership, building on people’s capacity and strengths and providing support to individuals tailored to their situation.

• **Transformation Challenge Award:**
  This Government funded award will help to deliver more customer focussed, integrated and efficient public services. It will also deliver more integrated support to the most vulnerable and help communities to be more self-sustaining.

• **Travel Transformation Programme:**
  Aims to develop a more efficient way for people to move around the county, that makes sense to them.

**The prevention agenda**

Local authorities have a renewed responsibility for public health as leaders of the public health system, enabling the broader determinants of health that impact on people’s health and wellbeing to be addressed, such as people’s local environment, transport, housing and employment. These wider environmental factors are estimated to influence between 15% and 43% of our health.

Long-term illness and disease places pressure on the NHS and social care system. People are living longer but avoidable ill health affects many in later life with consequential cost to both health and social care. The recently published NHS 5 Year Forward View (NHS England 2014) reiterates the importance of prevention for the future viability of the NHS.

Prevention interventions can take place at a population or individual level and are usually classified as primary, secondary or tertiary prevention.

• **Primary prevention** aims to protect healthy people from developing a disease or experiencing an injury. Examples are vaccination programmes and decreasing levels of smoking in the population.

• **Secondary prevention** aims to halt or slow the progress of disease in its early stages. Examples are breast screening and taking low-dose aspirin to prevent heart disease.

• **Tertiary prevention** focuses on helping people manage long-term health problems, such as diabetes and heart disease, to prevent further deterioration in health and quality of life. Examples include cardiac or stroke rehabilitation programs.
The evidence base for prevention interventions is growing, including mass media campaigns to promote healthy eating, and those interventions which are targeted at disadvantaged groups, such as interventions to reduce substance misuse among vulnerable people. Work by the Kings Fund (2014) estimated return on investment (ROI) for each £1 spent on a variety of prevention programmes, and are summarised in Table 1.

All organisations in Suffolk, including the voluntary and community sector are committed to working in partnership to achieve transformation in the way that health and care services are delivered, based on four main outcomes:

- People manage their own health and social care with the right support when needed.
- Communities are easy and supportive places to live with a health or care need.
- The health and care system is co-ordinated and effective.
- Higher cost interventions are replaced with effective lower cost interventions, reducing the demand for hospital based and crisis services (Suffolk County Council 2014).

Table 1: Return on investment for £1 spent on prevention programmes

<table>
<thead>
<tr>
<th>Evidence based Intervention</th>
<th>Savings for each £1 invested</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Health care costs</td>
</tr>
<tr>
<td>School based Public Health programmes</td>
<td>-</td>
</tr>
<tr>
<td>Teenage pregnancy services</td>
<td>£11</td>
</tr>
<tr>
<td>Parenting programmes</td>
<td>-</td>
</tr>
<tr>
<td>Activity programmes</td>
<td>-</td>
</tr>
<tr>
<td>Warm, safe housing</td>
<td>£70</td>
</tr>
<tr>
<td>Social support (befriending)</td>
<td>-</td>
</tr>
<tr>
<td>Drug treatment</td>
<td></td>
</tr>
</tbody>
</table>

Source: the Kings Fund (2014)
Focusing on prevention and self-care will necessitate behaviour change, acknowledging that the choices people make can have a profound impact on lifestyle including education, crime and health. There are a range of interventions that can influence behaviour, generally ‘nudging’ people in the right direction to behaviour change. There is also an element of eliminating choice or ‘shoving’; banning smoking in public spaces, or restricting choice such as preventing takeaways setting up close to schools.

Supporting behaviour change should be based on assessment of the target group, meeting local need identified through the JSNA, evaluation and strategies to address relapse and maintaining change. Staff training and harnessing the power of the community are key factors in the success of behaviour change, particularly if it is large scale (LGA 2013).

Source: Suffolk County Council (2014)

Figure 2: Current and future workload of the Health and Social Care system

Figure 3: The spectrum of behaviour change interventions, the ladder of intervention

Harnessing the power of communities has gained traction in the past few years as organisations seek different ways to approach reducing health inequalities, including the widening gap between the most affluent and most deprived, and acknowledging the growing concern regarding the impact of increased life expectancy and those people living many more years with ill health and disability. The identification of social networks, and practice that sustains community resilience were highlighted as key roles of local government and health practitioners by the World Health Organisation in 2009. Resilience enables people to both cope with adversity and reach their full potential. Public sector interventions that sustain resilience are those that:

• Strengthen social relationships and opportunities for community connection for individuals and families, especially those with greatest need.

• Build and enable social support, social networks and social capital between communities.

• Strengthen and/or repair relationships between communities and health and social care agencies.

• Improve the quality of social relationships of care between individuals and professionals (Improvement and Development Agency (IDeA) 2010).

**A Joint Health and Wellbeing Strategy for Suffolk 2012-2022**

Suffolk Health and Wellbeing Board agreed a strategy for 2012-2022, which is due to be refreshed in 2015. The strategy provides a focus for everyone whose work contributes to health and wellbeing, and promotes the use of existing countywide and local groups to deliver the outcomes wherever possible.

‘Our vision is that people in Suffolk live healthier, happier lives. We also want to narrow the differences in life expectancy between those living in our most deprived communities and those who are more affluent through greater improvements in more disadvantaged communities.’

Four strategic outcomes were identified from information in the JSNA, and evidence that shows action in these areas will help us attain our long-term aims.
Outcome 1:
Every child in Suffolk has the best start in life.

Outcome 2:
Suffolk residents have access to a healthy environment and take responsibility for their own health and wellbeing.

Outcome 3:
Older people in Suffolk have a good quality of life.

Outcome 4:
People in Suffolk have the opportunity to improve their mental health and wellbeing.
Priorities for action within each of the outcomes were developed using the views of organisations and individuals across Suffolk. The priorities provided a focus for plans across health, local authorities, the voluntary and community sector, and other relevant organisations, to address issues which are too complex and multi-faceted for any one organisation to achieve alone.

Why are we adopting a life course approach?

The facts are stark. Disadvantage precedes birth, and people living in poorer areas die sooner, and live more of their lives with a disability or in ill health.

(Suffolk County Council 2011)

This report is themed around a life course approach and takes heed of the outcome frameworks for Adult Social Care, the NHS and Public Health. A life course approach is where population needs are considered from the different perspectives along the path of life. Adopting a life course approach enables us to provide clarity on the wider factors that affect people at different stages and key transition points in their lives (Institute of Health Equity (IHE) 2010). It highlights the importance of childhood experiences in reducing health inequalities, with the foundations for virtually all aspects of human development being established in early childhood. These experiences can have lifelong impact on health and wellbeing, and we need to develop a greater understanding of how they influence socioeconomic position and risk of disease in later life.

The Chief Medical Officer’s model of influences and actions along the life course highlights where individual and community actions and influences can impact most (Department of Health (DH) 2014). It also echoes the changing demographic and economic profile of society both nationally and locally, including factors such as the average retirement age increasing and emphasising the impact of work, expertise and experience, increasingly extending into old age (DH 2014). See figure 4.

Figure 4: Life course influences

Source: DH (2014)
Painting a picture of Suffolk

"Suffolk is a large county covering approximately 1,466 square miles, mainly comprised of low-lying arable land with the wetlands of the Broads in the North East, the Suffolk Coast and Heaths Area of Outstanding Natural Beauty in the East, and the sandy heathlands of Breckland in the North West. Suffolk has a mix of vibrant market towns and includes Britain’s biggest and busiest seaport in Felixstowe."

By 2021

It is estimated that 24.5% of residents will be 65+

2011 Census data indicates 8.2% of Suffolk residents were born outside the UK

4.7% of Suffolk residents were from an ethnic group other than white

Total population 2012

732,332

Suffolk population by age, 2012

- 0-4: 6%
- 5-15: 12%
- 16-24: 10%
- 25-64: 51%
- 65-84: 18%
- 85+: 3%
Area

Suffolk is a large county covering approximately 1,466 square miles, mainly comprised of low-lying arable land with the wetlands of the Broads in the North East, the Suffolk Coast and Heaths Area of Outstanding Natural Beauty in the East, and the sandy heathlands of Breckland in the North West. Suffolk has a mix of vibrant market towns and includes Britain’s biggest and busiest seaport in Felixstowe. It is served by two international airports located outside the county, and has many road and rail network links.

Natural environment

Over 36% of Suffolk is either nationally or locally protected for its wildlife or landscape value. The Dedham Vale and Suffolk Coast and Heaths Areas of Outstanding Natural Beauty (AONBs) and the Norfolk and Suffolk Broads, are places in which the quality of landscape is formally recognised and given special statutory status to conserve and enhance natural beauty, and in the case of The Broads, an additional duty to promote open-air recreation.

Population

The total population is in excess of 732,000, and has grown by 10.3% since 1998 -based on 2012 estimates, (Office for National Statistics (ONS) 2013). The England growth for the same period was 9.6%.

The age profile in Suffolk is changing. In particular the number of older people is increasing rapidly, with an estimated 20.9% of the population aged 65 or more in 2012 (compared to 16.9% for England as a whole). The proportion of residents aged 65 and over is predicted to rise, in 2021 it is estimated 24.5% of Suffolk residents will be 65 and over (compared to 19.1% for England).

2011 Census data indicate that 4.7% of Suffolk residents are from an ethnic group other than white*; nearly double the percentage in 2001 (2.8%), but much less than the England and Wales figure of 14.1%1. Forest Heath and Ipswich have some of the highest proportions in the East of England region of people who are not white*.

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1 Census table KS201EW
There were 34,968 residents in Suffolk in 2011 from ethnic groups other than white, an increase of 16,520 since 2001. Ipswich is more multicultural with 11.1% of its residents from an ethnic group other than white, the percentage in the remainder of the county is much lower, Babergh and Mid Suffolk have the lowest proportions at 2.2%.

Suffolk has also seen an increase in the arrival of migrant workers. A major new analysis of increases to the migrant populations of local areas in England’s regions has been undertaken by the Migration Observatory, find the link here.

Figure 6: Proportion in each main ethnic group in 2001 and 2011

Source: ONS (2012) and Suffolk Observatory (2013). Note: For visual clarity the axis starts at 70%

Country of birth data indicates that approximately 8% of Suffolk residents were not born in the UK (compared to 13% for England and Wales), an increase from 2001 (when 6% of Suffolk residents were not born in the UK). The highest proportion of non-UK born residents can be found in Forest Heath, and is likely to reflect the high proportion of US armed forces personnel. The highest proportion of residents born in other EU countries can be found in Ipswich – 5.0% of all usual residents (just over 6,500 people).

### Adult qualifications

The percentage of adults educated to the highest level (NVQ level 4+, most often this equates to undergraduate degree level or above) is lower in Suffolk (27.7%) than the national average (33.1%). However, a lower proportion of Suffolk residents have no qualifications (8.7%) than across England and Wales as a whole (10.1%).

### Work and economy overview

Although unemployment and worklessness rates in Suffolk are generally lower than nationally, wage rates are persistently lower. Improving educational attainment and workforce skills remain important challenges in attracting more well paid jobs and taking advantage of new employment sectors.

The Suffolk economy is characterised by stable employment and growth rates but lower than average productivity and wages.

- The total size of Suffolk’s economy (Gross Value Added, or GVA) in 2013 was around £15.2 billion.
- GVA per head in Suffolk was £20,620 in 2013, considerably below the national average of £23,755.

### Table 2: Country of birth for all usual residents by area, 2011

<table>
<thead>
<tr>
<th>Area</th>
<th>All usual residents</th>
<th>United Kingdom</th>
<th>Ireland</th>
<th>Other EU</th>
<th>Other countries</th>
</tr>
</thead>
<tbody>
<tr>
<td>Babergh</td>
<td>87,740</td>
<td>95.0%</td>
<td>0.4%</td>
<td>1.8%</td>
<td>2.7%</td>
</tr>
<tr>
<td>Forest Heath</td>
<td>59,748</td>
<td>77.0%</td>
<td>0.8%</td>
<td>5.1%</td>
<td>17.1%</td>
</tr>
<tr>
<td>Ipswich</td>
<td>133,384</td>
<td>88.2%</td>
<td>0.4%</td>
<td>5.0%</td>
<td>6.5%</td>
</tr>
<tr>
<td>Mid Suffolk</td>
<td>96,731</td>
<td>95.3%</td>
<td>0.3%</td>
<td>1.7%</td>
<td>2.7%</td>
</tr>
<tr>
<td>St Edmundsbury</td>
<td>111,008</td>
<td>91.5%</td>
<td>0.5%</td>
<td>3.4%</td>
<td>4.6%</td>
</tr>
<tr>
<td>Suffolk Coastal</td>
<td>124,298</td>
<td>93.9%</td>
<td>0.4%</td>
<td>2.0%</td>
<td>3.7%</td>
</tr>
<tr>
<td>Waveney</td>
<td>115,254</td>
<td>96.2%</td>
<td>0.3%</td>
<td>1.5%</td>
<td>2.0%</td>
</tr>
<tr>
<td>Suffolk</td>
<td>728,163</td>
<td>91.8%</td>
<td>0.4%</td>
<td>2.9%</td>
<td>4.9%</td>
</tr>
<tr>
<td>England and Wales</td>
<td>56,075,912</td>
<td>86.6%</td>
<td>0.7%</td>
<td>3.6%</td>
<td>9.0%</td>
</tr>
</tbody>
</table>

Source: ONS (2012) (KS204EW)
The New Anglia Local Enterprise Partnership works with businesses and public sector partners, to help grow jobs in Norfolk and Suffolk, it has been established as a catalyst to create jobs and remove the barriers to growth (New Anglia 2014). Both Norfolk and Suffolk are global leaders in life sciences, food and agriculture and the ‘all energy’ sector and have been chosen by government to lead the country on the development of the green economy, as the government’s Green Economy Pathfinder. The LEP are transforming the economy through the development and delivery of ambitious programmes, which will ensure that companies have the funding, support, skills, and infrastructure needed to grow jobs and flourish.

A map of the partnerships achievements such as the Green Economy Pathfinder, and Great Yarmouth & Lowestoft Enterprise Zone and the European Investment Strategy can be found by following this link: www.newanglia.co.uk/wp-content/uploads/2014/01/New-Anglia-LEP-A3-Map-HR.jpg

When broken down by industrial sector, Suffolk as a whole has a broadly similar composition of employment to England and Wales. However, at Local Authority level there are some variations. The presence of the two largest US Air Force bases in the UK (Lakenheath and Mildenhall) in Forest Heath, provide employment for many, as do the UK armed forces bases at Honington, Wattisham and Woodbridge. It is important to note that in early 2015 the United States Airforce announced their withdrawal from Mildenhall, which is likely to impact upon the economy over the next four years.

Several of Suffolk’s districts and boroughs have above average employment in production, the vast majority of which refers to manufacturing activities. St Edmundsbury and Waveney in particular have a large proportion of employment in production. Transport and communications is a vital sector in Suffolk Coastal.

Employment data indicates that over a quarter (26.8%) of Suffolk employees are employed in public administration, education and health occupations (Nomis 2015). This area could be susceptible to future public sector cuts.
The contribution of the voluntary and community sector in Suffolk

In 2014 Community Action Suffolk in partnership with the National Council for Voluntary Organisations (NCVO) set up a new data tool for Suffolk which gives a picture of the size and characteristics of the voluntary sector in Suffolk: www.communityactionsuffolk.org.uk/data/.

There are 2,938 registered charities in Suffolk providing a wide range of services and activities which benefit Suffolk residents and contribute to health and wellbeing. In Suffolk the voluntary and community sector (VCS) is diverse and consists significantly of smaller charities. 1,290 have an income of £10k or under, however, together registered charities have an income of over £218.5m. The data tool does not include information about faith groups and other civil society organisations with whom the estimated income of the sector would be around £800 million.

The VCS provides services across the age ranges, the largest number (1,441) working with children and young people and 847 support older people. The activities provided are also wide ranging with 1,174 charities providing education and training, and 340 focussing on the advancement of health. The sector supports the prevention of long-term ill health and social isolation, providing opportunities for physical exercise (591 amateur sports organisations) and access to social activities (435 dedicated to arts, culture and science).

These organisations contribute significantly to what makes Suffolk a good place to live. However, the challenge facing all partners is how to increase access to the wide range of activities which are available, particularly those residents who are disadvantaged or at risk. A key aspect of the programmes for change underway in Suffolk is the building of stronger community networks linking residents to the support that they need, which should be responsive to changing needs in their communities.
Wider determinants of health
The wider determinants of health refer to the set of conditions in which people are born, grow up, live and work. The diagram below shows how individual determinants, including a person’s age, sex and hereditary factors, are nested within the wider determinants of health, which include lifestyle factors, social and community influences, living and working conditions and general socioeconomic cultural and environmental conditions.

From the Black report (Black et al. 1980) to the Marmot report in 2010 (Institute of Health Equity (IHE) 2010), evidence has shown that these social determinants are responsible for significant levels of health inequalities. A baby born into a home with parents that are well educated and financially well off has a better chance of living longer, without disease or disability, than a baby born to parents who are not. This is largely because the social and economic inequalities in our society help to determine our health outcomes.

Figure 7: The determinants of health and wellbeing in our neighbourhoods

Source: Barton and Grant (2006)
The Annual Public Health Report in 2014 outlined how these inequalities impact throughout the life course in Suffolk:

**Figure 8: Inequalities throughout the life course in Suffolk**

Persistent and unacceptable inequalities in opportunities and outcomes across the county are commonly associated with deprivation, and are highlighted throughout the life course sections of this report, along with relevant wider determinants, such as education and employment. Those wider determinants that are cross-cutting over the life course are presented here.

**Deprivation**

Deprivation refers to unmet needs caused by a lack of resources of all kinds, not just financial. It is important to recognise that not every person in a highly deprived area will themselves be deprived. Equally, there will be some deprived people living in the most affluent areas.

The Indices of Deprivation attempt to measure a broader concept of multiple deprivation, made up of several distinct domains (Department for Communities and Local Government (DCLG), 2011). These domains are income, employment, health and disability, education, skills and training, barriers to housing and services, crime and the living environment.
According to the Indices of Deprivation 2010, Suffolk is a relatively affluent county with pockets of deprivation. Income deprivation mainly affects the urban areas in the county: parts of Ipswich and Lowestoft and parts of the market towns. However, 7.4% of Suffolk's population lived in the 20% most deprived areas in England, equating to about 53,000 people. Ipswich remains the most deprived local authority (LA) in Suffolk, being ranked 87th out of 326 LAs in England. Ipswich has risen in the rankings from 109 in 2007, but remains outside the top 20% of worst deprived LAs in England.

Figure 9: Index of Multiple Deprivation, ranking of local concentration of deprivation relative to all England, 2010

Source: DCLG (2011)
Rural deprivation is a particular issue in Suffolk, where pockets of deprivation are masked by areas of relative affluence, a situation which may serve to exclude people more. In 2011, The Suffolk Foundation commissioned a report 'Hidden Needs: hidden deprivation and community need in Suffolk' which identified ten pockets of rural deprivation which were amongst the 10% most deprived in the East of England (Fenton et al. 2011).

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 more defined area would.

The data in the Indices of Deprivation 2010 is now over five years old. Since 2010 government policies relating to the economy, benefits system and housing market in England will have produced changes in the distribution of deprivation in Suffolk that may not be reflected in the figures we have. Updated figures are expected in summer 2015.

**Issues**

- High levels of health inequalities in Waveney and Ipswich are well known, however the generally affluent nature of Suffolk hides pockets of rural deprivation that require further scoping and action.

- A lack of up to date data on the Indices of Deprivation.

- There is a need for all partners to work together to address persistent inequalities that affect people’s life chances.

**Housing**

The quality of the home has a substantial impact on health; a warm, dry and secure home is associated with better health. It is estimated that the detrimental effect on health of poor housing conditions costs the NHS in excess of £600 million a year. The exact relationship between poor housing and health is complex and difficult to assess. However, evidence suggests that poor housing is associated with an increased risk of cardiovascular diseases, respiratory diseases and depression and anxiety. The health effects of poor housing disproportionately affect vulnerable people: older people living isolated lives, the young, those without a support network and adults with disabilities.

Studies using population data suggest that the strongest links between housing and health are for:

- Accidents - 45% of accidents occur in the home and accidents are in the top 10 causes of death for all ages.

- Cold - cold homes are linked to increased risk of cardiovascular, respiratory and rheumatoid diseases, as well as hypothermia and poorer mental health.

(Houses of Parliament 2011)
In Suffolk…

In April 2013 there were a total of 331,300 homes in Suffolk, with the highest concentrations in Ipswich, Suffolk Coastal and Waveney (DCLG 2014).

Evidence shows that home owners have better physical health outcomes, more positive mental health and higher self-esteem, which all contribute to overall wellbeing. However, home ownership, especially cases where home owners have high mortgages, could lead to increased levels of stress, which is detrimental to health. Nearly two million households in England spend more than 50% of their income on housing costs, and more than two million households have fallen behind their mortgage or rent payments (King's Fund 2014).

At the 2011 Census (ONS 2014) 67.9% of people of all ages in Suffolk owned their homes, (either outright or with a mortgage or loan or shared ownership), compared with 68.3% in East of England and 64.1% in England as a whole. In local authority districts this ranged from 57.3% in Forest Heath and Ipswich to 75.9% in Mid Suffolk.

A total of 32.1% of people of all ages in Suffolk rented their homes, by either social renting or private renting, compared with 31.7% in East of England and 35.9% in England as a whole. In local authority districts this ranged from 24.1% in Mid Suffolk to 42.7% in Forest Heath and Ipswich.

The State of Ipswich report (Ipswich Borough Council 2014) also notes that some areas of Ipswich are highly mobile, with 31% having moved within the last two years. Such a
transient community can make it difficult to build a sense of community cohesion. There has been an increase in people renting since the 2001 Census both nationally and in Suffolk.

Evidence shows that living in overcrowded housing can adversely affect family relationships, child development and education and health (Shelter 2005). The Census defines overcrowding as households with an occupancy rating of -1 or less, indicating that a household has at least one fewer room/bedroom than required. According to the 2011 Census, a total of 5.7% of residents of all ages in households in Suffolk lived in overcrowded housing, compared with 7.9% in East of England and 11.1% in England as a whole. In local authority districts, this ranged from 3.6% in Mid Suffolk to 9.8% in Ipswich (ONS 2014a).

Living in a cold home can be associated with ill health, and even risk of death, however provision of central heating is widespread in households in Suffolk. The 2011 Census recorded that only 2.0% of residents of all ages in households in Suffolk did not have central heating, ranging from 1.2% in St. Edmundsbury to 3.0% in Ipswich. For those aged 65 and over a total of 2.5% of residents did not have central heating. This ranged from 1.4% in Forest Heath to 5.4% in Ipswich (ONS 2014b).

However, although a home may have central heating, some households cannot afford to use it. A household is said to be in fuel poverty when residents cannot afford to keep adequately warm at reasonable cost, given their income. The Government now monitors fuel poverty in England using the Low Income High Costs Indicator (LIHC). The LIHC definition considers a household to be fuel poor if:

- They have required fuel costs that are above average (the national median level).
- Were they to spend that amount, they would be left with a residual income below the official poverty line.

Suffolk has a higher proportion of fuel poor households (9.7%) when compared to its geographical neighbours; 9.5% in Norfolk, 8.3% in Cambridgeshire and 7.6% in Essex in 2012. Being a largely rural county Suffolk has both a high number of solid fuel properties as well as numerous areas off the gas grid, which further compounds the issue of fuel poverty.

Suffolk’s Warm Homes Healthy People project was set up to help vulnerable residents of Suffolk stay warm and healthy in their homes and to reduce home heating costs. The project aims to achieve the following goals:

- To reduce excess winter deaths (EWDs) due to cold housing.
- To help vulnerable householders in fuel poverty.
- To improve the thermal comfort in poorly insulated homes.
- To work with local partners especially the voluntary and community sectors.
- To supplement other national and local funding sources.
- To target the most vulnerable and be consistent with the Cold Weather Plan.

Since the project launched in 2011, Warm Homes Healthy People has provided the following:

- Over 2,400 free home energy efficiency surveys.
• Over 850 fuel payments, paid directly to the householder’s energy company.
• More than 1,300 insulation referrals.
• 134 grants towards the cost of heating repairs or replacements.

Homelessness

Research from Crisis (2012) highlights the impact of homelessness on health. Difficulties in sleeping, poor diet, maintaining personal hygiene, access to health care and treatments can all contribute to poor health. Figures from the Public Health Outcomes Framework (PHOF) measure homelessness acceptance and households in temporary accommodation. Homelessness (acceptance) is defined as eligible households that are unintentionally homeless and in priority need, for which the local authority accepts responsibility for securing accommodation under the Housing Act. Households in temporary accommodation are the number of households in temporary accommodation such as hostels, bed and breakfast and women’s refuges on the last day of the financial year. It is also shown as a rate per 1,000 households. As the rate for these indicators only refers to people who have made contact with a LA it cannot be taken as an accurate reflection of need.

Suffolk’s rate for homelessness acceptance in 2013/14 was 1.9 per 1,000 households (number = 610), lower than both the national and regional averages (both being 2.3 per 1,000 households). The rate for households in temporary accommodation for Suffolk in 2013/14 was 0.5 per 1,000 households (number = 160) which is also lower than the national and regional rates (2.6 and 1.5 per 1000 households respectively).

Official homelessness measures are likely to significantly underestimate the extent of homelessness both in Suffolk and nationally including people who do not show up in official figures and are the ‘hidden homeless’. These can be individuals and families who become homeless but find a temporary solution by staying with family members or friends, or squatters and are often referred to as ‘sofa surfers’ or ‘concealed households’.

Issues

• A lack of affordable housing to attract and retain young people.
• A lack of suitable lifetime homes. The Lifetime Homes Standard is 16 design criteria that intend to make homes more easily adaptable for lifetime use at minimal cost.
• The impact of the ‘Bedroom tax’ is still not fully understood.
• People may be able to afford the rent but not the initial deposit for properties.
• A lack of owner occupied sheltered homes for the elderly - this is a significant need with the increasing proportion of older Suffolk residents.
• The true picture of homelessness in Suffolk is unknown.

Suffolk’s housing needs are constantly changing. The demand for smaller homes has increased, as has the need for housing that suits older and disabled people. At the same time, in some locations, the quality of housing stock needs attention, to ensure all residents live in warm and safe accommodation. Suffolk’s Health and Wellbeing Board have recognised that working in partnership to support the right mix of homes for the county is of prime
importance and the first Suffolk Housing Charter, demonstrating a commitment to a joint approach in Suffolk, will be launched in July 2015.

**Crime**

Studies show that fear of crime can adversely affect both physical and mental health. Worry about crime harms health, which in turn serves to heighten worry about crime (Jackson and Stafford 2009). One study found that participants reporting greater worry were just over 1.5 times as likely to have a common mental disorder, and just under twice as likely to have depression, compared to those reporting low fear of crime (Stafford et al. 2007).

Suffolk Police is committed to enhancing the quality of life for everyone in Suffolk. As of the 31st March 2014 there were 1,252 police officers, 954 police staff, 187 police community support officers and 233 special constables in Suffolk (Suffolk Police and Crime Commissioners (PCC) (2015).

Suffolk Police is made up of many departments working together to help keep the residents of Suffolk safe, secure and informed. There are 29 Safer Neighbourhood Teams (SNTs), who work in the heart of local communities to tackle policing issues and prevent more serious issues occurring. Suffolk Police works closely with other organisations to effectively tackle crime and anti-social behaviour, and to deliver a service that is visible, accessible and responsive to what local people need.

**Trading Standards**

Trading Standards is one of the smallest services in Suffolk County Council and one of the oldest services in Local Government. The service enforces a network of laws that to protect both consumers and legitimate traders from rogue traders.

For a number of years the service has prioritised taking action against doorstep traders and ‘scams’ as well as preventing unsafe consumer goods from reaching European markets through the port of Felixstowe.

For the year 2014/2015 there were 25 prosecutions against rogue traders resulting in fines of £81,100 and the recovery of over...
£164,000 in proceeds of crime. In addition, 700 samples of consumer goods were taken at Felixstowe port of which 25% were found to be unsafe.

**Community Safety**

The Community Safety Team is a small team within Suffolk County Council, consisting of experts in various key Community Safety areas who are able to take a county system-wide view of their specialisms. This enables the Team to coordinate various community safety resources across Suffolk, directing resources where they are most needed.

The world of Community Safety is wide-ranging and complex, involving a multitude of organisations including the Constabulary, Police and Crime Commissioner, Fire Service, Borough and District Councils and a multitude of third sector/voluntary organisations. Building and maintaining strong and effective partnerships is therefore fundamental to the work of the Team. The Team coordinates regular countywide partnership meetings in order to bring all relevant partners together to discuss and resolve current issues, and over the past year have organised three successful conferences on Hate Crime, Restorative Approaches and Domestic Abuse.

Over the past year, the Team has undergone a full review, which has led to discussions involving all key partners regarding the future of Community Safety delivery across Suffolk, to ensure partners are working together as effectively and efficiently as possible.

**Issues**

The 2013/14 PCC Annual Report highlighted that patterns of crime are changing, with increasing levels of cyber related criminal activity, and improvements are needed to tackle this form of crime. The rural nature of Suffolk can pose challenges in relation to policing, however the formation of two rural crime teams to combat rural crime was a key action in 2013/14. Crime and disorder reduction grants are also available to those securing or contributing to securing a reduction of crime and disorder in Suffolk. In 2013/14 a Community Safety Fund was created with in excess of £700,000 of funding, and the Safer Suffolk Fund was created for 2014/15 with £300,000 of funding.

**Transport**

Transport includes walking and cycling, as well as the use of private vehicles, public transport and goods vehicles. Transport can have a wide range of beneficial and detrimental effects on health.
The number of cars in Suffolk has increased by over 60,000 in the last ten years (Suffolk County Council 2013). Latest Census data (for 2011) shows that just over 255,000 Suffolk households had access to a car or van (82.1% of all households). The proportion of households with access to a car or van was higher in rural areas of Suffolk (89.2%) compared to urban areas (77.5%), but this still means that around 1 in 10 rural households (just over 13,000) do not have access to a car or van. This is an important consideration because of the potential implications for access to services and key amenities.

Source: Adapted from Faculty of Public Health Medicine (2000)
The 2013 Annual Public Health Report highlighted that the benefits of car travel include the freedom it brings people to travel conveniently over greater distances than would be possible by walking and cycling. However, it also notes that it is associated with increased harms to health from air pollution, noise, climate change, physical inactivity, and road traffic incidents as well as substantial personal financial costs. The cost of physical inactivity, poor air quality and noise associated from transport across towns in England has been forecast as being up to £25.4 billion per annum. Just under half of drivers indicate that they would like to drive less, given practical alternatives (Lyons and Chattergee 2008).

Public transport is a sustainable alternative to car travel. It provides environmental benefits, reduced isolation and can provide health benefits when combined with walking and cycling. There are in excess of 200 local bus service routes in Suffolk as well as 13 demand responsive transport schemes. Suffolk also has frequent direct trains from London Liverpool Street and from Norwich to Ipswich, Stowmarket and Diss.

Census data shows that the percentage of Suffolk residents using public transport (bus, train, tram, light rail, metro) to travel to work fell from 5.8% to 3.5% between 2001 and 2011 (although the actual number of people using public transport to get to work increased slightly, by 1.4%, or almost 250 people). This may be due to both infrequently and timetabling of local transport, particularly in rural areas, where it may not be possible to get from home and back in one day. One of the County Council’s 9 transformation programmes focusses on exploring how commercial, community, home to school and non-emergency hospital transport services can be reorganised and deliver more capacity particularly in rural areas.

Suffolk has a wealth of public rights of way for walking and cycling, with 3,400 miles of footpaths, bridleways and byways, and 500 miles of cycle tracks, cycle lanes and waymarked leisure cycling routes, including three national cycle routes. However, Census statistics from 2001 and 2011 show a decrease in the number of people who regularly cycle to work. This may be due to a lack of facilities at work such as access to secure cycle racks and showers.

**Active travel**

Walking and cycling are important because they are good for health and the environment and can be quicker (for short journeys) and
cheaper than alternatives. Walking and cycling, also known as “active travel” can be combined with public transport to allow longer journeys to be undertaken and enable physical activity to be incorporated into daily commuting and other journeys.

In Suffolk...

**Walking**

Walking is the most popular form of physical activity and there are many health benefits of keeping active through walking including reducing the risk of chronic illness. 7 in 10 people in Suffolk regularly walk for at least thirty minutes once a month, while more than half (56%) walk for at least thirty minutes once a week. Over a fifth (22%) walk for thirty minutes, five times a week.

The key aim of the [Suffolk Walking Strategy](#) is to encourage more people to be active through walking. The two over-arching aims of the strategy are:

- Walking to be seen as beneficial, easy, inclusive, accessible, pleasant and safe.
- Walking to become the ‘default’ option for journeys of 20 minutes or less.

Embedding activity in daily routines, such as travel to work, is the most effective way to maintain an active lifestyle. The change to how we travel to work is reflected across all districts in Suffolk. People are making fewer journeys by foot.

Table 3: Suffolk districts: walk to work on regular basis

<table>
<thead>
<tr>
<th></th>
<th>2001</th>
<th>2011</th>
<th>Change +/-</th>
</tr>
</thead>
<tbody>
<tr>
<td>Babergh</td>
<td>8.9%</td>
<td>6.0%</td>
<td>-2.9</td>
</tr>
<tr>
<td>Forest Heath</td>
<td>10.6%</td>
<td>6.4%</td>
<td>-4.2</td>
</tr>
<tr>
<td>Ipswich</td>
<td>13.8%</td>
<td>10.8%</td>
<td>-3.0</td>
</tr>
<tr>
<td>Mid Suffolk</td>
<td>6.9%</td>
<td>4.7%</td>
<td>-2.2</td>
</tr>
<tr>
<td>St Edmundsbury</td>
<td>11.9%</td>
<td>8.6%</td>
<td>-3.3</td>
</tr>
<tr>
<td>Suffolk Coastal</td>
<td>8.0%</td>
<td>5.2%</td>
<td>-2.8</td>
</tr>
<tr>
<td>Waveney</td>
<td>9.7%</td>
<td>6.1%</td>
<td>-3.6</td>
</tr>
<tr>
<td>Suffolk</td>
<td>10.1%</td>
<td>7.0%</td>
<td>-3.1</td>
</tr>
<tr>
<td>England</td>
<td>10.0%</td>
<td>6.3%</td>
<td>-3.7</td>
</tr>
</tbody>
</table>

*Source: Nomis (2014)*
Issues

• The fall in the number of people walking and the rise in obesity and other health conditions related to a lack of physical activity.

• Real or perceived barriers to walking, including lack of time, adverse weather or a lack of safe and attractive places to walk.

• Narrow pavements and a lack of dropped curbs.

• Lack of places to sit down.

Evidence shows that in order to be effective, interventions to promote walking should be:

• Tailored to people's needs.

• Targeted either at sedentary individuals or individuals already motivated to change.

• Individually tailored: mass-media campaigns may increase knowledge and awareness but are unlikely to result in behaviour change.

• Brief: telephone prompts were equally as effective as in-depth telephone counselling.

• Group oriented: the social aspect can increase the number of people continuing to walk (C3 Collaborating for Health, 2012).

Cycling

The first Suffolk Cycling Strategy was published in 2014. With a growing population which will place increasing pressure on our road network, we have to consider how best to encourage people to take to their bikes.

There is strong evidence for effectiveness of cycling in providing many health benefits of physical activity. However, despite its popularity and recent relative increase in participation, cycling levels are in long-term decline due to a number of perceived and real barriers such as risk of injuries, road safety, environmental factors and infrastructural issues.

Evidence shows that community wide promotional activities such as the Suffolk Year of Cycling (www.suffolkyearofcycling.co.uk) have potential to increase cycling, but further research is needed to consider the most effective way to promote cycling in specific target groups.

The number of people who regularly cycle in Suffolk for at least thirty minutes once a month is 12%. 6% of us cycle for at least thirty minutes once a week, 2% cycle for thirty minutes, five times a week.

Census statistics from 2001 and 2011 also show a decrease in the percentage of people in Suffolk who regularly cycle to work.

This change to how we travel to work is reflected across all districts in Suffolk. People are making fewer journeys by bicycle.
Table 4: Suffolk districts: cycle to work on regular basis

<table>
<thead>
<tr>
<th>District</th>
<th>2001</th>
<th>2011</th>
<th>Change +/-</th>
</tr>
</thead>
<tbody>
<tr>
<td>Babergh</td>
<td>2.7%</td>
<td>1.3%</td>
<td>-1.4</td>
</tr>
<tr>
<td>Forest Heath</td>
<td>4.6%</td>
<td>2.6%</td>
<td>-2.0</td>
</tr>
<tr>
<td>Ipswich</td>
<td>5.7%</td>
<td>3.1%</td>
<td>-2.6</td>
</tr>
<tr>
<td>Mid Suffolk</td>
<td>3.8%</td>
<td>1.9%</td>
<td>-1.9</td>
</tr>
<tr>
<td>St Edmundsbury</td>
<td>3.5%</td>
<td>2.1%</td>
<td>-1.4</td>
</tr>
<tr>
<td>Suffolk Coastal</td>
<td>5.4%</td>
<td>3.0%</td>
<td>-2.4</td>
</tr>
<tr>
<td>Waveney</td>
<td>8.4%</td>
<td>3.6%</td>
<td>-4.8</td>
</tr>
<tr>
<td>Suffolk</td>
<td>4.9%</td>
<td>2.6%</td>
<td>-2.4</td>
</tr>
<tr>
<td>England</td>
<td>2.8%</td>
<td>1.9%</td>
<td>-0.9</td>
</tr>
</tbody>
</table>

Source: Nomis (2014)

Issues

• The fall in the number of people cycling and the rise in obesity and other health conditions associated with a lack of physical activity.

• A perception that cycling on our roads is a dangerous activity.

• Lack of dedicated cycle paths throughout the county.

Evidence shows that community-wide promotional activities and improving infrastructure for cycling have the potential to increase cycling by modest amounts, but further research is needed to consider how best to promote cycling in children and adolescents and through workplace initiatives (Yang et al. 2010).

Road safety

The Public Health Outcomes Framework contains an indicator regarding the rate of people of all ages reported killed or seriously injured (KSI) on the roads (per 100,000 population). In the three year period 2011/2013 the rate for Suffolk was 44.6, worse than the England rate of 39.7 (PHE 2015).

2009/2013 data from Suffolk Roadsafe (2014) indicates the county’s resident casualty rate is 31.2 per 10,000 population, this is below the current rate for Great Britain. There has been an 18% decrease in average annual resident casualties over the last five years. The casualty rate varies slightly between districts, with the highest rates in Ipswich and the lowest in St Edmundsbury.

About five out of six injured residents (83%) are injured on Suffolk’s roads, with most of the remainder injured in neighbouring counties. Motor vehicle drivers from Suffolk are 8% less likely to be involved in a collision than the
national norm, although drivers resident in Ipswich and Mid Suffolk are closer to national involvement rates (Suffolk Roadsafe 2014).

The national trend of young adults experiencing disproportionately high levels of road risk is more pronounced in Suffolk than elsewhere in the country. The casualty risk to 16-24 year olds is over twice the risk of all other residents. Conversely, children under 16 and adults over 65 are at considerably lower risk than the county’s residents in general.

Resident pedal cycle casualty rates are currently 17% lower than the national average, but adult cyclist casualties have risen steadily over the last five years, while child cyclist casualties fell. This increase appears to be strongly localised in Ipswich and Waveney, and is most noticeable in our more deprived communities.

**Issues**

- Motorcyclists from Suffolk are involved in collisions more often than the national average and are at greater risk of suffering higher severity injuries than other road user groups.

- Young drivers from Suffolk are at a higher risk of collision involvement than the national average, although the absolute numbers have declined by 27% in the last five years.

- Adult pedal cyclist casualties on Suffolk’s roads have increased in recent years.

The overall road safety trend in Suffolk is positive: local residents are at lower risk of being injured than the national average, and collisions on the county’s roads are becoming less frequent. However, significant risk remains, particularly for young adult drivers in rural districts, and both motorcyclists and pedal cyclists in urban areas (Suffolk Road Safe 2014).

For further information on transport and health, and road safety in Suffolk see:

- Suffolk Roadsafe 2014 Area Profiles
- The Annual Public Health Report 2013 Moving forward? Travel and health in Suffolk
- Suffolk Local Transport Plan 2011-2031
- The Suffolk Cycle Strategy: Medical and Public Health Evidence

**Environment**

The natural environment is undoubtedly one of Suffolk’s key strengths. Evidence suggests that the natural environment can help people feel less stressed; more relaxed and better able to concentrate, with similar effects seen in people with mental and physical health problems. The diagram below summarises the associations seen in the evidence.
Figure 13: The effect of the natural environment

Mind map describing the effect of the natural environment

- Views of nature help stress, concentration, improves decision making and prevents illness
- Living near nature keeps people healthier
- Forest walking can improve emotion, wellbeing and mood
- Recovery from surgery is faster and pain reduced
- For those with mental illness mood is elevated, relaxation increased and stress reduced
- Behaviour modified in children, teenagers and elderly

Keeping people healthy
Urban communities
Natural environment on health and wellbeing
Restoration from illness
Physical activity

Can increase community integration
Can increase community support
Can reduce crime, vandalism and violence
People living in close proximity to walkable green space are likely to exercise more, not be obese, and live longer
Outdoor exercise is likely to have a more positive effect on blood pressure, self esteem, mood than in artificial environments
Group activities e.g. gardening, walking can increase social wellbeing

Source: Institute of Rural Health (2008)

Public access to nature is an opportunity to improve health and wellbeing, as well as connecting and educating people about the natural environment. There are over 5,600 kilometres of public rights of way in Suffolk providing one of the densest networks of access in England. In addition, there are 4,858 hectares of open access land providing the public with the opportunity and the right to roam in areas of heathland habitat. Increasing the use of good quality green space for all social groups is likely to improve health outcomes and reduce health inequalities. It can also bring other benefits such as greater community cohesion and reduced social isolation (Public Health England (PHE) 2014).

In Suffolk...

In 2008 Suffolk’s Community Strategy, Transforming Suffolk was published with the ambition ‘By 2028 we want Suffolk to be recognised for its outstanding environment and quality of life for all; a place where everyone can realise their potential, benefit from and contribute to Suffolk’s economic prosperity, and be actively involved in their community’. The strategy consists of four key priorities, one being to create Suffolk as the Greenest County by being an exemplar in tackling climate change and protecting and enhancing the natural and historic environment.
Climate change

Climate change from man-made greenhouse gas emissions is changing the world we live in. We are seeing more heatwaves and flooding, changing patterns of infectious disease and it is affecting global food and water supplies. This is why leading academics have identified it as the biggest threat to global health of the 21st century.

Climate UK (2012) identified the following key risks and implications of climate change for health and wellbeing in the East of England:

- Being one of the warmer parts of the UK, increases in temperature may lead to increased levels of mortality and morbidity due to heat
- Increased flooding may lead to increased numbers of deaths, injuries and people suffering from mental health effects as a result of flooding.
- Increasing ozone levels by the end of the century may lead to increased levels of mortality and respiratory hospital admissions.

Recent figures released by the Met Office showed that 2014 was the warmest year on record in the UK since 1910 and all the UK’s top eight warmest years have happened since 2002 (Met Office 2015).

Air quality

The increase in mortality risk associated with long-term exposure to particulate air pollution is one of the most important effects of air pollution on health (PHE 2014a). Suffolk currently has nine Air Quality Management Areas (AQMAs), where the limit levels for nitrogen dioxide are exceeded, of which eight are solely associated with road traffic. Five are in Ipswich, where additional areas are shortly to be added and the extent of the existing ones reviewed. There is also an area in each of Sudbury, Newmarket and Woodbridge. The ninth AQMA is in the Felixstowe Dock area, with contributions from dock activities as well as road traffic.

Flooding

Being flooded increases the risk of physical and mental illness, and causes severe disruption to both home and community life and wellbeing. Natural England (2014) found that adults who had suffered from flooding had four times the background level of psychological distress. In Suffolk 5,000 homes are at risk from tidal flooding, 1,600+ in Ipswich alone (based on Environment Agency Shoreline Management Plans) and in addition there are over 20,000 homes potentially at risk from river flooding – particularly in the Gipping, Stour and Waveney valleys. There are also an estimated 80,000 properties currently at risk from surface water or flash flooding. In total this equates to about 1 in 6 properties potentially vulnerable to some form of flooding.

Issues

- There is a vital role in protecting, maintaining and improving local green spaces and creating new areas of green space to improve access for all communities. Such efforts require joint work across partners, particularly public health, planning, transport, and parks and leisure. The New Anglia Local Enterprise Partnership’s Strategic Economic Plan sets out New Anglia’s ambition to harness Suffolk’s natural assets to support
growth. Actions include developing our understanding of natural capital, support creation of 1,000 hectares of new wild spaces and influencing allocation of EU funding to support investment in our natural capital. Suffolk’s Nature Strategy shares these ambitions to better understand the value of, and protect, Suffolk’s natural capital.

• To ensure that our future generations can have a healthy life and are able to manage the impacts of climate change it is vitally important that our children learn how to live sustainably from a young age. Equipping them with these skills early on will give them the ability to enjoy outdoor exercise and activity, understand the importance of healthy eating and where food comes from, and understand the benefits of living low carbon lifestyles.

• Climate change predictions suggest the frequency and severity of extreme rainfall events is very likely to increase, associated with generally wetter winters and increased storminess triggered by higher temperatures. As well as the obvious direct human impacts of flooding, the cost in terms of the economy, insurance and investment in flood defences is huge. As an indication, the estimated cost to the UK of the 2013/14 tidal surge and winter storms was over £1 billion. Planning services that are resilient to climate change will reduce risks, including service delivery and operational risks, and can also deliver health co-benefits.

For a full report on the environment in Suffolk please see our JSNA Webpages at: www.healthysuffolk.org.uk/JSNA/reports
Prenatal before birth

“...Our genes provide us with some basic biological building blocks or heredity, but genes can be influenced at every stage by our environment and experiences...Our ‘environment’ begins in the womb so even at the very earliest stages our genes can be influenced and this can affect brain development.”
(Minded, 2014)

80.7 years Male life expectancy
84.1 years Female life expectancy
7,792 live births in Suffolk in 2013

15-20% Suffolk women estimated to be obese or overweight during pregnancy
19.6 per 1000 The rate of conceptions in Suffolk teenage women

12.5% The percentage of women smoking during pregnancy in 2013/14
Giving every child the best start in life and reducing health inequalities begins before conception and throughout pregnancy. This includes ensuring the child has the best environment to grow and a strong foundation for future development is established. Early intervention not only improves the life chances for our children, but also reduces future costs as intervening early, before behaviours become entrenched, is likely to be more effective.

There is clear evidence that pregnancy and the early years are critical to the future health and wellbeing of both children and adults and evidence based early interventions can have significant short and long-term positive impacts. Smoking, alcohol, poor nutrition, and stress or the absence of a warm loving relationship can have significant short and long-term negative impacts (DH 2013). During pregnancy parents are also particularly receptive to learning and making changes to the way they live their lives (DH 2009).

The elements which promote good foundations for positive and early development include:

- Good maternal physical and mental health
- Breastfeeding
- Full term pregnancies and healthy birth weight (above 2.5kg)

Risk factors which may prevent the best start in life:

- Smoking during pregnancy
- Mental health of the mother (including postnatal depression)
- Being a young mother
- Parental disability
- Parental substance (drug or alcohol) misuse
- Domestic abuse

Wider factors such as employment, housing, societal influences and economic status all have a role in shaping children’s futures. We want every mother to experience a healthy pregnancy, with the best possible outcomes for both mother and child. This means identifying and minimising the risks that can either be modified or avoided.

What are we doing well since the last report in 2011?

- We are joining up our children and young people’s services (Making Every Intervention Count).
- Pregnant women are offered booking with a named midwife by 12 weeks of pregnancy.
- All pregnant women are offered access to the Healthy Child Programme: the first 5 years of life (DH), including an assessment by a health visitor at 28 weeks, or earlier if identified as requiring additional support by the midwife.
- In the Waveney area mothers have access to a specialist midwife for perinatal mental health, have integrated care plans and follow the perinatal mental health pathway as required.
- The under 18 conception rate has decreased by 34% between 1998 and 2012.
- A Suffolk Maternity Health Needs Assessment was completed in 2014 to inform future planning and resource prioritisation.
• The Family Nurse Partnership programme for teenage parents is available in both the Ipswich and the Waveney areas of Suffolk.

• There is evidence of better collaborative working between midwives, health visitors and children’s centres in recent years, although there is still some inconsistency in approach, which requires further sustained improvement.

• There are examples of joint initiatives by some children’s centres and midwifery teams to meet the needs of pregnant women, such as joint provision of evening antenatal parenting classes to improve access for pregnant women and their partners. The healthy child collaborative in the Waveney area is an example of joint initiatives between children’s centres and midwifery.

• There is a new integrated sexual health service across Suffolk that combines general and specialist services, and is accessible and appropriate for young people.

• Community midwives link specifically with substance misuse services to ensure pregnant women misusing drugs or alcohol receive specialist support.

• Suffolk has a dedicated protocol (ACCORD) for joint working between adult services and children’s services to ensure the needs of a child / children with a parent / carer with an additional need are protected and the family as a whole has the best possible outcomes. The ACCORD Protocol was reviewed and updated in 2014.

**What our population looks like**

• 7,792 live births in Suffolk (in 2013).

• In 2013, 78% of all births were to women aged 20-34 with the peak age being those aged 25 – 29.

• Birth projections for Suffolk indicate the number of live births remained fairly stable with a short-term peak in 2014/2015.

• In Suffolk in 2013 there were 118 multiple births with the highest number in those mothers aged 30-34. Multiple births have increased risk to both mother and her babies.

• 12.5% of women were smoking at the time of delivery in 2013/14, similar to the national average of 12.0% and worse than the regional average of 10.8%. Smoking at the time of delivery increases in areas of higher deprivation.

• Suffolk has similar rates of stillbirth and mortality around the time of birth when compared to the regional average, but slightly lower rates compared to the national average.

*Sources: Public Health England (PHE) (2015), Suffolk County Council (2014)*

**How long can Suffolk babies expect to live on average?**

Latest available data indicates that both men and women in Suffolk live longer lives than the England average (Public Health England 2015). Women both locally and nationally generally live longer than their male counterparts.
How long we can expect to live is a good indicator of health. Life expectancy and living in an area of relative deprivation are closely associated. The most recent data for Suffolk indicates that a boy born in the most deprived areas of Suffolk has a life expectancy 6.4 years lower than a boy born in the least deprived areas. A girl born in the most deprived areas of Suffolk will have a life expectancy 4.2 years lower than a girl born in one of the least deprived areas. Over the past decade, males in Suffolk have shown a consistently larger gap in life expectancy when compared to females. The graph below also indicates that the gap in life expectancy does not appear to be decreasing and may even be increasing.

What is the slope index of inequality?
This measures inequalities in life expectancy within Suffolk. The SII is a measure of the social gradient in life expectancy, i.e. how much life expectancy varies with deprivation. It takes account of health inequalities across the whole range of deprivation within Suffolk and summarises this in a single number.
Mental health

Mental health issues during pregnancy and around the time of birth can include mild, moderate and severe depression, a range of anxiety disorders, and severe mental illness such as puerperal psychosis, bipolar disorder and schizophrenia (Tameside & Glossop 2011).

The number of pregnant women known to have mental ill health is less than half the estimated number we would expect to see, which may indicate unmet need (as reported in the Suffolk Maternity Needs Assessment in 2014) (Suffolk County Council, 2014a).

In Waveney mothers have access to a specialist midwife for perinatal mental health, have integrated care plans and follow the perinatal mental health pathway as required. However, this doesn’t appear to be the case Suffolk wide. The Suffolk Maternity Needs Assessment identified a lack of services for midwives to refer pregnant women to, which leads to some inconsistency in the management of pregnant women affected by mental illness (Suffolk County Council, 2014a).

During 2014 Suffolk County Council and NHS England reviewed and amended the Parental Mental Health pathways that are part of the Healthy Child Programme 0-5 Integrated Commissioning and Delivery Toolkit. The work brought together professional groups and organisations to develop an integrated and supported approach to the care of families affected by perinatal mental health conditions, and has resulted in a Suffolk Clinical Network which will ensure the work is implemented and is developed further to provide good quality services for families in Suffolk.

A perinatal infant mental health (PIMHS) pilot in the north of the county worked with five families with infants, where the mother had complex mental health issues with an aim to keep the family together and ensure safeguarding. The success of this pilot in achieving positive outcomes for the mother and child has resulted in the extension of the pilot for a further year. Emphasis of the project is on interagency and interdisciplinary work between services, a combination of child, youth or adult mental health assessment, support and treatment offered by Child and Adolescent Mental Health Services (CAMHS), adult mental health, children’s centres and children’s specialist (social care) services. The partners will work jointly and focus on the mental health needs of the parents and their caregiving capacity as well as the parent–infant relationship.

Lifestyle factors

Smoking in pregnancy

Smoking in pregnancy is harmful to the mother and baby. In Suffolk 1 in 8 (12.5%) mothers are smoking at the time of delivery which is similar to the England average (Public Health England (PHE) 2015). Smoking rates in pregnancy vary by age and social group: pregnant women from unskilled occupation groups are five times more likely to smoke than professionals, and teenagers who are pregnant are six times more likely to smoke than older mothers (ASH 2013). 2013/14 data indicates that in some parts of Suffolk such as Waveney, approximately 1 in 6 women (16%) are smoking at the time of delivery, this can result in long-term health inequalities.

There are significantly increased risks to mother and baby through smoking in pregnancy and at the time of birth, including stillbirth. Babies are more likely to be born prematurely and with a low birth weight (below
2.5kg), twice as likely to die from cot death, be taken into hospital twice as often during the first eight months of life, two and a half times more likely to suffer from psychiatric disorders such as ADHD (Attention Deficit Hyperactivity Disorder), and become smokers themselves in later years (Suffolk County Council, 2014b).

Pregnant women in Suffolk receive a carbon monoxide test at their first screening appointment that indicates if they are smoking. They are also asked at the time of birth if they smoked during their pregnancy.

Figure 16: Smoking at time of delivery in Suffolk, 2010-2014

Source: Public Health England 2015

**Alcohol in pregnancy**

Alcohol can harm a developing baby. High levels of alcohol consumption during pregnancy can cause foetal alcohol syndrome which leads to damage to the brain and nervous system. The relationship between the level of alcohol consumption and harm to the mother and baby is not easily quantifiable. Therefore, the Department of Health advises that, ideally, pregnant women should abstain from drinking alcohol, and if they cannot abstain, should avoid drinking more than 1-2 units, equivalent to one 125ml small glass of wine once or twice a week.

At present there is no way of measuring or recording the impact of maternal alcohol consumption on the baby and only limited data is available on the prevalence of Foetal Alcohol Syndrome (FAS). It is hoped to address this in a Needs Assessment to examine the impact of parental substance misuse being undertaken in 2015.

**Unhealthy weight in pregnancy**

West Suffolk maternity services reported that for the period April to September 2014, of 1,396 antenatal bookings, approximately 18% of women had a recorded body mass index (BMI) of more than 30. Healthy BMI is 18.5 – 24.9, an adult is considered overweight with a BMI between 25 and 29.9, and obese if the BMI is over 30. Data was not available for the whole of Suffolk at the time this report was published. National data indicates that 15-20% of pregnant women are likely to be overweight or obese during pregnancy (NHS Choices 2015).
Weight loss programmes are not recommended during pregnancy as they may harm the health of the unborn child. National guidance recommends maintaining a healthy weight before, during and after pregnancy by eating healthily, being physical active and gradually losing weight after pregnancy. Women who are overweight during pregnancy increase their risk of illnesses such as gestational diabetes, and high blood pressure and have higher risks of affecting the health of their child, including health problems in later life, such as obesity and diabetes (National Institute for Health and Care Excellence (NICE), 2010).

Health services including contraception, fertility and pre-conception advice services, GP practices, pharmacies and children’s centres should prioritise this health advice to all women of child bearing age, in line with the principles of Making Every Contact Count (MECC).

**Infectious disease in pregnancy**

Whooping Cough or Pertussis can be a serious illness for very young children. Pertussis has increased in recent years and the Department of Health responded by enhancing the vaccination programme to include pregnant women in 2012. By vaccinating the mother while she is pregnant, better protection is afforded to the child for the first few months of life before he or she is able to benefit from being vaccinated directly. An estimated 72% of pregnant women have been vaccinated for Pertussis in Suffolk, and there is evidence of good uptake when offered, although this is not currently consistent across the whole county, with lower uptake in the Waveney area.

Pertussis cases in the Anglia and Essex region rose from 72 to 909 from 2011 to 2012, but fell to 456 in 2013, this may be attributed to the introduction of Pertussis vaccination. Flu is more dangerous for pregnant women than other adults. Flu vaccination is recommended for pregnant women, with 47% of women being vaccinated in Suffolk in 2013. The national target is 75% although no area in England has achieved this to date.

**Teenage conceptions**

Teenage pregnancy is associated with poorer health and wellbeing outcomes for both mother and baby. Babies born to very young mothers tend to achieve less and have more health problems than babies born to more mature women.

Figure 17 illustrates the drop in under 18 conception rates since 2007. Both the regional and national rates for under 18 year olds have declined relatively sharply since 2007; the fall in Suffolk had been less dramatic up to 2012, although shows a sharper fall in 2013, to stand at 19.6 per 1000 females aged 15-17 years. This current rate for the county has again fallen below the regional rate (of 21.0 per 1000), having been higher than the regional average in 2012 (24.8 per 1000 compared to 23.2 per 1000).
In 2013, the conception rate per 1000 in Suffolk was 19.6 with a maternity rate of 11.0 per 1000 and an abortion rate of 8.6 per 1000.

Between 1998 and 2013 the under 18 conception rate in Suffolk decreased by 47.7%. This is broadly similar to the national picture over the same period, but slightly higher than the fall recorded in the East of England region.

Although the under 18 conception rate in Suffolk is decreasing, in 2013 44.0% of such conceptions led to abortion compared with 35.5% in 1998. The 2013 figures for Suffolk are lower than the regional and national averages, both of which exceed 50%.

The maternity rate in 2013 for women aged 15-17 was 11.0 per 1000, which is similar to regional and national averages.

Despite having the highest under 18 conception rate in the county, Ipswich experienced one of the largest falls in this rate between 1998 and 2013, of 51.3%.

National and local data suggest a significant association between teenage conception rates and deprivation levels at the electoral ward level in Suffolk and nearly 50% of the variation in these conception rates could be explained by deprivation (Suffolk County Council 2014c).
Some groups of young people are particularly vulnerable to early sexual activity and unplanned pregnancy (Swann et al. 2003):

- Young people in or leaving care
- Homeless young people
- Children who have been excluded from or who are non-engaged with school
- Children of teenage mothers
- Young people of Caribbean, Pakistani or Bangladeshi ethnicity
- Young people who are involved in crime

In 2013 the Department of Health published a sexual health improvement framework for England which highlights the national fall in under 18 conceptions over recent years, but confirms the need to continue to reduce pregnancies in this age group.

Investing in services to prevent teenage pregnancy is important and valuable, for every £1 spent on contraception to prevent teenage pregnancy, £11 is saved through fewer costs from terminations, antenatal and maternity care (Teenage Pregnancy Associates, 2011).

Sexual health services have been commissioned in Suffolk, which will promote ease of access to information, contraception and treatment for all ages but with particular attention paid to ensuring young people can access services in their local area. Many young people ask their GP to provide contraception but others prefer to use open access sexual health services. Sexual health services work closely with children and young people’s

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### Figure 18: Summary of teenage conception outcomes and risks

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>15%</strong></td>
<td>The proportion of all young people not in education, training or employment that are either teenage mothers or pregnant teenagers.</td>
</tr>
<tr>
<td><strong>20%</strong></td>
<td>By age 30, teenage parents are 20% more likely to have no qualifications</td>
</tr>
<tr>
<td><strong>22%</strong></td>
<td>Teenage mothers are 22% more likely to be living in poverty by age 30</td>
</tr>
<tr>
<td><strong>3x</strong></td>
<td>Teenage mothers have 3x higher rate of postnatal depression, and for three years after birth they also have a higher risk of poor mental health</td>
</tr>
<tr>
<td><strong>63%</strong></td>
<td>Children of teenage mother have a 63% increased risk of being born into poverty (and more likely to have accidents and behavioural problems)</td>
</tr>
<tr>
<td><strong>60%</strong></td>
<td>The infant mortality risk is 60% higher among babies born to teenage mother</td>
</tr>
<tr>
<td><strong>3x</strong></td>
<td>Teenage mothers are 3x more likely to smoke throughout their pregnancy</td>
</tr>
<tr>
<td><strong>50%</strong></td>
<td>Teenage mothers are 50% less likely to breastfeed</td>
</tr>
</tbody>
</table>

*Source: Department for Children, Schools and Families (DCSF) (2010) & DH (2013a)*
services and other agencies supporting young people, to ensure a holistic approach is delivered, including health promotion. Contraception and sexual health promotion are particularly important in preventing unplanned teenage pregnancy in order to address the high rates of abortion that we are seeing in Suffolk.

**Supporting teenage parents: Family Nurse Partnership**

The Family Nurse Partnership (FNP) Programme is currently available in the Ipswich and the Waveney area. The programme intensively supports first time mothers aged 19 and under, throughout pregnancy until the child reaches the age of 2, when the health visiting service takes over.

The purpose of the Family Nurse Partnership is to:

- Improve the outcomes of pregnancy by helping women improve their antenatal health.
- Improve their children’s health and development by enabling parents to provide more competent care for their children.
- Improve women’s life course by helping them with planning subsequent pregnancies, finishing their education and finding employment.

**Key issues**

**Inequalities:**

- Over the past decade there has been a consistently larger gap in life expectancy for males when compared to females. The most recent data for Suffolk indicates that a boy born in the most deprived areas of Suffolk has a life expectancy 6.4 years lower than a boy born in the least deprived areas. A girl born in the most deprived areas of Suffolk will have a life expectancy 4.2 years lower than a girl born in one of the least deprived areas. Over the past decade males in Suffolk have shown a consistently larger gap in life expectancy when compared to females. As the gap in life expectancy does not appear to be decreasing there is potential for greater health inequalities in Suffolk (see Figures 8 and 15).

- Some children are starting life at a disadvantage in Suffolk as their mother smoked during pregnancy. 1 in 8 mothers in Suffolk smoked at the time of delivery in 2013/14. This can result in long-term health inequalities.

- Life outcomes for teenage parents and their children are poorer than those of older mothers. The Family Nurse Partnership Programme, which offers intensive support throughout pregnancy and the first two years of life is currently available in Waveney and Ipswich but excludes vulnerable teenage mothers from other areas of the county.

- The percentage of low birth weight babies was higher in the most deprived areas compared to the least deprived areas (see Figure 8).
• The rate of teenage conceptions in the most deprived areas was higher compared to the least deprived areas, with outcomes for teenage parents and their children being poorer compared with older mothers (see Figure 8).

**Opportunities for prevention:**

• Ensure timely provision of mental health services for pregnant women in need. The number of pregnant women known to have mental ill health is less than half the estimated number we would expect to see, which may indicate unmet need (as reported in the Suffolk Maternity Needs Assessment in 2014). It is important because recognised and untreated mental health illness may result in insecure attachment through a mother being unable to nurture her baby due to mental ill health.

• Ensure that smokers in Suffolk quit as soon as possible, particularly women prior to pregnancy. There are significantly increased risks to mother and baby through smoking in pregnancy and at the time of birth, including stillbirth. Although similar to the regional and England average, the number of women smoking during pregnancy is high in Suffolk.

• Encourage pregnant women to avoid both alcohol and drugs. The number of pregnant women drinking at levels, which present potential or actual danger to both themselves and their unborn child, is unknown.

• Reduce the numbers of women who are overweight or obese prior, during and after pregnancy. The scale of obesity among pregnant women is unknown, although there has been some recent attempt at capturing initial data in West Suffolk, this is unlikely to indicate the full scale of the problem.

• There are currently no health improvement key performance indicators targeting women of reproductive age, e.g. the number of women aged 15-44 years referred to weight loss, smoking cessation or alcohol services by providers.

• There is no consistent approach to communicating healthy lifestyle messages to women of reproductive age in Suffolk, including high risk groups such as young mothers, women living in deprived areas and women with limited education.

• Since the Healthy Schools programme was discontinued and with the increase in the numbers of Academies, there is inconsistent provision of good quality personal, social and health education. Academies are publicly funded independent schools.

• Further improve the coverage of screening and immunisations in pregnant women in Suffolk, and ensure new programmes are rolled out effectively to protect Suffolk families.

**Service implications:**

• In 2014 the Suffolk Maternity Needs Assessment identified a need to review perinatal mental health services, including a clear pathway for staff training and referral. Within Waveney there is a multi-agency perinatal infant mental health pathway and forum in place, a specialist midwife for perinatal mental health services and integrated care plans.
• There appears to be some inconsistent collaborative working between midwives, health visitors, children’s centres and GPs, which could affect the care of pregnant women, as well as the efficiency of the system.

• Pertussis vaccination for pregnant women provides a child more protection in the first few months of life than vaccinating the child directly. Pertussis vaccination is not consistently offered to pregnant women in Suffolk.

**Useful resources:**

- Maternity needs assessment
- State of Suffolk’s Children
- 2014 Annual Public Health Report
EARLY YEARS (0-4)

"Where we live, how we are cared for, the experiences we have, what we eat, see, hear and feel, all affect our health and wellbeing not only as babies and toddlers but on into adulthood. Interventions in early infancy have been shown to produce better outcomes and can improve educational attainment, economic status and health, including mental health."

The estimated number of children aged 0-4 years old in Suffolk (2012)

4,270,000

59%
of Suffolk children achieving a good level of development age 4-5

78%
The percentage of Suffolk mothers starting to breastfeed in 2013/14

22%of all Suffolk 0-4 year olds live in Ipswich

22.1%of children aged 4-5 in Suffolk are overweight or obese

23%increase in the number of live births in Suffolk between 2002 and 2011
Where we live, how we are cared for, the experiences we have, what we eat, see hear and feel, all affect our health and wellbeing not only as babies and toddlers but on into adulthood. We have known for many years that child development and school success are influenced by early experience, but more recent evidence has shown us that it also influences our health as adults, for example breastfeeding reduces the risk of type 2 diabetes in adulthood (Owen et al. 2008 and Liu et al. 2010).

Interventions in early infancy have been shown to produce better outcomes and can improve educational attainment, economic status and health, including mental health. They can also reduce future costs. We know that in Suffolk children achieve less than the national average in educational attainment, and although the underperformance is seen in all ability groups for both boys and girls across Suffolk, those in more deprived areas have worse outcomes than those in affluent areas.

What are we doing well since the last report in 2011?

- Immunisation rates in Suffolk are consistently above the England average.
- The percentage of mothers breastfeeding shortly after birth increased in Suffolk between 2010/11 and 2013/14, from 70.5% to 78.4%. This most recent figure was higher than the equivalent percentages for both the East of England (76.7%) and England (73.9%). However 2012/13 data indicates the percentage of mothers breast feeding 6-8 weeks after birth is lower in Suffolk compared to the national average (45.6% compared to 47.2%) and is also below the regional average (46.6%).
- Breastfeeding services in Waveney have been awarded the UNICEF Baby Friendly Stage 3 (full) accreditation.
- James Paget University Hospital is hoping to obtain UNICEF Baby Friendly stage 3 accreditation, Ipswich Hospital Trust and West Suffolk Hospital Trust applied for UNICEF baby friendly level 2 accreditation, and children and young people’s community services applied for stage 1 to be completed during 2015.
- Health visiting numbers have increased across the county in line with the national guidance which will enable the Healthy Child Programme; the first 5 years of life (DH) to be implemented as a universal offer, with targeted provision to parents who require additional support.
• An Early Help Strategy is being developed in which Suffolk organisations work together to share information and support young people and families from the earliest stages, identifying problems and targeting support where it is needed most.

• School readiness is improving with 59% of children in Suffolk achieving a good level of development at age 5. This represents a 10% increase since 2013 and places the percentage of children within Suffolk achieving this within 1% of national figures. The gap between the lowest 20% achievers and the rest continues to narrow in Suffolk and is slightly narrower than England. We are making progress in this area but sustained improvement is required.

• Making Every Intervention Count (MEIC) is being implemented across the county.

• The oral health project ‘Keep Suffolk Smiling’ will offer targeted advice on good oral health and provision of toothbrushes and toothpaste to children at their 12 month health visiting assessment.

What our population looks like

• There are an estimated 42,700 0-4 year olds in Suffolk.

• There was a 23% increase in the number of live births in Suffolk between 2002 and 2011.

• The largest proportions of 0-4 year olds (as a proportion of the total local authority population) reside in Forest Heath (7.4%).

• Ipswich is our largest town and has the largest numbers of 0-4 year olds (just over 9,500).

• The estimated population of 0-4 year olds in Suffolk is forecasted to decline between 2012-2037.

• By age 4-5, 1 in every 5 children in Suffolk is overweight or obese (22.1%).

Sources: PHE (2015) and Suffolk County Council (2014)

Family composition

The 2011 Census shows that there are around 311,000 households in Suffolk.

Table 5: Households with dependent children

<table>
<thead>
<tr>
<th>Dependent children</th>
<th>All categories: all households</th>
<th>Households with no dependent children</th>
<th>Households with dependent children: total</th>
<th>Youngest dependent child: age 0 to 4</th>
<th>% of households with dependent children where youngest is age 0-4*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Babergh</td>
<td>37,522</td>
<td>27,567</td>
<td>9,955</td>
<td>3,525</td>
<td>35.4%</td>
</tr>
<tr>
<td>Forest Heath</td>
<td>25,376</td>
<td>18,190</td>
<td>7,186</td>
<td>3,290</td>
<td>45.8%</td>
</tr>
<tr>
<td>Ipswich</td>
<td>57,298</td>
<td>40,484</td>
<td>16,814</td>
<td>7,400</td>
<td>44.0%</td>
</tr>
<tr>
<td>Mid Suffolk</td>
<td>40,306</td>
<td>28,977</td>
<td>11,329</td>
<td>4,098</td>
<td>36.2%</td>
</tr>
<tr>
<td>St Edmundsbury</td>
<td>45,802</td>
<td>32,646</td>
<td>13,156</td>
<td>5,242</td>
<td>39.8%</td>
</tr>
<tr>
<td>Suffolk Coastal</td>
<td>53,558</td>
<td>39,679</td>
<td>13,879</td>
<td>4,882</td>
<td>35.2%</td>
</tr>
<tr>
<td>Waveney</td>
<td>50,883</td>
<td>38,010</td>
<td>12,873</td>
<td>4,931</td>
<td>38.3%</td>
</tr>
<tr>
<td>Suffolk</td>
<td>310,745</td>
<td>225,553</td>
<td>85,192</td>
<td>33,368</td>
<td>39.2%</td>
</tr>
</tbody>
</table>

Source: ONS (2013) *(out of all households with dependent children)
39% of Suffolk households with dependent children include a 0-4 year old, meaning there are 33,368 children living in a household where the youngest dependent child is aged 0-4. The highest proportions of households with young children are found in Forest Heath and Ipswich.

The structure of families in England has changed dramatically in the last 50 years. Figures from the ONS show a decline in marriages and an increase in cohabiting couples, with households containing two or more families representing the fastest growing household type.

Numbers of lone parents have increased, 90% of whom are women. There are 6,063 lone parent households in Suffolk where the youngest child is aged 0-4 (ONS 2013) with implications for employment and living standards. Almost 1 in 4 of lone parents in the UK are not in any sort of paid employment, and the universal credit scheme leaves most with an income too low to provide a decent minimum standard of living (Gingerbread 2012). Child deprivation would be potentially much higher if parents were not sacrificing their own living standards for their children’s sake (Economic and Social Research Council 2014).

Children in lone parent families are twice as likely compared to those in couple families to live in relative poverty (Department for Work and Pensions (DWP) 2013). Recent reports have indicated that 40% of single parents were behind on bills, and of single parents in arrears, 64% were at least three months behind on at least one bill (Rabindrakumar 2013). Applying these percentages to Suffolk single parent households would mean that approximately 8,000 lone parent households with dependent children are behind on bills.

Figure 19: Lone parent households in Suffolk, 2011
In Suffolk, lone parents with dependent children are more likely to live in deprived areas. In wards in Suffolk there is a moderate positive (statistically significant) correlation between proportions of lone parents with dependent children and deprivation.

Based on the number of children in low income families, 2012 data indicates that there are 18,905 children in Suffolk aged under 16 living in poverty (PHE 2015). This equates to approximately 15% of children in Suffolk. The proportions are higher in Ipswich and Waveney at 21-22%.

The importance of attachment

Up to 40% (20,000 children in Suffolk) of children do not experience secure attachment (Suffolk County Council 2014a).

This may be a result of stress experienced in either pregnancy or early life, or lack of bonding / attachment between the child and main caregiver. It has a potential impact throughout life, with evidence suggesting it increases the risk of lower educational attainment, an inability to form adult social relationships, increased anxiety and depression and lower self-worth. Please see the glossary for a broad definition of attachment.

The first two years of life is a period of rapid brain growth, which is influenced not only by genetics but by a child’s emotional and physical environment. Our early experiences determine whether our brain architecture provides a strong or weak foundation for all future learning, behaviour and health. The basic building blocks of the brain are constructed and developed through an ongoing process, which begins before birth and continues into early adulthood, although the first three years are the most important as the brain is developing at the greatest rate. From birth to eighteen months, connections in the brain are connected at a rate of one million per second (see figure 20).
Primary caregivers who are dependable, available and responsive to their babies needs are able to create a secure base for their child to explore the world and enable them to develop a sense of security and resilience throughout life.

Young children naturally reach out for interaction through babbling, facial expressions and words. Adults interact with responsive vocalising and gesturing. This goes back and forth like a game of tennis, and it is these experiences which have a direct effect on the child’s brain structure and function. The development of these first skills provides the infrastructure for emotional stability to develop and grow through their childhood (Centre on the Developing Child, 2007).


Figure 20: 1001 critical days


Figure 21: Brain development and neglect

Source: HM Government (2011)
Insecure attachment is associated with delayed language development, challenging behaviour, aggression, hyperactivity and defiance. As they grow older the young person is more likely to; not be in employment, education or training (NEET); have poorer employment opportunities, lifestyle and health outcomes; a higher risk of alcohol and substance misuse and more likely to be in the criminal justice system. They are more likely to suffer mental health problems, particularly those related to controlling emotions, and less likely to be able to form lasting relationships. Figure 21 illustrates the impact of neglect throughout life in terms of brain development, and taxpayer costs.

When a caregiver regularly ignores the child's emotional needs, 25% of children will learn to avoid their parent when they are distressed (Moullin et al. 2014). If the caregiver responds in an unpredictable manner to the child's distress a further 15% of this subgroup will learn to resist them.

**Suffolk Family Focus**

There are 1,150 families in Suffolk that fall into the Government's definition of a troubled family. These families are usually well known to different services and are often prominent in their neighbourhoods where they are more likely to be involved in crime and antisocial behaviour.

Troubled families are defined as those who meet three of the following criteria:

- Are involved in youth crime or antisocial behaviour.
- Have children who are regularly truanting or not in school.
- Have an adult on out-of-work benefits.
- Cause high costs to the public purse (often families who are involved with many different agencies).

The main focus is to work with families who have multiple high cost problems, and prevent further problems from escalating. This includes intervention programmes, and empowering and supporting families to change their entrenched behaviour.

Priorities for action:

- Early intervention and prevention
- Promoting a family focus across the work of all agencies including support to Suffolk Family Focus
- Supporting parents to improve their own circumstances

**Table 6: Number of Suffolk Family Focus families**

<table>
<thead>
<tr>
<th>Year</th>
<th>Families worked with</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012/2013</td>
<td>428</td>
</tr>
<tr>
<td>2013/2014</td>
<td>577</td>
</tr>
</tbody>
</table>

Source: Suffolk County Council (2014a)
The expanded national Troubled Families Programme which started in January 2015 allows all cases that come to the notice of Children and Young People’s Services to potentially be an identified Suffolk Family Focus family.

The new challenge set by the DCLG is to work with 3,950 families over the next 5 years, and collect a greater amount of data and information on the families we work with. This will lead to a greater understanding of the issues each family has and the interventions that have been effective.

**Supporting parenting**

Quality of parenting affects children’s long-term physical, emotional, social and educational outcomes and therefore the differences in parenting between social groups have implications for health inequalities (PHE 2014). Parenting interventions could reduce inequalities in health across the social gradient if they result in better living conditions for families, higher maternal wellbeing, good parenting actions, or improved outcomes for children (Tameside & Glossop 2011). Effective parenting programmes are training programmes shown to improve the quality of parent-child relationships, and improving the skills of parents in managing child behaviour (Parsonage 2014). They can also improve the mental health and wellbeing of the parents involved, sibling behaviour (Parsonage 2014), and improve family relationships.

**Evidence suggests that good parenting actions will result in:**

- More children with secure attachment: more parents engaging positively with, and actively listening to, their children.
- An increase in the number and frequency of parents regularly talking to their children using a wide range of sentence structures and reading to their children every day.
- More parents setting and reinforcing boundaries.
- Improved cognitive, social and emotional, language and physical health outcomes.
- The positive effect of parenting interventions on outcomes and behaviours, which are linked to positive health and developmental outcomes for children.
- Mothers’ actions are important from a very early stage and parental circumstances can have an important influence on parenting ability.

(UCL Institute of Health Equity 2014)

There are many services across Suffolk, delivered by a range of organisations. The Parenting Coordinators Team works in partnership to make the most effective use of resources and provide choice for parents. Across Suffolk 98 parenting programmes were run in 2013 (although not all are evidence based programmes). The Parenting Coordinators team received approximately 1,200 referrals across all programmes. Details of the programmes are available at (www.suffolk.gov.uk/theparenthub).

**Free early learning for 3 and 4 year olds**

Early education enables children to play and learn together, whilst they are supported by qualified professionals. They take part in fun, interesting and challenging play activities,
both indoors and outdoors. This supports them to develop the skills they need to do well in school and further education, in order for them to develop into healthy and achieving adults.

All children, regardless of family circumstances, are eligible to receive free early education from the term after their third birthday. This continues until they start school full time. Each child is entitled to 15 hours of free early learning each week for up to 38 weeks a school year. Some childcare providers can offer a ‘stretched offer’ for example 11 hours for 50 weeks.

The uptake of 3 and 4 year old children benefiting from funded early education places (as at January 2014) is lower than the England average.

From September 2014, 40% of the 2 year old population are eligible for a free early education place in the same way as the universal offer for 3 and 4 year olds. Take up of the 2 year old offer in Suffolk is growing; 1,850 children accessed a place in December 2014 out of an estimated 2,721 children who were eligible (68%).

<table>
<thead>
<tr>
<th>Area</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>97%</td>
</tr>
<tr>
<td>East of England</td>
<td>97%</td>
</tr>
<tr>
<td>Suffolk</td>
<td>93%</td>
</tr>
</tbody>
</table>

Source: Department for Education (DfE) (2014)
Local figures are not known but national research suggests that approximately 1 in 10 children experience a SLCN (primary and secondary need) (Law et al. 2000), which is equivalent to 4,300 children aged 0-4 in Suffolk and 14,000 children aged between 0-16. This compares to 1,800 children and young people in Suffolk with a primary or secondary statement relating to SLCN in 2014. This number is considerably lower than the estimated 14,000 children with needs. It could be explained by children experiencing sub clinical difficulties, no longer requiring a statement due to their difficulties resolving in pre-school years or the SLCN not being identified.

In Suffolk, there continues to be challenges in relation to accessing speech and language therapy, with the demand for services exceeding provision. This inevitably means that some children may not get the help they need in a timely manner and could lead to the adverse outcomes identified above later in life. Partners across Suffolk are working together to develop services which support the needs of the children, their families and enhancing the skills, knowledge and understanding of professional working within them. As part of this, a need for universal training has been identified with plans in place to develop training packages and toolkits in the future.

**Breastfeeding**

Breastfeeding is good for mothers and babies. It helps bonding and attachment, provides babies with the essential nutrients to thrive and contains antibodies to fight infections.

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Table 8: A summary of SLCN outcomes

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental health</td>
<td>Poor communication has been shown as a risk factor for mental health problems. Without effective help a third of children with speech, language and communication difficulties need treatment for mental health problems in adult life.</td>
</tr>
<tr>
<td>Behavioural and emotional difficulties</td>
<td>60-95% of children and young people with Social, Emotional and Behavioural Difficulties (SEBD) have communication problems which may go unrecognised within the UK.</td>
</tr>
<tr>
<td>Criminal justice</td>
<td>There is strong relationship between children with SLCN and youth crime (ICAN 2006) with 40-60% of children involved with the criminal justice system experiencing some form of SLCN.</td>
</tr>
<tr>
<td>Educational achievement</td>
<td>SLCN can have a significant impact on educational attainment with a larger proportion of children with SLCN excluded from school for committing physical assaults.</td>
</tr>
<tr>
<td>Employment</td>
<td>SLCN are associated with adverse employment histories with breaks in employment, redundancy, unemployment and interpersonal difficulties at work.</td>
</tr>
</tbody>
</table>

Sources: Clegg et al. (1999), Crew and Ellis (2008), Snowling et al. (2010) and Cross (2011).
off illness. The World Health Organisation (WHO) recommends that babies are breastfed exclusively for the first 6 months of their life and are fed on demand.

Suffolk data for the 2013/14 financial year shows that the proportion of mothers starting breastfeeding at birth is above the England average (78.4% for Suffolk and 73.9% for England), at 6-8 weeks the proportion of women breastfeeding is lower than the England average. This indicates that there is still much room for improvement. There are inequalities in breastfeeding across the county with higher rates in some areas compared to others. Areas of high deprivation have the lowest prevalence of mother’s breastfeeding at 6-8 weeks.

Figure 22: Breastfeeding at 6-8 weeks CCG Data 2013/14

Source: Suffolk County Council (2014a)
**Immunisation**

Immunisation has transformed maternal and child health almost eliminating deaths from diseases like measles and serious disability from polio and rubella. Immunisation not only protects children from illness but also stops them from spreading the infection to other children, too sick or too young to be immunised themselves. During 2014, in addition to the routine immunisations, new targeted Measles Mumps and Rubella (MMR) and Meningitis C programmes for children and a new flu immunisation programme for 2 year olds were introduced. There are further developments planned to the influenza and rotavirus immunisation programme in the near future, offering improved protection.

Immunisation data for Suffolk suggests that immunisation rates are better than the England average overall. 2012/13 data shows:

Table 9: Immunisation Data, 2012/13

<table>
<thead>
<tr>
<th>Immunisation Type</th>
<th>Suffolk %</th>
<th>England %</th>
<th>Target %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dtap / IPV / Hib vaccination (1 year old)</td>
<td>96.6%</td>
<td>94.7%</td>
<td>95%</td>
</tr>
<tr>
<td>Dtap / IPV / Hib vaccination (2 years old)</td>
<td>96.9%</td>
<td>96.3%</td>
<td>95%</td>
</tr>
<tr>
<td>Meningitis C vaccination</td>
<td>96.0%</td>
<td>93.9%</td>
<td>95%</td>
</tr>
<tr>
<td>Meningitis C 2yr booster</td>
<td>95.5%</td>
<td>92.7%</td>
<td>95%</td>
</tr>
<tr>
<td>Meningitis C 5yr booster</td>
<td>93.3%</td>
<td>91.5%</td>
<td>95%</td>
</tr>
<tr>
<td>PCV vaccination</td>
<td>96.1%</td>
<td>92.7%</td>
<td>95%</td>
</tr>
<tr>
<td>PCV vaccination 2yr booster</td>
<td>95.0%</td>
<td>91.5%</td>
<td>95%</td>
</tr>
<tr>
<td>MMR vaccination (1 dose 2yrs)</td>
<td>93.9%</td>
<td>92.3%</td>
<td>95%</td>
</tr>
<tr>
<td>MMR vaccination (1 dose 5yrs)</td>
<td>93.4%</td>
<td>93.9%</td>
<td>95%</td>
</tr>
<tr>
<td>MMR vaccination (2 doses 5yrs)</td>
<td>89.4%</td>
<td>87.7%</td>
<td>95%</td>
</tr>
</tbody>
</table>

*Source: PHE (2014a)*
Developing a healthy lifestyle

We know physical activity is important throughout life for good health. Inactivity contributes to obesity, long-term health conditions and premature death (PHE 2013). There is also a proven link between active mothers and active children. A recent Southampton based study found a direct and significant association between physical activity levels and sedentary time in British children (at 4 years) and their mothers (Hesketh et al. 2014). Although the study was primarily looking at mother and child activity it notes that health promotion efforts should consider inclusion by the whole family i.e. dads and siblings. The study found that only 53% of mothers engaged in 30 minutes of moderate-to-vigorous activity (at least once a week).

It is important that a child has a healthy balanced diet. This includes consuming a variety of different fruit and vegetables; the recommendation is 5 portions of fruit and vegetables a day. Although data indicates that children aged 1.5-3 years were the highest consumers of ‘fruit’ compared to other age groups (PHE 2014b), other research suggests that only 1 in 5 children in the UK eat their recommended 5 a day (British Heart Foundation 2013).

Overweight and obese children aged 4-5 years old

Overweight and obese children are more likely to become overweight or obese adults, with an increased risk of developing earlier health problems even in childhood (Government Office for Sciences 2007). Although rare, child-specific health problems resulting from obesity include early puberty, type 2 diabetes, anorexia and bulimia, hip pain, and bowing of the lower legs (Suffolk County Council 2014a). The National Child Measurement Programme (NCMP) is a nationally mandated public health programme, and is part of the Government’s approach to tackling child obesity. Children are weighed and measured in reception and year 6.

Findings from 2013/14 indicate:

- By age 4-5, 1 in every 5 children in Suffolk is overweight or obese (22.1%).
- Although this figure is similar to the England average (22.5%), this is still a cause for concern due to the impact it will have in later life.
- It is apparent that efforts must be directed at preventing and tackling excess weight and obesity at the pre-school age, since a high proportion of children are already obese or overweight by the time they start Reception class.
Local authority obese and overweight data is presented below. Waveney has a consistently higher prevalence of overweight children in reception year at school. Child weight management services are available to all Suffolk children identified as being overweight or obese.

Figure 24: Local authority prevalence of overweight including obese, reception year, 2008-2014

Source: Public Health England (2015a). Note: Axis does not start at zero

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**Figure 23: Percentage of children overweight or obese at age 4-5 years in Suffolk (2013/14)**

Note: underweight value not charted as too small (0.49%). Source: Public Health England (2015a)
Smoking

The ban on smoking in public places significantly reduced the harm caused by second-hand smoke but children are still at risk of harm if there is smoking in cars and their homes. If someone smokes inside a car the concentration of second-hand smoke increases very quickly due to the confined space, even if windows are open or air conditioners are used. Following an MP vote, smoking in cars with children will be banned in England from October 2015.

Children whose parents smoke but who live in a smokefree home have lower cotinine levels (a metabolite of nicotine, that can indicate exposure to tobacco smoke) (0.35ng/ml) compared to children living in a home where smoking is permitted inside (1.58ng/ml). This indicates a reduced risk of harm for children living in smokefree homes (Jarvis et al. 2011). Young adults who lived in smokefree homes as children are more likely to prefer to live in smokefree accommodation once they leave home (Rigotti et al., 2009).

Table 10: Estimates of incidents of childhood disease attributable to secondhand smoke (SHS)

<table>
<thead>
<tr>
<th>Disease type</th>
<th>Age range (years)</th>
<th>Estimated Suffolk events attributable to second hand smoke</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lower respiratory infections</td>
<td>2 and under</td>
<td>598</td>
</tr>
<tr>
<td>Middle ear infections</td>
<td>0-16</td>
<td>2,350</td>
</tr>
<tr>
<td>Wheeze</td>
<td>2 and under</td>
<td>275</td>
</tr>
</tbody>
</table>

Source: Locally derived figures based on Royal College of Physicians (2010)

An estimated 112 children in Suffolk aged 0-14 were admitted to hospital as a result of specified diseases attributed to passive smoking in 2011.

This figure has been calculated by applying 2011 UK estimates to 2011 Census population figures for Suffolk, with the UK figures coming from Cancer Research UK (Cancer Research 2013).

Based on national figures from a Royal College of Physicians (2010) report, it is estimated that there are 3,223 additional incidents of childhood disease each year within Suffolk directly attributable to the effects of second hand smoke (see Table 10).
Key issues

Inequalities:

- Suffolk is reasonably affluent overall, but has significant pockets of rural and urban deprivation. There is robust and compelling evidence to support a co-ordinated and sustained approach to tackling deprivation and poverty in Suffolk. There are 18,905 children under 16 living in poverty. In addition, there are over 6,000 lone parent households where the youngest child is under 4, who are more likely to live in deprived areas.

- Fewer babies who live in deprived areas are breastfed compared to more affluent areas.

- Obesity at school entrance age is rising (20.1% 2013 to 22.1% 2014).

- The percentage of obese children is higher in the most deprived areas compared to the least deprived areas (see Figure 8).

- 59% of children in Suffolk achieve a good level of development at the end of reception with a lower percentage of children with free school meal eligibility status achieving the same standard (see Figure 8). Although this is improving this is still worse than the national level.

Opportunities for prevention:

- There is compelling evidence to support a co-ordinated and sustained approach to tackling deprivation and poverty in Suffolk.

- Promote the benefits of secure attachment. The first 1001 Critical Days (NSPCC 2014) highlights the importance of pregnancy and the first two years of life for the developing child. Early experiences determine whether the brain architecture provides a strong or weak foundation for all future learning and behaviour. Up to 20,000 children in Suffolk do not experience secure attachment, with a potential impact throughout life, including lower educational attainment, and the inability to form strong adult social relationships, increased anxiety, depression and lower self-worth.

- Ensure that interventions to support parenting are delivered early for maximum benefit. Supporting parents in their parenting can improve life chances. The number of referrals to parenting programmes is small in relation to the potential number of children with insecure attachment. A range of evidence based, well-facilitated interventions, delivered as early as possible when problems arise, will contribute to the best outcomes for children and their families.

- Increase the number of babies who are breastfed in Suffolk. Although the number of women breastfeeding their babies at six weeks has improved in the past few years, less than half of babies born in Suffolk are breastfed at 6-8 weeks.

- Encourage preschool children in Suffolk to be active for 3 hours over the course of a day. There is very limited data available on activity rates in young children, but the number of under-fives who meet recommended levels of physical activity can be increased by ensuring parents, early-years professionals and practitioners understand the type and amount of physical activity under-fives should do to benefit their health.
• Ensure children have every opportunity to maximise their physical and cognitive development to ensure they are ready for school. 41% of children in Suffolk do not achieve a good level of development at age 5. Despite progress this is still an issue which requires sustained improvement to maximise the child’s potential for educational attainment and life chances. The percentage of 3 and 4 year old children benefiting from funded early education places (as at January 2014), is lower than the England average.

• Children born now are likely to have a greater life expectancy than previous generations, but potentially more years with ill health, including long-term conditions, cancers and dementia, which will place pressure on the NHS and other services. The 0-5 Healthy Child Programme, Making Every Intervention Count and Making Every Contact Count, help promote lifestyle choices, as well as giving clear messages in early years settings.

• Suffolk will continue to see additional episodes of childhood disease each year within Suffolk, directly attributable to the effects of second hand smoke.

• Prevent children from being exposed to tobacco smoke. Increasing the number of smoke-free homes and cars within the county will decrease episodes of childhood illness.

**Service implications:**

• The number of children and young people with a speech, language and communication need is currently estimated (as approximately 16,000 0-18 year olds) and there is insufficient data available to improve accuracy.

• There continue to be challenges in the provision of speech and language therapy in relation to the level of clinically assessed need, with the demand for services still exceeding NHS provision. Access to Speech and Language Therapy services has long waiting times which may be due to resources or the complexity of the children referred to its service.
Educational disadvantage starts from a very young age and can have a profound impact across a person’s life course. Childhood and adolescence is a key period of physical and emotional development and it is important that the foundation for living and ageing well becomes established, with emphasis on a healthy lifestyle, including being physically active and eating well.

- 12.4% of 5-15 year olds in Suffolk in 2012 (90,700)
- 14.1% of students from a Minority Ethnic group in Suffolk state funded primary schools
- 83% of young people in Suffolk own a smartphone
- 31.7% of children aged 10-11 in Suffolk are overweight or obese
- 7 children age 11-14 in Suffolk start smoking every day
The experience children aged 5-15 have in the education system and the lifestyle they lead will have a lasting impact for the rest of their lives, and educational disadvantage can start from a very young age and can have a profound impact across a person's life course. In Suffolk, levels of attainment have been comparatively poor in recent years when looked at in relation to regional and national neighbours.

There is strong evidence to support the link between education, health and wellbeing (PHE 2014):

- Pupils with better health and wellbeing are likely to achieve better academically.
- Effective social and emotional competencies are associated with greater health and wellbeing, and better achievement.
- The culture, ethos and environment of a school influences the health and wellbeing of pupils and their readiness to learn.
- A positive association exists between academic attainment and physical activity levels of pupils. With children and young people who are aerobically fit achieving higher academic scores.

There is also an association between the proportion of adults with no qualifications and the proportion of children failing to achieve good levels of attainment. There is evidence to support an association between economic deprivation and poor health outcomes.

Educational attainment is a highly significant factor in determining the social wellbeing and consequent health of the population. In Suffolk, around a quarter of the variation in GCSE attainment can be accounted for by the deprivation level of the pupil home which is nearly 46% for children at KS2 (age 7-11) (Suffolk County Council 2014). There is a gap in health and educational outcomes between people living in the most affluent and deprived areas of Suffolk that will continue throughout life unless this is addressed.

Children in vulnerable groups can have significantly lower levels of qualifications than the general child population which are further hampered where overall school population attainment is low. Risk factors can be identified as persistent absence, exclusion, lack of parental involvement and lack of aspiration. All of these areas are recognised in the Raising the Bar recommendations and need to continue to be addressed as part of the ongoing work to improve school attainment in Suffolk.

Childhood and adolescence is a key period of physical and emotional development and it is important that the foundation for living and ageing well becomes established, with emphasis on a healthy lifestyle, including being physically active and eating well. Taking up sport as a child or young person, for example, is associated with an increased likelihood of physical activity in adulthood, and a reduced likelihood of diseases associated with physical inactivity (Centre for Economics and Business Research 2014).

Focusing on the emotional health and wellbeing of children is a long standing national and local priority. Early intervention and preventative approaches can reduce issues escalating later in life.
What are we doing well since the last report in 2011?

- Raising the Bar was launched in 2013 with the following strategic objectives:
  - Every child reaches their potential
  - Every child attends a good or outstanding school
  - Every child is given the best preparation for life before and beyond school
- The school nursing service is commissioned by public health with a service specification, which reflects evidence based outcomes.
- The first evidence based lifestyle survey was offered to pupils in primary and secondary schools in 2014. Although only 5 secondary schools and 14 primaries took part in the first year, it is expected that numbers will increase over the next few years. The intention is to provide Suffolk with a longitudinal study of lifestyle behaviours in young people.
- We are improving integration of health and social care by joining up children and young people's services (Making Every Intervention Count).
- 3,000 primary school children in Suffolk have received free swimming opportunities through an outreach programme linked to the great East Swim.
- 2,000 schoolchildren took part in the Go Run for Fun programme which came to Suffolk in 2014.
- Six Doorstep Sports Clubs have been established in areas of deprivation in Lowestoft and Ipswich to encourage physical activity from an early age.
- Livewell and East Coast Community Healthcare support family based programmes to increase physical activity, good nutrition and weight loss for children who are overweight or obese.
- A strategy addressing poverty in Suffolk is in development.

What our population looks like

- There are an estimated 90,700 5-15 years old in Suffolk, the proportion (12.4%) of the total population is similar to the England average of 12.6%.
- The percentage of 5-15 year olds living in the District /Borough populations is similar across the county ranging from 11.7% in Waveney to 12.9% in Babergh.
- Ipswich is our largest town and has the largest numbers of 5-15 year olds (just under 17,000 individuals).
- The population of 5-15 year olds is forecasted to increase by 4.7% (4,300 individuals) between 2012-2037.
- The number of school aged children and young people is growing as the county sees spikes in localised population growth, net increases in immigration and a large amount of new developments for the revitalised housing market. Pupil forecasts show the total school population will increase by over 4,500 (5%) in the next 5 years (primary age increasing to over 6%; secondary starting to increase in the
next couple of years and continuing for at least the next 10 years). Within this growth there are particular growth ‘hot spots’ such as Ipswich, North Lowestoft and Forest Heath.

Sources: ONS (2013), Suffolk County Council (2014a) and Suffolk County Council (2015)

Ethnicity and first language

Data from the 2014 School Census shows that in Suffolk 14.1% of primary school pupils and 10.1% of secondary school pupils in state funded schools were from Minority Ethnic Groups. This is the equivalent of 6,028 primary school pupils and 4,521 secondary school pupils. Just over 100 (110) pupils attending Special Schools in Suffolk were from Minority Ethnic Groups, accounting for 13.4% of all pupils attending Special Schools (DfE 2014).

Pupils from ‘Other White’ and ‘Mixed’ ethnic groups account for 4.3% and 4.7% of all pupils respectively in Suffolk (whether at primary, secondary or special schools). Pupils from an Asian background make up 1.6% of all Suffolk pupils, with those from Black and Chinese groups accounting for under 1% of pupils (DfE 2014).

January 2014 data for Suffolk (DfE 2014) indicates:

• In state funded primary schools 14.1% of students were from a Minority Ethnic Group (England value: 29.5%).

• In state funded secondary schools 10.1% of students were from a Minority Ethnic Group (England value: 25.3%).

• In Ipswich 7.6% of individuals speak a primary language other than English.

• 7.4% of primary school pupils and 5.0% of secondary school pupils (state funded) in Suffolk have a first language other than English.

• Polish is the most frequent non-English language spoken, with Portuguese also spoken by a relatively large number of people.

• There are 855 households where only the children speak English as a first language, and may therefore be relied upon as interpreters, within their families and communities. 2011 Census data indicates the highest concentrations occur predominantly in Ipswich, where 350 households were identified (ONS 2013a).

Poverty

Suffolk can be perceived as a relatively affluent county where there is little poverty. However, although there are not large areas of deprivation, pockets of poverty are present, and these are strongly associated with poorer life chances and poorer health. Professor Peter Townsend, a leading authority defines this as ‘relative poverty’, when:

“...resources are so seriously below those commanded by the average individual or family that they are, in effect, excluded from ordinary living pattern.”

(Townsend, 1979)

• Suffolk data from October 2014 indicates that based on tax credit data, (used to estimate the percentage of children on low incomes) 13.3% of children are
below the poverty line, this rises to 21.1% when housing costs are considered (End Child Poverty 2014). The proportions are higher in Ipswich and Waveney. Ward data indicates that the following have the highest proportions of under 16 year olds below the poverty line including housing costs: Yoxford in Suffolk Coastal (39.0%), Normanston in Waveney (38.8%) and Kyson in Suffolk Coastal (37.4%) (End Child Poverty 2014).

- As mentioned in the early years section, based on the number of children in low income families, 2012 data indicates that there are 18,905 children in Suffolk aged under 16 living in poverty (PHE 2015). This equates to approximately 15% of children in Suffolk. The proportions are higher in Ipswich and Waveney at 21-22%.

- There is a strong link between poverty and poor health, educational and social outcomes.

- Children in more deprived areas can also experience higher levels of mental ill health, especially conduct (behavioural) and emotional disorders. This is particularly evident in vulnerable groups like Looked After Children, children with learning disabilities and difficulties and young offenders.

Figure 25: Increasing inequalities diagram

As Suffolk children grow so do inequalities in educational and health outcomes.

Source: Adapted from Suffolk County Council (2014a)
By age 5, at a national level, there are already clear differences in achievement between the poorest children and their better-off counterparts, with strong associations between a child's social background and their readiness for school, as measured by their scores on entry into Year 1.

Most notably the gap in outcomes between children in deprived vs non-deprived areas increases with age. Recently published data indicates that there are 45 Suffolk wards with at least 25% of children in poverty after housing costs (approximately ¼ of all Suffolk wards) (End Child Poverty 2014). As mentioned earlier, Yoxford ward (in Suffolk Coastal) has the highest percentage - with 39% of children in poverty after housing costs. This is not seen as a 'stereotypically deprived' area of Suffolk and reaffirms that there will be some deprived people living in more affluent areas.

A recent report on the true impact of poverty on school life (Holloway et al. 2014) highlighted the impact of poverty in relation to:

- School meals
- School uniforms
- Cost of materials and trips

A key finding was:

“Across the country, millions of families are struggling with the cost of school life, leading to too many children missing out on the opportunity to make the very most of their education. The findings of this inquiry show that the impact of school costs is leading to children feeling embarrassed, bullied and excluded because they cannot afford the same things as their peers”.

(Holloway et al. 2014)

Figure 26 below illustrates; children from lower socioeconomic status (SES) groups that performed well initially on tasks (cube stacking and language use at 22 months) were, on average, overtaken by others from higher socio-economic groups by the time they commenced their primary school education.

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Figure 26: Differential trajectory of children by socio-economic group from 22 to 118 months

The impact of housing

Poor quality housing can also have detrimental effects on children. Factors such as central heating, damp accommodation, overcrowding and living in a house of multiple occupation can all adversely affect physical, social, and psychological development. The impact of poor housing can affect a child for a lifetime (Harker 2006).

People living in poverty are more likely to live in poor quality housing, which can have detrimental effects on children.

Census data indicates there are approximately 1,500 children in Suffolk age 0-15 with no central heating in their household. There are approximately 10,500 children aged 0-15 in Suffolk living in households where there is at least one fewer rooms/bedrooms than the family need.

In addition to daily activities such as the ability to cook and wash, overcrowding contributes to conflict within the family and for young people the ability to have space to do their homework and relax (4children 2013).

Free school meals and pupil premium

The pupil premium is additional funding given to schools to raise the attainment of disadvantaged pupils and close the achievement gap between them and their peers. It is currently paid to schools and was extended to Early Year and Childcare settings in April 2015.

At present eligibility for free school meals, or previous eligibility in the last six years is used as the main measure of deprivation at pupil level. This will have to be replaced by a new measure as every child in early years becomes eligible for a free school meal each day.

In 2014/2015, Suffolk schools received the following funding for each child registered as eligible for free school meals at any point in the last 6 years:

• £1,300 for primary-aged pupils
• £935 for secondary-aged pupils

In 2011/12, the proportion of primary school pupils in Suffolk eligible for and claiming free school meals was 13.6%, lower than both the regional and national figures. The same trend is noted within figures for secondary schools, where 9.8% of Suffolk pupils are eligible and claiming free school meals, compared to 11.2% in the East of England, and 16.0% in England.

Looked After Children

Looked After Children (LAC) are some of our most vulnerable children, who have been placed in residential or foster care following removal from their home environment to ensure their safety. They become the responsibility of the local authority and require an environment which enables them to have the same opportunities as their peers, including being healthy, safe and given the opportunity to move successfully into adulthood (NSPCC 2015).

Key facts:

• 726 Looked After Children (LAC) in Suffolk (March, 2014)
• 9% of LAC are not up to date with vaccination programmes (March, 2012)
• 42% of LAC had not received their regular dental check

• 36% of LAC (compared with 75% of the general Suffolk population) achieved a level 4 or above in Key Stage 2 assessment in 2012

• 23% of LAC in Suffolk entered for GCSEs achieved at least 5 A-C grades in 2012 (compared to just under half the general population)

• National data indicates 45% (327) of LAC in Suffolk are likely to suffer from a diagnosable mental health problem, compared to 8-11% of the general child population

There is strong evidence to suggest that LAC have poorer health, welfare and social outcomes. Levels of mental ill health are significantly above those of the general child population, while levels of educational attainment are significantly lower (Suffolk County Council 2014).

NICE evidence (NICE n.d.) suggests that 45% of LAC have a diagnosable mental health condition compared with 8-11% of the general child population. There is also evidence that LAC experience reduced rates of uptake to interventions to protect health such as immunisation programmes (Hill, Mather and Goddard, 2003) and dental health checks (Poynor and Welbury, 2004). Looked After Children are also at risk of achieving lower educational attainment than the general child population.

Elected members have a duty of care towards Looked After Children, a key role in ensuring that the interests of Looked After Children are of high priority, and to provide support that puts their needs first as they are in loco parentis. The need for protection, safety and where necessary timely, intelligent intervention is the same as any child, in any family, needs from their parents – whether biological, adoptive or corporate (DfE 2013).

**Children in Need (CIN)**

Children in Need (CIN) are defined as those who are aged under 18 and:

• Need local authority services to achieve or maintain a reasonable standard of health or development

• Need local authority services to prevent significant or further harm to health or development

• Or he/she is disabled.

*(Section 17(10) of the Children Act 1989)*

Suffolk statistics (2014) indicate:

**At the end of March 2014 there were**

3,489

Children in Need (CIN) in Suffolk

(Source: DfE (2015))
Raising the Bar aims to improve aspirations and achievement of all children and has encompassed the specific needs of vulnerable children.

**Children with additional needs**

The government’s Special Educational Needs and Disabilities (SEND) Reforms Programme is designed to transform the current education system for children and young people with special educational needs (SEN) and disabilities. The Children and Families Act 2014 and the 0-25 Code of Practice underpin the reforms. In Suffolk, we want all children and young people to receive an education that enables them to:

- Achieve their best
- Become confident individuals
- Make a successful move into adulthood, whether into employment, further or higher education, or training.

Suffolk set up a multi-agency working group to consider requirements arising from the Children and Families Act 2014 as well as work streams relating to Special Educational Needs Reform, developing a coordinated response and embedding the requirements of the reforms.

A total of 8,950 Suffolk children in state funded primary, secondary and special schools had a statement of special educational need in January 2014. A percentage breakdown by primary type of need is provided below. Please note some totals do not sum to 100% due to rounding. These are only children of school age, with an identified need, and are therefore likely to underestimate the true level of those with a difficulty or disability.

<table>
<thead>
<tr>
<th>Suffolk</th>
<th>Total Number of those with a recorded difficulty or disability</th>
<th>State-Funded Primary Schools</th>
<th>State-Funded Secondary Schools</th>
<th>Special Schools</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total Number of those with a recorded difficulty or disability</td>
<td>4,570</td>
<td>3,465</td>
<td>915</td>
</tr>
<tr>
<td></td>
<td>Hearing Impairment %</td>
<td>1.6</td>
<td>2.9</td>
<td>0.4</td>
</tr>
<tr>
<td></td>
<td>Visual Impairment %</td>
<td>0.9</td>
<td>2.0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Multi-Sensory Impairment %</td>
<td>0.3</td>
<td>x</td>
<td>0.5</td>
</tr>
<tr>
<td></td>
<td>Physical Disability %</td>
<td>3.3</td>
<td>4.1</td>
<td>6.0</td>
</tr>
<tr>
<td></td>
<td>Autistic Spectrum Disorder %</td>
<td>7.7</td>
<td>12.0</td>
<td>12.8</td>
</tr>
<tr>
<td></td>
<td>Learning Difficulty (any severity) %</td>
<td>26.1</td>
<td>34.5</td>
<td>76.7</td>
</tr>
<tr>
<td></td>
<td>Other Difficulty/Disability %</td>
<td>60.3</td>
<td>44.5</td>
<td>3.3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>England</th>
<th>Total Number of those with a recorded difficulty or disability</th>
<th>341,405</th>
<th>233,935</th>
<th>99,760</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Hearing Impairment %</td>
<td>2.3</td>
<td>3.0</td>
<td>1.4</td>
</tr>
<tr>
<td></td>
<td>Visual Impairment %</td>
<td>1.3</td>
<td>1.7</td>
<td>0.8</td>
</tr>
<tr>
<td></td>
<td>Multi-Sensory Impairment %</td>
<td>0.2</td>
<td>0.1</td>
<td>0.2</td>
</tr>
<tr>
<td></td>
<td>Physical Disability %</td>
<td>4.1</td>
<td>4.0</td>
<td>3.5</td>
</tr>
<tr>
<td></td>
<td>Autistic Spectrum Disorder %</td>
<td>8.3</td>
<td>10.7</td>
<td>22.5</td>
</tr>
<tr>
<td></td>
<td>Learning Difficulty (any severity) %</td>
<td>29.5</td>
<td>36.9</td>
<td>52.0</td>
</tr>
<tr>
<td></td>
<td>Other Difficulty/Disability %</td>
<td>54.3</td>
<td>43.5</td>
<td>19.6</td>
</tr>
</tbody>
</table>

Source: DfE (2014a)
**Signs of Safety**

The Signs of Safety approach to deliver transformational change for children has been adopted by Suffolk and has secured additional grant funding from the Department for Education Innovations programme in 2014. It signals a strong commitment to working differently with children and families.

Successful and sustainable change in family intervention work is based primarily on two key factors:

- What the family themselves bring to the table.
- The relationships they have with the professionals working with them (McKeown 2000).

Working collaboratively, openly and honestly with the family, using skilled questioning to understand the concerns from all perspectives, and keeping the child’s interests central, gives a much richer and deeper understanding of what is needed to produce a better outcome for the child. Significantly, it is proving to be more engaging for families – even where there has previously been resistance – and is empowering families to take control of their own lives and the future of their children.

Implementing this new way of working is a multi-year endeavour which is reaching out to partner agencies in all sectors through an expanding programme of awareness and training sessions and joint working groups.

Information and practice examples are shared on the Local Safeguarding Children Board website (Suffolk Safeguarding Children Board 2015). University Campus Suffolk has been engaged to provide an impact evaluation of the programme.

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**Useful resource:**

Signs of Safety: information about the origins and world-wide practice base is available here: [www.signsofsafety.net](http://www.signsofsafety.net)

**Hidden Harm**

The Suffolk definition of Hidden Harm is: The harm experienced by a child or young person living with parents/carers or other significant family member as a result of that adult’s substance misuse or poor parental mental health or as a result of domestic abuse within the family setting. This definition recognises that these factors may result in the child / young person taking on the role of “young carer”. A range of services to address Hidden Harm are in place and are being further developed as a collaboration between Suffolk County Council, the voluntary sector and mental health services.

**Education**

**Raising the Bar**

Whilst there have been improvements in educational attainment, Suffolk remains below the national average. This has been identified as a priority within the county and Raising the Bar (RtB) which was launched in 2012 to ensure a joined-up approach between schools, school governors, local authorities, early years providers, the VCS and other providers. It aims to ensure everybody understands their own valuable contribution towards supporting young people to gain the skills and qualifications that will help them be successful in the future.
Raising the Bar has the following priorities:

- Improving schools
- Learning Partnership
- Teacher recruitment (to be led by the Learning Partnership)
- Work inspiration

The national curriculum Key Stages of education:

What are the Key Stages?

The National Curriculum is divided into four Key Stages that children are taken through during their school life. For example, Key Stage 1 is taught during Years 1 and 2 of primary school. Targets defined in the National Curriculum are assessed at the end of each Key Stage. Prior to Key Stage 1, the early years foundation stage (EYFS) sets standards for the learning, development and care of children from birth to 5 years old.

The four Key Stages

<table>
<thead>
<tr>
<th>Key Stage</th>
<th>Ages</th>
<th>Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Key Stage 1</td>
<td>5-7</td>
<td>1 and 2</td>
</tr>
<tr>
<td>Key Stage 2</td>
<td>7-11</td>
<td>3, 4, 5, 6</td>
</tr>
<tr>
<td>Key Stage 3</td>
<td>11-14</td>
<td>7, 8, 9</td>
</tr>
<tr>
<td>Key Stage 4</td>
<td>14-16</td>
<td>10, 11</td>
</tr>
</tbody>
</table>

Attainment at age 5

By age 5, at a national level, there are already clear gaps in achievement between the poorest children and their better-off counterparts, with strong associations between a child’s social background and their readiness for school as measured by their scores on entry into Year 1 (Ofsted 2014).

The Early Years Foundation Stage (EYFS) profile is a measure of achievement that occurs at the end of a child's first year of school. In Suffolk (2014) the development of Suffolk children was similar to the England average. However children from less affluent families did less well.

Table 12: percentage of children achieving a good level of development at the end of reception 2013/14

<table>
<thead>
<tr>
<th></th>
<th>Suffolk</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>The percentage of children achieving a good level of development at the end of reception</td>
<td>58.9</td>
<td>60.4</td>
</tr>
<tr>
<td>The percentage of children with free school meal status achieving a good level of development at the end of reception</td>
<td>42.4</td>
<td>44.8</td>
</tr>
</tbody>
</table>

Source: PHE (2015)
Attainment at Key Stage 2

Key Stage 2 (KS2) applies to primary school children between the ages of 7 and 11. Pupils are expected to make at least two levels of progress between KS1 and KS2 – this is classed as making ‘expected progress’. Despite improvements in reading and writing compared to 2013, Suffolk still falls behind the England percentage in relation to pupils making expected progress in key subjects. In relation to those obtaining a level 4 or above in tests (the expected attainment level at the end of Key Stage 2), the data shows a gender divide, with girls outperforming boys in nearly all areas (apart from mathematics where they performed equally). The largest difference was observed in the percentage of children obtaining a level 4 or above in grammar, punctuation or spelling. 64% of boys achieved a level 4 or above compared to 77% of girls (DFE 2014b).

Table 13: Percentage of pupils making expected progress between Key Stage 1 and Key Stage 2, Suffolk 2012-2014

<table>
<thead>
<tr>
<th>Percentage of pupils making expected progress between Key Stage 1 and Key Stage 2 in:</th>
<th>Area</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reading</td>
<td>Suffolk</td>
<td>85%</td>
<td>84%</td>
<td>87%</td>
</tr>
<tr>
<td></td>
<td>England</td>
<td>90%</td>
<td>88%</td>
<td>91%</td>
</tr>
<tr>
<td>Writing</td>
<td>Suffolk</td>
<td>84%</td>
<td>89%</td>
<td>89%</td>
</tr>
<tr>
<td></td>
<td>England</td>
<td>90%</td>
<td>92%</td>
<td>93%</td>
</tr>
<tr>
<td>Mathematics</td>
<td>Suffolk</td>
<td>80%</td>
<td>81%</td>
<td>84%</td>
</tr>
<tr>
<td></td>
<td>England</td>
<td>87%</td>
<td>88%</td>
<td>89%</td>
</tr>
</tbody>
</table>

Source: DfE (2014b) and https://www.gov.uk/government/statistics/national-curriculum-assessments-at-key-stage-2-in-england-2014 Note: 2014 figures are based on provisional data. Final data has been used for 2012 and 2013 figures

Latest evidence from Save the Children (2014) indicates that Waveney is among the worst-performing in England for the reading ability of children from low-income families. Combined with other evidence for children living in deprived areas or in poverty, outcomes across the county will be affected, and their ability to become resilient adults compromised. This may be compounded by Suffolk’s low wage economy and the growing number of lone parents. Inter-generational problems are likely to continue without concerted and co-ordinated effort across the Suffolk system.

High quality Personal, Social and Health Education (PSHE) is also important and promotion of education about healthy behaviours in Suffolk schools needs to occur consistently.

School attendance

Suffolk has recently made progress in improving school attendance for primary and secondary schools. However, the attendance of Suffolk pupils is still below their national peers, in both primary and secondary schools. The County strategy to improve attendance at all schools in Suffolk is beginning to make a difference and this will be monitored to ensure continued improvement.
National data for the full school year 2012 to 2013 indicated that overall absence levels for primary schools were higher in Suffolk compared to the East of England and England, and also for secondary schools Suffolk compared to the East of England and England.

In addition Suffolk has reviewed its attendance strategy and is currently collecting local attendance data from all schools half-termly. This is allowing a more robust and timely set of intervention processes to take place with schools and families. Early intervention is key to delivery of the outcomes that will improve attendance performance for Suffolk.

**State-funded Primary Schools**


**State-funded Secondary Schools**

School attendance has improved in Suffolk and should improve the opportunities for schools to deliver good attainment outcomes for children. However, education attainment is influenced by both the quality of education children receive and their family’s socioeconomic circumstances. It is the responsibility of the parents/carers of children of compulsory school age to ensure that they receive a suitable education by regular attendance at school or otherwise. There is a strong correlation between better education, better employment and better health and wellbeing outcomes that translates into significant differences in the risk of chronic disease and life expectancy throughout a lifetime.

Key vulnerable groups can be identified who are at higher risk of failing to achieve their educational potential. These include: LAC, children of Black Caribbean, Pakistani, Somali or Turkish ethnicity, children from Gypsy, Roma and Traveller communities, children with special educational needs (including learning disabilities and speech, language and communication difficulties), young carers and children without parental educational support.

**Children’s health in Suffolk (5-15 years)**

The foundations for positive health and wellbeing continue into the 5-15 age group, with a focus on building resilient, healthy children. The Healthy Child Programme 5-19 supports a multi-agency approach to the health and wellbeing of children and young people. School nurses are key professionals in supporting children and young people in the developing 5-19 year olds to have the best possible health and education outcomes.

The health-promoting schools approach is a type of whole school approach that includes health education in the curriculum, changing the school's social and/or physical environment, and involving students’ families and the local community. A systematic review on the effectiveness of the health-promoting schools approach in promoting students’ health and wellbeing found positive results in building resilience, body mass index, physical activity, physical fitness, fruit and vegetable intake, tobacco use, and being bullied (Langford et al. 2014).

**Smoking**

“33,000 young people in Suffolk have smoked at some point”

The proportion of children who have smoked has declined to 22% in 2013 (Health and Social Care Information Centre (HSCIC), 2014) but still equates to 33,000 young people in Suffolk. Young people who played truant or have been excluded from school in the previous 12 months are almost twice as likely to smoke regularly compared to those who have not played truant or been excluded (HSCIC, 2014).

7 children aged 11-14 start smoking in Suffolk every day

This figure has been calculated by applying 2011 UK estimates to 2011 Census population figures for Suffolk, with the UK figures coming from Cancer Research UK (Cancer Research 2013)
Estimates of smoking amongst young people suggest a slightly higher proportion of Suffolk’s young people smoke than the national average.

Of young people aged 11-15 years in Suffolk, 1.8% are estimated to be occasional smokers (England = 1.5%), and a further 3.5% regular smokers (England = 3.1%).

Equivalent figures for 15 year olds in Suffolk indicate that 4.7% of 15 year olds in Suffolk are occasional smokers and 9.5% are regular smokers (England figures: 4.0% and 8.7%).

A ‘regular’ smoker is defined as smoking at least one cigarette a week and ‘occasional’ is defined as ‘usually smoking less than one cigarette a week’ (Local Health 2015).

Overweight and obesity in 10-11 year olds (year 6)

Findings from 2013/14 indicate:

- By age 10-11 31.7% of children in Suffolk are overweight or obese.
- Although this is lower than the England value (33.5%), this still equates to 3 children in every 10 being obese.

Local authority obese and overweight data is presented below. The figures indicate that the percentage of overweight and obese children have been rising in Ipswich – and the 2013/14 figure is higher than the England value. Babergh and St Edmundsbury also appear to have had a recent rise.

Figure 29: Local Authority Prevalence of overweight (including obese) at Year 6, 2008-2014


Note: Axis does not start at zero
The Health Survey for England 2012 physical activity data (HSCIC 2013) reveals that:

- 21% of boys and 16% of girls aged 5-15 years met recommended levels of physical activity.
- The proportion of girls meeting recommended levels was 23% in those aged 5-7 years and 8% in those aged 13-15 years.
- The proportion of boys meeting the recommended levels was 24% in those aged 5-7 years and 14% in those aged 13-15 years.

Road safety

The casualty risk in Suffolk’s more deprived communities is higher than might be expected based on population size alone (Suffolk Road Safe 2014).

High child casualty rates are apparent in the Lowestoft and Beccles areas, and analysis has shown that children in the county’s most deprived communities are at disproportionately high risk. Resident child casualty rates are below the national average in every district of Suffolk except Waveney, and resident child casualties have dropped significantly over the county as a whole in the last five years (Suffolk Road Safe 2014).

Oral health

Tooth decay is one of the most common oral diseases affecting our children, and is largely preventable. Oral health in children and young people in Suffolk is generally good and 82% of five year olds are free of dental decay, compared to the national average of 72%. Good oral health is fundamental to general health and wellbeing, and the consequences of decay include pain, time off school, loss of sleep, reduced nutrition, problems with speech and chewing, self-consciousness and embarrassment.

In Forest Heath dental decay prevalence is higher in five year olds than the East of England average. The proportion of five year old children who had one or more teeth extracted on one or more occasion in Forest Heath was 3.3% compared to an England average of 3.1%. To demonstrate the range, the equivalent figure in Suffolk Coastal was 0.3% (Crosse and Patel 2014).

People living in deprived communities have consistently poorer oral health than those from higher socioeconomic groups (Marmot and Bell, 2011) and there is direct correlation between levels of deprivation (Indices of Deprivation DCLG 2011) and dental decay.

Children who showed signs of sepsis were twice the national average in Forest Heath. The implications are serious as such teeth will often require extraction, usually under a general anaesthesia, exposing children to unnecessary risk of complications. This is a serious health issue which can and should be prevented.
The pattern for twelve year old children in Suffolk is generally similar to that of the five year olds. In Forest Heath only 65% of twelve year olds are free from dental decay.


Figure 30: Percentage of five year old children with decay experience (d3mft>0*) by lower tier Local Authority area, 2012

Figure 31: Percentage of twelve year old children with decay experience (d3mft>0*) by lower tier Local Authority area, 2008/09

*see glossary for definition
What are we doing in Suffolk?

A needs assessment was undertaken on the oral health of children and young people in Suffolk age 0-19 years in July 2014 (Crosse and Patel 2014). A 0-5 “Keep Suffolk Smiling” project was launched in February 2015, with all health visitors and children’s centre staff trained in evidence based dental health promotion. Promotional toothbrushes and toothpaste are given to all parents of young children and a formal evaluation process had been built in.

Children’s emotional and mental health

The emotional health of children and young people has increasingly become a priority. A recently published PHE report (2015b) looking at the promotion of children and young people’s emotional health and wellbeing highlighted that in an average class of 30 15-year-old pupils:

- three could have a mental disorder;
- ten are likely to have witnessed their parents separate;
- one could have experienced the death of a parent;
- seven are likely to have been bullied;
- six may be self-harming.

The 2013 Child and Adolescent Mental Health Services Needs Assessment for Suffolk found that there appears to be large numbers of children and adolescents in the county who have undiagnosed mental health conditions or who are not able to receive a service. Its primary recommendation was the development of integrated care pathways across all aspects of mental health and wellbeing for children and young people.

National prevalence rates for childhood mental disorder have been estimated by the ONS (Green et al, 2005). For Suffolk’s child population as a whole, it is estimated approximately 10% have an emotional or mental health difficulty, approximately 9,500 cases at any one point in time. While we can categorise childhood mental illness into a number of different disorders, the most common disorder diagnosed is conduct disorder.

2014 Suffolk Cyber Survey

One of the key findings from the 2014 Suffolk Cyber Survey was that young people sharing highly personal and/or explicit content with each other across mobile devices are vulnerable to harmful online content and aggression. 2,988 children and young people aged from 10 years old and upwards took part in the survey conducted by e-Safer Suffolk to monitor trends in their online activity.

The 2014 Suffolk Cyber Survey also highlighted:

- Around 83% of Suffolk’s young people own a smartphone, and tablet ownership was 80%, with 10 – 11 year olds using tablets more than smartphones.
- 74% of children and young people are accessing the internet at home and 71% of parents do not limit the time that their

Useful resource:

Child and Adolescent Mental Health (CAMHS) Needs Assessment for Suffolk
children are on the internet.

- 31% of young people are spending more than 5 hours a day online.
- The main activities that children and young people engage in are highly social; watching videos and films, online gaming and using between 3 and 5 social networking sites on average to message friends.
- 74% go online for homework and research.
- Parents are taking on the responsibility to support their children in the safe use of the internet. However the majority (89%) have been taught to be safe online at school.
- Cyberbullying rates have risen to 23% which is in line with national trends.
- Those respondents who admitted to ‘posting or sharing a nude or revealing selfie’ are exposed to other harmful content and conduct on line. 61% visited pro-anorexia websites often; 65% had viewed violent images and videos and 65% had looked at websites talking about people trying to hurt or kill themselves.

Source: Suffolk County Council (2015a)

These figures highlight both the positive and negative implication of internet and social media use. Although the internet is undoubtedly a vital learning tool, it can also make young people vulnerable to bullying, and expose them to violence and other graphic images. Nearly 1 in 3 of the children in this survey spent more than 5 hours a day online – which is likely to impact on levels of physical activity.

Key issues

Inequalities:

- It is estimated that approximately 1 in 7 children live in relative poverty (15%) in Suffolk (PHE 2015c). After including for housing costs there are areas that experience much higher levels of poverty (End Child Poverty 2014). Deprivation and poverty including ‘hidden pockets’ in rural areas are the root cause of poor outcomes for many children and families.
- Evidence from Save the Children (2014) indicates that Waveney is among the worst-performing in England for the reading ability of children from low-income families.
- Health measures for Suffolk’s Looked After Children are poorer than the rest of the population, including uptake of vaccinations, dental check-ups and mental health. They also have lower education attainment throughout school.
- The percentage of pupils eligible for free school meals was 3x higher in the most deprived areas (see Figure 8).
- The percentage of pupils that were persistently absent was almost twice as high in the most deprived areas (see Figure 8).
- The percentage of obese children was higher in the most deprived areas compared to the least deprived areas (see Figure 8).
Opportunities for prevention:

• Improve the numbers of children who are fit and of a healthy weight in Suffolk. Unless the current trajectory for childhood and adult overweight and obesity is reversed and levels of cardiorespiratory fitness improved, co-morbidities and long-term conditions, particularly diabetes will continue to rise, placing undue pressure on all organisations in the county, especially in the NHS.

• Ensure Suffolk school children have access to high quality Personal, Social and Health Education (PSHE). There is an inconsistency in the promotion of education about healthy behaviours in Suffolk schools including SRE (Sex and Relationships Education), substance misuse, domestic abuse and mental health. There is also a gap in engaging parents in positive parenting and the healthy lifestyles agenda.

• Improved access to emotional and mental health and wellbeing support for all children is needed. Evidence indicates this must be addressed in the school curriculum.

• Evidence-based action is required at school, community and family levels to increase physical activity and to reduce prolonged periods of sedentary behaviour among children and young people.

• Consider targeted interventions for children from deprived communities to improve opportunities to reach their full potential.

• Resilience for all children needs to be improved, but proportionately for children from deprived communities. Evaluations of American and British programmes have found that peer tutoring and mentoring can increase academic attainment, improve social integration, increase self-confidence, improve attendance, reduce disciplinary referrals, and improve attitudes towards school.

• Prevent children from being exposed to tobacco smoke, either through starting smoking themselves or exposure to secondhand smoke.

• Hidden Harm is a key factor in the breakdown of families and puts children at risk of negative outcomes. We need to establish the extent and impact of Hidden Harm in Suffolk.

• A range of services to address Hidden Harm are in place and are being further developed as a collaboration between Suffolk County Council, the voluntary sector and mental health services. We must continue the development of the Hidden Harm collaboration.

Service implications:

• There should be a focus on ensuring there is multi-agency involvement in the implementation of the Healthy Child Programme (5-19) and on ensuring the potential of the school nurse workforce is maximised.

• Improved access to affordable, good quality childcare (0-19) would support parents to continually engage in employment and training opportunities.

• Targeted support is needed for those children with conduct disorders and Autism/ Learning Difficulties (LD)/ Attention Deficit Hyperactivity Disorder (ADHD)/ Special Educational Needs (SEN).
MOVING INTO adulthood (16-24)

"Good health in adolescence is central to wellbeing and the bedrock for good health in later life. Investing in young people’s health provides huge dividends for their current wellbeing and their future health. Getting it right at this age also reduces long-term costs to the health system."

(Hagell and Coleman 2014)

- The percentage of Suffolk children achieving 5+ A*-C grades including English and Mathematics GCSEs in state funded schools (2013/14)
- Chlamydia diagnoses recorded in the 15-24 age group. This equates to a 6.8% positivity rate and 22.3% of the eligible population being tested
- The estimated number of 16-24 year olds in Suffolk in 2012
- The number of 16-24 year olds in Suffolk with a recorded special educational need or disability
- 5.2% of Suffolk 16-18 year olds who were Not in Education, Employment or Training in February 2015
“We need to think about investing in the health of our young people as a route to improving the economic health of our nation”

Dame Sally Davies, Chief Medical Officer (2013)

Good health in adolescence is central to wellbeing, and the bedrock for good health in later life. Investing in young people’s health provides huge dividends for their current wellbeing and their future health. Getting it right at this age also reduces long-term costs to the health system (Hagell and Coleman 2014).

Adolescence and young adulthood is a critical life stage which is different to childhood and has important repercussions for adulthood. Young people experience huge physical, psychological and behaviour changes as they mature from children to adults with development taking place in the following domains:

- Physical development
- Cognitive development
- Emotional development
- Social development
- Behavioural development

During this life stage the brain undergoes reorganisation and ‘fine tuning’ with changes in anatomy and functioning resulting in a brain that is more efficient and adapted to the surrounding environment. During their second decade, young people become better at weighing up risk, learning from experience, moral thinking, political thought and at controlling impulses (Coleman, 2011).

There is evidence from MRI scans that brain development continues up to the age of 25 (Giedd, 2004).

During this life stage young people develop a sense of personal identity, self-esteem, autonomy and learn coping strategies and resilience for dealing with life’s events and challenges. They seek independence and responsibility.

Peer groups are both important and influential. Brain changes mean they are likely to seek out novel experiences and take risks, which can present challenges in terms of young people’s health, especially as many life-long health behaviours are set during this period of time. Getting it right at this age also reduces long-term costs to the health system (Hagell and Coleman 2014), however this stage in the life course is often omitted or less concentrated on (Viner et al. 2015).

Adolescence and early adulthood represent a key time to intervene as it represents the second fastest growth spurt after infancy, and the main causes of death and illness between the ages of 16 and 24 being largely preventable, including, for example, road traffic accidents.

Inequalities exist around rates of teenage conception, chlamydia diagnoses, obesity and many other aspects of young people’s health depending on where they live, reflecting the associations with poverty and deprivation. Analysis of data from the Health Survey for England has shown significant income inequality associated with general health and smoking throughout adolescence and into early adulthood. Relationships between deprivation and obesity are also strong in adolescence (Hagell and Coleman 2014).

There is growing evidence that shows that treating different, specific health issues will not
tackle the overall wellbeing of this generation of young people (DH 2013). Mental and physical health are intertwined, and at the heart of their wellbeing are their relationships with others. Young people think about their health holistically and want an integrated, youth friendly approach. Public Health England have developed six core principles for working with young people based on what works for this age group, and build on the concepts of resilience (PHE 2015).

The 16-24 age group is seen as a key transitional life stage as it marks many life ‘milestones’ such as the end of compulsory education, the official start of adulthood, the legal drinking age and the start of many new journeys, such as work, further education, travel opportunities and, for some, entry to the housing market. However, concern has been raised as to whether this cohort represents a ‘lost generation’ that have been heavily impacted by the recession, increasing costs of university places, tougher job markets, and high house prices (The Independent 2010).
What are we doing well since the last report in 2011?

• MyGo Ipswich was opened in 2014 as the UK’s first employment centre specifically designed for young people aged 16-24. It combines the experience of the private, public and charity sectors and offers free training, career coaching and employment support.

• Suffolk Young People’s Health Project (also known as 4YP) provides and co-ordinates services that improve the social, emotional, and physical health and wellbeing of 12-25 year olds in Suffolk.

• The Source website managed by the Youth Support Service operates to improve accessibility to services for young people.

• Rising High in Suffolk advertises work experience, apprenticeships, internships and graduate placements from all councils in Suffolk.

• The local government in Suffolk has formed a collaborative ‘Exemplar Employer programme’, which seeks to develop and offer quality placements for young people of all ages and abilities.

• Making Every Intervention Count seeks to provide the best possible outcomes for young people and their families.

• All Suffolk sexual health clinics are self-referral, and do not require a GP referral letter. They are open to men and women of all ages, with a free, confidential and non-judgemental service.

• Suffolk continues to promote and encourage under 25s to have regular screening for chlamydia under the National Chlamydia Screening Programme.

• There are targeted services for young people in Suffolk who are finding their drug and/or alcohol use is becoming a problem for them or those who care about them. Individuals can also get help if someone else’s use of alcohol is seriously affecting their life.

What our population looks like

• There are an estimated 74,400 16-24 year olds in Suffolk.

• The forecasted population of 16-24 year olds is set to decrease between 2012-2037.

• The largest proportions of 16-24 year olds reside in Forest Heath and Ipswich (12.1% of the total Forest Heath and Ipswich populations).

• Ipswich is our largest town, and the largest numbers of 16-24 year olds are located in Ipswich (just over 16,000 individuals).

• There are an estimated 2,454 16-24 year olds in Suffolk with a recorded special educational need or disability.

• 5.2% of Suffolk 16-18 year olds were Not in Education, Employment or Training (NEET) in February 2015.

• 11.5% of Suffolk 16-18 year olds who had a recorded disability or long-term health condition, or where there had been identified special educational needs, were Not in Education, Employment or Training (NEET) in November 2014.

Sources: ONS (2013), Suffolk County Council (2014) and Suffolk County Council (2015)
What young people say

There is growing evidence to support young people's participation in the design and delivery of services which are applicable to them (Improving young people's health and wellbeing, PHE, 2014). The Prince's Trust Annual Youth Index (Prince’s Trust 2015), now in its seventh year, tracks the concerns of young people over time. A sample of 2,265 16-25 year olds took part in an online poll, conducted by YouGov on behalf of The Prince's Trust in Autumn 2014. The figures have been weighted and are representative of the UK population aged 16-25. There is no in depth survey for Suffolk young people, but the results of the Prince's Trust survey is likely to be applicable to our own population of 16-24 year olds.

The 2015 results show that there are a significant number of young people in our communities who live their lives feeling anxious, unsafe and unhappy, and the further they are from education or employment, the more likely this is to be their experience.

Key findings

- More than one in ten (13%) of young people feel too anxious to leave the house and this increases to 35% among young people Not in Education, Employment or Training (NEET).
- More than a third (36%) often feel anxious about everyday situations, rising to 52% of young people Not in Education, Employment or Training (NEET).
- A fifth (20%) claim they “fall apart” emotionally on a regular basis. This increases to a third (33%) of young people Not in Education, Employment or Training (NEET).
- 46% of NEETs say they avoid meeting new people and 39% find it hard to make eye contact with people.
- Six in ten (62%) of 16-25 year olds have been bullied at school.
- For one in ten (10%) of those that have been bullied, the bullying lasted more than five years.
- Of those who have been bullied, 94% were emotionally or verbally abused.
- More than one in five (23%) were physically attacked.
- More than one in ten (13%) respondents experienced cyber bullying.
- More than one in five (22%) did not attend school as a result of being bullied.
- More than one in ten (12%) of young people say their childhood was “traumatic”.
- One in ten (9%) were physically attacked at home during their childhood.
- 17% witnessed emotional abuse at home during their childhood.
- More than one in ten (12%) report being scared of the adults in their childhood.
- More than half (56%) of respondents did not receive any help after their last setback in life, rising to 71% among those who didn't have anyone to talk to about their problems while growing up.
- Half (50%) of respondents claim that they lost confidence in themselves following a setback, increasing to 59% amongst those who are young people Not in Education, Employment or Training (NEET).
- As a result of a setback in life, 47% of young people Not in Education,
Employment or Training (NEET) felt that even if they tried, they would not succeed. This compares to 31% of all young people.

- The survey defined a “setback” as a family/relationship breakdown, losing a job, failing an exam, major illness or bereavement, or other significant negative events.

(Prince’s Trust 2015)

**Mental health and self-harm**

Mental health problems affect approximately one in ten children and young people. These include depression, anxiety and conduct disorder, and are often a direct response to what is happening in their lives. Good mental health allows young people to develop the resilience to cope with life events and grow into secure healthy adults.

Self-harm is not usually a suicide attempt but a way of expressing deep emotional feelings, such as low self-esteem, although this may be associated with increased risk of suicide later. Research suggests self-harm often results from traumatic events or situations, or relationship problems.

For all age groups in Suffolk, annual prevalence of self-harm is approximately 0.5%. A national survey of young people aged 15-16 years estimated that more than 10% of girls and more than 3% of boys had self-harmed in the previous year (NICE 2011).

An increase in cases of self-harm has been reported in early release data from the 2013 survey for the Health Behaviour in School Aged Children study. The full report is due out during 2015 but initial (unpublished) reports suggest that 20% of 15 year olds hurt themselves in the previous year (cutting, biting and burning), compared with 7% in the last comprehensive survey of self-harm in this age group in 2002. Although preliminary data, it is an important trend to monitor (BBC 2014).

There has been stability nationally in age-specific suicide rates for 15-29 year olds since the mid-2000s. In 2011 the rate for young men was 13.3 per 100,000, and 4 per 100,000 for young women.

**Education-GCSE attainment**

Educational attainment is a good predictor of health and wellbeing in later life and is a highly significant factor in determining the social wellbeing and consequent health of the population.

Suffolk children perform less well than their peers nationally at all education stages from foundation stage (age 5) to Key Stage 4 (age 16). 51.7% of Suffolk children achieved 5+ A*-C grades including English and mathematics GCSEs in 2013/14 compared to 56.8% nationally (state funded schools only) (DfE 2014). Only 22.7% of Suffolk students with free school meal eligibility status achieved this same standard (compared to 33.7% nationally) (DfE 2014). Raising the Bar is a Suffolk wide initiative to address attainment.

**Further education**

Following a change in the law, young people born on or after 1 September 1997 must stay in some form of education or training until their 18th birthday – for example school, college, apprenticeship/training or part-time education or training - as well as being employed, self-employed or volunteering for 20 hours or more a week.
2011/12 data indicates that 51% of Suffolk students who entered an A Level or other Level 3 qualification went on to study at a UK Higher Education Institution, compared to 54% for England. (All mainstream schools and colleges, including independents) (DfE 2014a). 78% went on to education or employment / training destinations compared to 74% for England overall. National data indicates a lower level of higher education provision in Suffolk. Additionally the graduate retention rate is lower in the East of England, indicating that the county loses a higher percentage of graduates with skills and qualifications to other geographical areas.

Although recent data indicates the graduate salary premium is narrowing, the median graduate salary in England stood at £31,000 during the third quarter of 2014, the average non-graduate salary was £22,000. Graduates and postgraduates have better employment prospects than non-graduates (Department for Business Innovation and Skills 2014).

**Not in Education, Employment or Training (NEET) in 16-18 year olds**

The proportion of young people Not in Education, Employment or Training (NEET) age 16-18 years has been consistently higher in Suffolk than regional averages for many years, although the number staying on into further education is gradually increasing. Rates appear to fluctuate in Suffolk and can be seen in Figure 32. 26.1% of care leavers in Suffolk aged 16-18 were in this group (Suffolk County Council 2015).

More recent NEET figures indicate that although the figures for Suffolk are improving, they are also improving nationally, and we are not narrowing the gap.

There is a need to understand both the individual and collective barriers to learning and ensure that NEET individuals are not treated as one homogenous population in order to improve their chances.
Raising the Participation Age (RPA) is the Government’s policy which sets out a new requirement for young people to continue in learning or training after the age of 16. In Suffolk there has been an increase in participation rates over the last two years. However, whilst we continue to improve the proportion in learning at both 16 and 17 years, Suffolk’s rate of progress has slowed and we remain below national indicators both for participation (particularly at 17 years) and for NEET measures at 16 and 17 years.

Half (51%) of jobless young people report that anxiety has influenced their ability to look for a job - twice the proportion of all young people (25%). 39% of young people who are NEET consider anxiety prevents them from having positive relationships, 38% from eating properly and 33% from learning new skills (Prince’s Trust 2015).

MyGo Ipswich was opened in 2014 as the UK’s first employment centre specifically designed to support young people aged 16-24 getting into employment, and maximising their potential.

MyGo plans to expand their services beyond Ipswich, into rural and urban areas across Suffolk, and will include the use of tablet software, meaning young people can access MyGo services without having to travel.

Young adults living at home

In Suffolk...

- 33,000 20-34 year olds are living with one or both parents
- 49% of 20 to 24 year olds live with their parents
- 21% of 25 to 29 year olds live with their parents
- 8% of 30 to 34 year olds live with their parents
Young adults living with their parents were more likely to be unemployed (ONS 2014).

There are both advantages and disadvantages of living at home for longer; from a young person’s point of view they may be more financially secure, and be able to save for a deposit for a house. However, there may be social impacts such as ‘arrested development’, starting families later on, and this living situation may place an emotional and financial burden on parents (National Housing Federation 2013).

Sexual health

Sexually transmitted infections (STIs), including HIV, remain one of the most significant causes of illness among young people aged between 16 and 24 years old. Many STIs can lead to long-term fertility problems if left untreated and strains of Human Papillomavirus (HPV) may cause cervical cancer.

In 2013, 1,276 Chlamydia diagnoses were recorded in the 15-24 age group, which is the age range that is encouraged to screen for the infection. This equates to a 6.8% positivity rate and 22.3% of the eligible population being tested (PHE 2015a).

Figure 35: Chlamydia diagnoses by age group per 100,000 population, 2013

Source: Health Protection Agency (2015)
Local authority data indicates that Ipswich had the highest rate of Chlamydia diagnoses per 100,000 population (aged 15-24) in Suffolk, a rate that was significantly higher than the England average. All other districts in Suffolk have significantly lower rates of Chlamydia diagnoses than the national average.

**Risk taking behaviour**

Risk-taking or risky behaviours are those actions that can be dangerous to health or emotional wellbeing in the short or long-term.

**Substance misuse**

Crime survey figures (ONS 2012) estimate that approximately 1,690 young people in Suffolk aged 16-19 used Class A drugs in 2011/12 and a further 550 used Class A/B drugs. Evidence from the 2013/14 Young Person’s Quarterly Activity Report (National Drug Treatment Monitoring System (NDTMS) 2014) shows that over a third of young people in treatment in Suffolk are aged 17, this is more than the national average.

![Figure 36: Age of young people in substance misuse treatment, 2013/14](source: NDTMS (2014))
Figure 37 shows the wider vulnerabilities of young people in substance misuse treatment in Suffolk, 2013/14. Compared to the England average, Suffolk has higher percentages of young people in treatment that:

- Self-harm
- Experience domestic abuse
- Are involved in anti-social behaviour
- Have mental health problems
- Are a child in need
- Have a child protection plan
- Have housing problems

Conversely, percentages of young people in treatment in Suffolk are lower than nationally for the following vulnerabilities:

- Being affected by others’ substance misuse
- Being a Looked After Child
- Not in Education, Employment or Training (NEET)
- Being involved in sexual exploitation.

**Alcohol**

Alcohol misuse can be linked to behaviours that put a young person at risk of unsafe sex, violence and other criminal behaviours.

In a survey of 10,000 young drinkers aged 15-16 years NICE (2012):

- 28% stated that they had experienced violence when drunk
- 13% had regretted alcohol-related sex and
- 45% had experienced memory lapse after drinking.
Figure 38 shows under 18s admitted to hospital with alcohol-specific conditions as there are no statistics relating specifically to the 16-24 age group. Rates of under 18s admitted to hospital with alcohol-specific conditions were highest in Waveney.

Suffolk’s rate of hospital stays by young people due to alcohol in 2010/11-2012/13 was 27.8 per 100,000 population (under 18). This is above the East of England figure (26.8 per 100,000 population) but significantly below the England figure (42.7 per 100,000 population) (PHE 2015b).

Figure 38: Under 18s admitted to hospital with alcohol-specific conditions: Persons, 2010/11 - 2012/13


In England it is estimated that:

- 2.85 million children in England aged 11 – 17 years have never consumed alcohol (1.58 million aged 11-15 and 1.27 million aged 16 – 17)
- 20 million units (around 9 million bottles of beer) were consumed by 11-17 year olds in an average week (Fuller 2009).
- The proportion of teetotal young adults (those aged 16 to 24) increased by over 40% between 2005 and 2013
- Over 1 million children (391,000 aged 11 – 15 and 623,000 aged 16-17 years old) drink alcohol on a weekly basis
- 486,000 young people are drinking alcohol more than once a week, (177,000 aged 11-15 and 309,000 aged 16 – 17)
- 20 million units (around 9 million bottles of beer) of alcohol were consumed by 11-17

- The proportion of young people reporting they were binge drinking has fallen by more than a third since 2005, from 29% to 18% (ONS 2015).

There is no local data available to observe whether this trend is reflected locally.

**Smoking**

National data is collected for smoking in those up to 18 year olds, and for those between 18-34. Young people tend not to attend smoking services, as they don’t perceive their smoking as a problem until later in life.

National data for secondary school pupils shows a continuing fall in overall rates of smoking, confirmed again in the latest survey from the HSCIC, which noted that in 2013 less than a quarter (22%) of secondary school pupils had tried smoking at least once. By comparison in 1996 nearly half the age group had tried smoking at least once (HSCIC 2014).
There are some modelled estimates of young people’s smoking habits which indicates that almost 16% of 16-17 year olds in Suffolk are regular smokers (England = 14.8%) and a further 6.8% occasional smokers (England = 5.9%) (Local Health 2015).

**Physical activity**

Males are more likely than females to be active at almost every age, physical activity declines with age in both sexes, but more steeply in females (DH 2011).

Research has found that there is as much as a 24% decrease in physical activity over the 12 years from adolescence to early adulthood, representing the biggest decline in physical activity across a person’s life. The steepest decline found was in young men entering college or university. (Kwan et al. 2012).

Levels of physical activity as measured by the Active People Survey suggest that in Suffolk as a whole, smaller percentages of people are physically active than nationally. At local authority level however the picture is varied.

The chart below shows that Babergh, Mid Suffolk and Suffolk Coastal had higher percentages of people aged 14 and over and those aged 16 and over involved in regular physical activity than the England average, whereas Ipswich and Waveney had the lowest percentages of their 14 and over and 16 and over populations involved in regular physical activity.

Figure 39: Physical activity in young people, 2013/14

**Physical activity**

Percentage of people aged 14+ and 16+ that completed at least four sessions of at least moderate intensity for at least 30 minutes in the last 28 days

Local authority districts in Suffolk, Suffolk County and England

April 2013-April 2014

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<tr>
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<th>People aged 14+</th>
<th>People aged 16+</th>
<th>England 14+</th>
<th>England 16+</th>
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<tr>
<td>Babergh</td>
<td>40.1%</td>
<td>33.4%</td>
<td>30.9%</td>
<td>38.5%</td>
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<td>Forest Heath</td>
<td>36.2%</td>
<td>32.5%</td>
<td>28.9%</td>
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<td>Ipswich</td>
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<td>Mid Suffolk</td>
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<td>St Edmundsbury</td>
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<td>Suffolk Coastal</td>
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<td>Ipswich</td>
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<td>Waveney</td>
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<td>Suffolk</td>
<td>35.5%</td>
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</table>

Source: Suffolk County Council (2014)
Youth justice

The Youth Justice System (YJS) in England and Wales works to prevent offending and re-offending by young people under the age of 18 years. The system is different to the adult system and is structured to address the needs of young people. Data for Suffolk for 2012/13 (Ministry of Justice 2014) shows that:

- Overall there were 1,042 proven offences by young people in Suffolk in 2012/13.
- 79.1% of these were perpetrated by male offenders.
- 28.7% of total offences were classed as violence against the person.
- There were 23 custodial sentences. This equates to a rate of 0.34 per 1,000 10-17 year olds; the England rate was 0.64.
- Between 2001 and 2011 there were 718 first time entrants aged 10-17 years into the youth justice system in Suffolk.

Road incidents

Young adults experience disproportionately higher levels of risk on the roads, and this is even more pronounced in Suffolk compared to elsewhere in the country (Suffolk Road Safe 2014). Those aged 16 to 24 in Suffolk experience a casualty risk rate that is twice the risk of the general population.

Social media

Use of mobile devices to access the internet and social media such as Facebook, Twitter and Instagram is the accepted way of communication for adolescents and young adults. There are many benefits of the use of the internet and other screen based media in terms of education and communication. However, there are also associated risks including personal safety, mental health and bullying, and sedentary lifestyles.

Booker et al. (2015) describe how the increased use of screen based media contribute to more sedentary lifestyles, which may have implications for health and wellbeing in later life. This research highlights continuities in health behaviours and wellbeing from adolescence into later life, and notes that health-related practices and behaviours can be reinforced by prevailing social norms.

Learning disabilities

A recent Learning Disabilities Needs Assessment resulted in the further requirement of a stand-alone report to map current service provision in order to get a clear picture on both health and care services provided for people with learning disabilities (LD) aged 14-25 years in Suffolk. A focus on the costs associated with service providers is underway, and currently the areas of supported housing and residential care have been reviewed.

‘Make your Mark’ report

The UK Youth Parliament hold an annual UK wide ballot ‘Make your Mark’ where all young people can vote on what they think their members should campaign on for the year ahead. Numbers of young people voting were up in 2014, and the most important issues in Suffolk for young people were found to be: the living wage, exam results and mental health (Youth Parliament 2015).
**Key issues**

**Inequalities:**

- The proportion of young people Not in Education Employment or Training (NEET) in the most deprived areas was five times higher compared to the least deprived areas (see Figure 8).

- Males are more likely than females to be active at almost every age, physical activity declines with age in both sexes, but more steeply in females.

- There are health inequalities in this age group. There is substantial variation around rates of teenage conception, chlamydia diagnoses, obesity and many other aspects of young people’s health depending on where they live, reflecting the associations with poverty and deprivation.

- Teenage pregnancy is associated with poorer health and wellbeing outcomes for both mother and baby.

- This stage of the lifecourse receives less attention than others (Viner et al. 2015).

**Opportunities for prevention:**

- Monitor suicide rates and take every opportunity to prevent suicides in Suffolk.

- One in six 16-17 year olds in Suffolk are regular smokers, and it requires focused activity to decrease numbers and minimise risk.

- Although part of normal development, some risk-taking behaviours can impact on health or emotional wellbeing in the short or long-term.

- There is a need to develop the evidence base on prevention and early intervention in adolescence at both a national and local level.
• Promote the benefits of physical activity so it becomes embedded, and is continued throughout an individual’s life.

• Fill the gap in information about how Suffolk young people regard their lives and their future prospects.

• Improve young people’s participation in the commissioning and design of services, particularly more marginalised and excluded young people.

• Strengthen collaborative partnership working across the services provided to young people.

• Support Raising the Bar initiatives to continue to raise attainment at GCSE level and improve access to higher education.

• Ensure ongoing attention is given in policy, service design and delivery during this important life stage.

**Service implications:**

• There has been no in depth analysis of issues affecting this age group. This is partly due to a lack of data.

• There is a lack of new information on many mental health problems, with no new nationally representative data since 2004, when some behavioural and emotional problems in 11-15 year olds were analysed.

• There is a need to improve young people’s participation in the commissioning and design of services, particularly more marginalised and excluded young people.

• More collaborative partnership working needs to be developed across the sectors providing services to young people.

• Commitment to increasing attainment at GCSE level and higher education through Raising the Bar should continue.

• There is a lack of information about how Suffolk young people regard their lives and their future prospects. A new national survey was a key recommendation in the Chief Medical Officer’s 2013 report.

• We should consider commissioning a health needs assessment as part of the JSNA to further investigate local issues for this age group, including primary research.
Work is considered the most important determinant of population health and health inequalities. It has a direct impact on health, income, housing, environment and transport and affects individuals, families and society. The correlation between education, employment and health is stark, with people who are living in poorer areas dying sooner, and living more of their lives with a disability or in ill health.

- 51% of the Suffolk population is aged 25-64
- 84% of Suffolk residents aged 25-64 rated their health as good or very good in 2011
- 950 The total number of deaths of people under 65 in Suffolk in 2013
- The estimated number of 25-64 year olds in Suffolk in 2012
- The percentage of people self rating their health as bad or very bad in the most deprived areas was twice as high compared to the least deprived areas

The estimated number of 25-64 year olds in Suffolk in 2012
Work is considered the most important determinant of population health and health inequalities. It has a direct impact on health, income, housing, environment and transport and affects individuals, families and society. People in poor health are at greatest risk of unemployment and therefore may feel less able to contribute to wider society (DH 2014). The correlation between education, employment and health is stark, with people who are living in poorer areas dying sooner, and living more of their lives with a disability or in ill health.

A healthy standard of living provides the most secure basis for health and wellbeing, although for some people there may be challenges in achieving this aspiration through personal circumstances or lifestyle choices. Changes in the state pension system will mean that in the future people have to remain in employment beyond this period of their lives into older age.

The Global Burden of Disease study (The Lancet 2014) demonstrates the impact on our health of poor diet, obesity, lack of exercise, smoking, high blood pressure and too much alcohol. It also demonstrates that mental health is the largest single cause of disability. Physical and mental health are closely linked – people with severe and prolonged mental illness die on average 15 to 20 years earlier (NHS England 2014). The importance of prevention has been highlighted in the NHS Five Year Forward View (NHS England 2014) and the Public Health England priorities, “From evidence into action: opportunities to protect and improve the nation’s health” (PHE 2014).

We want people in Suffolk to be as well as possible for as long as possible, but like the rest of the country we are currently facing an epidemic of largely preventable long-term disease, 40% of the UK’s overall disability-adjusted life years lost are caused by tobacco, high blood pressure, overweight and obesity and low physical activity. This is through their contribution to diseases such as heart disease, stroke and lung cancer (The Kings Fund 2014).

Although the best health and wellbeing outcomes will be achieved by embedding healthy lifestyles in young children, the 25 to 64 age population in Suffolk is ideally placed to begin making lifestyle choices which reduce the likelihood of enduring ill health in later life. Over the past few years, there has been a focus, nationally and locally, to help people lessen the risks they take with their health. This process needs to be accelerated and addressed in a more systematic way to help people live healthier lifestyles.

As shown in the graph overleaf, the five highest risk factors contributing to early death and reduced quality of life in the UK are:

- Smoking tobacco
- Having high blood pressure
- Being overweight or obese
- Lack of physical activity
- Excessive alcohol consumption

Useful resource:
The NHS Five Year Forward View From evidence into action: opportunities to protect and improve the nation’s health
What are we doing well since the last report in 2011?

• Following the changes to the health and care system, including local authority responsibility for leading health and wellbeing, there is acknowledgement that all organisations need to work together to make the prevention of ill health a priority.

• There is recognition that targeting the working age group (25-64) is effective for supporting people with long-term conditions to be as healthy as they can, and ensuring they maintain a good quality of life for as long as possible. This is important in relation to the provision and cost of healthcare, as the number of long-term conditions any one individual has increases with age. By the age of 65, 50% of people have at least two long-term conditions, and this continues to rise.

• Suffolk organisations have signed up to a Mental Health Crisis Care Concordat, pledging to work together with people who use mental health services to provide the best possible care.

• A five-year mental health commissioning strategy is being developed, supported by a series of mental health conversations.

• The Joint Health and Wellbeing Strategy highlights the importance of mental health as one of its four outcomes: Making mental health everyone’s business.
• An assessment of demand on the Suffolk Constabulary was published in January 2013 and found that 12% of daily police business has some link with mental health, increasing to 40% for reported rape offences and 60% for missing persons reports. In response, the CCGs and police have collaborated in Ipswich to bring health professionals together with police officers to help people who are displaying mental health symptoms. Ongoing evaluation is in place.

• Suffolk aspires to be the Most Active County in England, with a plan to achieve this that includes mass participation events and normalising and increasing everyday activity such as walking and cycling.

• Suffolk’s first cycling strategy sets a vision for cycling in Suffolk to increase the number of adults who cycle regularly every week from the current 13%.

• The Suffolk Get Healthy Get Into Sport project supports the transition of individuals from healthcare and other settings into community sport and physical activity.

• An integrated lifestyle service commissioned in the west and east of the county in 2010 is being retendered to cover the whole county. A series of health equity audits highlighted where healthy lifestyle services are used and where efforts need to be targeted in order to decrease health inequalities.

• In 2013 18.5% of Suffolk adults smoked, similar to the England value of 18.4%, and is a small decrease from 2012. In 2012 19.6% of Suffolk adults smoked, similar to the England average of 19.5% (ONS 2013).

• Almost 30% of people who have stopped smoking have come from the most 20% deprived of our population, as a result of a targeted approach by stop smoking services.

• The Suffolk Alcohol Strategy: Healthy, Safe & Prosperous 2014-2022 has been developed, led by a partnership group and supported by robust action plans.

• A new integrated Drug and Alcohol service has been commissioned starting in April 2015.

• The Reducing the Strength Campaign was launched in 2011 to cut the sales of cheap, strong alcohol and levels of street drinking. 100 of 140 retailers in Ipswich have voluntarily joined the scheme, leading to a reduction in crime and in the number of street drinkers.

• The Health and Wellbeing Board has agreed that housing, as a key determinant of health, is a cross-cutting issue for the four strategic outcomes identified in the Joint Health and Wellbeing Strategy. A housing and health charter has been developed which sets a challenge for housing, health and care professionals to work together to integrate health and housing.

What our population looks like

• Over 50% of the Suffolk population are aged 25-64.

• There are an estimated 371,600 25-64 year olds in Suffolk.

• Ipswich is our largest town and has the largest numbers of 25-64 year olds, at just
over 71,100 individuals (this is 52.9% of the total Ipswich population).

• The forecasted population (numbers) of 25-64 year olds is set to decrease between 2012-2037.

Sources: ONS (2013) and Suffolk County Council (2014)

Overall health of Suffolk residents

The 2014 Health Profile for Suffolk (PHE 2014a) indicates that overall the health of people in Suffolk is generally better than the England average.

How Suffolk people rate their own health

The 2011 Census data (ONS 2013a) shows how Suffolk residents age 25-64 self-rate their health:

• 84% of residents rated their health as good or very good.

• 12% of residents rated their health as fair.

• 4% of residents rated their health as bad or very bad.

• 87.0% of residents reported that their day-to-day activities were not limited (higher than the England percentage).

• 5.2% reported that their day-to-day activities were limited a lot (lower than the England percentage).

• Variation is noted at local authority level for example 83.2% of Waveney residents in this age group reported that their day-to-day activities were not limited, compared to 89.0% in Forest Heath.

Figure 42: Self-reported health status in Suffolk age 25-64, 2011

Source: ONS (2013a)
The data above shows that, as you would expect, the number of people that report daily activities limited a little or a lot, are similar to those that rate their health as fair to very bad. Interestingly, there are more people reporting that their daily activities are limited a lot, than there are people reporting their health as very bad.

Income deprivation (from the IMD 2010) and self-reported limitation of activities are positively correlated in Suffolk. 33.7% of the variation in those reporting that their day-to-day activities are limited a lot could be explained by income deprivation.

In 2013 there were 950 deaths from all causes in Suffolk for people aged under 65.

**Premature death**

Premature death is described as death which occurs in the under 75 age group and is a key indicator of health inequalities in Suffolk between people living in the most deprived wards compared to others.

There were 5,954 premature deaths (people under 75 years of age) in Suffolk between 2011 and 2013 (PHE 2015). Rates of premature deaths from specific conditions (e.g. lung cancer, liver disease, heart disease) are generally lower in Suffolk than nationally, but in the case of breast cancer, Suffolk’s rate is worse than the national average. There were 243 premature deaths from breast cancer in Suffolk between 2011 and 2013, a rate of 23 per 100,000 females aged under 75.
Cancer

Cancer is the leading cause of premature death in Suffolk, as in the rest of England, accounting for approximately 42% of premature deaths in males and 51% in females. There are on average nearly 900 premature deaths from cancer each year in Suffolk. Although the rate of premature deaths due to cancer has fallen by 25% over the last fifteen years there is some indication that the rate of decline is starting to slow. No district or borough differed significantly from the all Suffolk rate for premature deaths from cancer.

Suffolk generally compares well to the whole of England, but those living in the 10% most deprived parts of Suffolk experience significantly higher levels of premature mortality compared to England, and people living in the most deprived 20% areas of Suffolk experience significantly higher mortality rates compared to Suffolk overall. The difference between the most and least deprived areas is considerable, with those living in the most deprived parts of Suffolk experiencing a premature mortality rate of 40% higher than those living in the least deprived.

**Cancer**

![Figure 45: Age standardised mortality rates from malignant neoplasms (cancers), people under 75 years old by deprivation decile, 2008-12](image)

*Source: NHS Indicator Portal (2014)*

**Deaths not caused by illness:** 123
- Intentional self-harm / event of undetermined intent: 53
- Accidents: 60

**Cancer**

- **Circulatory diseases:** 169
  - Acute myocardial infarction: 38
  - Ischaemic heart disease: 89
  - Cerebrovascular diseases: 22
  - Other ischaemic heart diseases: 51

- **Mental and behavioural disorders:** 8
  - Vascular and unspecified dementia: 5

- **Diseases of the nervous system:** 50
  - Multiple sclerosis: 19
  - Epilepsy: 10

- **Respiratory diseases:** 49
  - Bronchitis, emphysema and pulmonary disease: 23

- **Cancers and neoplasms:**
  - Ovarian and prostate cancers: 29
  - Respiratory related cancers: 69
  - Malignant cancers of digestive organs: 94
  - Breast cancer: 49
  - Colon cancer: 17
  - Skin cancer: 14

**Total deaths in 2013 for those aged under 65 (from all causes): 950**

**Digestive diseases:** 65
- Liver diseases: 42

**Deaths not caused by illness:** 123
- Intentional self-harm / event of undetermined intent: 53
- Accidents: 60

**Figure 44:**
Deaths under 65 in Suffolk, 2013

*Source: ONS (2014) Please note, the figure includes all ages from 0-65 to avoid the potential of identifying individuals.*
Late diagnosis is a recognised key factor contributing to poorer outcomes from cancer and is more common amongst lower socioeconomic groups and in some ethnic minority groups. About half of cancers could also be prevented by lifestyle changes (physical inactivity is estimated as the principal cause of 21-25% of breast and colon cancer for example) (WHO 2015), and accounts for the most of the variation in cancer incidence between the most and least deprived population groups.

The chart shows that the most deprived areas in Suffolk experience significantly raised mortality compared to the county as a whole and the less deprived areas experience lower mortality rates than the county as a whole.

**Cardiovascular diseases (including heart disease and stroke)**

Heart disease and stroke account for about 25% of early deaths in Suffolk. Although premature mortality has fallen in Suffolk by more than 50% in the last fifteen years mirroring the national and regional trend there are indications that the rate of decline is beginning to slow.

Approximately 500 people die early from cardiovascular disease (CVD) each year in Suffolk. There is good evidence that much of the disease is preventable (approximately 14% of CVD deaths are linked to smoking (ASH 2015). Being physically active can decrease the risk of CVD by 33% (British Heart Foundation Centre for Physical Activity and Health 2013). Tackling the substantial and widening excess burden of death due to cardiovascular disease in disadvantaged communities is a major challenge in Suffolk.

The chart shows, like premature mortality from cancer, that the most deprived areas in Suffolk experience significantly raised mortality compared to the county as a whole and the less deprived areas experience lower mortality rates than the county as a whole.

Figure 46: Age standardised mortality rates from diseases of the circulatory system by deprivation decile in Suffolk, people under 75 years old, 2008-12

![Graph showing age-standardised mortality rates from diseases of the circulatory system by deprivation decile in Suffolk, people under 75 years old, 2008-12](image)

Source: ONS (2014a) and Suffolk County Council (2014)
**Long-term conditions**

Health needs arising from long-term conditions are threatening to overwhelm the NHS and social care. By 2020 the number of people living with diabetes, chronic obstructive pulmonary disease (COPD) and coronary heart disease is expected to increase by 21,000. The number of people with high blood pressure is also an indicator of future problems, as untreated it can increase the risk of a heart attack, stroke and kidney disease. It is likely that available data tends to underestimate the true prevalence of long-term conditions as it is reliant on disease registers.

The most common long-term conditions experienced by the Suffolk population are:

- High blood pressure – 14.9% (111,629 on disease register all ages)
- Depression – 7.4% (44,290 on disease register 18 years and over)
- Asthma – 6.6% (49,111 on disease register all ages)
- Diabetes - 6.1% (37,840 on disease register over 17 years old)
- Coronary heart disease – 3.7% (27,948 on disease register all ages)

*Source: PHE (2015), PHE (2015a), HSCIC (2014) and Suffolk County Council (2015)*

Figure 47: Prevalence of diseases by local authority - estimated prevalence of selected diseases, 2013/14, persons of all ages, estimated percentage of population with the disease

*Source: HSCIC (2014) and Suffolk County Council (2015)*
Diabetes

There are 37,840 adults (aged 17 and over) in Suffolk with diabetes (2013/14); this is 6.1% of all registered patients in the county aged 17 and over (PHE 2015a). Diabetes UK estimates that around 850,000 people in England have diabetes but haven’t been diagnosed, suggesting that there are many adults with diabetes in Suffolk that have not been diagnosed.

In terms of the treatment of diabetes, 58.1% of adults with diabetes in Suffolk had well controlled blood glucose in 2013/14. This is worse than the national average. At CCG level, the equivalent figures were 60.9% for Ipswich and East Suffolk CCG (similar to the national average) and 52.0% in West Suffolk CCG (worse than the national average).

Obesity is believed to account for 80-85% of the risk of developing type 2 diabetes, while recent research suggests that obese people are up to 80 times more likely to develop type 2 diabetes than those with a BMI of less than 22 (Diabetes.co.uk 2015). Physical inactivity is estimated to be the main cause of 27% of recorded cases of type 2 diabetes (WHO 2010).

Adult mental health

One in four people will experience a form of mental illness at some point in their lives, and one in six of the population is experiencing a common mental health condition at any one time. Common mental health disorders are anxiety, depression, panic disorders, phobias and obsessive compulsive disorder as well as less common conditions, such as psychosis (Suffolk County Council 2014a).

Estimated people in Suffolk aged 18-64 with a mental health condition in 2014:

- A common mental disorder (see definition above) – 68,423
- A borderline personality disorder – 1,912
- An antisocial personality disorder – 1,489
- Psychotic disorder – 1,700
- Two or more psychiatric disorders 30,606

Source: Projecting Adult Needs and Service Information (PANSI) (2014)

Timely intervention which supports people to improve their emotional wellbeing and resilience is well evidenced. For example, physically active adults have a 20-30% lower risk of depression, distress and dementia (British Heart Foundation Centre for Physical Activity and Health (2013)).

The Suffolk Wellbeing Service is a valuable local resource: www.readytochange.org.uk/Suffolk/pages/Home.aspx

A recent needs assessment has estimated there are around 83,000 people in Suffolk, aged 16-74, with anxiety, depression or both at any one time.

Household surveys provide estimates for levels of less common mental health conditions and also distress and minor mental health issues including sleep problems, irritability, worry and physical symptoms which are caused by anxiety. These minor symptoms affect up to 29% of adults aged 16-74. It has also been shown that, in Suffolk, levels of depression and severe mental illness, self-harm and suicide increase with levels of deprivation.

Personality disorders are a complex group of conditions identified through how an individual thinks, feels and behaves. People with a personality disorder may find it difficult to: make or keep close relationships; get on
with people at work, and friends and family; keep out of trouble or control their feelings or behaviour; listen to other people and avoid becoming unhappy or distressed and upsetting or harming others. The number of people with personality disorder is estimated to be around 24,000 people aged 16 to 74 in Suffolk. More men are affected than women although the type of personality disorder which is most prevalent varies between men and women.

Evidence has also shown that people with mental health conditions are at greater risk of physical ill health and early mortality.

The most recent mortality data shows that among residents of Suffolk in 2013, there were 67 deaths from suicide (from self-harm and injury undetermined whether accidentally or purposely inflicted). Of these 54 were men and 13 women. The main risk factors for suicide are living alone, unemployment, drug or alcohol misuse and a history of mental illness. The majority of suicides occur in males under 60 and the main methods used are hanging and poisoning.

Self-harm is defined as when somebody damages or injures their body on purpose, with a non-fatal outcome. Self-harm is not usually a suicide attempt but a way of expressing emotional distress. It can be associated with alcohol and substance misuse. Self-harm increases the risk of later suicide and can be associated with other mental health conditions.

Hospital admissions following self-harm represent the more severe cases, usually after self-poisoning, and around 60% of admissions are for female patients. There has been an upward trend locally in admissions, increasing in line with national trends. The admission rate for self-harm in Suffolk was significantly higher in women than the rate among men. There is a statistically significant association between age-sex standardised emergency admission rates for self-harm and deprivation in Suffolk.

Mental health problems occurring during pregnancy or in the first postpartum year are referred to as perinatal. Mental health disorders may start at this time or may be pre-existing conditions that relapse or recur and can range from anxiety to severe mental illness, including psychosis.

It is estimated that between 10 and 15% of women experience some mental health conditions during pregnancy. Serious mental illness only occurs in around 2 in 1,000 and there is an increased risk in women with a pre-existing serious mental illness. However psychiatric disorders lead to up to 15% of maternal deaths (in pregnancy and six months post-delivery). Estimates suggest up to 1,500 women in Suffolk per year may experience depression and anxiety during and after pregnancy. A further 40 will experience serious mental illness or psychosis.

**Armed forces**

A recent report concluded the majority of serving and ex-service personnel have good mental health (Samele 2013). However, in those with mental health conditions the most common are depression or anxiety. The Armed Forces Covenant defines the community as: ‘Those towards whom the Nation has a moral obligation due to service’.

Deployed reservists are more likely to experience problems than regulars or non-deployed reservists. There are high levels of heavy alcohol consumption among serving personnel but low reported levels of dual diagnosis (where severe mental illness and
problematic drug and/or alcohol use is diagnosed). The report estimates levels of post-traumatic stress disorder (PTSD) to be between 4-6% in returning personnel from Iraq, compared to 8-15% in US soldiers. Delayed onset PTSD is estimated to occur in 3.5% of personnel. Suicide rates are lower in serving personnel than in the general population, except in males aged under 20. Levels of self-harm are also lower.

A report from the campaigning organisation Forces Watch concluded younger recruits are significantly more likely to suffer post-traumatic stress disorder, to drink at levels harmful to health, and to behave violently on their return from war. It also claims that young recruits from disadvantaged backgrounds are at greatest risk and more likely to lack strong social support when they leave the forces in order to manage their problems. A report is available from the Ministry of Defence (MOD), annual summary & trends over time, 2007/08 - 2012/13, which provides statistical information on new episodes of care of personnel by the Community Mental Health team for outpatient care, and admissions to the MOD’s inpatient care contractor. The populations at risk for new episodes of mental health conditions were: army and RAF personnel, females, non-officer ranks, and those aged between 20 and 39 years. The commonest disorders were adjustment disorder and depression; PTSD was a rare occurrence, accounting for 1.8 per 1,000 of new episodes.

Armed forces population data by CCG and LA is available and gives a figure of 3,600 Armed Services personnel and entitled civilian persons, of which 2,180 are army, 1,400 are RAF and the remainder are Naval or other.

Learning disabilities

For various reasons, including better survival rates, improved diagnosis and changing trends in age of conception, rates of learning disabilities (LD) in children and adults in the UK are predicted to increase by 14% between 2001 and 2021. People with learning disabilities have higher and more complex health needs with significantly different patterns of health and social care usage and higher rates of mortality and morbidity than the general population.

There are an estimated 13,700 people in Suffolk with a mild, moderate or severe learning disability and this is projected to rise by 5% to around 15,000 by 2030. There are an estimated 2,800 people with complex or severe learning disabilities. However, less than 2,000 people are formally registered as having a learning disability on either Suffolk County Council (SCC) or NHS Primary Care LD registers. This difficulty in calculating an accurate county LD population reflects similar difficulties nationally.

Figures show high volume of hospital admissions per year for patients of Suffolk CCGs with an underlying learning disability (1,400 on average). While many admissions relate primarily to the learning disability itself or to the physical condition underlying a learning disability, there are many admissions for conditions related to these disabilities (Suffolk County Council 2014b). Regular health checks are regarded as an essential component of health care for people with learning disabilities. Housing in settled accommodation, access to day services and employment are key social care concerns (Suffolk County Council 2014b).
There are major difficulties in calculating accurate numbers for learning disability populations in Suffolk and across the United Kingdom. In all regions, there is predicted to be a large proportion of the LD population who do not present to health or social care services until late in life and for whom identification of need and potential support is problematic (Suffolk County Council 2014b).

**Lifestyle behaviours**

We know that, by choosing a healthy lifestyle, those living in Suffolk will improve their health and wellbeing. As a county this necessitates organisations working together to create the right environment. For example, the availability of green spaces makes it easier to take exercise. Ensuring that healthy lifestyle messages are clear and appropriate for different audiences is another key theme. In order to ensure individuals are able to maintain or increase their quality of life, access to good quality healthy lifestyle advice and support is vital.

People who do not smoke, eat 5 a day, do the recommended amount of physical activity a week and drink alcohol within the recommended guidelines will have better physical and mental health. This is even more important for people with long-term conditions.

The most recent figures suggest that in Suffolk:
- 18.5% of adults aged 18 and over in Suffolk smoke.
- 65.3% of adults aged 16 and over in Suffolk are overweight or obese.
- 26.6% of adults aged 16 and over in Suffolk are classified as being physically inactive.
- 23.1% of adults aged 16 and over in Suffolk are classified as ‘increasing’ or ‘higher risk’ drinkers.

(Source: Suffolk County Council 2015)

## Smoking

Smoking remains the single greatest cause of ill health and preventable death. Reducing levels of smoking will lead to improvements in health and contribute significantly to reducing inequalities. Smoking related illness kills 3 people every day in Suffolk - more than obesity, alcohol, road accidents and illegal

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Table 14: Learning disability baseline estimates by age for Suffolk districts: 2014 and 2030

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<td>2075/2158</td>
<td>1350/1319</td>
<td>1595/1561</td>
<td>1636/1548</td>
<td>1534/1477</td>
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Source: PANSI (2014). Note: 2030 estimates indicated in blue
drug use put together. In Suffolk, smoking is associated with 6,881 hospital admissions and over 1,100 deaths (around 15% of all deaths) every year. Although smoking prevalence has decreased nationally and locally over recent decades, it is estimated that smoking prevalence in deprived areas is still around 30%. Smoking accounts for about half of the difference in life expectancy seen between our lowest and highest income groups (Marmot 2010). Smoking rates in adults with depression are approximately twice as high as among adults without depression. In addition, people with depression can have particular difficulty when they try to stop smoking and have more severe withdrawal symptoms during attempts to give up (Mental Health Foundation 2015).

Overall in Suffolk almost 1 in 5 people smoke (18.5%), in our poorest communities this is almost 1 in 3. Men in the 20% most deprived areas are more than twice as likely to smoke (32.9%) compared with men in the least deprived areas (14.3%). Smoking rates amongst women are lower than those for men but still highest in the most deprived areas (26.1%) compared to the least deprived areas (10.2%) (Chapelle 2015). For example 2013 data indicates that 14.6% of Mid Suffolk residents were estimated to be smokers overall, for those in routine and manual occupations this estimate rose to 26.2% (PHE 2015a). The following chart looks at estimated smoking prevalence by local authority.

Figure 48: Estimated smoking prevalence by Local Authority, 2011-2013

Smoking is highly addictive and it is difficult to quit despite the vast majority of smokers knowing it is harmful and saying they want to stop. Suffolk County Council spends over £2 m per year on services to help people stop smoking. The proportion of people smoking in Suffolk has lessened but the decrease is slowing.
Estimated smoking population for Suffolk: 117,819

Each year in Suffolk we estimate that smoking costs society approx. £194.5m

- The estimated output lost from early deaths in Suffolk is: £57.9 million
- The estimated cost of lost productivity from smoking breaks in Suffolk is: £41 million
- The total cost to the NHS of smoking in Suffolk is: £38.1 million
- The estimated cost of lost productivity from smoking-related sick days in Suffolk is: £35.3 million
- The estimated cost of passive smoking in Suffolk (from lost productivity due to early death, not including NHS costs and absenteeism) is: £10.1 million
- The cost of smoking related fires in homes in Suffolk is: £7.2 million
- The cost of cleaning smoking materials litter in Suffolk is: £4.8 million

Each year, smokers in Suffolk spend approx. £208.3m on tobacco products. This contributes roughly £158.7m in duty to the Exchequer. This means that there is an annual funding shortfall of £35.7m in this area.

Source: Suffolk County Council (2014)

Figure 49: Costs of smoking in Suffolk summary

Figure 50: Cost of smoking in Suffolk chart

Estimated cost of smoking in Suffolk (£millions)

- Output lost from early death: £57.9 million
- Smoking breaks: £41 million
- NHS care: £38.1 million
- Sick days: £35.3 million
- Passive smoking*: £10.1 million
- Domestic fires: £7.2 million
- Smoking litter: £4.8 million

Source: Suffolk County Council (2014)
Alcohol is a complicated issue. It has potential for great harm, not only associated with serious ill health but also domestic violence, neglect, crime and disorder. But it also plays a significant and important role in our society. The alcohol business sector is particularly important in Suffolk, not only a significant employer but a major player in the county’s tourism industry.

Excessive intake of alcohol poses a significant risk to the health and wellbeing of individuals, families and communities and is the third greatest overall contributor to ill health after smoking and raised blood pressure (NICE 2012). Many adults drink alcohol, and for many it never causes problems. But for some, alcohol is devastating, leading to imprisonment, injury, disability, death, family breakup and poverty. For others it stops them making the best of life, shortening the years in which they enjoy good health or preventing them from doing well at school or work.

A further dilemma is that alcohol use contributes to health inequalities, with less well-off people and communities enduring more of the illness and disruption that alcohol causes.

Data from the Local Alcohol Profiles for England (LAPE) (PHE 2014b) shows that over the past 3 years there has been an average of 5.44 alcohol related deaths each week. This means that in Suffolk approximately 5 deaths each week are due to issues related to excessive alcohol use – such as hypertensive diseases, various cancers and falls.

| Table 15: Alcohol specific and alcohol related mortality in Suffolk, 2010-2012 |
|---------------------------------|---------------------------------|
| **Alcohol specific mortality**  | **Alcohol related mortality**   |
| **2010-12**                     | **2010** | **2011** | **2012** | **2010-12** |
| **Number of deaths**            | **Number of deaths** |
| Males                          | 91       | 191      | 177      | 160         | 527         |
| Females                        | 54       | 114      | 101      | 107         | 322         |
| All persons                    | 146      | 305      | 278      | 267         | 849         |

Source: PHE (2014b)  Note: See the glossary for a definition of terms used
Physical activity

Physical inactivity is the fourth leading risk factor for global death, with 17% of deaths in the UK attributed to it, and is not only associated with obesity but also other diseases and conditions, including coronary heart disease, type 2 diabetes, cancers of breast and colon, chronic obstructive pulmonary disease (COPD), asthma, osteoporosis, depression and dementia. Only 30% of the UK population are active enough to improve their health (Intelligent Health 2014).

- 43.6% of adults in Suffolk (16yrs+) do not meet recommended levels of physical activity.
- Over 50% of adults in Suffolk do no sport or active recreation.
- An estimated 1,000 lives are lost every year in Suffolk due to physical inactivity.
- 74% of people with a limiting disability in Suffolk do not undertake any sport or active recreation.
- 55% of women in Suffolk do no sport or physical activity compared to 44.1% of men.
- The health cost of physical inactivity in Suffolk is £14 million per year.
- 24.3% of adults and 15.7% of year 6 children in Suffolk are obese.
- An older person remaining active in Suffolk and independent at home defers £11,500 per year from social care costs.
- Physical activity reduces the risk of mental health disorders including depression, cognitive decline and dementia and improves self-perception of mental wellbeing, increases self-esteem, lowers likelihood of sleep disorders and enables a better ability to cope with stress.
- 51% of adult residents in Suffolk want to start playing sport or do a bit more sport.

Source: Most Active County (2014)

Physical inactivity is estimated as the principal cause for approximately: 21–25% of breast and colon cancer burden of disease; 27% of diabetes burden and 30% of ischaemic heart disease burden (WHO 2014).

Recommended guidelines (DH 2011) for physical activity in adults are 150 minutes of moderate intensity or 75 minutes of vigorous intensity activity per week. Adults should also undertake physical activity to improve muscle strength on at least two days a week and should minimise the amount of time spent being sedentary (sitting) for extended periods. In Suffolk only 56.4% of adults meet recommended levels of physical activity (PHE 2014). 37,000 deaths per year could be prevented in England if the activity guidelines from the Chief Medical Officer were met (Pakravan 2014).

The estimated annual costs of physical inactivity in Suffolk are as below:

- More than £14 million in total;
- More than £7.6 million for coronary heart disease;
- More than £2.6 million for diabetes;
- More than £1.8 million for breast and colon cancers.

Source: Pakravan (2014)

Compared to a physically active person, a physically inactive person may experience:

- 38% more days in hospital;
• 13% more specialist visits;
• 5.5% more GP visits;
• 12% more nurse visits.

Source: Sari (2009)

**Obesity**

Obesity is an increasing concern in society, costing more than £5 billion each year. More than half of all adults are overweight or obese. Obesity can reduce overall quality of life and lead to premature death. Being overweight or obese significantly elevates the risk of developing diseases and health problems like diabetes, heart disease and certain cancers. The NHS is now spending more on bariatric surgery for obesity than on the lifestyle programmes that were shown to reduce obesity more than a decade ago. Excess weight can also make it more difficult for people to find and keep work, and it can affect self-esteem and mental health (LGA 2015).

It should be noted that regardless of BMI or weight, activity levels have the potential to impact on life expectancy. For example, individuals classified as active but overweight (25 to 29.9 BMI) have the same life expectancy as active and normal weight. However, normal weight but inactive individuals may have 3.1 fewer years of life compared to obese (30 to 34.9 BMI) but active individuals (British Heart Foundation Centre for Physical Activity and Health 2013).

The Chief Executive of the NHS has recently warned that obesity will bankrupt the health service unless Britain gets serious about tackling the problem. The UK has higher levels of obesity and overweight people than anywhere in Western Europe except for Iceland and Malta (Ng et al. 2013).

• In the UK nearly two-thirds of men and women are obese or overweight – more than at any other time in the past three decades.
• Around 800,000 are ‘morbidly obese’ – with a Body Mass Index (BMI) of 40 or higher.
• By 2050, the prevalence of obesity is predicted to affect 60% of adult men and 50% of adult women.
• The World Health Organisation has estimated that between 7% and 41% of certain cancers are attributable to obesity and overweight. Income and social deprivation have an important impact on the likelihood of becoming obese. Women and children in lower socioeconomic groups are more likely to be obese than those who are wealthier.
• Across ethnic minority groups, there are also clear variations in prevalence of obesity, with people, particularly women, of Black Caribbean origin being more likely to be obese than the general population, along with women of Black African and Pakistani origin.
• Estimates suggest that being overweight (BMI 25 to 30) reduces life expectancy by about three years, and being obese (BMI 30 or more) can reduce life expectancy by 10 years. It is difficult to estimate the number of deaths attributable to obesity each year, but it is likely to be at least 6% (30,000 people) in England, with perhaps a third of these before state retirement age (LGA 2015).

Figures from the Active People Survey 2012 show that around two thirds of adults (those aged 16 and over) in Suffolk (65.3%) are classified as having ‘excess weight’ i.e. they
are either overweight or obese. This is not
dissimilar to the national average of 63.5%.
The chart below shows how this ‘excess
weight’ is broken down into those that are
obese and those that are overweight for
Suffolk and for England as a whole.

Around a fifth (21.8%) of adults in Suffolk
are obese, a figure slightly below the
national average of 23.0%. However a higher
proportion of adults in Suffolk are overweight
compared to the England average: 43.5%
compared to 40.8%. The table below shows
the estimated number of people (aged 16+) in
Suffolk that have excess weight.

Figure 51: Excess weight in adults, 2012

Table 16: Excess weight in adults aged 16+ in Suffolk, estimated numbers of people, numbers rounded to the nearest
100, 2012

<table>
<thead>
<tr>
<th></th>
<th>Number overweight</th>
<th>Number obese</th>
<th>Number with excessive weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suffolk</td>
<td>260,300</td>
<td>130,600</td>
<td>390,900</td>
</tr>
</tbody>
</table>

Source: Sport England (2013) and Suffolk County Council (2014)
Data regarding admissions to hospital in Suffolk for patients with a primary or secondary diagnosis of obesity indicates that in 2013/14 there were: 1,303 admissions in the West Suffolk CCG area, 3,323 admissions in the Ipswich and East Suffolk CCG area and 1,476 admissions in the Great Yarmouth and Waveney CCG area (HSCIC 2015). Suffolk has a higher proportion of obesity linked inpatient admissions at 734 per 100,000 people than the East of England (688 per 100,000) and England (679 per 100,000).

A comprehensive range of adult weight management services are provided through an integrated programme of healthy lifestyle services in Suffolk. The services include a 12 week multi-component weight management programme incorporating nutritional advice, behaviour change and physical activity that are normally delivered through supportive group settings in a variety of locations. These include men only courses delivered at Ipswich Town Football Club and those located within partner leisure centres, which also then allows the easy incorporation of access to leisure facilities during the programme. Public Health Suffolk has also partnered with commercial organisations to provide slimming on referral. 1:1 Personal Health Plans are provided by community health coaches and include 6 x 30 minute, one to one client led sessions to support clients to lose weight, learn about healthy eating, increase physical activity or improve their general health and wellbeing. As part of the programme clients set measurable healthy lifestyle goals.

**NHS health check programme**

The NHS health check programme aims to prevent heart disease, stroke, diabetes, kidney disease and certain types of dementia and is available to everyone between the ages of 40 and 74, who has not already been diagnosed with one of these conditions. People are invited once every five years to have an assessment of their risk of these conditions, and are given support to help them reduce or manage the risk. In Suffolk NHS health checks are delivered by GPs or in a group setting such as workplaces. In 2013/14 53.7% (22,857 people) of eligible people completed an NHS health check.

**Living at home in Suffolk**

Housing and health are inextricably linked. Living in a house which is in good condition, which the occupiers can afford to heat and in an area in which they feel safe and well supported underpins the wellbeing of individuals and families.

**Domestic abuse**

Nationally and locally it is recognised that domestic abuse involves an ongoing pattern of behaviour that will inevitably get worse and more frequent over a period of time unless interventions are in place to respond to victims at all levels of risk.

Suffolk County Council supports the national definition which details domestic abuse as:

*"Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality".*
This can encompass, but is not limited to, the following types of abuse:

- psychological
- physical
- sexual
- financial
- emotional

In **Suffolk:**

- There are an estimated 16,000 cases of domestic abuse each year, it is a significant issue across all communities.
- 7,361 domestic abuse incidents were reported to the police in 2011/12.
- 71% of reported incidents are from 17–44 year olds.
- 29% of these are from 17-24 year olds.
- West Suffolk Youth Offending Service report that 44% of young people who offend are from households where there is domestic abuse.
- From police statistics for January 1st 2012 to March 31st 2012, around a third of domestic abuse incidents in Suffolk involved alcohol.
- From police statistics in 2010, between April and June there were 803 domestic abuse incidents where at least one child was present.

During 2015 a Needs Assessment will be completed on Hidden Harm, which will include domestic abuse and will be added to the suite of resources as part of the JSNA.

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**Figure 52: National information on domestic abuse**

- The number of women killed each week by their partner or ex-partner: 2
- Female victims of serious sexual assault that were assaulted by their partner or ex-partner: 54%
- The proportion of domestic violence incidents that are repeated incidents. Victims of domestic violence are more likely to experience repeat victimisation than victims of any other types of crime: 76%

**Sources:** Womens Aid (2011), Smith, Coleman, Eder et al (2011), Chaplin, Flatley and Smith (2010)
**Housing**

“*In 90% of rural local authorities the average homes costs over eight times the average salary.*”

*National Housing Federation (2014)*

Data from Zoopla (September 2014) indicates that the average property value in Suffolk was just under £236,000. The average asking price for a property was £314,108 and the average rent was £1,012 per calendar month. Over the last 5 years the average price paid was £201,891, with over 52,000 property sales recorded (Zoopla 2014).

The top three towns with the highest turnover (number of sales over the last 5 years (excluding new build properties) divided by the number of homes in a given area) in Suffolk are Aldeburgh (16.0% turnover), Haverhill (15.5% turnover) and Southwold (15.4% turnover) (Zoopla 2014).

According to the report published by the National Housing Federation, there are 62 rural local authorities where houses are less affordable than London (National Housing Federation 2014). They took local salaries into account, mapping the affordability of homes for the people who live in those areas (ibid). All 5 of Suffolk’s rural areas featured in the list (excluded areas were Ipswich and Waveney). St Edmundsbury had the highest affordability ratio – where the median house price was 11.7 times the mean annual earning of a resident.

Table 17: National Housing Federation Affordability Ratio Data: House prices vs income levels by rural local authority in England

<table>
<thead>
<tr>
<th>Name</th>
<th>Median house price</th>
<th>Mean earning</th>
<th>Affordability ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>St. Edmundsbury</td>
<td>£227,117</td>
<td>£19,438</td>
<td>11.7</td>
</tr>
<tr>
<td>Babergh</td>
<td>£236,527</td>
<td>£20,462</td>
<td>11.6</td>
</tr>
<tr>
<td>Suffolk Coastal</td>
<td>£255,997</td>
<td>£22,589</td>
<td>11.3</td>
</tr>
<tr>
<td>Mid Suffolk</td>
<td>£219,787</td>
<td>£20,873</td>
<td>10.5</td>
</tr>
<tr>
<td>Forest Heath</td>
<td>£179,541</td>
<td>£18,221</td>
<td>9.9</td>
</tr>
</tbody>
</table>

Source: National Housing Federation (2014). Note: Ipswich and Waveney excluded as not classed as rural for this analysis

“*High house prices, low wages, seasonal rental and jobs markets, high levels of second home ownership, and an ageing population are all placing pressure on to rural communities and local services... Families and young people are still being priced out of our villages and market towns. Housing associations are addressing the challenges faced by rural areas, not only through the supply of new and affordable homes, but also through the range of other specialist services they provide*”.

*National Housing Federation (2014)*
Suffolk has a higher percentage of second homes when compared to England as a whole (1.8% vs 1.1%), but when this figure is broken down to local authority level, this is mainly inflated by the high proportions of second homes in the coastal areas of Suffolk Coastal and Waveney. The proportion of higher banded properties (D-H) is highest in Suffolk Coastal (see Figure 51 below). Higher banded properties incur higher council tax payments.

**Suffolk employment**

There is a strong link between better education, better employment and better health and wellbeing outcomes.

Although unemployment and worklessness rates in Suffolk are generally lower than nationally, wage rates are persistently lower. Improving educational attainment and workforce skills remain important challenges in attracting more well-paid jobs and taking advantage of new employment sectors.
2014 data indicates there were 369,700 economically active ‘working-age’ (16-64) residents in Suffolk.

In 2013, there were some 356,000 jobs in Suffolk – including employees, self-employed, government-supported trainees and HM Forces.

Resident analysis shows that in 2014, the median earnings of full-time workers residing in Suffolk were approximately £26,000 per year. This lags behind the average in the East of England (£28,700) and England (£27,500).

Source: Nomis (2015)

Figure 55: Employment by occupation (SOC 2010) in Suffolk districts and boroughs 2013/14

Source: Nomis (2014). Note: More information on the New Anglia LEP can be found in the ‘Painting a picture of Suffolk’ section, however it encompasses the geographical areas of Suffolk and Norfolk.
Employment by occupation

Employment by occupation provides an indication of the skill levels and earnings of residents. The first two occupation types (managers, directors and senior officials and professional occupations) generally require high skill levels and command higher salaries. More Suffolk residents are employed in these jobs than on average across England and Wales, although there is variation at district and borough level. Suffolk has a diverse employment base with a broad mix of jobs. Current priority growth sectors in the Suffolk economy include ICT, advanced manufacturing and engineering, energy and biotech.

St Edmundsbury and Suffolk Coastal have a high proportion of residents employed as managers, directors and senior officials and in professional occupations, reflecting the relative affluence of these local authorities. Ipswich residents tend to be employed in lower skilled occupations such as sales and customer service and elementary occupations.

Over a quarter of residents in Forest Heath are employed in professional and technical occupations, reflecting the presence of the USAF air bases of Mildenhall and Lakenheath in the district and is significantly above the national average. The withdrawal of the United States Airforce from Mildenhall is likely to impact upon the economy over the next four years. Waveney has a lower proportion of people holding professional occupations, but almost one in five residents in the district are employed in skilled trades work, where earnings are above average.

Despite higher levels of managers, directors, senior officials and professional occupations, levels of pay are consistently below the regional and national average; a significant challenge in the Suffolk economy. There is little sign of the gap closing according to the last eight years of data, with earnings in Suffolk declining slightly to fall further behind during 2010-2012. In 2014, gross weekly earnings for Suffolk workplaces were £467, approximately £53 below the Great Britain average and £39 below the regional average (Nomis 2015).
**Adult qualifications**

The percentage of adults educated to the highest level (NVQ level 4+, most often this equates to undergraduate degree level or above) is lower in Suffolk (27.7%) than the national average (33.1%). 8.7% of Suffolk residents have no qualifications compared to 10.1% across England and Wales.

Suffolk Coastal and St Edmundsbury have above average skill levels and very low levels of people with no qualifications.

Almost a third of the adult population of Forest Heath is educated to NVQ 4+ level, just below the national average, but there is an above average proportion of residents in the district with no qualifications. Waveney has a low proportion of residents educated to NVQ level 4 and above, with fewer than one in five adults in the district at this skill level.

**Unemployment**

Unemployment in Suffolk is consistently below the national average, and is usually below the New Anglia LEP average. Unemployment levels have increased over the past eight years due to the recession, though there are signs that they are beginning to fall again.

**Job Seekers Allowance (JSA) claimants**

Job Seekers Allowance claimant statistics provide a proxy for unemployment and are released regularly at local geographical levels.
The number of people claiming Job Seekers Allowance has seen a sustained decrease since early 2012 aside some seasonal peaks at the beginning of subsequent years. Claimant unemployment levels are highest in Ipswich (2,384 in August) and Waveney (1,412), while the remaining local authorities in Suffolk each have less than 1,000 residents claiming Job Seekers Allowance.

Areas of relatively high claimant rates in Suffolk are concentrated in urban areas, particularly Ipswich and Lowestoft. There are smaller pockets of claimant unemployment in many market towns such as Haverhill, Sudbury, Stowmarket and even Woodbridge.

The prison population

There are three prisons within Suffolk. HMP Norwich and HMP Wayland in Norfolk serve as resettlement prisons for the Suffolk population. The prisons located in Suffolk are:

- Warren Hill Prison – located near Woodbridge in Suffolk, this prison ceased to be a male juvenile young offender institution in early 2014, and was re-categorised as a category C (prisoners who cannot be trusted in open conditions but are unlikely to try to escape) male establishment.
- Highpoint - a large category C prison near Newmarket in Suffolk that holds about 1,300 adult men on two distinct sites, Highpoint North and South.
- Hollesley Bay - an open prison in Woodbridge, Suffolk for adult men, including young offenders aged 18-21.

Sources: Criminal Justice Inspectorates (2015) and Justice (2015)

The prison population include some of the most vulnerable members of society. Prisoners
have a disproportionately higher incidence of mental health disorders, drug misuse, blood borne viruses and sexually transmitted diseases. Around two thirds of prisoners are aged between 21-40 years old, and the most common physical disorders suffered by prisoners are asthma, diabetes, cardiovascular disease and blood borne viruses. Monthly prison population data for August 2014 (Ministry of Justice 2014) is provided in Table 18.

Prisoners also have high levels of “health risk” behaviours such as substance and alcohol misuse and smoking, which increase their chances of poor health and premature death in the future. Smoking is more common among offenders, and there is a strong relationship between high smoking prevalence and low socioeconomic status. However, smoking prevalence is much higher among prisoners than among lower socioeconomic groups as a whole (PHE 2015b). Tackling health inequalities is a national and local priority for prison health care.

The Care Act placed responsibility on Local Authorities for the social care needs of prisoners within the county from April 2015, whereas the responsibility for healthcare provision is the responsibility of NHS England.

### Key issues

#### Inequalities:

- Health outcomes for the most deprived people in Suffolk are significantly poorer than those living in more affluent communities.
- There were 5,954 premature deaths (people under 75 years of age) in Suffolk between 2011 and 2013. Premature deaths from cancer are up to 40% higher in the 20% most deprived parts of Suffolk.
- Tackling the widening excess burden of death and ill health due to cardiovascular diseases (CVD) in disadvantaged communities is a major challenge. It includes the need to continue to maximise population coverage of effective treatments and target initiatives to reduce lifestyle risk factors towards the most deprived communities in Suffolk.
- Late diagnosis is a recognised key factor in contributing to poorer outcomes from cancer and is more common amongst lower socioeconomic groups and in some ethnic minority groups.

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Table 18: Prisons in Suffolk and current population (August 2014)

<table>
<thead>
<tr>
<th>Prison name</th>
<th>Operational capacity</th>
<th>Population (includes prisoners on authorised absence)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Highpoint (North and South)</td>
<td>1,343</td>
<td>1,326</td>
</tr>
<tr>
<td>Hollesley Bay</td>
<td>437</td>
<td>431</td>
</tr>
<tr>
<td>Warren Hill</td>
<td>208</td>
<td>180</td>
</tr>
</tbody>
</table>

*Source: Ministry of Justice (2014)*
• An in-depth understanding should be developed of the needs of protected groups and vulnerable people including Female Genital Mutilation and Sickle Cell, through the commissioning of a suitable needs assessment.

• The percentage of people rating their health as bad or very bad in the most deprived areas was twice as high compared to the least deprived areas (see figure 8).

• The rate of early deaths in males is twice as high when directly comparing the most and least deprived areas. The rate of early deaths in females is also greater when directly comparing the most and least deprived areas (see figure 8).

• Smoking rates in adults with depression are almost twice as high as among adults without depression.

• Smoking is more common among offenders, and there is a strong relationship between high smoking prevalence and low socioeconomic status. However, smoking prevalence is much higher among prisoners than among lower socioeconomic groups as a whole.

**Opportunities for prevention:**

• There is good evidence that many early deaths from cardiovascular disease are preventable. Approximately 500 people die early in Suffolk from cardiovascular disease each year with 15-20% linked to smoking.

• About half of cancers could be prevented by lifestyle changes and lifestyle factors account for the most variance in cancer incidence between the most and least deprived population groups.

• Improve management of risk factors for disease such as high blood pressure and diabetes.

• Increase the uptake of the NHS Health Check, which aims to decrease the risk for heart disease and stroke.

• Maintain strong cancer screening coverage and ensure new programmes are effective.

• Increase public awareness of early cancer signs to improve early diagnosis.

• Continue to improve healthy lifestyles in Suffolk particularly around alcohol and tobacco use and physical activity.

• By 2020 the number of people living with diabetes, chronic obstructive pulmonary disease (COPD) and coronary heart disease is expected to increase by 21,000.

• Alcohol is the leading risk factor for preventable death in 15-49 year olds.

• The systematic approach agreed by the Health and Wellbeing Board should drive down the numbers of people smoking in Suffolk.

• A comprehensive, co-ordinated system wide approach to prevention should be developed at a population and individual level including primary, secondary and tertiary prevention (see glossary for definitions).

• Increase the number of people who are of a healthy weight. The long-term obesity issues should be addressed, including
supporting people to maintain weight loss especially those with long-term conditions such as diabetes.

• We need to ensure that physical activity is a normal part of daily life, making it easy, and cost-effective in every community.

• Premature mortality due to cancer requires a concerted and co-ordinated approach by all organisations and communities in improving prevention and public awareness. Early diagnosis and treatment is required to ensure that premature mortality from cancer continues to fall.

• People of all ages with disabilities are living longer and have higher survival rates due to advances and improvements in health and care, this means that demand for services is also rising.

• One in four people will experience a form of mental illness at some point in their lives, and one in six of the population will experience a common mental health condition at any one time.

**Service implications:**

• In 2013/14 just over half (53.7% (22,857 people)) of eligible people completed an NHS health check.

• The impact of population change and its related impact e.g. increases in migrant workers, their contribution to employment, impact on service demand, and changing community dynamics needs to be understood in more detail.

• Reductions in public sector funding, require innovative ways of delivering services including building community resilience, making the most of community assets, and supporting people to help themselves.

• The Care Act placed responsibility on Local Authorities for the social care needs of prisoners within the county from April 2015. The social care needs of prisoners are more complex than those of the general population, and level of demand is currently unknown.
As people age, develop long-term conditions and become frailer, it is important to support them to remain healthy and socially connected so that they can remain independent and manage their own care and support needs for as long as possible.

15,000
The number of people in Suffolk who go up to a month without speaking to anyone

70%
The percentage of 65+ year olds owning their home outright in 2011

59,000
The predicted 85+ population in 2037, a large increase from 21,500 in 2012

31.1%
By 2037, it is anticipated that almost a third of the population in Suffolk will be 65+ (257,000 people)

153,000
or 20.9%
The estimated number of people in Suffolk aged 65+ in 2012
As the population of older people in Suffolk increases we want to ensure they can enjoy a good quality of life. It remains a challenge to create an environment that enables older people to be active, engaged and independent in safe, supportive communities that value their experience and contribution. Maintaining physical and mental health and emotional wellbeing ensures that older people can contribute to society as equal citizens. Physical activity declines with age to the extent that by the age of 75 years only one in ten men and one in 20 women are active enough for good health (PHE 2014). This is important because people who enter old age healthily have a longer healthy life expectancy, free of disability. In Suffolk people on average are likely to develop a long-term illness or disability before they reach 65 and most of this is due to conditions such as coronary heart disease, diabetes, cancer and stroke. However, if individuals reach retirement without developing a disability they are estimated to live a further 8.5 years (males) and 9.7 years (females) in good health.

Around a third of people over 65 volunteer at least once a month, many provide childcare for their grandchildren, and many more provide care for their relatives or friends. Older people continue to contribute to the local economy (estimated at £100 billion nationally) and are more likely to be active participants in their own local communities. Older people are also more likely to vote.

It is widely recognised that as the proportion of older people increases, the current way health and social care services are provided is unlikely to be sustainable. Choosing a healthy lifestyle is likely to reduce demand on health and social care in the long-term and evidence based treatment of conditions such as cancer, coronary heart disease, diabetes and stroke can contribute to healthier life expectancy. Appropriate housing, access to transport and a safe environment can help improve quality of life, independence and promote social inclusion. Evidence suggests that social isolation is a contributing factor in over 60% of preventable illnesses.

Tackling excessive alcohol use, reducing falls and associated injuries, physical activity programmes, good quality housing and well-designed living environments are crucial (e.g. safe road crossings, good public transport, and access to green spaces for exercise and relaxation) (WHO, 2009).

**What are we doing well since the last report in 2011?**

- The health and social care system in Suffolk is being redesigned to provide person-centred coordinated care. This will shift the system from the current reactive model to a more proactive and planned model which focuses more on prevention and self-care. The Better Care Fund has been created to support some of these changes and early adopter site have been established in Sudbury and Ipswich.

- A new system of social care, Supporting Lives; Connecting Communities is a person centred approach to planning and designing care, collaborative working between all organisations involved in a person’s care, keeping people living independently at home, helping people to help themselves, putting people in touch with what’s happening in the community that can help them, getting people back to
independence as quickly as possible after a crisis and providing ongoing support for those that need it.

- A new model of working has been introduced, based on having asset based conversations with people which focus on helping them help themselves with short term support at appropriate times.

- Risk stratification is being rolled out across GP practices in Suffolk to enable case finding and case management to support people living with multiple conditions (often frail and elderly). The use of this tool can help in many ways, e.g. enabling a GP practice to identify patients who have a high number of A&E attendances.

- West Suffolk CCG and Ipswich & East Suffolk CCG have established Integrated Falls and Fragility Fracture (FFF) prevention groups, a falls prevention strategy and are actively working on promoting falls prevention and bone health across the county.

- The use of telecare and assistive technology is increasing in Suffolk, e.g. Ipswich & East CCG project on assistive technology for falls and fracture prevention; West Suffolk CCG project using “Airedale model” (telecare to support care homes).

- Ipswich and East Suffolk CCG is providing strength and balance exercise and falls rehabilitation programmes, aimed at maintaining health and wellbeing, social activity and a positive attitude to prevent falls and fractures.

- Launch of the Ipswich Falls Directory of Services for health and social care professionals.

- A Suffolk prevention strategy is currently being developed.

- A Suffolk Care Homes group has been established which is working to improve the quality of care for people living in care homes.

- A Dementia Needs Assessment has been completed and an Integrated Dementia Commissioners Group established to take forward some of the recommendations from the report. The Health and Wellbeing Board is supporting the development of Dementia Friendly communities.

- A Housing and Health Charter for Suffolk 2014 has been developed by the Suffolk Strategic Housing Partnership in conjunction with the Health and Wellbeing Board.

- The Warm Homes Healthy People project was started in 2011 to help prevent an estimated 350 deaths in Suffolk each winter. It won the National Energy Action and British Gas Community Action Awards 2013-14.

- Beginning to address social isolation and loneliness. For example the rural coffee caravan campaign in 2013, and a campaign to reduce social isolation and loneliness in 2015 by Age UK.

- The Fit Villages programme has been commissioned to deliver physical activity opportunities in rural communities mainly for older people.
What our population looks like

- In 2012, there were 153,000 people aged 65 and over living in Suffolk, accounting for 20.9% of the county’s total population.
- Of these, 131,500 were aged between 65 and 84 years, and 21,500 were aged 85 and over.
- By 2037, it is anticipated that almost a third (31.1%) of the population in Suffolk will be aged over 65 (257,000 people).
- A third (33.1%) of Suffolk residents living in care homes are aged 65 to 84 years old (1,611 people), whilst more than half (57.1%) are aged 85 or over (2,774 people).
- Minority Ethnic Groups make up 1% of Suffolk’s over 65 population (1,500 people) compared to 4.7% within England as a whole. Older people within this group are likely to have specific needs. Information and services therefore need to be tailored to meet these in order to ensure that they are not disadvantaged.

Sources: ONS (2013), ONS (2013a) and Suffolk County Council (2015)

More on demographics

The over 65 population is expected to account for a higher percentage of the national population by 2037, but in Suffolk the figure is considerably higher; almost a third of Suffolk’s population in 2037 will be people aged over 65.

- 257,000 people aged over 65;
- 198,000 aged 65-84 years;
- 59,000 aged 85 and over.

The percentage of males and females in Suffolk changes as the population ages.

Figure 58: Population 65+, projected increase 2013 and 2037

<table>
<thead>
<tr>
<th>Persons aged 65 and over as a percentage of persons of all ages</th>
<th>Suffolk County and England 2013 and 2037</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>2037</td>
</tr>
<tr>
<td>65-84 years</td>
<td>85 years and over</td>
</tr>
<tr>
<td>Suffolk</td>
<td>England</td>
</tr>
<tr>
<td>18.5%</td>
<td>15.7%</td>
</tr>
<tr>
<td>23.9%</td>
<td>19.1%</td>
</tr>
<tr>
<td>3.0%</td>
<td>3.0%</td>
</tr>
<tr>
<td>7.1%</td>
<td>5.0%</td>
</tr>
<tr>
<td>21.5%</td>
<td>18.7%</td>
</tr>
<tr>
<td>31.1%</td>
<td>24.0%</td>
</tr>
</tbody>
</table>

Source: ONS (2014)
• 65 and over: 45.9% males and 54.1% females.
• 65 to 84 years: with 47.5% male, 52.5% female.
• 85 years and over: 35.8% males, 64.2% females.

Source: ONS (2013)

The chart opposite shows the current percentage of Suffolk’s population accounted for by people aged 65 and over and how this is expected to change by 2037. Figures for England are shown for comparison (2012 based population projections).

Life expectancy at 65 in Suffolk

The healthy life expectancy of an individual is important, as it is not only the amount of time lived, but the quality of life that has a great impact on wellbeing as a whole. In Suffolk men can expect a healthy life expectancy of 66.1 years, and women 68.2 years (2010-12 data). For England this figure is slightly lower, men can expect a healthy life expectancy of 63.4 years, and women 64.1 years.

Figure 59 shows trends in overall life expectancy at age 65 for males and females in Suffolk and England from 2000 to 2013. Life expectancy at 65 increased steadily from 2000 and 2012. Between 2010 to 2012 it was significantly higher in Suffolk compared to England as a whole.

Life expectancy at age 65:
• Males in Suffolk 19.4 years, compared to 18.6 years in England.
• Females in Suffolk 21.8 years compared to 21.1 years in England.

Figure 59: Life expectancy at age 65 for males and females in Suffolk and England from 2000-2013

Source: ONS (2013b)
Mortality (death)

In 2013 there were 6,498 deaths from all causes in people aged 65 years and over which accounted for 87.3% of all deaths in Suffolk.

Figure 60: Deaths age 65+ in Suffolk, 2013

Source: ONS (2014a)
Mortality rates in the elderly in Suffolk were higher in males than in females. For both males and females in all age groups mortality rates in the elderly in Suffolk decreased between 2003-07 and 2008-12. This decrease in mortality rates in the elderly reflects the increase in life expectancy at age 65 that occurred in Suffolk during the period.

Figure 60 shows that in all elderly age groups mortality rates for all causes of death were lower in Suffolk than in the East of England and England as a whole. This probably reflects the relative affluence of Suffolk compared to the East of England and England. However, in all areas mortality rates in these age groups decreased between 2003-07 and 2008-12.

Source: ONS (2014a)

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3 Note: The ONS mid-year estimates for Suffolk in 2013 contain an error relating to the foreign armed-forces population of Forest Heath and neighbouring districts. Therefore rates have been calculated using 2012 data.
Deaths by cause among the elderly in Suffolk

The leading causes of mortality in over 65s are:

- Cardiovascular disease
- Cancer
- Respiratory diseases

Poverty and deprivation

The Income Deprivation Affecting Older People Index (IDAOI) is a measure of income deprivation amongst residents aged 60 years and over (DCLG 2011).

The map shows that the most deprived wards in Suffolk on the IDAOPI are spread across the county. Many wards in Ipswich and Lowestoft feature in the most deprived fifth of the population, along with pockets in Beccles, Brandon, Bury St Edmunds, Felixstowe, Haverhill, Leiston, Newmarket, Sudbury, and Wickham Market.

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Note: The ONS mid-year estimates for Suffolk in 2013 contain an error relating to the foreign armed-forces population of Forest Heath and neighbouring districts. Therefore rates have been calculated using 2012 data.
The health of Suffolk’s older population

General health and limitation of daily activities

The 2011 Census asked people aged over 65 in Suffolk to report on their health and ability to continue day-to-day activities. Figure 64 shows how people aged over 65 self-rate their day to day health in Suffolk showing it is similar to the England average.

Figure 64: Self-reported health status in people aged 65+, 2011

Source: ONS (2013a)
The diagram above shows how people over 65 rate their limitations to participate in daily activities. Almost a quarter of 75 to 84 year olds and half of over 85’s report that their day to day activities are limited by poor health.

Long-term conditions and hospital admissions

As people get older they develop more long-term conditions e.g. dementia, osteoporosis, diabetes and COPD. 50% of people over 65 have two or more long-term conditions, once over 75 years this percentage rises to 70% and for the over 80s those with three conditions is 60%. Figure 64 shows that over time the number of long-term conditions any one individual may have increases with age.
Hospital admissions and falls

Overall, in Suffolk, there is also an increasing trend in emergency admissions to hospital for those aged 75 years and above. National data indicates that an increasing number of patients are older and frail, and nearly two thirds (65%) of people admitted to hospital are over 65 years old (Royal College of Physicians 2012).

Falls are a leading cause of death and disability in older people, with between 10-25% of people who fall sustaining a serious injury. Falls have a significant impact on individuals and the health and social care system. Hip fracture is the most common serious injury related to falls in older people (DH 2009). Falls are a leading cause for spiralling decline into vulnerability and dependency in many of Suffolk’s older people. Mortality and morbidity are high - with about 10% of people sustaining hip fracture dying within one month, 50% ending up permanently disabled, and 30% dying within 12 months.

Close to half of previously independent older people become partly dependent and a third become totally dependent, following a hip fracture. Multi-factorial assessment and interventions which include physical exercise programmes (strength and balance training) have been shown to be effective and are likely to enable older people to remain independent longer.

There is a relationship between physical activity and hip fracture risk, the more physical activity people do the less their risk of suffering a hip fracture. Individuals doing the greatest amounts of moderate physical activity may experience a 36-38% reduction in the risk of a hip fracture (British Heart Foundation Centre for Physical Activity and Health (2013)).

According to the National Hip Fracture Database, numbers of people aged 60 years and over with a hip fracture who were admitted to Suffolk hospitals in 2013 are as follows:

- Ipswich Hospital: 466
- James Paget Hospital: 352
- West Suffolk Hospital: 337

National trends and costs associated with falls and fragility fracture is growing, and the DH predict double the associated costs by the year 2020. They also estimate a 35% increase in incidence of hip fracture by the year 2020.

Data from the National Hip fracture Database (NHFD) also shows that over 20% of all older people admitted to Suffolk hospitals with a hip fracture in 2013 were discharged to nursing or residential care. Work done on joining up older peoples services in Suffolk also identified falls as the leading reason for permanent admission to long-term residential care in Suffolk – with each placement carrying a mean life-time cost of £64,000 to adult social care budgets. There is strong evidence on the effectiveness of falls prevention interventions, and this should be used systematically to reduce the incidence of falls in Suffolk.

Dementia

Dementia is a syndrome in which there is deterioration in memory, thinking, behaviour and the ability to perform everyday activities. Although dementia normally affects older people it is not a natural consequence of old age and there is evidence that there is potential to delay both the onset and progression of the condition.

It is caused by a variety of diseases and injuries such as Alzheimer’s disease or stroke and is one of the leading causes of disability and dependency among older people.
The number of people in Suffolk living with the condition is projected to increase. Currently of those diagnosed with the illness, around one third of those affected live on their own and over two thirds live in a care setting. The population aged 65 and over is expected to increase by over 75,000 people (49%) from 2012 to 2030. As a result, there will be a rise in the number of people living with health problems and in particular dementia, placing even more pressure on dementia services in Suffolk. Dementia has a significant impact on the quality of life of those living with the condition and the family and friends who care for their loved ones. The condition is complex and can cause extensive physical, psychological, emotional and financial stresses to those with dementia, their family carers and the wider community.

There is a significant focus on improving diagnosis and support for people with dementia and their carers to enable them to live as independently as possible, but only a small proportion of the total population have access to services and there is variation in the accessibility of services across the county. In Suffolk, it is estimated that approximately 6,000 people with dementia remain undiagnosed.

Raising awareness of dementia among the general public and professionals will help reduce fear, stigma and social isolation that people with dementia and their family carers experience. The Health and Wellbeing Board have committed to support making Suffolk a dementia friendly community.

Table 19: Total numbers predicted to have dementia aged 65+, Suffolk

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2025</th>
<th>2030</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total numbers predicted to have dementia aged 65+</td>
<td>11,771</td>
<td>16,336</td>
<td>19,454</td>
</tr>
</tbody>
</table>

Source: Projecting Older People Population Information (POPPI) (2014)

Useful resource:
Dementia Needs Assessment

Positive mental health and reducing social isolation

15,000 people in Suffolk go up to a month without speaking to anyone.

Source: Age UK Suffolk (2015)

Older people are particularly vulnerable to social isolation or loneliness which may be due to loss of friends and family, mobility or income. It can adversely affect health and wellbeing and increase use of GPs, the local police and social care services. There is strong evidence of a link between loneliness and poor physical and mental health and wellbeing, with a marked negative effect on mortality. Social isolation is a contributing factor in over 60% of preventable illness.

The influence of social isolation or loneliness on the risk of death is comparable with well-established risk factors such as smoking and alcohol consumption and exceeds the influence of other important risk factors such as physical inactivity and obesity (Holt-Lunstad et al. 2010). It also produces changes in the body that increase the risk of heart disease (Ong et al. 2012).
Depression is the most common mental health condition in older people - some 13-16% have sufficiently severe depression to need treatment. Men are more likely than women to die by suicide at all ages. This is also true for older men over 75, who have higher rates of death by suicide. This may reflect the impact of depression, social isolation, bereavement or physical illness. Alcohol dependency is also common among older adults who attempt suicide (DH 2012).

Interventions to improve older people’s mental health and prevent depression can also promote independence. These include group activities, social support to reduce social isolation and loneliness, interventions in healthcare settings e.g. counselling and mental health education (IDeA 2009).

Creating age-friendly physical and social environments will have a big impact on improving active participation and independence of older people (WHO 2013).

Lifestyle factors

Prevention plays a central role in supporting healthy ageing. People who enter old age healthily with few or no limitations to daily living, have higher life expectancy, use up fewer resources and do better than those who smoke, are obese or have a long-term condition (WHO 2009), which indicates that investing in primary prevention is beneficial.

Smoking remains one of the leading causes of premature death and disability. Behaviour related factors such as smoking, being overweight and physical inactivity have been found to be strongly associated with disability, which have an impact on life expectancy and disability-free life expectancy. Reducing obesity and smoking and increasing physical activity levels could significantly reduce the amount of time lived with a disability. Improving population health and health-related behaviour could potentially reduce demand on social care in the long term (IDeA, 2009).

Programmes to support healthy ageing should therefore include smoking cessation programmes. National estimates suggest that in 2010 13% of people aged 60 and over smoked cigarettes (ONS 2012). Assuming this percentage is applied in Suffolk, this suggests:

Around 25,300 people aged 60 and over in the county smoke.

Giving up smoking between 60-75 years of age for example, can reduce the risk of premature death by 50%.
Older people and alcohol

A national survey by the Institute of Alcohol Studies indicated that 63% of males and 42% of females aged 65 and over had drunk alcohol in the week prior to completing the survey (Institute of Alcohol Studies, 2014).

These figures suggest that in Suffolk 45,700 males and 35,900 females aged 65 and over had drunk alcohol in the week prior to the survey (total: 81,600). The table below shows how this breaks down for the 65-84 year old and over 85 age groups (numbers rounded to the nearest 100).

Excessive drinking in the older age groups is rising, with alcohol related deaths in the UK in 2012 up 18% for men and 12% for women, aged 75 and over. Alcohol-related hospital admissions, illnesses and mental health disorders are also rising (Siddique 2014) with a third of older people with drinking problems developing them for the first time in later life.

Bereavement, physical ill health, difficulty getting around, becoming a carer, social isolation and loneliness can lead to boredom and depression and alcohol can make these difficulties more bearable. There is less pressure to give up drinking than with younger people, especially when there is no pressure to go to work, fewer family responsibilities, changes in routine or other circumstances (Royal College of Psychiatrists 2014).

There is growing evidence to suggest that safe drinking levels for older people could be less than the current recommended daily limits as they break down alcohol more slowly than younger people. Approximately a third of all prescribed drugs are prescribed to the over 65s and alcohol can interfere with some medicines and increase the likelihood of confusion and falls (Royal College of Psychiatrists 2011).

Table 20: Estimated number of older people in Suffolk drinking alcohol in the past week

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Males</th>
<th>Females</th>
<th>Total persons</th>
</tr>
</thead>
<tbody>
<tr>
<td>65-84 years</td>
<td>40,700</td>
<td>30,000</td>
<td>70,700</td>
</tr>
<tr>
<td>85+ years</td>
<td>5,000</td>
<td>6,000</td>
<td>10,900</td>
</tr>
<tr>
<td>All persons 65+</td>
<td>45,700</td>
<td>35,900</td>
<td>81,600</td>
</tr>
</tbody>
</table>

Source: Derived from Institute of Alcohol Studies (2014)
Learning new skills

More than half of older people (aged 65+) in Suffolk use the internet (52.9%) (Age UK 2013). This makes the county one of only four in England where the percentage of older people ‘online’ is greater than the percentage that are ‘offline’. Applied to the latest population estimates this suggests around 83,600 older people in Suffolk are ‘online’. As services become more digitalised across the county this still leaves almost half of the older population unable to access them.

Grandparents

Grandparents can play a vital role in a child’s development and wellbeing, and they can offer support, and guidance to both parent and child. A 2013 survey indicated 7million grandparents provide regular childcare for their grandchildren aged under 16 in Great Britain (Trade Union Congress 2014).

Housing, care and independence

Housing

Housing and health are inextricably linked. Safe and warm accommodation is essential to personal wellbeing for people of all ages. It enables people to access basic services, build good relationships with neighbours and others to maintain independence.

As people grow older their housing needs change with 70%-90% of time spent in the home, indicating that a warm, secure environment that meets individual needs is crucial for health and wellbeing (Baltes et al.1990). It is estimated that around £35,000 in

Figure 67: Older people online, 2013

Older people ‘online’

Percentage of residents aged 65 and over using the internet
Top and bottom 5 areas in England

<table>
<thead>
<tr>
<th>Area</th>
<th>% of over 65’s resident in area</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suffolk</td>
<td>63.0%</td>
</tr>
<tr>
<td>Bedfordshire</td>
<td>53.8%</td>
</tr>
<tr>
<td>Buckinghamshire</td>
<td>53.4%</td>
</tr>
<tr>
<td>Oxfordshire</td>
<td>52.9%</td>
</tr>
<tr>
<td>Surrey</td>
<td>50.0%</td>
</tr>
<tr>
<td>Hall &amp; East Ridng</td>
<td>31.5%</td>
</tr>
<tr>
<td>South Yorkshire</td>
<td>31.3%</td>
</tr>
<tr>
<td>Cumbria</td>
<td>30.2%</td>
</tr>
<tr>
<td>West Yorkshire</td>
<td>29.7%</td>
</tr>
<tr>
<td>Tyne &amp; Wear</td>
<td>27.7%</td>
</tr>
</tbody>
</table>

Source: Age UK (2013)
care costs could potentially be saved each year per household, if a fully joined up approach was taken to making homes fit for purpose (Suffolk County Council 2014). There is a need to stimulate the market in housing through better planning and support for older people to move into appropriate housing that meets possible future needs before crisis arises.

At the 2011 Census (ONS 2014) 77% of people aged 65 or over in Suffolk owned their homes, (either outright or with a mortgage or loan or shared ownership), compared with 77.0% in East of England and 74.6% in England as a whole. In local authority districts, this ranged from 69.4% in Ipswich to 80.8% in Suffolk Coastal. 70% of those aged 65 and over owned their home outright with no mortgage (or shared ownership) in Suffolk.

23% of people aged 65 or over in Suffolk rented their homes, compared with 23.0% in East of England and 25.4% in England as a whole. In local authority districts this ranged from 19.2% in Suffolk Coastal to 30.6% in Ipswich.

## Carers

Caring for relatives and friends when they are in need is a challenge that most people encounter at some point in their lives. When a family member or friend becomes sick or experiences ill health, it has the potential to change lives forever and can have a profound and lasting effect on the health and wellbeing of family members who look after them. The support offered by carers is critical and is one of the most valuable assets within our communities. The health of those being cared for is important, however the health of the carers themselves can sometimes be overlooked. Survey evidence suggests approximately 70% of older carers experience high levels of physical and mental ill health (Carers Trust 2015).

Carers may be any age and come from any cultural background, and many are invisible to the health and care system. This is partly because they do not define themselves as ‘carers’ and dislike the label, believing it detracts from their identity as parents, sons, daughters, partners or friends (Royal College of General Practitioners (RCGPs) 2013).

The 2011 Census reports that there are 77,745 people of all ages providing unpaid care in Suffolk, which represents 10.7% of the total population and is marginally higher than the East of England and England (both 10.2%) average. Over 19,000 of these were over 65. This may be subject to under-reporting however, if respondents do not consider themselves a carer.

The number of hours of unpaid care provided by this age group is broken down as follows:

- 52.5% (10,464 people) provide between 1 and 19 hours of unpaid care a week.
- 12.3% (2,454 people) provide between 20-49 hours of unpaid care a week.
- 35.1% (7,000 people) provide 50 or more hours of unpaid care a week.

In November 2013 there were 12,150 people claiming Carers Allowance, which suggests that many carers are not aware of the support that is available. The number of older carers is expected to increase across all age groups with a projected total of almost 31,300 unpaid carers over 65 in Suffolk by 2030 (POPPI 2014). This represents a 57.1% increase on the 2011 Census figure of 19,918 carers. Figure 68 shows the projected number of unpaid carers in Suffolk aged 65 and over.

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Household reference persons – Table LC4201EW
With the rising elderly population, the demand for carers is likely to increase, whilst the potential number of people available to care is likely to fall.

Source: POPPI (2014)

Useful resource:
Suffolk Family Carers Health Needs Assessment
Residential care

A third (33.1%) of Suffolk residents living in care homes are aged 65 to 84 years old (1,611 people), whilst more than half (57.1%) are aged 85 or over (2,774 people) (ONS 2013a). This chart shows that people aged over 85 years make up a higher percentage of the care home population in Suffolk compared to the national average. Suffolk has high rates of permanent admission to residential care and nursing homes in people aged 65 and over when compared to many other regions in England. This is illustrated in the figure below.

Figure 69: Care home residents by age, 2011

<table>
<thead>
<tr>
<th></th>
<th>65-84 years</th>
<th>85 years and over</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suffolk</td>
<td>33.1%</td>
<td>57.1%</td>
</tr>
<tr>
<td>England</td>
<td>33.6%</td>
<td>48.7%</td>
</tr>
</tbody>
</table>

Source: ONS (2013a)

Figure 70: Permanent admissions to residential and nursing care homes for people aged 65+ (rates per 100,000 population age 65+)

Source: HSCIC (2014)
A growing body of evidence suggests that adopting a more proactive rather than a reactive approach to the treatment of care home residents can improve outcomes for both residents themselves and for the wider health and social care system e.g. developing ways to improve access to specialist medical care and support within care homes. This could prevent issues escalating as a medical emergency, and ensure that the care provided is in accordance with an individual’s wishes. Many of these admissions could be delayed or avoided through good support for family carers. Evidence suggests that those who have no carer are more likely to be admitted to care homes. Carer-related reasons for admission to nursing or residential care are common, with carer stress the reason for admission in 38% of cases and family breakdown (including loss of the carer) the reason in a further 8% of cases.

**End of life**

Improving end of life care is a priority for health and social care services both nationally and locally, particularly because we live in an ageing society. To do this it is important that we understand trends in need and plan ahead.

Around half a million people die every year in England. In Suffolk there are about 7,000 deaths a year (7,448 in 2013) (ONS 2014a). Nationally, we know that trends in the age of death are changing, with the number of deaths increasing in those aged over 85 and decreasing in those aged 65 to 84. The same is likely to be true for Suffolk given our ageing population. Deaths in the older age-groups are higher due to the increased likelihood of frailty and multi-morbidity associated with old age (PHE 2013).

The quality of end of life care can be measured by how well we meet people’s preferences for place of care and place of death. A survey on British adult attitudes to dying, undertaken as part of the 2012 British Social Attitudes Survey, found that two thirds (67%) of people said they would prefer to die at home, while only 7% said they would prefer to die in hospital (PHE 2013).

As illustrated in Figure 71, in Suffolk, deaths in hospital have fallen from about 48.2% in 2010 to 43.7% in 2014. In contrast, deaths at home and in care homes have increased from 44.3% in 2010 to 49.8% in 2014, suggesting that the quality of end of life care is improving. However, given that the majority of adults say
they would like to die at home, more needs to be done to ensure that Suffolk residents get care and can die in their preferred place. Work is therefore ongoing to ensure people plan for their future by encouraging them to have advanced care planning conversations with their care providers. Advanced care planning is a process of discussion between individuals and their care providers (e.g. nurses, doctors, care home managers or family members) during which one may choose to express their views, preferences and wishes about their future care.

Figure 71: Place of death for Suffolk residents, 2010-2014

Distribution of deaths by place of death

Deaths from all causes
Residents of Suffolk County
Death registered in calendar years 2010-14
Persons of all ages

Source: Suffolk County Council (2015)
Key issues

Inequalities:

• Over 77,000 people provide unpaid care in Suffolk, 19,000 of these were over 65. The number of older carers is expected to increase across all age groups with a projected total of almost 31,300 unpaid carers over 65 in Suffolk by 2030.

• Suffolk men can expect a healthy life expectancy of 66.1 years, and women 68.2 years.

• Survey evidence suggests approximately 70% of older carers experience high levels of physical and mental ill health.

• There are differences in the use of services between Minority Ethnic Groups in Suffolk.

• Access to vehicles and public transport in Suffolk can be an issue for some older people due to the rural nature of the county.

• Just over a fifth (21.4%) of people aged over 65 in Suffolk reported in 2011 that their day-to-day activities were limited ‘a lot’ as a result of a long term health problem or disability, rising to half (50.6%) of those aged 85 and over.

Opportunities for prevention:

• Men are more likely to die by suicide than women, even in the over 75 age group. There are opportunities to improve older people’s mental health and prevent depression and also to promote independence.

• The health of carers needs protecting, but many carers are unaware of their rights. Work needs to be done to proactively raise awareness of the rights of family carers, to carers themselves and employers.

• Continue to improve homes for older residents in Suffolk; well-designed living spaces can help prevent falls, and increase the overall quality of an individual’s life.

• There are opportunities to prevent social isolation and loneliness through volunteering, improved access to transport solutions and community engagement.

• Develop improved and integrated services to manage emerging health and care issues early to prevent future need.

• Encourage older people to remain as physically active and independent as possible.

Service implications:

• The demographic change anticipated in Suffolk between 2013 and 2037 is quite stark. Suffolk’s health and care system, as it is currently designed, is not sustainable in the face of the projected future level of need and will need to adapt. Taking a more preventive approach will allow more people to reach old age as healthily as possible and delay the onset of long-term conditions. A more proactive system will also deliver better care to the increasing number of older people living with multiple long-term conditions and support them to remain independent longer.

• The economic situation, people having to work longer until retirement and decreased pensions will all compound without further action on prevention. Failing to pursue integration of health and social care beyond the present and continuing to focus on individual conditions rather than individuals will continue to lead to fragmented, poorly coordinated care, which is inefficient,
ineffective and delivers poor patient experience (Health Service Journal 2013).

• As our population ages, we have to provide care that meets the needs and demands of an older population. The increased prevalence of people living with multiple long-term conditions and a rise in the number of people needing social care, will require a shift from traditional models of service provision to more coordinated and efficient models.

• Many people living with long-term conditions, complex needs, mental and physical disabilities, need to access a variety of services (e.g. health care, social care, housing, education, etc.) simultaneously. The services are often fragmented and therefore not easily accessible, leading to poor user experiences and inefficiency.

• Coordination of care for patients with multiple and complex needs can be poor, and those with long-term conditions tend to have a poor quality of life.

• The Dementia needs assessment (2014) identified significant gaps in information about dementia services for use by commissioners. This includes gaps in information about the true prevalence of disease, characteristics of people with dementia, incidence of dementia and the number of family carers. There is also missing information about service activity, such as the number of referrals and diagnoses made at memory assessment services.

• Since the launch of the national and local dementia strategies in 2009, local memory assessment services have been commissioned across Suffolk. Service activity data that is required to monitor and evaluate these services is not currently available.

• Nearly 50% of older people in Suffolk are currently not ‘online’, which presents implications for the continued development of digitalised services, including healthcare provision.

• Provision of dementia services in Suffolk is fragmented; which may impact on people with dementia and their family carers receiving confusing services. Although many of the services provided receive positive feedback from people with dementia and their family carers, only a small proportion of the total population have access to services and there is variation in the accessibility of services across the county. This must be addressed urgently in order to improve the quality of care and support, equity of access, and to meet the increasing demand on services.

• National guidance recommends the joint commissioning of dementia services. Evidence and case studies of joint commissioning best practice can be used to inform the initiation of joint commissioning of dementia services in Suffolk.

• Good communication and supporting the “Making Suffolk a dementia friendly county” initiative will support better diagnosis.

• With the rising elderly population, the demand for carers is likely to increase, whilst the potential number of people available to care is likely to fall.

• The number of carers claiming allowances is disproportionate to the number of people caring for others in Suffolk. We need to support people to receive the benefits they are entitled to.
Note: references are split by section, thus a reference of ‘ONS 2012’ in the Introduction and ‘ONS 2012’ in the Wider Determinants section may refer to different articles.

1. Introduction


2. Painting a picture of Suffolk

3. Wider determinants of health


(2001: Table KS15 2011: Table QS703EW)


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5. Early years (0-4)


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**7. Moving into adulthood (16-24)**


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ONS (2014a) *ONS Annual District Extract (and mid-year population extracts)*


Suffolk County Council (2014) *Public Health team data*


Suffolk County Council (2015) *Public Health team data*


**9. Retirement and older people (65+)**


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ONS (2014a) *VS3 tables: mortality by cause 2003-12*


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Suffolk County Council (2015) *Public Health team data*


Useful Resources and Links

Public Health Outcomes Framework

Find out about differences in life expectancy and healthy life expectancy between communities: www.phoutcomes.info

NHS Outcomes Framework

Sets out the outcomes and corresponding indicators used to hold NHS England to account for improvements in health outcomes: www.gov.uk/government/publications/nhs-outcomes-framework-2014-to-2015

Adult Social Care Outcomes Framework

Explore the latest data on outcomes for adults using local authority funded care and support in your area, including carers: http://ascof.hscic.gov.uk/
Glossary

**ACCORD Protocol:** An approach to collaboration for adults and children's services to ensure that parents with additional needs are given the right support to parent effectively, reducing the risk of negative consequences for their children.

**Alcohol specific conditions:** Conditions that are wholly related to alcohol (e.g. alcoholic liver disease or alcohol overdose). A list of alcohol-specific conditions with their ICD-10 codes and associated attributable fractions can be found at: [www.nwph.net/nwpho/publications/AlcoholAttributableFractions.pdf](http://www.nwph.net/nwpho/publications/AlcoholAttributableFractions.pdf)

**Alcohol attributable (related) conditions:** Alcohol-specific conditions plus conditions that are caused by alcohol in some, but not all, cases (e.g. stomach cancer and unintentional injury). For these latter conditions, different attributable fractions are used to determine the proportion related to alcohol for males and females. A list of alcohol-attributable conditions with their ICD-10 codes can be found at: [www.nwph.net/nwpho/publications/AlcoholAttributableFractions.pdf](http://www.nwph.net/nwpho/publications/AlcoholAttributableFractions.pdf)

**Attachment:** Attachment is one factor of the parent/child relationship the purpose being to make a child safe, secure and protected. Primary caregivers who are dependable, available and responsive to their babies needs are able to create a secure base for their child to explore the world and enable them to develop a sense of security and resilience throughout life – secure attachment. When a child experiences a primary caregiver who is negative or unpredictable they are more likely to have an insecure attachment with them. This may manifest in a number of ways including: reduced social interaction, distress, anxiety and/or fear, or a lack of trust towards the primary caregiver/others.

**Body Mass Index (BMI):** BMI is a measure of whether you are a healthy weight for your height. For most adults: a BMI of 25 to 29.9 means you are considered overweight, a BMI of 30 to 39.9 means you are considered obese a BMI of 40 or above means you are considered severely obese.

**Census:** Census statistics help paint a picture of the nation and how we live. They provide a detailed snapshot of the population and its characteristics and provide information that government needs to develop policies, and to plan and run public services such as health and education.

**Children in Need:** Section 17 of the Children Act 1989 defines a child as being in need in law if: he or she is unlikely to achieve or maintain or to have the opportunity to achieve or maintain a reasonable standard of health or development without provision of services from the LA; his or her health or development is likely to be significantly impaired, or further
impaired, without the provision of services from the LA; he or she has a disability.

**Child Protection Plan:** If a child is the subject of a Child Protection Plan, they have been assessed as being at identified risk of harm and the plan will be the vehicle through which the risk will be reduced.

**Clinical Commissioning Groups:** groups of GPs, including other health professionals who from April 2013, commission the majority of NHS services for their patients.

**d3mft>0:** Decayed/missing/filled teeth - Individuals with decay experience (i.e.: with one or more obviously decayed, missing (due to decay) and filled teeth).

**Deprivation:** Since the 1970s the Department has calculated local measures of deprivation in England. Deprivation covers a broad range of issues and refers to unmet needs caused by a lack of resources of all kinds, not just financial. The English Indices of Deprivation attempt to measure a broader concept of multiple deprivation, made up of several distinct dimensions, or domains, of deprivation.

**Greenest County:** Creating the Greenest County is an aspiration that involves the whole county in enhancing the natural and historic environment and responding to climate change. The partnership provides an overall aspiration for many existing projects, encourages further recognition and resourcing of them and seeks to inspire further actions in communities, businesses and schools.

**Gross Value Added (GVA):** GVA measures the contribution to the economy of each individual producer, industry or sector in the United Kingdom. GVA is used in the estimation of Gross Domestic Product (GDP).

**Health and Wellbeing Board/strategy:** set up in every upper-tier local authority to improve health and care services and the health and wellbeing of local people. The Board brings together key commissioners to assess the needs of the local population through the Joint Strategic Needs Assessment, to produce a Health and Wellbeing Strategy to inform the commissioning of health, social care and public health services and to promote greater integration across health and social care.

**Immunisation Types:** The combined DTaP/IPV/Hib is the first in a course of vaccines offered to babies to protect them against diphtheria, pertussis (whooping cough), tetanus, Haemophilus influenzae type b (an important cause of childhood meningitis and pneumonia) and polio (IPV is inactivated polio vaccine). The PCV vaccine protects against pneumococcal infections that can cause pneumonia, septicaemia or meningitis.

**LiveWell Suffolk:** LiveWell Suffolk is the county’s free healthy lifestyle service. They provide free information and practical support to help local people become healthier.

**Making Every Intervention Count (MEIC):** Making Every Intervention Count is the programme of work to focus on re-shaping Children and Young People’s Services so they remain effective into the future and provide the best possible outcomes for children and families within available resources. [www.suffolk.gov.uk/your-council/about-suffolk-county-council/children-and-young-peoples-services/making-every-intervention-count/](http://www.suffolk.gov.uk/your-council/about-suffolk-county-council/children-and-young-peoples-services/making-every-intervention-count/)

**Office for National Statistics (ONS):** Since 1 April 2008, Office for National Statistics (ONS) is the executive office of the UK Statistics Authority.
Obesity: Children are classified as overweight (including obese) if their BMI is on or above the 85th centile of the British 1990 growth reference (UK90) according to age and sex. For more information please view: [www.noo.org.uk/uploads/doc/vid_11601_A_simple_guide_to_classifying_BMI_in_children.pdf](http://www.noo.org.uk/uploads/doc/vid_11601_A_simple_guide_to_classifying_BMI_in_children.pdf)

For most adults a BMI of 25 to 29.9 means you are considered overweight, a BMI of 30 to 39.9 means you are considered obese and a BMI of 40 or above means you are considered severely obese.

Public Health Outcomes Framework: The Public Health Outcomes Framework sets out a vision for public health, desired outcomes and the indicators that will help us understand how well public health is being improved and protected. It contains indicators that intend to measure progress in achieving positive health outcomes and reducing health inequalities.

Prevention (primary, secondary and tertiary): Primary prevention aims to protect healthy people from developing a disease or experiencing an injury. Examples are vaccination programmes and decreasing levels of smoking in the population.

Secondary prevention aims to halt or slow the progress of disease in its early stages. Examples are breast screening and taking low-dose aspirin to prevent MI.

Tertiary prevention focuses on helping people manage long-term health problems, such as diabetes and heart disease, to prevent further deterioration in health and quality of life. Examples include cardiac or stroke rehabilitation programs.

Qualifications:

No Qualifications: No academic or professional qualifications

Level 1 qualifications: 1-4 O Levels/CSE/GCSEs (any grades), Entry Level, Foundation Diploma, NVQ level 1, Foundation GNVQ, Basic/Essential Skills

Level 2 qualifications: 5+ O Level (Passes)/CSEs (Grade 1)/GCSEs (Grades A*-C), School Certificate, 1 A Level/ 2-3 AS Levels/VCEs, Intermediate/Higher Diploma, Welsh Baccalaureate Intermediate Diploma, NVQ level 2, Intermediate GNVQ, City and Guilds Craft, BTEC First/General Diploma, RSA Diploma

Level 3 qualifications: 2+ A Levels/VCEs, 4+ AS Levels, Higher School Certificate, Progression/Advanced Diploma, Welsh Baccalaureate Advanced Diploma, NVQ Level 3; Advanced GNVQ, City and Guilds Advanced Craft, ONC, OND, BTEC National, RSA Advanced Diploma

Level 4+ qualifications: Degree (for example BA, BSc), Higher Degree (for example MA, PhD, PGCE), NVQ Level 4-5, HNC, HND, RSA Higher Diploma, BTEC Higher level, Foundation degree (NI), Professional qualifications (for example teaching, nursing, accountancy)

Other qualifications: Vocational/Work-related Qualifications, Foreign Qualifications (Not stated/ level unknown).

Raising the Bar: Raising the Bar (RtB) is Suffolk’s response to tackling levels of education attainment in Suffolk.

Relative and absolute poverty: Absolute poverty and relative poverty are both valid concepts. The concept of absolute poverty is that there are minimum standards below which no one anywhere in the world should ever fall. The concept of relative poverty is that, in a rich country such as the UK, there are higher minimum standards below which no one should fall, and that these standards
should rise if and as the country becomes richer (definition from The Poverty Site).

**Socioeconomic status:** Socioeconomic status is a term generally used to identify a person’s status relative to others based on characteristics such as income, qualifications, type of occupation, and where they live.

**Signs of Safety:** The Signs of Safety is an innovative strengths-based, safety-organised approach to child protection casework. The model of its approach was created in Western Australia by Andrew Turnell and Steve Edwards, who worked with over 150 front-line statutory practitioners and based it on what those practitioners know works well with difficult cases. [www.signsofsafety.net/organisations/suffolk-county-council/](http://www.signsofsafety.net/organisations/suffolk-county-council/)

**Slope Index of Inequality (Life Expectancy):** This is a key high-level health inequalities outcome and is core to the aims of the Department of Health. It highlights inequalities in life expectancy at birth. Life expectancy at birth is calculated for each national deprivation decile of lower super output areas and then the slope index of inequality (SII) is calculated based on these figures. The SII is a measure of the social gradient in life expectancy, i.e. how much life expectancy varies with deprivation. It takes account of health inequalities across the whole range of deprivation within England and summarises this in a single number. This represents the range in years of life expectancy across the social gradient from most to least deprived, based on a statistical analysis of the relationship between life expectancy and deprivation across all deprivation deciles.

**Troubled Families:** Families are characterised by there being no adult in the family working, children not being in school and family members being involved in crime and anti-social behaviour. These families almost always have other, often long-standing problems which can lead to their children repeating the cycle of disadvantage. Other problems such as domestic violence, relationship breakdown, mental and physical health problems and isolation make it incredibly hard for families to start unravelling their problems.
### Acronyms

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<th>Description</th>
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<tr>
<td>ADHD</td>
<td>Attention Deficit Hyperactivity Disorder</td>
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<tr>
<td>AONB</td>
<td>Areas of Outstanding Natural Beauty</td>
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<td>AQMA</td>
<td>Air Quality Management Areas</td>
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<td>BME</td>
<td>Black or Minority Ethnic Group</td>
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<td>BMI</td>
<td>Body Mass Index</td>
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<td>CAMHS</td>
<td>Child and Adolescent Mental Health Services</td>
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<td>CAS</td>
<td>Community Action Suffolk</td>
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<td>CCG</td>
<td>Clinical Commissioning Group</td>
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<td>COPD</td>
<td>Chronic Obstructive Pulmonary Disease</td>
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<td>CSIP</td>
<td>Care Services Improvement Partnership</td>
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<td>CVD</td>
<td>Cardiovascular Disease</td>
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<td>DCLG</td>
<td>Department for Communities and Local Government</td>
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<td>DCSF</td>
<td>Department for Children, Schools and Families</td>
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<td>DfE</td>
<td>Department for Education</td>
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<td>DH</td>
<td>Department of Health</td>
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<tr>
<td>Dtap</td>
<td>Diphtheria, tetanus, acellular pertussis</td>
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<td>DWP</td>
<td>Department for Work and Pensions</td>
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<td>EHC</td>
<td>Education, Health and Care (plans)</td>
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<td>EYFS</td>
<td>Early Years Foundation Stage</td>
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<td>FAS</td>
<td>Foetal Alcohol Syndrome</td>
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<td>FNP</td>
<td>Family Nurse Partnership</td>
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<td>GCSE</td>
<td>General Certificate of Secondary Education</td>
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<td>GP</td>
<td>General Practitioner</td>
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<td>GVA</td>
<td>Gross Value Added</td>
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<td>HIB</td>
<td>Haemophilus Influenzae type B</td>
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<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>HPV</td>
<td>Human Papilloma Virus</td>
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<tr>
<td>HSCIC</td>
<td>Health and Social Care Information Centre</td>
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<tr>
<td>IDAOPi</td>
<td>Income Deprivation Affecting Older People Index</td>
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<tr>
<td>IDeA</td>
<td>Improvement and Development Agency</td>
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<td>IHE</td>
<td>Institute of Health Equity</td>
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<td>IPV</td>
<td>Inactivated Poliovirus Vaccine</td>
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<td>JSNA</td>
<td>Joint Strategic Needs Assessment</td>
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<td>LA</td>
<td>Local Authority</td>
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<td>LEP</td>
<td>Local Enterprise Partnership</td>
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<td>LGA</td>
<td>Local Government Association</td>
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<td>LIHC</td>
<td>Low Income High Costs Indicator</td>
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<td>MMR</td>
<td>Measles Mumps and Rubella</td>
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<td>MOD</td>
<td>Ministry of Defence</td>
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<td>NCMP</td>
<td>National Childhood Measurement Programme</td>
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<td>NHFD</td>
<td>Data from the National Hip fracture Database</td>
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<td>NCVO</td>
<td>National Council for Voluntary Organisations</td>
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<td>NEET</td>
<td>Not in Employment, Education or Training</td>
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<td>NHS</td>
<td>National Health Service</td>
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<td>NICE</td>
<td>National Institute for Health and Care Excellence</td>
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NSPCC
National Society for the Prevention of Cruelty to Children

ONS
Office for National Statistics

PANSI
Projecting Adult Needs and Service Information

POPPI
Projecting Older People Population Information

PCC
Police and Crime Commissioner

PCT
Primary Care Trust

PCV
Pneumococcal Conjugate Vaccine

PHE
Public Health England

PHOF
Public Health Outcomes Framework

PIMHS
Perinatal Infant Mental Health Service

PTSD
Post Traumatic Stress Disorder

RCGP
Royal College of General Practitioners

ROI
Return on Investment

SCC
Suffolk County Council

SEN
Special Educational Needs

SEND
Special Educational Needs and Disability

SHA
Strategic Health Authority

SLCN
Speech, Language and Communication Needs

SNT
Safer Neighbourhood Team

SRE
Sex and Relationship Education

STI
Sexually Transmitted Infection

VCS
Voluntary and Community Sector

WHO
World Health Organisation

YJS
Youth Justice System
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